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Competence to consent

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Rice University, 1989

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RICE UNIVERSITY

COMPETENCE TO CONSENT

by

BECKY COX WHITE

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REQUIREMENTS FOR THE DEGREE

DOCTOR OF PHILOSOPHY

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COMPETENCE TO CONSENT

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Abstract

Informed consent is valid only if the person giving it is competent. Although allegedly informed consents are routinely tendered, there are nonetheless serious problems with the concept of competence as it stands. First, conceptual work upon competence is incomplete: the concept is unanalyzed and no logic of competence has been identified. It is thus virtually impossible to reliably discern who is (not) competent.

Traditional work on competence has explicature three dichotomies from which the necessary conditions for the possibility of competence will be identified, viz., that competence 1) is either a global or a specific notion; 2) is present in varying degrees or in virtue of a threshold; 3) and may or not include appeals to consequences. Past efforts have failed to notice a fourth dichotomy: competence as an affective or cognitive notion. Failure to designate the appropriate arms of these dichotomies is responsible for there being, at present, no reliable test for competence. The inadequacies of a highly regarded particular test for competence, the mental status examination, are examined in light of this failure.
Competence is located within the rule-governed practice of informed consent. That practice and hence, competence, is justified through a Kantian analysis of respect for persons. This analysis reveals that the logic of competence requires assessment in terms of 1) specific rather than global concerns; 2) degrees of ability rather than a threshold; 3) both cognitive and affective abilities; and 4) no appeal to consequences.

Based upon the analyses of consent as an example of decision making within the practice of informed consent and of respect for persons, the capacities which jointly comprise competence are identified. These are the capacities to receive, recognize, and retrieve information; to reason about, relate to oneself, and rank options; to choose among alternatives; and, under certain circumstances, to defend one's choice.

Identification of the logic of competence and explication of and justification for the capacities that comprise competence to consent provide a conceptual foundation for the crucial concept of competence that the informed consent process currently lacks. It should facilitate construction of a test for competence.
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COMPETENCE TO CONSENT

INTRODUCTION

Questions of competence most often arise within the health care setting when persons must make decisions regarding therapy. There are in health care moments of choice when patients must elect to 1) embrace a recommended therapy; 2) eschew the recommended regimen, but pursue an alternative therapeutic avenue; or 3) refuse therapeutic intervention entirely. Such moments are gathered under the rubric of "informed consent", but they also include informed refusals. (To save words I will usually speak, throughout this work, only of consent. I mean this term to cover refusals as well.)

Questions of competence emerge in situations requiring informed consent or refusal because one of the requirements for a legally and morally (as will be discussed below) valid consent or refusal is that the person giving it be competent. Since informed consent is required for health care interventions, it is important to establish a thorough understanding of competence so that health care professionals may better assess who is (not) competent and thus capable of consenting to or refusing health care.

There is widespread agreement that competence ought to be assessed in terms of capacities; i.e., one is competent to do a task, T, if one possesses the particular capacities
necessary for doing T. For example, it is suggested that a person is competent to consent if she possesses, variously, the capacities to receive information, remember information, weigh information, recognize information as pertinent to the decision at hand, adopt a coherent set of values and make decisions in accordance with this set of values, choose, and justify a choice. Confusion arises because such capacities 1) may not (all) be present in some persons who seem to be generally capable of managing their affairs; 2) may be present in some persons who do not seem generally capable of managing their affairs; and 3) may be present in varying degrees in different persons or within one person at different times.

To date consensus about what capacities—and in what number or degree—constitute a general competence to consent has not been forthcoming. Clearly some concerted effort must be made regarding a conceptual analysis of competence, and it is that project that this thesis undertakes. Chapter One will explicate and critique the work, both conceptual and practical, done on competence to date. Chapter Two will put forth a concept of personhood and locate an appropriate theory of competence within that concept and within the practice of informed consent. Chapter Three will explicate the necessary conditions for the possibility of competence. It will do so on the basis of the analyses of the concepts of competence and personhood.
I will not, within the scope of this work, attempt a justification of informed consent or of its practice (in a technical sense to be discussed in Chapter Two). Nor will I propose or describe an actual test for competence, or discuss how competence might be applied to particular patient populations (e.g., children). These are interesting and important projects, but ones whose analysis would be as major a project as the ones I will address. As such they must necessarily must delayed.

I turn, now, to competence to consent.
CHAPTER ONE

I. THE CONCEPT OF COMPETENCE

A. The Need to Distinguish the Concept from the Tests

The problem that plagues all extant work on competence is that there has been, uniformly, a failure to distinguish the capacities that are constitutive of competence from the tests for the presence/absence of those capacities. If a person, P, is competent to do T if and only if P possesses the capacities requisite to satisfactorily doing T then, at the very least, P's competence can be determined only if we know what capacities are necessary to the satisfactory completion of T.1

The question naturally arises as to why this distinction between capacities and tests is important. The simplest answer is that the former serve a theoretical function, that of constituting competence; the latter serve a practical function, that of determining when persons are or are not competent. The conceptual analysis of competence is framed in terms of capacities; they are the meaning of competence, of what we are talking about when we ascribe competence to someone. Certain conglomerations of capacities in persons serve to make them competent. The ability to identify the presence or absence of those capacities is what is meant by a test for competence.
In philosophical terms, a conceptual analysis of competence is an ontological project, that of determining the constituent components of competence. Testing for competence is an epistemological issue, that of determining how we know that someone is competent. Assessing these two quite different matters can be problematic in quite different ways. In the former we need to elucidate the necessary conditions for the possibility of competence. Although virtually all writers who have concerned themselves with competence have posited some capacities that are included within that concept, there has been no uniform identification of the requisite capacities.\(^2\) This might mean that, from an ontological perspective, the nature of competence is inaccessible. Or, more optimistically, it might merely mean that the attempts to establish its nature were in some way misdirected, and that these mistakes can be avoided in future efforts. On the other hand, we might be able to determine the nature of competence, but still be unable to test for it. That is, the answer to the epistemological question might elude us. Certainly there has been no widely successful test for competence that has surfaced to date.\(^3\)

These possibilities are problematic for health care in that one of its central practices, that of informed consent, depends upon being able to answer both questions. Informed consent requires that persons giving it be competent. If it is impossible to determine what it means to be competent or
to determine whether or not someone is, this requirement is meaningless.

In the case of competence to consent there has been no identification of requisite capacities. Although valid consent or refusal requires a competent patient, and although determination of a patient's competence to consent or refuse requires an enumeration of what capacities constitute such competence, no list of necessary or sufficient capacities exists.4

This failure to specify the capacities that are constitutive of competence has not, oddly enough, impeded competence testing. There are currently a number of suggested tests for competence, and I will consider these in detail later. My points here are to note that tests for competence must be distinguished from capacities that constitute competence, and that to date these aspects of competence have not been separated. As a matter of convenience, I shall take the work of Roth, Meisel, and Lidz [143]5 to be representative and use it as an example of the lack of precision that attends the work in this area.

The work of Roth et al exemplifies the conceptual confusion that surrounds the field in that the authors, without ever specifying what they mean by competence, suggest five tests for its presence. Their "tests" include "1) evidencing a choice, 2) 'reasonable' outcome of choice, 3) choice based on 'rational' reasons, 4) ability to understand,
and 5) actual understanding" ([143], p. 280). These "tests", however, are not so much tests as examples of capacities that might serve, in whole or in part, to constitute competence. Their presence or absence seem to be the sort of thing one would want to identify in an assessment of competence. But of course the presence or absence of such capacities is not the same thing as a test for that presence/absence. A bit more discussion should clarify this claim and my reasons for making it.

From "evidencing a choice" to "actual understanding" it is clear that something other than tests are under consideration. A test for a capacity is not the same thing as the presence of a capacity, but is a specified method for assessing that presence. Take, for example, the definition of Roth et al for the "test" termed "evidencing a choice":

The competent patient is one who evidences a preference for or against treatment. This test focuses... on the presence or absence of a decision. Only the patient who does not evidence a preference either verbally or through his or her behavior is considered incompetent ([143], p. 280).

Now surely the mere "evidencing a choice", without further specification, tests for nothing over and above the bare physical ability to nod or shake one's head or to utter "yes" or "no". Yet these capacities are not evidence (or at least not reliable evidence) that a choice has been made at all. The concept of choice, as opposed to merely pointing
toward one or another option, will be expanded in the follow-
ing chapter. Here I will only say that genuine choice in-
volves rational deliberation, i.e., the acquisition and
reasoned consideration of the facts of the matter. As such
choice necessarily incorporated identifying different
alternatives, acquiring information about them, weighing
risks and benefits of each option, assessing probabilities of
success of various possible acts, and considering how
alternatives will affect one's life on the whole. This being
so, testing for choice requires, at the very least, evidence
that one recognizes a plurality of alternatives and
consciously and deliberately picks among them.

Without these sorts of conceptual qualifications, "evid-
dencing a choice" cannot be understood; hence, it ought not
be presumed, in and of itself, to test for competence. As
described by Roth et al, "testing" for competence is analo-
gous to saying that one has the capacity for competence if
one has the capacity for competence. Similarly, a student
might be said to know history if she knows history. But the
test for her knowledge of history is a list of questions to
which she either does or does not provide correct answers and
on the basis of which it is determined to what extent she
does, in fact, know history. Evidencing a choice may, per-
haps, be a capacity that wholly or partially constitutes
competence. But a test for, rather than a suggested
description of, capacities inherent in competence remains to
be provided.

Ultimately we see that the list of tests is actually a recitation of capacities. It becomes apparent that there are, in fact, no tests at all.\(^8\) This is not surprising, given that a conceptual analysis of competence has yet to be completed. Any test necessarily awaits that project.

B. Basic Issues Regarding the Concept of Competence

Virginia Abernethy has argued that competence is a global notion; that is, that "the presumption of competence should be overcome only when significant dysfunction in an array of cognitive and interpersonal domains can be demonstrated" ([1], p. 57, emphasis added).\(^9\) Nonetheless, most scholars have argued that competence is not global, but rather that the requisite capacities should vary according to context.\(^10\) If competence is context-dependent, competence would be determined for particular tasks. Then one is competent for this task if one possesses those capacities requisite to its performance. With context-dependent competence it would be necessary to determine how (if) capacities for competence vary between situations generally, between situations in health care and other spheres of activity, and between different health care situations.

It will be helpful to schematize the sundry possibilities for competence, as doing so more clearly exhibits the often subtle differences between them. The schemata for
global competence (GC) and specific competence (SC) are

**GC:** A person (P) is competent (C) for any task (T) because Standard (S) is met (or met to Degree D).

**SC:** P is C for this T because S is met for this T (or met to D).

Regardless of whether competence is determined to be a global or specific concept, there are the further issues of 1) whether competence is a notion of threshold or of degree, and 2) whether competence is a notion that will vary according to what is at stake.

I turn first to the question of whether competence is a notion of threshold rather than of degree. Here one would need to determine if competence is a watershed concept, such that persons on one side are completely competent to consent, while those on the other are completely incompetent. On a threshold conception of competence, any person possessing the necessary capacities is deemed fully competent to make the relevant decisions, while anyone lacking the capacities would have decisions fully made for her by someone else.¹¹

Conversely it might be determined that competence turns upon the extent to which persons possess particular capacities, i.e., that competence is a question of degree. With a degree conception of competence, persons could be more or less in possession of the necessary capacities, hence more or less competent.¹² Then the more competent a person is, the greater would be the obligation on the part of others to
honor her decisions. The less competent the person is, the less others are bound to respect her decisions.\textsuperscript{13} Consider the schemata for threshold competence (TC) and degree competence (DC)\textsuperscript{14}:

\begin{align*}
\text{TC:} & \quad P \text{ is } C \text{ for any } T \text{ because } S \text{ has been met.} \\
\text{DC:} & \quad P \text{ is } C \text{ to degree } D \text{ for any } T \text{ because } S \text{ has been met to } D. \textsuperscript{15}
\end{align*}

As an example of the opposition of the threshold and degree conceptions, consider the "ability to understand" in a situation requiring an informed consent/refusal, say, a woman with End Stage Renal Disease (ESRD) for whom hemodialysis has been recommended.

On a threshold notion of competence, a person is probably competent\textsuperscript{16} to decide about therapy if she can recognize that she is ill, that a particular treatment has been recommended, that she is in a health care setting wherein such treatment can be provided, and that if she consents to that treatment her condition will probably improve. If she is aware of these facts, we would consider her to understand the situation and, therefore, competent to make decisions about treatment based upon that understanding.

But under a degree notion of competence, we might question her competence to make such a decision. Here we might require that she not only possess such a capacity for understanding, but also that the capacity is present to a greater
degree. We might want the woman to be able to understand not only that she is ill, but also what her prognosis is with and without treatment; not merely that hemodialysis has been recommended, but what alternative therapies exist and what her prognosis would be with each; not only that she is in a hospital, but that she is in a hospital that has demonstrated an ability for treating persons like herself; and not only that with hemodialysis she will probably improve, but what risks exist, the chances that each will occur, and how that relates to her chances for improvement.

In other words, on a degree theory of competence a person may be required not merely to understand but to understand, in some sense, thoroughly. And it is important to realize that those who understand more thoroughly would be seen as having greater decision making authority than those who understand to a lesser degree. The former would have stronger claims upon others to respect their choices than would the latter.

The third possibility is that competence determinations could be consequence-dependent, in the sense of changing as the seriousness of situations changes. Under this concept a person may be competent to consent to or refuse a therapy of minor import but not (necessarily) one of a major nature. Thus it might be that situations ought to be classified such that some are sufficiently important that a high level of
competence is demanded before letting a person make her own decisions, while other situations are of such minimal import that virtually no one should be precluded from deciding how they should be resolved. That is, competence might be a sliding scale notion. Under this system our woman with ESRD might not be competent to consent to or refuse hemodialysis, given the seriousness both of her condition and of the recommended intervention. She might, however, be competent to refuse a recommendation of a daily multivitamin, or that she ought to lose ten pounds.

Again the difference is clarified by recourse to the schema. Competence analyzed independently of an appeal to consequences (CIC)\textsuperscript{19} vs. competence that depends upon the changing significance of the consequences (CDC) are schematized as\textsuperscript{20}:

\begin{align*}
\text{CIC: } P \text{ is } C \text{ for any } T \text{ because nonvarying } S \text{ is met for } T. \\
\text{CDC: } P \text{ is } C \text{ for this } T \text{ because varying } S \text{ is met for this } T.
\end{align*}

Drane ([42], [43]), for example, claims that capacity to consent should vary according to the medical significance the situation holds for the person involved.\textsuperscript{21} Thus he argues that less competence is necessary to refuse a major harm or accept a major benefit than to refuse a major benefit or accept a major harm. Others ([16], [27], [28], [51]) argue that what is needed is a threshold of competence, such that
once the qualitative capacities for competence are
determined, anyone possessing them is competent to make
whatever decisions arise. As noted above, Abernethy [1]
recommends that competence refer to global capacity, while
most argue that specificity is preferable^{22}. The schemata of
the variations on the theme of competence nicely display
these distinctions:

GC: A person (P) is competent for any task (T) because
Standard (S) is met (or met to Degree D)
SC: P is C for this T because S is met for this T (or
met to D)
TC: P is C for any T because S has been met
DC: P is C to D for any T because S has been met to D
CIC: P is C for any T because nonvarying S is met for T
CDC: P is C for this T because varying S is met for this
T.

From the above discussion it should be clear that a
conceptual analysis of competence will need to consider all
three dichotomies. Important as each is in contributing to
an understanding of the concept, none is singularly
important. Rather, each is in itself conceptually incomplete
in virtue of its failure to attend to more than one aspect of
the issue. The particularity of emphasis renders all these
suggestions inadequate. For competence is not merely a
matter of global vs. specific, threshold vs. degree, or of
significance of consequences, medical or other. Instead
competence incorporates all these notions. As Table 1 shows,
there are various combinations of these aspects. Discussions
to date have focussed only upon single components of the
concept; hence their inadequacy.

Table 1. Some Possible Combinations of Aspects of Competence

<table>
<thead>
<tr>
<th>Global</th>
<th>Threshold</th>
<th>Not dependent upon consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global</td>
<td>Degree</td>
<td>Not dependent upon consequences</td>
</tr>
<tr>
<td>Specific</td>
<td>Threshold</td>
<td>Dependent upon consequences</td>
</tr>
<tr>
<td>Specific</td>
<td>Threshold</td>
<td>Not dependent upon consequences</td>
</tr>
<tr>
<td>Specific</td>
<td>Degree</td>
<td>Dependent upon consequences</td>
</tr>
<tr>
<td>Specific</td>
<td>Degree</td>
<td>Not dependent upon consequences</td>
</tr>
</tbody>
</table>

A correlation of Table 1 with the previous schematization shows what these possible combinations will mean:

P is C for all T because S is met for all T.
P is C for all T to D because S is met to D for all T.
P is C for this T because varying S is met for this T.
P is C for this T because nonvarying S is met for this T.
P is C for this T to D because varying S is met to D for this T.
P is C for this T to D because nonvarying S is met to D met for this T.

There is, moreover, the problem of what sorts of capacities ought to be included within the domain of competence. Certainly competence to consent requires mental (as opposed to merely physical) capacities. But what sorts of mental capacities are relevant? And how are they to be assessed?

Direct evaluation of mental function is, given current limitation of knowledge and technology, impossible. Thus mental function must be evaluated indirectly, through behavior. Behavior is most usefully assessed in terms of three functionally distinct but interactive mental systems.
The **intellect** is the information handling system; **emotionality** refers to feelings and motivations; while **control** determines the expression of behavior ([91], p. 12). Although these components are closely intertwined, and although there has been much discussion about how disorders of emotionality and control can interfere with the function of the intellect, there is nonetheless a consensus that competence to consent lies exclusively within the domain of the intellect, as will be shown in the next section.

This exaggerated emphasis upon the purely intellectual component of the mind seems unjustified. There are many conditions in which emotion or control (hereafter jointly referred to as affective components) should play a crucial role, not only in the assessment of competence but in its conceptual analysis as well. Such dysfunctions as severe depression or irrepressible rage ought to make this clear, as should such strong emotions as fear, hatred, or love.

More crucially there is the penetrating question of whether only the cognitive or intellectual components should count. Most persons include affective aspects in making decisions. This is to say that they attend not only to reason but also to feelings. Data garnered for decision making usually include not merely the facts, but how one feels about those facts; not merely the variety of possible outcomes, but which of those one would most prefer. One's preferences can count as reasons for choices, and these
preferences need not derive from reason alone.

Consider again the hypothetical patient with ESRD. She may include in her decision regarding hemodialysis not only cognitive aspects (e.g., risk/benefit ratios, variable prognoses with variable treatment regimes, etc.), but also numerous affective factors (e.g., that both she and her loved ones would be saddened to watch her prolonged suffering; that the rigidly circumscribed lifestyle demanded of patients on dialysis is incompatible with her need for independence.

Moreover, there are times when rational decision making is a fiction. At such times persons make decisions based upon "gut-level feelings". They would, in those instances, be hard-pressed to defend their rights to be decision makers in a world that demands an unadulterated rational basis for those rights.

The critic will claim that such purely affective decisions are somehow infrequent or odd. Nonetheless, it seems safe to say that many persons occasionally find themselves in the position of eschewing rationality as the basis for decision making. It is an interesting question as to whether such persons rationally choose to eschew rationality. That is, do they say to themselves something like the following: I know I am not rationally evaluating all the data as I should and would usually do; however, I feel so strongly about the options in this case that I wish to forego rational deliberation in favor of acting in accordance
with my feelings; Given their strength, that is the only rational thing to do.

Or is the process rather more like this: When presented with a situation that immediately invokes a strong affective response, I quickly act in light of that response and without reasoning about how I will act at all; Later when I reflect upon my actions, I might come to believe either that my reason would have supported the decision or would have countermanded it; but reason's counsel in no way motivated my original act.

This question will be addressed more fully in the next chapter, when affective and cognitive competence are examined. For now I simply note that situations of affectively directed decision making occur frequently in the medical setting where circumstances and decisions are laden with affective content. This, however, does not necessarily preclude capable decision making, as Drane remarks:

...ability to understand is not the same as being capable of conceptual or verbal understanding.... Real understanding ... may be more a matter of emotions. Following an explanation, the patient may grasp what is best for her with strong feelings and convictions, and yet be hard pressed to articulate or conceptualize her understanding or conviction ([43], p. 20).

With these thoughts in mind we can include among the schema both cognitive competence (CC) and affective competence (AC), i.e.,
CC: A person (P) is competent (C) for any task (T) if a standard (S), which includes cognitive capacities, is met (or met to degree D).

AC: A person (P) is competent (C) for any task (T) if a standard (S), which includes affective capacities, is met (or met to degree D).

Nonetheless, testing for competence is almost exclusively devoted to testing for intellectual or cognitive capacity. This emphasis is confirmed in an examination of the tools used for competence determinations. The most commonly used "full" (as opposed to abbreviated) tool is the mental status examination (MSE). The MSE may be defined as a systematic examination of a person's behavior, including "observations of the patient's appearance, attitudes, behavior, affective functioning, thought processes, consciousness, perceptual apparatus, orientation, memory, judgment, intelligence, and impulse control" ([98], p. 58)[29]. While the full MSE does evaluate all three areas cited above, the heaviest concentration is upon evaluation of the intellect.

The purpose of the MSE is threefold: first, to identify the presence of cognitive dysfunction; second, to differentiate functional from organic[30] disease and determine the most efficacious treatment; and third, to monitor the course of the patient as her condition improves or deteriorates with treatment. The presence of cognitive dysfunction is recognized when the patient is consistently unable to perform one or more of the cognitive tasks included in the MSE.
The problems with the MSE are discussed in detail in Section II.C. below. The point here is that, given its emphasis on evaluation of the intellect or cognition, its use as a tool for competence determinations arbitrarily excludes the affective system that participates in a person's mental and behavioral life. 31 Given both the intimate relation between cognitive and affective aspects of the mind and the role of affect in decision making, this exclusion is arbitrary. That is, insofar as 1) emotionality and control interact with intellect; 2) persons include affective date per se in the decision making calculus; and/or 3) at least occasionally people make decisions on the basis of affect alone, an adequate conceptual analysis of competence must include an analysis of affect. Such an analysis may reveal that affect is irrelevant to competence. If so, its exclusion from decision making competence will have been justified, and tools for competence determinations need not address affect. To date, however, the evidence supports a claim that affect play a part in decision making. Hence its exclusion by the MSE is unwarranted.

Were all the mental systems to be included in competence concerns, the possibilities for the constitutive components of competence would be even further expanded, as is shown in Table 2.
Table 2. More Possible Combinations of Aspects of Competence

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So we see if all possible conceptual components of competence are acknowledged, its analysis will include many more foci than are currently considered to be the case. It will at least include greater attention to the affective aspects of the mental realm.

The purpose of informed consent is to allow persons to make important decisions in ways that are most consistent with their capacities for self-determination. When those capacities are reduced, the purpose of informed consent is not realized. Moreover, this is as problematic when patients consent to treatment as when they refuse it.33

What constitutes competence to consent will depend upon which capacities constitute competence. Returning once more to our hypothetical ESRD patient helps demonstrate this point. We assume that she was fully independent prior to her illness and that her independence is limited now only because of that illness. Then if we equate competence with the
capacity to understand 1) On GC she will be competent to consent since she understands more than she fails to understand, such that she has been self-determining in her life prior to her illness and continues to be so in the other spheres of her life; 2) On SC she will be competent to consent in this situation only if she understands the nature of this situation; 3) On TC she will be competent to consent to this and all other interventions if her capacity to understand is present at the threshold level (however that is defined); 4) On DC she is competent to consent to the extent (i.e., more or less) that she understands her situation; 5) On CIC she is competent to consent to any decision if her capacity to understand meets the relevant standard; and 6) On CDC she must be more competent to understand if the consequences of her decision are major than if the consequences of her decision are minor.

Put another way, the conceptual analysis of competence must determine the capacities that jointly constitute the necessary conditions for the possibility of competence to consent (the standard) and the extent (i.e., degree, whether stable or variable) to which those standards must be present. Ultimately, having articulated the requisite capacities, standard, and degree, designations of competence require a test for its presence or absence. I reiterate: none of these currently exists.
Given all the confusion surrounding the conception of and the testing for competence, it may be useful to turn to the analysis of a technique currently much used to allegedly detect the presence (or, by default, absence) of cognitive incapacitation—the mental status examination. Since competence often becomes an issue when patients must make choices, and since choice involves cognitive capacities, we shall turn to the MSE, which is thought to effectively evaluate cognitive capacities.

II. THE MENTAL STATUS EXAMINATION

A. Purpose of the Mental Status Examination

Regardless of the fact that competence is a poorly understood concept, it is nonetheless common to "test" for its presence (or absence) through use of the mental status examination (MSE). According to MacKinnon and Yudofsky [98], the MSE was originally developed as a tool for describing and understanding psychoses, or as a way of relating unusual or bizarre behavior to aberrant mental processes. According to Keller and Manschreck [78], the MSE was established to locate areas of dysfunction that required more thorough diagnostic investigation.

Currently the MSE functions as a device by which all (as opposed to only pathological) aspects of mental functioning are purportedly assessed. But on no account was the MSE
purported to have been established for the purpose of assessing competence in spite of the fact that it has been pressed into service for doing so. We turn now to an examination of the examination.

B. Components of the Mental Status Examination

The generic MSE takes many forms, as many people have constructed many varieties of mental status examinations. Such variability occurs with regard to 1) descriptions of the characteristics to be evaluated and 2) tests included for the purpose of making those evaluations. Nonetheless, all MSE's evaluate certain mental traits: 1) level of consciousness, 2) attention and perception, 3) language usage, 4) memory, and 5) cognition. For purposes of this work, I follow the format of Richard L. Strub and F. William Black in The Mental Status Examination in Neurology, as their discussion of the basic components is, in my opinion, the clearest. Unless otherwise noted, all references in this section will be to this work.

The initial portion of the MSE involves certain housekeeping tasks: the patient relates the usual biographical data, while the health care professional (HCP) assesses the patient's neatness, cleanliness, appropriateness of dress and demeanor to the occasion, mood, affect, attitude regarding the encounter, etc. The patient then recounts the history of her illness, with the HCP requesting clarification or
amplification as necessary.

The next section of the MSE is an assessment of the level of consciousness. Consciousness is a person's awareness of and capacity to relate to self and surroundings (p. 29). Consciousness exists along a continuum, and there are generally considered to be "five principal levels": 1) alertness, 2) lethargy, 3) obtundation, 4) stupor, and 5) coma (p.29).

One who is alert is awake and cognizant of stimuli, both external and internal, that are presented to her. The lethargic person is less than fully alert, often dozes when not actively stimulated, and even when awake has difficulty concentrating on the task at hand. Obtundation is present when a person responds not to normal but only to persistent stimuli and, once aroused, is confused. The stuporous person requires not only persistent but also stronger or louder stimuli before she will respond, and the response is reduced (e.g., only a moan or an attempt to withdraw from the stimulus). The comatose person is totally unresponsive to all stimuli (pp. 29-30).

Testing the level of consciousness is fairly simple: the HCP begins by speaking to the patient. If she responds appropriately (for example, if the HCP asks the patient's name and she replies, "Sally Smith, and you must be Ms. Jones, the therapist."), she is alert. If, on the other hand, the HCP must continually stimulate (verbally or tac-
tilely) the patient who then either concentrates poorly and responds slowly, or responds confusedly, incoherently, or not at all, then the patient is respectively lethargic, obtunded, stuporous, or comatose. Patients who are other than alert have an altered level of consciousness.

Once the level of consciousness has been determined\textsuperscript{37}, an assessment of the patient's attention is made. Attention is the capacity of a person to concentrate upon a particular stimulus—here the questions on the MSE—in spite of other stimuli the environment may contain (p. 41).

Attention is commonly evaluated using the "Digit Repetition" and the "Serial Sevens Subtraction" tests. In "Digit Repetition" the patient repeats a series of randomly grouped numbers (e.g., 8-1-5-9-3-6-2). Persons with normal intelligence and attention can repeat five to seven numbers without error (p. 43). In "Serial Sevens Subtraction" patients are asked to count backwards from 100 in decrements of seven. Persons who cannot concentrate upon the instructions or the task are thought to have a disorder of attention.\textsuperscript{38}

The next area to be evaluated is language. Not only is it important to determine language integrity as a particular area; it is also crucial to establish such integrity as a foundation for the aforementioned analysis of attentiveness and the forthcoming assessment of memory and cognition. Initially the HCP takes note of the patient's spontaneous conversation to apprise fluency, articulation, and presence of
any abnormal speech patterns. In a more structured fashion, the HCP will assay fluency, comprehension, and the capability to repeat words. 39

Fluency is deliberately tested by instructing patients to name as many members as possible from a designated category in a timed period. The unimpaired person can name, for example, eighteen to twenty-two animals in one minute (p. 53) and thirty-six to sixty words beginning with the letters F, A, and S in a three minute period (p. 54). Anything less signifies impairment of verbal fluency.

Comprehension is appraised via the patient's responses to a series of commands and questions. The patient may be instructed to point to a window or asked if the sun is shining. If the patient points or answers correctly, comprehension is intact. 40 Hearing, speech production and the relationship between these two faculties are evaluated by asking the patient to repeat words and sentences pronounced for her by the HCP. Since the normal person can correctly repeat up to nineteen syllables, failure to mimic the presenter prior to the completion of that number indicates impairment (p. 55).

The fourth concern of the MSE is that of memory. Memory is best described as an information storage and retrieval system, the capacity to encode within the mind the experiences of the moment for recall at a later time. Memory is generally divided into three spheres: short-term (immediate
recall), recent (immediate going back through the last few weeks or months) and remote (occurrences more distant than a few months ago). Strub and Black, however, divide memory into short-term memory, orientation, remote memory, and new learning ability. For consistency I will continue with the Strub and Black analysis.

Short-term memory is often tested using the "Digit Repetition" test, described above. Orientation is tested by having the patient recite personal biographical data (name, age, birth date, etc.) and identify his present location (address, city, state, etc.) and the time (day, date, year, season). More than two errors is considered diagnostic of memory impairment (pp. 81-82).

Remote memory is apprised by having the patient relate more distant biographical date (place of birth, educational information, and so forth), as well as responding to questions of social history (e.g., name four presidents in office during the patient's lifetime).

New learning ability is assessed in a variety of ways. The patient may be presented with pairs of words, following which the HCP will reiterate one of the words and the patient is expected to state the word with which it was paired. Or the HCP might tell a story, the patient then having to recall the ideas included therein. In a story containing twenty-six distinct bits of information, failure to recall at least eight of them is indicative of impairment. Additionally,
patients may be asked to recall where objects have been hidden, or to draw simple patterns from memory. Failure at such tasks signifies dysfunction.

The foregoing capacities are all basic capacities. This is to say that they are, by and large, functionally self-contained. Thus, impairment in one area does not necessarily effect the capacities in another. One might suffer impairment in the capacity to maintain attention without degradation of language integrity. Or language skills might be diminished without any depreciation in memory. Although performance in all basic areas is enhanced by healthy performance in the others, each can operate independently. This is not the case for the last area addressed by the MSE: cognition.42

Cognition, or the ability to engage in advanced intellectual activity, is actually a battery of capabilities, often referred to as higher cognitive functions. Together these enable the advanced intellectual activity possible for most humans. Included in this group are storage of an impressive fund of acquired information which can be manipulated to permit successful responses to new situations, capacity to calculate, social awareness, insight, judgment, and abstract thinking. Each is tested separately.

The possession of a general fund of information is commonly thought of as "intelligence", and its presence is
tested using standard intelligence tests such as the Stanford-Binet and the Wechsler Adult Intelligence Scale (WAIS). Such tests are, however, complex and require a large block of time for their administration. More helpful in clinical situations are abbreviated tests, e.g., a list of ten questions ranging from "easy" (How many weeks are in a year?) to "difficult" (What is the Acropolis?). The average person should be able to answer at least six of the questions.43

The ability to calculate constitutes an easy way to test the ability to manipulate old knowledge (i.e., recognition of symbols, utilization of arithmetic skills, etc.). Patients are given increasingly difficult problems in addition, subtraction, multiplication, and division. Any patient with an adequate educational background should obtain a perfect score.

Social awareness and judgment are assessed to determine whether or not the patient possesses interaction skills. Testing here is anecdotal and highly subjective. Situations are recounted to patients. In the most common scenario, the patient is asked how he would behave upon finding a stamped, addressed envelope lying in the street. The patient who gives the expected answer ("I would mail it.") passes, but it is unclear what kind of answer counts as a failure. More will be said about this problem in the following section.

Even more problematic is appraising insight, i.e., the patient's realistic awareness of her life circumstances.
There is currently no available test for the presence/absence of insight, other than the interviewer's "gut level" feeling that the patient either does or does not have it.

Finally, the MSE attempts to estimate the capacity for abstract thinking, that is, the ability to think beyond the particular to the general, to extract the essence of a situation, to recognize when that essence applies to new situations. Standard examinations for abstract thinking include Proverb Interpretation, Similarities, and Conceptual Series Completion.

In Proverbs Interpretation the patient is asked to explain proverbs of varying degrees of difficulty. So, if the patient is asked to explain the meaning of "Don't cry over spilled milk", she might respond variously with 1) "The milk's all over the floor." (very concrete response); 2) "It's gone; don't worry about it." (semi-abstract response); or 3) "Don't be concerned about events that are beyond control." (abstract response). The more ably the patient can progress beyond particular facts to underlying principles or main ideas, the more advanced the thought processes."

This concludes the description of the components of the standard MSE. As noted previously there are many variations, depending upon the purposes for which the exam is administered, the HCP administering the exam, the clinical circumstances surrounding the administration, and a host of other
variables. For interesting variations, the reader is referred to Strub and Black [158]; Ginsberg [58]; or Reitan and Wolfson [132] in particular, or to the neurological and psychiatric/psychological literature generally.

C. An Internal Critique of the Mental Status Examination

Broadly considered, the problems with the MSE fall into two designations: logistical and conceptual. Logistical problems include widespread lack of reliability and/or validity of the individual components of the MSE; the incomplete nature of the MSE; problems of contamination of the components themselves; and the quandary that, since there is no agreement as to just what is being tested by the MSE, there can be no assurance that existing tests verify the presence or absence of competence. Conceptual difficulties include the lack of a conceptual analysis of competence with well-enunciated, hence testable, characteristics; and the related difficulty that, whatever competence might be, the MSE was designed to ascertain something else. Each of these issues will be considered separately.

The first of the logistical problems is that the validity of many of the MSE components remains unproven, in spite of long term, widespread use. Recalling that the first component of the MSE is the test for level of consciousness, we may concede that this test, alone of the MSE components, presents few problems. The patient who fails to respond to
any external stimulus is probably not competent (regardless of what competence is determined to be) to consent. Failure to acknowledge and act upon the stimuli necessary for one's consent to be informed, such as attempts by HCP's to provide information about risks, benefits, etc., would disqualify the patient from the realm of competence. One must be aware, however, that the level of consciousness is not necessarily fixed. That a patient has an altered state of consciousness at the time of the MSE does not guarantee that she will not be fully alert in the future.

Moving on to evaluations of attention, we find problems with both Digit Repetition and Serial Sevens Subtraction. Keller and Manschreck note ([78], p. 205) that Digit Repetition correlates strongly with intelligence levels and, as such, is an inadequate measure of attention. Aaron Smith, interested in discovering the utility of the Serial Sevens Subtraction test, enlisted a cohort of 132 adults "with above average education, socioeconomic status, and presumably general intelligence" ([154], p. 80). Of these subjects, only 56 flawlessly completed the test; the rest committed between one and twelve errors. Three subjects abandoned the effort entirely ([154], p. 80). Smith concluded that poor performance on this test may have no diagnostic import or significance.

Language assessment is always a bit tricky. The failure to display verbal fluency or to accurately repeat words or
sentences may be due to a pure language defect; but it may also reflect memory impairment and, as such, have nothing to do with language directly. Bizarre or inappropriate verbiage may reflect disordered thought content (e.g., schizophrenia) rather than of language ([98], p. 63). Or it may merely reflect cultural differences between patient and HCP, with unshared idiomatic usage interfering with communication [70].

The same correlation with intelligence that made Digit Repetition suspect as a measure of attention likewise casts doubt upon its validity as a test of memory. Moreover, this test, as well as the logical memory stories, requires a capacity for new learning. Should this capacity be impaired, the failure would reflect that dysfunction rather than a memory deficit. Furthermore, questions of social history (e.g., naming past presidents) are related to education as well as to memory. Thus, inability to perform adequately may reflect educational deprivation rather than memory malfunction.

Tests of cognition suffer from similar defects. Intelligence tests, widely used for decades, may be considered reliably diagnostic of organic disease only if more than 60% of the responses are incorrect. Too, there are problems with standardization of questions, variability of populations, and error analysis in clinical situations ([78], [99]).

The more abbreviated versions, available for use at the
bedside, may reveal intellectual deficiencies, but there is no in principle reason to insist that this renders the patient incompetent. To insist that cognitive deficits in and of themselves render a person incompetent to consent is to settle by fiat, rather than by reasoned argument, which arms of the aforementioned dichotomies to adopt. In the first place, it insists upon a global analysis of competence, in that persons who fail to achieve an "adequate" score are designated incompetent to consent for all choices. This may, however, not be the case. While there is evidence that persons with scores below twenty on, for example, the Mini-Mental State Examination (MMSE) do have trouble managing large amounts of new and complex data, there is also evidence that such persons are not incapacitated for all decisions [161]. Put another way, the scores cannot decree with certainty that persons are incompetent to handle specific decisions. This, nonetheless, is the result of focusing exclusively upon cognition. The same case can be made vis a vis the threshold-degree and cognitive-affective dichotomies, namely, that assuming that cognitive deficits as reflected by a score of less that twenty on the MMSE are per se diagnostic of incompetence arbitrarily decrees that competence is a threshold and an exclusively cognitive notion.

It is easy to understand why clinicians make a quick leap from cognitive impairment to a diagnosis of incompetence to consent. Valid informed consent requires that the patient
be informed and competent. Cognitive deficits make it difficult both to inform patients (e.g., a patient may have difficulty remembering complex, esoteric data) and for patients to manipulate that information to reach a "rational" decision. Nonetheless, given the paucity of work to date on the conceptual analysis of competence, this move is suspect. It may turn out that these intuitions of clinicians are correct, that health care decisions are too complex to be competently managed in the face of cognitive deficits; but that remains to be determined.

The lack of a well-defined causal relation between cognitive deficits and incompetence should give pause to HCPs who are quick to label patients incompetent on the basis of such impairment. But those who are unconcerned about this conceptual gap may yet be concerned about the reliability of the tests themselves. Even the best of such bedside tools, the MMSE, has a 39% false positive record, i.e., the patient is labelled demented when dementia was not present [6] and a 43% false negative record, i.e., the patient is labelled normal when impairment is present [146].

Ineptitude in calculation, social awareness or judgment may reflect deficits of attention, concentration or memory, rather than cognitive impairment per se. But it may reflect instead differences in cultural background or educational opportunity rather than true pathological deficits. Additionally, there have been no studies concerning either
the reliability or the validity of calculation tests, and no evidence that they or the test for good judgment are diagnostically useful [78]. Like many other components, they are affected by the level of the subject's education.52

No test for insight exists, making insight assessment purely subjective. Rather, as Havens remarks, "Insight means largely the extent to which the patient's understanding agrees with that of the examiner" ([63], p. 1208). Such subjectivity also can infect evaluations of social awareness and judgment. Take as an example the situation where the patient is asked what she would do if she were to find a stamped, sealed, addressed envelope lying in the street. The "correct" answer is "I would mail it", but patients, surrounded as they are by their own particular sets of circumstances, might understandably answer in other ways. Does the poor, jobless, hungry patient who answers "I would open it to see if it contained any money" show appropriate social awareness and judgment or not? Subjectivity enters when the tester must decide how to rate unexpected or creative responses.

Further, the tests alleged to assess abstract thinking are beset by a plethora of problems. First, there is low interrater reliability, i.e., the same response is judged differently by different interviewers. Second, there is no evidence that poor performance is diagnostic of organic disease. Finally, there is no difference in the number of
concrete responses between normal and schizophrenic patients [78].

The final logistical difficulty is that there is a great deal of uncertainty as to just what, in fact, constitutes an appropriate understanding of data provided through use of MSE’s. To begin with, given the varieties of uses to which the MSE has been extended, there is no certainty as to just what the MSE is, on any particular occasion, testing [161]. Also, although the aura surrounding mental status testing implies impartiality, MSE’s are not objective in any pure sense. In many instances, no studies have been done to establish what counts as "normal" results. There is, at best, an expected answer or point score, without any indication that these reflect normalcy [63].

Moreover, the results of an MSE are often interpreted through a further diagnostic aid, such as the DSM III. Whether or to what extent such taxonomies reflect reality (as opposed to cultural relativism or prejudice), is surely debatable. Such concerns expose the most pressing conceptual concern (and one which will be dealt with extensively in the following section): what exactly are the philosophical foundations for the (types of) questions included in the MSE? Given that no satisfactory analysis of competence exists, that the MSE was not designed to assess competence (whatever it may be), that there is uncertainty as to what the MSE data actually illustrate, and that MSE results are often inter-
preted through possibly subjective systems—given all these defects—one wonders why the use of MSE's is so widespread and just what it is clinicians think they discover by using it. Or perhaps the appropriate concern is what value its use either fosters or protects.

Clearly the battery of tests which jointly comprise the MSE is deficient, either actually or as a result of the failure to demonstrate validity or diagnostic efficacy.\(^{55}\) Furthermore, most of the components are subject to extraneous influences which can significantly alter the ratings. Nearly all aspects of the MSE can be negatively affected by anxiety.\(^{56}\) Lower scores are common in the elderly\(^{57}\), as well as in the poorly educated\(^{58}\) or the innately less intelligent\(^{59}\). Language barriers also effect scores \([70]\), as do cultural differences between patient and interviewer\(^{60}\), socio-economic status\(^{61}\), and even gender \([154]\).

As noted above, it may be that some or all of these factors are relevant to competence ascriptions. A certain level of intelligence, for example, might be necessary to be competent to consent. Or perhaps certain affective states preclude such competence. The point I am making here is that absent a conceptual analysis of competence that guides us in determining what characteristics constitute competence to consent, the usefulness of such tests as the MSE remains an open question. Thus, at present, we are in a state of uncertainty as to what such tests tell us about a person's
competence.

Importantly, there is too much leeway for interjection of subjective value into evaluations. Lacking objective standards, interviewers may judge patients according to personal estimations of what constitutes an appropriate response.\textsuperscript{62} But these estimates may be quite inappropriate from the perspective of the patient ([161]).\textsuperscript{63} And there are always questions of how to differentiate "abnormal" from "creative", and of what to do with unexpected answers on non-quantitative questions.

Lastly we must recognize that MSE's make no effort at all to assess much of a person's behavior (Recall from Section I. that evaluations are based upon indirect evidence--behavior). Since we infer mental status from a subject's behavior, what are we to do about the fact that much of this behavior is not assessed at all?\textsuperscript{64} MacKinnon and Yudofsky [98] remark, for example, that there is no test available to measure impulse control. Moreover, what are we to make of the fact that there is not extant test that measures the compatibility of particular decisions with a person's total belief system?\textsuperscript{65}

In addition to the array of logistical difficulties that plague the MSE there are conceptual problems that bear consideration. The first conceptual difficulty is ontological: there is no assurance that those capacities that jointly
comprise competence can be identified. That there is no clear concept of competence with well-defined, testable, characteristics has been discussed above in Section I. These remarks need not be repeated here, other than to reiterate that, absent an analysis of competence that identifies those capacities necessary for decision making in general and informed consent in health care settings in particular, it is sheer nonsense to claim that the MSE or any other examination is testing for the presence or absence of competence. Once a conceptual analysis has been completed, it may be possible to signify portions of current MSE's that address competence, or to include new tests that will assay it. But until a conceptual analysis of competence identifies its components, the MSE's ability to detect it remains an open question.

The second, related, conceptual hardship is that the MSE was not designed to evaluate competence (whatever is meant by the term). Rather it was established, first, to assess psychoses [98] or to pinpoint areas of organic dysfunction as a preliminary step in diagnostic testing, and then, following diagnosis and the initiation of treatment, assess patients' responses to therapeutic interventions [78]. That it has been pressed into service as a tool for competence assessment is more indicative of the lack of a precise tool for that purpose than of the genuine applicability of the MSE. In sum, the MSE is being used (ineffectively, I would add) for a purpose for which it was not designed.
Moreover—and for my purpose, most crucially—there is no way to correlate the MSE with even those broad aspects, noted above in Section I.B., that constitute the possible components of competence. Recall

Table 2. More Possible Combinations of Aspects of Competence

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Given the MSE's emphasis on cognition, all combinations including the affective component are rendered irrelevant by the use of the MSE for competence determinations, leaving

Table 3. Fewer Possible Combinations of Aspects of Competence

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</table>

Further, although the MSE is a series of tests for individual capabilities (e.g., language integrity, attention, etc.), it is nonetheless used to test for global competence. Its use for global determinations follows from its general failure (though not necessarily an inherent inability66) to
incorporate, either in the individual components or in the overall evaluation, the particular nature of particular patients' particular situations. By this I mean that the MSE components are not structured, individually or collectively, to account for the impact a patient's current condition and personal history may have upon that patient's performance. Thus the MSE, as it stands, is inapplicable to determination of specific competence. Ruling out combinations with "specific" competence, we get

Table 4. Even Fewer Combinations of Aspects of Competence

<table>
<thead>
<tr>
<th>Cognitive Global</th>
<th>Threshold</th>
<th>Not dependent on consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Global</td>
<td>Degree</td>
<td>Not dependent on consequences</td>
</tr>
</tbody>
</table>

If we opt for a threshold notion of competence, we need to designate the threshold. That is, we must enumerate those capacities that must be present for a person to be competent. There is, in principle, no reason why the requisite appropriate threshold could not be designated. The problem is that it is unclear just how one would go about designating an appropriate line of demarcation.

Assuming it is possible to identify the characteristics constitutive of competence, one would still need to be able to determine which/how many of those characteristics determine the threshold. That is, one would 1) designate at what level or in what number the requisite capacities must be present; 2) decide which, if any, particular characteristics
are necessarily present; 3) determine which, if any, subsets of characteristics are jointly sufficient to achieve the level; 4) justify 1) through 3). Until this is done, there is no way for the MSE to discern competence according to a threshold, leaving

Table 5. Fewest Possible Combinations of Competence Aspects

Cognitive  Global  Degree  Not dependent on consequences

Finally, if a degree notion of competence prevails, it will still be necessary to determine what capacities are to be included and the extent to which a person must possess them. Here the criticism parallels that for a threshold determination: the MSE is unhelpful for competence evaluation until this has been done.

As with the definition of a threshold, there is in principle no reason why the requisite appropriate degree could not be defined. But again it is unclear how one would proceed. Again assuming a list of characteristics, one would need to 1) choose the degree(s) at which persons are considered competent; 2) decide which, if any, particular characteristics are necessarily present or necessarily present to some (what?) degree; 3) determine which, if any, subsets of characteristics are jointly sufficient to achieve the degree; and 4) justify 1) through 3). Until this is done, there is no way to discern competence according to degree, leaving
Table 6. No Possible Combinations of Aspects of Competence

The same criticisms apply, ceteris paribus, to determinations of competence which omit "Cognitive" aspects and include "Affective" in their place.

Thus we find that, even given such limited agreement as does exist upon the conception of competence, the MSE is not a tool that can help with competence determinations.

D. Summary

The MSE suffers from serious defects, both logistically and conceptually. Logistically, the MSE suffers from a lack of validity and from questionable efficacy of most of the testing procedures, contamination of data by extraneous factors, incompleteness of the test itself, and the introduction of subjectivity into the assessments. Conceptually, it is unclear what the MSE is actually evaluating, and there is surely no evidence to support a belief that whatever is being tested is or relates to competence (especially given the impoverishment of that concept). Given such a panoply of problems, one must wonder why such tests continue to be so widely used and trusted. But more crucially we want to know what values should be supported or protected by the institution of informed consent. It is to those questions that we now turn.
NOTES

1. It might be suggested that we can know, post facto, that P is competent to do T by checking to see if T got done (by P or at P's behest). This approach might be useful in some spheres. For example, P will be recognized as a competent cook if the meal is tasty (or, the proof is in the pudding). However it is often the case that competence must be determined prior to a person's undertaking an activity, as when the consequences of failure are potentially catastrophic but preventable. We would surely want some guarantee that P is a competent pilot before we board a plane where she is at the controls. Likewise we might want assurance that persons are competent before having them choose between health care options.

2. See, in this regard, [1], [2], [15], [34], [71], [90], [122], [135], [139], [141], and [160].

3. See, in this regard, [6], [7], [8], [16], [28], [29], [34], [48], [49], [53], [59], [70], [78], [79], [96], [101], [108], [115], [116], [135], [141], [143], [146], [154], [157], [160], [161], [170], and [174].

4. See [1], [2], [15], [34], [71], [90], [121], [135], [139], [141], and [160].

5. For further examples the reader is referred to [1], [2], [16], [18], [42], [53], [58], [70], [78], [91], [98], [132], and [161].

6. See, in this regard, Aristotle's Nichomachean Ethics, Book III, Chapters 1-3, 1109b 30-1113b 2.

7. The same argument, ceteris paribus, applies to the other "tests".

8. In a discussion with Robert Arnold, M.D., he proposed that these "tests" may, in fact, be actual tests and that what is really lacking is an appropriate definition of competence. This is an interesting suggestion and surely a possibility at the outset. However the second chapter will show that this is not the case. These "tests" fail in virtue of appealing to an outcome rather than a process. As such, their appeal is restricted to an assessment of outcomes and such an appeal is incompatible with the value that underpins the entire practice of informed consent: respect for persons.
I would, however, like to take this opportunity to thank Dr. Arnold for his many helpful suggestions on this chapter.

9. To my knowledge the only other advocate of a global notion of competence is Stephen Wear. For his account, see [172].

10. Additional discussion of this position may be found in [8], [16], [17], [27], [28], [39], [42], [43], [59], [71], [108], [121], [127], [135], [142], [143], [157], and [175].

11. Discussions of this position may also be found in [8], [16], [27], [28], [59], [121], [174], and [175].

12. See also [7], [14], [17], [59], [108], [157], [175].

13. For additional analyses of the relationship of competence to the respect tendered a person's decisions, see [16], [27], [108], [125], [127], [135], and [172].

14. Note that these are the schemata for competence as a global notion. If competence is a specific notion, "any" would be replaced by "this".

15. It may turn out, pragmatically, that "degree D" is not a single value but a range of values. That is, to be competent to degree D may, in practice, be a matter of falling within a specified range. The competent to D will be "competent to D... D_n". I am grateful to Dr. Larry Temkin for pointing out this possibility.

16. I say "probably competent" because, given that competence is, to date, an unanalyzed concept, it would be presumptuous to claim that such assessments are made with certainty.

17. See note 13, supra.

18. Advocates of this position include [11], [27], [28], [42], [43], [56], [59], [118], [120], [127], [143], [174], and [175].

19. The considerably shorter list for advocates of this position includes only, to my knowledge, [49] and [121].

20. As with TC and DC above, the schema for CDC presumes a global notion of competence. A specific notion would again require changing "any" to "this". Since a global notion of competence inherently precludes an appeal to consequences, CIC stands as is.

21. See also [28].

22. See note 10, supra.
23. One might assume that there are eight possible combinations of the aspects of competence—four for global and four for specific. However since a global determination of competence by definition precludes appeals to consequences as a basis for declaring a person incompetent, only six combinations are possible.

24. See [59], [108], [121], [143], and [148].

25. For discussions of the impairment that disorders of emotionality can cause to the function of the intellect, see [9], [21], [28], [30], [33], [34], [42], [53], [141], and [172]. Nonetheless, it has also been determined that mental illness does not, in itself, necessarily impair a person's competence (as it is currently considered). Thus affliction with, for example, paranoid schizophrenia does not inherently render one incapable of making competent decisions in realms that are unaffected by particular delusions or other aberrant thought processes. For interesting discussions on this topic, the reader is referred to [101], [141], and [142].

26. See [70] and [160].

27. See, for example, [2], [30], [34], [42], [43], [50], [69], [71], [85], and [90].

28. See, especially, [30].

29. An extensive critique of this examination will be offered below. For now, suffice it to say that the seeming objectivity attributed to the MSE is a fiction.

30. Organic disease has an anatomical or physiological basis. For example, cerebral vascular accidents (strokes) occurring within Broca's area can result in a person's being unable to speak. They exemplify organic disease. Conversely, functional disease has no (known) anatomic or physiologic basis but is rather "all in her head". Mutism that occurs after profound psychological trauma is thought to be an example of functional disease. One can differentiate between organic and functional disease by evaluating all segments (see below) of the MSE to see if the patient fails "consistently". If a patient fails all portions of the examination that are controlled by the same particular brain areas, the dysfunction is almost always organic in nature. Functionally ill patients tend to fail erratically from an anatomic or physiologic perspective.

31. It is not the case that the MSE altogether excludes analysis of a patient's affective system. It is, rather, that attention to the affective system is de-emphasized, while attention to the cognitive system is over-emphasized. The
effect of such selective emphasis is to virtually, if not entirely, exclude affective input.

32. Recalling that the category "Global" is incompatible with the category "Dependent upon consequences" will explain why there are twelve, rather than sixteen, possible combinations here.

33. In truth, the issue of competence is rarely confronted as long as the patient acquiesces to the recommendations of the health care professionals (HCPs). It is only when patients dissent that the question of competence is raised ([2], [10], [28], [29], [42], [49], [71], [75], [121], [135], [143]). But the incompetent patient who consents does not exercise a capacity for self-determination. Regardless of how many other persons feel that cooperation with a recommended regimen is in her best interests according to their (and not necessarily her) assessment, consent is not diagnostic of competence. Nonetheless, patients who dissent are most likely to have their decision making authority usurped. Patients who assent to recommendations generally will not have to confront charges that they are incompetent to make decisions—even when, in fact, they are (however that determination is to be made).

34. As an indication of the plethora of variations, see [58], [80], [98], [132], [133], [146], [158], [161], [162], and [163].

35. There are a number of other components which might be included, depending upon the extended purposes for which the examination is being administered. For example, a thorough psychiatric evaluation would include investigation into the presence/absence of such abnormal mental phenomena as hallucinations, delusions, and the like. Moreover, different formats include different traits as well as different tests for those traits. For further discussion, the reader is referred to [58], [91], [132] or [158].

36. Strub and Black devote a chapter to each of the characteristics included in the MSE. For an extended discussion the reader is referred to the appropriate chapter in [158]. See also note 5 supra.

37. Common sense indicates that on many occasions the testing of many components of the MSE occurs simultaneously. If the patient and the HCP converse during the assessment of the level of consciousness, not only does the HCP determine that the patient is alert; she also acquires a great deal of information about the patient's attention and language integrity and, to a lesser degree, her memory and cognition.
38. For an evaluation of the tests used in the MSE, see the following section.

39. Additionally, the capacities to name objects, find objects as they are named, read, write, and spell are estimated. Ineptitude related to these tasks correlates with particular aphasias or alexias, or may result from educational deprivation. While interesting, these impairments have little to do with competence, per se.

40. It is considered necessary to make at least six inquiries to rule out the possibility of answers being correct solely as a result of chance.

41. Orientation is more commonly considered as a function of cognition. For an example of this more traditional treatment, see [58].

42. Strub and Black [158] include another capacity in their MSE: constructional ability; and they make a convincing case for its routine inclusion in any MSE. This capacity to draw or build in two or three dimensions requires the integration of occipital, parietal, and frontal lobe functions. It is therefore an extremely sensitive indicator of organic brain function and may be the earliest sign of organic disease. Nonetheless, as this thesis is concerned with competence, and early loss of constructional ability by itself is (probably) not correlated with loss of competence (other than, perhaps, as a prognostic tool), discussion of this component of the Strub-Black MSE will be foregone.

43. As an interesting aside I mention that I presented these ten questions to eight co-workers (three Ph.D.s, one J.D., three secretaries, and one doctoral candidate), all of whom consistently perform better than average at their various jobs. Only three of the eight were able to answer at least six questions. While this group undoubtedly does not constitute a statistically significant survey, it was nonetheless a surprise (at least to me) that most of these professionally productive and motivated people suffered from, at least according to one testing tool, intelligence deficits.

44. For a discussion of Similarities or Conceptual Series Completion, the reader is referred to Strub and Black ([158], pp. 132-134).

45. See, generally, [33], [82], [90], [161], and [167].

46. Smith's cohort was composed of his co-workers in the Department of Neurology and Psychiatry at the Nebraska Psychiatric Institute.
47. See, in this regard, [4], [54], [58], [66], [98], [103], [121], and [130].

48. See, generally, [6], [70], [146], and [161].

49. For a discussion of the different types of intelligence tests, see [147].

50. For the relationship of cultural and test results, see [4], [5], [58], [63], [94], [103], [113], [137], and especially [61].

51. See [4], [54], [58], [66], [98], [103], [121], and [130] for discussions of contamination of results by these extraneous factors.

52. This relationship is documented in [4], [54], [58], [66], [98], [103], [121], and [130].

53. See [23], [29], [49], [68], and [137].

54. What counts as health or illness may reflect cultural mores and social tenets rather than health or illness in any objective, universal sense. Consider, for example, the controversy over the DSM categorization of homosexuality as pathological: Originally the DSM nosology classified homosexuality as a paraphilia, i.e., a sexual attraction for an inappropriate object. After much articulate protest from homosexuals and therapists alike, the classification was changed so that "homosexuality" is no longer a psychopathological category. The pathological label now attaches only to "ego-dystonic homosexuality", i.e., the condition of a homosexual person's being distressed by his or her same-sex orientation.

55. See, again, [23], [58], [66], [137], and [143].

56. See [58] and [66].

57. See, in this regard, [4], [54], [66], [68], [98], [121], [130], [132], and [137].

58. For further discussion, see [4], [54], [58], [66], [98], [103], [121], [129], and [130].

59. See also [4], [54], [58], [66], and [103].

60. See note 50, supra.

61. See, for example, [47], [98], [103], and [137].
62. See, again, [23], [29], [49], and [68]. Moreover, personal or professional biases frequently affect results ([79], [108], [161], and [172]).

63. Scores are not only negatively affected. Keller and Manschreck [66] note that patients with good vocabularies and social skills can, in fact, hide quite serious cognitive deficiencies.

64. See, in this regard, [66], [85], and [137].

65. For discussions of this concern see [23], [93], [121], [126], [133], and [145].

66. In fact, particular components of the MSE might be quite useful as particular diagnostic tools.

67. Conversely, if we were merely testing for specific competence, Table 4 would look like this:

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Specific</th>
<th>Threshold</th>
<th>Dependent upon consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>Specific</td>
<td>Threshold</td>
<td>Not dependent on consequences</td>
</tr>
<tr>
<td>Cognitive</td>
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<tr>
<td>Cognitive</td>
<td>Specific</td>
<td>Degree</td>
<td>Not dependent on consequences</td>
</tr>
</tbody>
</table>

68. This list is not intended to be inclusive. There are probably further manipulations of the characteristics that are both possible and desirable. Nonetheless undertaking even this brief set of determinations is no mean feat. Moreover, it has yet to be effected.

69. As before, were we combining "specific" aspects, Table 5 would look thus:

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Specific</th>
<th>Degree</th>
<th>Dependent upon consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>Specific</td>
<td>Degree</td>
<td>Not dependent on consequences</td>
</tr>
</tbody>
</table>

70. Again this list is not intended to be inclusive, but to indicate the extensive nature of the task needed to yield a workable system.
CHAPTER TWO

I. COMPETENCE AND RESPECT FOR PERSONS

Chapter One, Section I.B. briefly introduced the commonly considered options for analyzing competence: global (GC) vs. specific (SC) competence, threshold (TC) vs. degree (DC) competence, and consequence-dependent (CDC) vs. consequence-independent (CIC) competence. In addition a previously unconsidered option, cognitive (CC) vs. affective (AC) competence, was introduced. This chapter will examine each of these options in greater detail, looking at various constituents of competence, as well as at the justifications, implications, and criticisms that attend each option. The chapter will end with suggestions for the necessary conditions for the possibility of competence to consent. Before turning to the detailed examination of each option, however, I wish to put forth the claim that the principle of respect for persons is the sole foundational principle to be used for appropriately analyzing the concept of competence. It is toward that argument that I now turn.

The role of persons as the bedrock of moral life was first described extensively by Kant. His universal law of morality, the categorical imperative, stated "Act so that you treat humanity, whether in your own person or in that of
another, always as an end and never as a means only" (Foundations of the Metaphysics of Morals, 429; [74], p. 47).\textsuperscript{1}

Put another way, persons were always to be treated with respect.

Kant grounded this mandate for respect in the capacity of persons for rational thought. He was convinced that "rational nature exists as an end in itself" (Foundations of the Metaphysics of Morals, 429, [74], p. 47). By this he meant that rationality was worthy of honor in its own right, whether or not such rationality was ever exercised. Persons, as beings possessed of a rational nature, were thus likewise worthy of honor and should always be respected (i.e., treated as "ends" rather than merely as means to other ends) in virtue of that nature.\textsuperscript{2}

The Kantian emphasis upon the ability of persons to reason has been espoused by many other authors since he wrote in the eighteenth century. Some\textsuperscript{3} have fully embraced Kant's grounding of morality in reason.\textsuperscript{4} Others have insisted that there is more to morality or personhood than mere rational capacity or action.\textsuperscript{5} Advocates of the latter, that is, of a richer and more expansive conception of what will count as a being who is worthy of respect, argue for respect on the basis of the possession of other valuable capacities. The expanded list of worthy characteristics includes the abilities to form interpersonal relationships, to seek and appreciate truth and beauty, to construct a unique identity based in part upon the
other abilities and to make plans, to name a few. However by all such accounts, one valuable ability is that of structuring one's life according to values, goals, and desires that one has made one's own, i.e., that one has chosen.

I will make no attempt herein to settle the vexing question of the necessary characteristics of personhood, either in a Kantian or any other restricted sense. It seems safe to say that there exist a number of capacities that we do in fact consider valuable and thus believe ought to be promoted and protected. For that reason I will intentionally use "person" and "human" interchangeably, recognizing that persons with diminished capacity for rationality may yet possess other valued traits, and vice versa.⁶

The issue before us now is the relationship between persons and consent. If it is granted that persons are, given their valuable capacities, special and thus worthy of respect, there still remains the question of what this special nature has to do with consent. This question is best answered by returning to the abilities in view of which persons are deemed to be worthy of respect.

One way of respecting persons is to promote and protect the valued capacities that they (actually or potentially) possess.⁷ It is, after all, in virtue of those capacities that persons are worthy of respect. Thus it stands to reason that they ought to be promoted when intermittent or only nascent and protected when extant.
Recall that one valued capacity is being able to construct a unique identity through the abilities to choose personal values and to set personal goals. An important part of personal identity is constructed by persons themselves. From a plethora of values and goals, individuals pick and choose those which they deem to be most important. In so doing they erect a value system and a life plan. Based upon chosen values and ends, persons also devise, from among many options, the most efficacious (for them) plans for achieving desired outcomes. The selected values, ends, and means may be revised throughout one's life; indeed, further information acquired along the way often leads to a reconsideration of these constructs. Moreover, some goal-directed undertakings fail, and so require revision of ends and, derivatively, of means. At each fork in the road, persons are required to re-evaluate. Whether they choose to persist or revise, they make on-going decisions in light of their existing plans and past choices. The permutations and combinations of choices available to each individual are enormous, and two people rarely (never?) choose identically throughout an entire life. This is what makes each personal identity unique.8

This brief explication of the nature of persons and the bases for their worthiness of respect requires mention of at least three important theoretical issues that have engaged philosophers for millennia. First, what constitutes an appropriate theory of personal identity (i.e., what are the
criteria by which we identify individuals as single personalities enduring through time, in spite of some rather enormous changes they undergo; Put another way, how do I and others know that the Becky White who finishes this thesis is the same person who started it two years ago? Second, what constitutes an appropriate theory of rationality (i.e., what we have reason to do and what counts as a (good) reason for acting)? Third, what constitutes the appropriate good(s) for individuals. Each of these issues has puzzled scholars for a very long time; none of the theories suggested as answers to these questions has been universally accepted. In fact, within all three areas of study, the topics continue to be hotly debated. Clearly within the scope of this work I cannot begin to address these questions in any definitive way. At best I can briefly review the work done in these areas and then state my own prejudices and presuppositions as to which theory is most compelling. This approach is not meant to settle any of the vexing questions, but only to indicate which ones I take to be most helpful to informing the matter of competence to consent.

The first concern has to do with the fact that, however settled it may be in "real life" as to the identities of individuals, theoretically the concept of personal identity remains a puzzle. The problem, very much abbreviated, is this: in view of what criteria can we say that a person, who experiences both physical and psychological changes over time,
is the same person throughout a life time (or at the beginning and end of any designated time span)? The "common sense" answer is that a person is the same person because she either is or "inhabits" the same corporeal mass (body). But the body surely changes in important ways. Most basically, the cells in the body die and are replaced by new (different) cells throughout one's life; so in a pure physical sense we are not the same people we were when we were born. Perhaps, then, it is because one's body has a certain, consistent appearance over time. But people gain or lose weight; some have plastic surgery or disfiguring accidents; others have organ transplants; and no one looks at sixty the same way she looked at six. Physical appearance changes dramatically over time. What we want is something that persists, on the basis of which we can say of it that it is the same thing and, hence, the same person.

One of the early analyses of these perplexities was offered by John Locke in his Essay Concerning Human Understanding (See especially Chapter 27). Given the sort of problems just noted, Locke concluded that personal identity cannot be purely a function of physical substance; it must include a mental function as well. Locke located identity in memory. According to Locke, White is the same person who did action A if she remembers doing A. (Note that actions can be physical events, such as playing softball or driving to work on Monday, or psychical events, such as choosing particular
values and goals over others.)

But there are problems with this analysis. In the first place, memory is unreliable. White might forget, in the "normal" way that we all sometimes do, that she did A. Or she might suffer a blow to the head with a resulting amnesia. Then what do we say when White, because she does not remember doing A, insists that she did not do A, especially if many of her friends and acquaintances were present when she did A and now attest to the fact that she did do A. If memory is the only tie to identity, then either 1) White did not do A; someone else, White¹ (who, oddly enough looks just like White and shares many of her other memories) did A; or 2) the person who did A was White, but that person no longer exists; in her place is a "new" person, White¹ (who, again oddly, looks like White and has her other memories). If 1), White's friends, who accompanied her to the ball park and saw her (or, at least, her body) hit home runs at her first three at-bats, will have their own identity problems (Who were they, if not the persons who played softball with White and who clearly remember doing so?) If 2), what happened to White? and who is this person, White¹, who everyone, including White¹, thinks is White? It thus seems implausible to rely solely upon the mind to determine the continuity of the identity of particular people. The most notable problem is that, whenever anything happens to interrupt the continuity of memory, persons would have to be thought to have died and their bodies would then
be inhabited by new (other) people.

But if not body and if not mind, then what? It would seem as if both are required to make up a person's identity. The most plausible analysis of personal identity would seem to require recognition that humans are psychophysical beings, i.e., possessed of both mind and body. I give, as evidence for this, the management of persons with dementing diseases (e.g., Alzheimer's). When the mind is no longer "there", i.e., when a person has no past because none of his memories are available to him, has he died? This is tough to assess. In one sense, we say that the person "died" when his mind did. The person is, in a very real sense, no longer available to us for personal interactions. Yet we continue to visit that person in the nursing home, so in some other sense he is still alive. It seems that we do identify both the mind and the body with personal identity.

This admittedly leaves unanswered a great many important questions regarding the actual criteria for both physical and psychical identity. These are sticky theoretical issues that would require a treatise unto themselves. I will say that, for considerations within health care settings the question of physical identity should probably require an identity of genetic composition. This is to say that White is White if she has the genetic composition she had at birth. This allows a great number of changes to occur within her physical corpus without changing her identity. (If, in the future, we acquire
the capability to clone whole individuals, or if, as in Woody Allen's "Sleeper" all that remains of the person is her nose, or some equally unlikely portion of anatomy, this criterion may have to be revised. For now, it seems adequate."
Likewise the health care setting would seem to require that White possess at least many overlapping memories as to what has gone on within her life. This is to say that she need not recall every thought or deed that has attended her existence, but she must remember many of them, and there must be some continuity to them (e.g., she can trace their development).

I cannot here defend this analysis of personal identity. I can only say that, within the health care setting in general and informed consent in particular, the dualistic conception of personal identity is the one that makes the most sense. This is because, within the practice of informed consent (as will be delineated below), persons are being asked, on the basis of their own psychologies (i.e., what goes on in their minds) to make decisions about what will happen to their bodies. If personal identity were merely a function of the body, the goal of medicine would be to preserve it unchanged at all costs, because only by so doing would the person be preserved. If, on the other hand, personal identity were only a function of mental events, there would be no need to tend to the body, but only to see that the mind had the right sort of stimuli.
Within the practice of informed consent we ask permission of people to allow manipulations of their bodies. This is because we recognize that what happens to these bodies affects the life of persons, considered as whole, unique individuals. We assume that the body is part of the person, or we would not ask his permission for interventions; we could manipulate the body, at will, as we can all other objects such as hemostats, blood pressure cuffs, and the like. We also assume that a mind attends that body, and that it has some interests in virtue of which some interventions are desirable and some are not. Again, were this not the case it would make no sense to seek permission at all. Suffice it, then, to say that I assume that identifiable persons are composites, that they are composed of minds and bodies that are inextricably intertwined with the well-being of each dependent at least in part upon the well-being of the other.\textsuperscript{10}

The second sphere of theoretical interest that this discussion depends upon in part is the question of what constitutes an appropriate theory of rationality. That is, what is the nature of a reason, and what counts as a good reason for (i.e., reasons that justify) actions. Traditionally there have been two major schools of thought in this regard. The first, known as self-interest theories, have claimed that it is reasonable to do whatever will promote one's own self interests considered impartially over time as
one has herself defined those interests. Put another way, it is always rational to act to achieve one's own well-being over the course of one's life.\textsuperscript{11} The second school of thought states that it is reasonable to do whatever is required by morality. Put another way, it is always rational to submerge one's own interests to meet the demands of moral action.\textsuperscript{12}

Both of these schools have been strongly supported and strongly criticized. Any discussion of the subtleties of the positions themselves, their strengths, or their weaknesses is beyond the scope of this paper. Put a brief exegesis is necessary to understand the compromise position that seems to me to be most compelling. According to self-interest theories, it is rational to do whatever will make my life, considered in its entirety, go as good as it possibly can. Assume for the sake of this discussion that my theory of the good is a desire-satisfaction theory. Then, according to a self-interest theory of rationality, it is rational to do whatever will yield the satisfaction of the greatest number of my desires throughout my life. One problem with this conception of rationality has to do with the fact that desires change over time, sometimes quite radically. Twenty years ago I wanted to by the best nurse possible; I now want to be the best philosopher possible. Most of my desires vis a vis my nursing career were satisfied. Nonetheless, it is safe to say that the majority of them had nothing to do with my being a good philosopher. So, on one interpretation, all the desires
that I acted to fulfill when I was a nurse interfered with my present desires of being a good philosopher. Had I ignored them and done philosophy instead, even though I did not at the time have any interest in philosophy, my life might have gone better, all things considered; it almost certainly would have gone better as a philosopher (though, of course, worse as a nurse).

The upshot is this: it may be impossible for a person to ever know that acting to satisfy one set of desires will, in fact, make her life go as well as possible. As Aristotle rightly noted, we can only say truly of a man that he had a good life after his life is over. Until his death, some great good or ill fortune may yet befall him that would require him and others to re-evaluate how his life went, well or ill, on the whole. So a problem with self-interest theories is that because they require us to consider all our desires over a life-time, we will many times be stymied as to which desires we ought to attempt to satisfy at any given moment.\textsuperscript{13}

Another problem with self-interest theories is that we often want to act upon desires that expressly make our lives go worse. Some of this inconsistency can be brought under the theory's umbrella. If, for example, I give a great deal of my disposable income to charity, there are a number of things I will have to do without. This, it may be argued, will nonetheless satisfy more desires than it will thwart; I will realize desires to feel good about myself, to help others, to
decrease world hunger, etc., and these will outweigh the frustration of my desires for a new car, nicer clothes, etc.

But some "other" desires are not so easily set aside. What if both Mr. Jones, (a complete stranger to me and about whom I have no desires) and I are both suffering from end stage renal disease and are the only eligible transplant recipients for a single kidney? Assume that I desire a new kidney only if my receiving it does not deprive a younger person who would have thereby many more "good" years from that transplant than I would have, and assume that Mr. Jones is twenty years younger than I am. Now it would seem that, in foregoing the transplant, I explicitly act against my own best interests. Even if I have this particular desire satisfied, and even if my few remaining months of life are made somewhat better by the knowledge that I have sacrificed my well-being for the good of another, it still seems fairly clear that I have in a larger sense acted against my own good. On the self-interest theory my doing so may have been praise-worthy, but it was nonetheless irrational. The problem, then, is that the theory labels as irrational certain desires that have been traditionally deemed laudable.

Summarizing, self-interest theories, then, require of a rational act that it maximize my well-being considered impartially throughout my entire life. The rational act promotes my good over time. This can lead to difficulties deciding just which desires to act upon, and it may designate
as irrational acts that are generally seen to be admirable.

The second major traditional contender for the theory of rationality is morality. According to this theory, the rational act is one which fulfills the mandates of morality any time the agent is required to act. According to theories of morality, it is rational to do whatever would be morally required of any agent situated as I am at anytime. Thus it is rational to do whatever is morally required of any one in my circumstances, regardless of whether or not this conduces to the satisfaction of the greatest number—or even any—of my desires, now or over time. Self-interest theories assume that, at least for rational action, only one person's interests count—mine. Morality assumes that the interests of every person count, that each of us is (as Nagel puts it) "one among others, equally real". The implication of this is that, when the dictates of morality and self-interest clash, the rational thing to do is whatever morality demands.

One problem with this has to do with the fact that morality can demand, at least by some lights, too much. If I am truly one among others, equally real, then I count as much as those others. But, the argument goes, from my perspective I ought to count (at least a little bit) more. To take a well-worn example, if morality requires that I be a good Samaritan whenever the opportunity arises, then all my time, energy, and talents may be taken up just in fulfilling this moral obligation. It does not take much imagination to
see that there are, if not infinite at least very, very many chances for coming to the aid of others. Indeed, I might be so inundated with Samaritan-demands that I am unable to attend to any of my own interests. I may never realize the goal of being the best nurse possible or the best philosopher possible (although I will be a super-Samaritan). The upshot is this: it may be impossible for me to ever elude the demands of morality.

Again, some of these worries can be brought into the theory. We might claim that not all situations demand a moral resolution. Some simply do not include a moral component. If, for example, there is no morally required reason for me to give a great deal of my disposable income to charity, then I am free to spend it on myself. This argument presumes that the boundaries of morality can be precisely (or at least generally) delineated. But this is an open question. Different theories seem to resolve it more successfully than others. Traditionally the charge that morality will take over one's life completely has been levelled at Act Utilitarianism, which requires of all acts that the agent compute which would have the best consequences, all things considered. Then it always seems to be the case that better results could be attained by my sacrificing my own good. But even deontological theories, which provide lists of obligations, can have trouble resolving which duties have priority in cases of conflict. And even here one can imagine that if I were to
take seriously the duty to honor my mother and father, that alone could require all of my time and energy. (Those who doubt this claim have never cared for an elderly parent who suffers severe physical and psychological compromise.) The problem, here, is that the theory can label as rationally required certain acts that have traditionally been deemed supererogatory.

Moral theories, then, require of a rational act that it maximize everyone’s well-being as considered by impartial moral rules that apply to all when trying to determine how to act. The rational act promotes anyone’s good at all times, regardless of how this affects realization of one’s own well-being. It is problematic in that it can take over one’s life completely.

A third theory of rationality, and the one that I shall adopt, has been developed by the twentieth century British philosopher, Derek Parfit. He terms this the Present-Aim Theory. Under this theory he advocates that the rational act is the one which best achieves (here, on a desire-satisfaction theory of the good) those desires that I have now. This theory is a "pure" theory in the sense of being twice relativized, to time (now) and to person (me). The problem with self interest theories, it is recalled, is that they cannot determine which desires are the most compelling, the ones I now have or the ones I will have in the future (or had in the past). Those theories are relativized to person (me),
but not to time. On the other hand, morality, like the Present-Aim Theory, is also "pure", but in the sense of being twice neutralized. It is neutral with regard to agents (anyone) and to time (anytime).

Parfit argues convincingly against the self-interest theories on the grounds that it is an impure hybrid. Specifically, if we are convinced by arguments against neutrality/morality (e.g., if we are convinced that I do count more), we cannot accept the temporal neutrality that self-interest theories demand. On the other hand, if we are convinced by arguments for neutrality (e.g., all times matter equally), we cannot accept agent relativity. Put another way, the arguments that cut against morality cut against the "impartially considered over time" aspect; while the arguments that cut against the Present-Aim Theory cut against the "I am special" aspect. This being so we are left with a choice between morality and present-aim theories. We can opt for a fully neutralized or a fully relativized theory.

I find the fully relativized, present aim theory preferable for two particular reasons (although, of course, others can be given in a fuller explication of this very complex theory). First, it is quite possible to include in my present desires a desire to behave in accord with moral dictates. This allows some possibility of having one's cake and eating it too. This is, of course, a gross oversimplification of the advantage of this theory. But it does
allow resolution of some of the traditional worries that have attended the choice between these theories, most notably how to allow people to act in their own best interests and still preserve the possibility for moral action. Second, this theory seems best able to address the concerns that arise specifically within health care setting under the rubric of informed consent. To begin with, in this setting the question before the patient is, ought I to allow a particular regimen. This can be rephrased as, would a particular regimen be in my best interests and, if so, ought I (or not) allow it? The practice of informed consent is not constructed to deal with questions of morality per se (although such questions often arise within the context); rather it was constructed as a means of assisting persons to pursue, through health care alternatives, their own good as they themselves have described it. This is to say that the practice of informed consent is constructed with a bias toward me. It is also constructed with a bias toward now, i.e., to allow a patient to decide what she ought consent to or refuse, at a particular time, in order to do what is best for herself. As such, it is also able to attend, if an agent so desires, to the temporal concerns that motivate self-interest theorists. Insofar as a patient has, among her present desires, a desire to consider wishes she may have in the future, or goals, values, and desires that she has adopted in the past, she may surely incorporate these into her present decision.
There is a third, pragmatic argument for seeing rational actions within the practice of informed consent as best served by the present aim theory: it allows for persons to change their minds in some fairly dramatic ways. One of the striking features of serious illness is that people, with enough frequency to worry health care practitioners, often abrogate past values and goals. The most common examples have to do with life and death decision making as when, for example, the person who has always said "Do everything to preserve my life" now says "Let me die in peace". There are usually explanations for such radical reversals, most commonly the patient's statement that she did not understand what "doing everything" would mean to her in terms of pain and suffering, financial strain, guilt for her significant others, and the like. If we demand, in accord with self-interest theories, that all her desires be considered equally, decades of wanting everything done can conceivably outweigh her current desires which are, as a matter of fact, based upon much better information. On the other hand if we demand, in accord with morality, that patients do the moral thing, we may be hard pressed to give content to that mandate in particular situations. For these reasons, then, this thesis will consider rational acts to be acts in concert with a present-aim theory. (I do not claim that this theory will be unproblematic vis a vis the practice of informed consent, only that it will be less so than its alternatives. In particular
it will be especially worrisome when applied to the notion of affective competence.)

The third theoretical concern that must be acknowledged is that there are widely divergent theories of what counts as the good for persons. As noted above (note 11), there are three major contenders: hedonism, desire satisfaction, and objective good. Hedonism argues that the good for persons is that they are, throughout their lives considered as wholes, happy. They will be happy insofar as they feel pleasure and avoid pain. Hence what human beings do (or really do, even though they may themselves be unaware of it) desire is to obtain pleasure and to escape pain. Conversely, desire satisfaction theorists admit to desires other than acquiring pleasure and averting pain. They claim that there are many different things people might desire (e.g., to act morally) and that realization of these desires, whatever their content, constitutes the good for persons. Objective good theorists claim that there are states of affairs that are inherently good or bad, regardless of whether they give persons pleasure or pain (e.g., sadism gives some people pleasure, but might be plausibly claimed to be inherently bad) or whether or not anyone desires them (e.g., acting morally might be claimed to be inherently good whether or not anyone desires to so act). In this work I embrace a desire-satisfaction theory of the good. I do this, again, for both theoretical and pragmatic
reasons. Theoretically, hedonism seems implausible. Although the only evidence that can be cited is empirical, it does seem to be beyond reasonable dispute that people define "the good" in terms of qualities other than pleasure and pain. There are many other things that, insofar as can be determined, make lives go better or worse, and most of these have to do with the realization or frustration of desires that people have. The same criticism can be made of the objective good theory: there are things that improve or diminish the quality of persons' lives that are independent of any particular approved list. Hedonism has only one item on the good list--pleasure--and one item on the bad list--pain. Objective good theories expand that list to include other items (e.g., contemplation of truth, appreciation of beauty). Nonetheless, most persons have different lists when it comes to defining the good, at least for themselves. Perhaps the more philosophically compelling argument is that neither hedonists nor objective list theorists have been able to make a logically conclusive argument for their positions. The latter have also been hampered by their inability to produce any plausible list of objective goods and evils. This, of course, does not settle the matter; but it does allow us to entertain other options. That desire-satisfaction theories accord much better with empirical observations seems, to me at least, to give it the edge.
Pragmatically, the practice of informed consent makes the most sense on this particular theory of the good. We are not, in consent settings, asking for people to tell us what would give them the greatest amounts of pleasure (although it is surely the case that discussions of pain and its avoidance or control inform many consents). Likewise, we are not displaying a list of objective goods and pointing out which therapeutic options would best promote the items on that list (although health care professionals certainly have opinions on which outcomes would be, clinically or generally speaking, better in what is, in their opinions, an objective sense--opinions that they do not hesitate, appropriately, to share with patients). Rather patients are asked to examine their situations and to determine what, given their own spectrum of desires, would be the option they would prefer. Thus, for practical as well as theoretical reasons, I herein opt for a desire satisfaction theory of the good. Again, I do not claim that this conception will be unproblematic, only that it is the least of the evils.

At this point a clarification is in order. What will it mean to combine a dualistic theory of personal identity, a Kantian theory of respect for persons, a desire-satisfaction theory of the good, and a present-aim theory of rationality? It will mean that people are the people that they are in virtue of their on-going minds and bodies. It will mean that
they use these minds and bodies to perform at least some of the activities that we take to be valuable (e.g., selecting values and goals by which to order their lives), activities that will then become part of the unique identity of individuals. It will mean that these individuals will have particular conceptions of what constitutes the good for themselves. It will mean that, based upon all the foregoing, they will have unique reasons for acting in particular ways at particular times.

The critic will note that different people will engage in these tasks differently and with differing degrees of success. One wonders whether this fact has any implications for competence to consent. Put another way, are people who undertake these activities infrequently or who execute them poorly still candidates for decision making in consent contexts? A full answer to this question must await the conceptual analysis of competence. Nonetheless it is possible to give a brief answer here: yes. Insofar as people undertake these activities at all, they actively constitute their own identities, their own preferences, their own conception of the good for self, and (other things being equal—e.g., the person is conscious, not suffering from amnesia, etc.)—will have particular preferences regarding particular consents. As such, they will be worthy of respect. This is not to say that all persons are equally adept at these tasks (nor even equally worthy of respect), but it is to say
that the selves that result are of their own making and may be presumed to be interested in making their own decisions and to have at least some of the capacities necessary for doing so (otherwise they would be/have been incapable of self-definition). To the extent that people possess the capacities discussed above, they are worthy of respect. As beings worthy of respect, they are considered to be competent decision makers until proven otherwise.\textsuperscript{15}

Now it might be the case that people who are less adept at setting goals, selecting means, or adopting values are so because they lack particular capacities; and it may be that these capacities are just those that are constitutive of competence to consent. This is an empiric question, however, and not amenable to resolution prior to completing a conceptual analysis of that concept. Suffice it to say that persons who are in any sense worthy of respect are assumed to be competent decision makers until shown not to be so.\textsuperscript{16}

We return to the decision points that mark the lives of individuals. One of the forks in the road that may require further decision making on the part of individuals is an encounter with the health care system. Illness, especially serious illness, often acts to thwart both means and goals. As such, illness can itself be a crossroads which requires a revision of life style.

It is crucial to remember that illness does not exist in
a vacuum. Rather it exists within persons; more particularly, it exists within persons who have previously adopted sets of values and aspirations upon whom and which sickness may be expected to have some impact. (How much impact depends, of course, upon the nature of the illness and how disruptive it is to the person's life plan.) Other things being equal, it may be safely presumed that the person most intimately involved, i.e., the patient, has the best understanding of how and to what extent her illness will entail a revision of values, ends, and means. As such, it is the patient who is best positioned to make decisions about what should be done to manage the offending illness.  

Health care requirements are best seen as yet another of life's situations about which decisions must be made. Like all other decisions, they are best made in the presence of as much pertinent information as possible. Assuming that the patient can be given all the relevant health care data (diagnosis, possible treatment modalities--including no treatment at all, risk/benefit ratios that attend the different treatments, variable prognoses, costs in terms of time, effort, discomfort, etc.) to enable her to be sufficiently informed regarding the important aspects of her decision, then she will be best placed to make the requisite decisions. This is because of all participants in the decision, she--and she alone--has direct and unlimited access to the other relevant values that must be considered. She,
and she alone, can best estimate what impact different choices will have upon her life as a whole; which choice will be most synchronous with her values, goals, and means; which of those, if any, she is prepared (even if reluctantly) to revise or to sacrifice; which of the options is a value, a goal, or a means she can comfortably embrace.\textsuperscript{18} Put another way, a person's consents and refusals regarding health care are particular instances of her exercise of those capacities that make her the kind of being deemed to be worthy of respect. That the consents or refusals occur within the health care setting, rather than within some other sphere, simply is not germane to the issue.\textsuperscript{19} We would hope, of course, patients would opt for those actions that lead (at least statistically) to the best outcomes insofar as their health is concerned. Nonetheless we must, given their privileged position regarding evaluation of how their lives should go on the whole, be prepared to accept patients' decisions when they (apparently) fail to promote their health or well-being.\textsuperscript{20}

This is, of course, why the practice of informed consent was adopted in the first place. Prior to the middle of the twentieth century, consent was not informed; prior to the twentieth century, consent was not sought ([51], pp. 74-86).\textsuperscript{21} The human rights activity of the mid-twentieth century resulted in, among other things, an insistence that all persons were special. Because this resolution turned upon the many special traits that inhere in persons, it also hinged in
part upon the ability to plan their own lives. This recognition led to the determined belief that they should be allowed to do so, even when others violently disagreed with those plans or when the choices were tragic. That set the stage for the requirement in health care of informed consent. Informed consent was established as a practice just because it was seen as a way of respecting persons.\textsuperscript{22}

Informed consent is applicable only to competent persons, however. The reasoning behind this is threefold. First, when we say we respect the capacities of persons to determine their own lives, what is in fact being respected is the capacity to consider, from a wide range of opportunities, values and goals to be embraced. There are, moreover, the further capacities to plan, on the basis of such selections, one's life in accordance with those values and goals, to construct a personal identity that is unique to the individual, to make a life that is genuinely one's own. It is these sorts of capacities that are deemed laudable.

We do not admire, nor deem meritorious, the mere capacity to pick A over B, in the sense of "pointing to" or "moving toward" A rather than B. These sorts of actions seem much too random or instinctual to be worthy of respect as choices made by individuals who are involved in self-definition (although, if they seem to indicate an individual's preference, we might want to defer to them for other reasons). It is only considered choice that we deem estimable, and considered
choice can only be made by persons with certain capacities for informability and cognition; i.e., considered choice can only be exercised by competent persons.

Second, some persons 1) never have been or 2) are not now or 3) never will (again) be competent to determine values and goals for themselves. Individuals who are born profoundly and irreversibly retarded, for example, simply never have such capacities. These persons need to have their interests both determined and protected by others. To offer them an opportunity to participate in the consent process is to offer them the chance to work against their own best interests. Likewise, it makes no sense to offer participation to infants and small children who now would have no idea what was being proposed (although many will be able to participate in future decisions). Nor can the irretrievably comatose avail themselves of decision making opportunities (although they once were able to do so). In such cases, to make the offer is an empty gesture. These persons would be totally unable to understand (or, in the case of the profoundly mentally handicapped or comatose persons, even to be aware of) the opportunity, let alone act upon it. They do not have the capacities to be competent decision makers.

But finally, persons who have the valued capacities may lose them temporarily. Think, for example, about persons who are delirious with fever, temporarily disoriented from a concussion, or heavily sedated for pain control. These
persons do not automatically, in virtue of physiological derangement, renounce or lose their values and goals. They do, however, lose their capacities to act in accordance with them. Consent is not solicited from these persons because, at such times, they do not possess the particular capacities for decision making in this instance. This exclusion prevents people from inadvertently acting to thwart their own best interests as they, themselves, have defined them. It is only when persons are capable of acting competently (as will be developed later) that they should be involved in the consent process. This is why consent is only sought from competent persons: because the practice of informed consent was in fact established as one means of recognizing the importance of protecting and enhancing the self-stated goals of persons capable of espousing them in the first place. It was established as a technique for respecting past, present, and future choices of persons; hence the competence requirement within the practice of informed consent.

It is, nonetheless, legitimate to ask why we ought to respect an individual's decisions, be he competent or otherwise. There are a number of ways to answer this question. One might respond, as do libertarians, that the value of freedom is the only universal value and, therefore, the only one that society must protect. There are, to be sure, other values that individuals do embrace, but these have subjective importance only. The crucial point, for the
libertarian, is that without the freedom to act upon these subjective values, they would be of academic interest only because, lacking universality, they could always be ignored by those who fail to share them. The problem with this position is that its intuitive obviousness is not shared by everyone. Numerous non-libertarians insist that there are other, equally important and universal values that ought to be protected. To my knowledge there has been no libertarian response to this challenge that has persuaded non-libertarians to abandon their counter-claims.

Conversely, one might support an axiology that recognizes a pluralism of values, but insist that personal choice always takes precedence. Then, whenever a value conflict arose, personal choice would always be granted priority. There is not the time nor the space to fully rebut this position. Suffice it here to say that notorious problems attend this position. In the first place, there is sufficient dispute that any particular value is always primary. And even were it possible to achieve agreement that personal choice always occupied a privileged position, such that it would win any competition with any other single value, that alone does not assure that it could maintain its primacy should a conglomeration of other values oppose it.

One might further pursue the claim that the universe contains a pluralism of values and interests, with different ones being attractive to different persons or groups. This
being so, what constitutes a person's best interests admits of different analyses and there will always be a question of which (whose) estimation to honor. Groups having particular biases (as, for example, the prejudice of HCPs for treatment of pathophysiology) may need to be constrained when that partiality impinges upon the values of others who do not share the background that gives rise to the biases (as, for example, may be the case with individual patients). Granting authority to individuals to override the judgments and recommendations of experts is one way of admitting the legitimacy of pluralistic values and their worth to individuals.

Whatever the ontological status of values, epistemological analyses have yielded a moral pluralism. This is to say that even if there is a single universal value, its nature has remained inaccessible. Currently a number of values are available for moral guidance. Which is primary or how the hierarchy is constructed varies among scholars. The only agreement seems to be that there will continue to be disagreement. As a result we seem at this time to be committed to a relationship between theories of morality and a political structure that goes something like the following:

It is a matter of fact people are concerned about the moral order and that they do espouse different values and rank them in different ways. Because attempts to discover the true ontological nature of (the hierarchy of) values have failed, consideration of and respect for these variable constructs is
warranted. Insofar as we believe that morality per se and attempts to elucidate its concepts are themselves valuable, it behooves us to respect the efforts of people to explicate morality. Efforts to do so have yielded diverse results, many of which are equally compelling and none of which has been determined to be the single correct approach. All, therefore, are worthy of consideration and respect.

The same respect that is due to agents in their efforts to explicate morality per se attends their efforts to identify the more personal values by which they will structure their lives. Insofar as they are beings worthy of respect, the same latitudes that attach to the moral enterprise generally will attach to their particular decisions. The implication of such tolerance is that there will exist for competent persons a "zone of privacy" in which they alone have decision making purview. Just as there are disparate but equally legitimate evaluations of the correct structuring of the moral order, so are there disparate but equally legitimate evaluations of the correct structuring of personal lives. So long as one's personal structure does not infringe upon similar structures of others, or harm them in any serious way, that structure must be respected. Respecting such structures is one way of respecting persons.

This is not to say that the choices of competent persons can never be overridden. Included within the plurality of values may be some very good—indeed, compelling—values that
at least sometimes argue for failing to respect the choices of competent persons. Nonetheless, overriding the choice of a competent person is an instance of failing to respect that person and always demands the strongest justification (assuming it will be possible to justify such intervention at all).

Within the practice of informed consent, however, to appeal to ethical principles or values other than respect for persons in an attempt to override a competent patient's decision is to miss completely the point of the practice. In a nutshell, persons are deserving of respect. This is because of certain valued capacities they possess, one of which is the capacity to structure their own lives according to values, goals, and means which they have chosen. One instance of such structuring is the decision making process that attends health care choices. The practice of informed consent was instituted to extend respect for persons into the health care setting. Failure to honor patients' choices is a failure to respect persons and, in a larger sense, an act against the entire moral endeavor. To appeal to other moral principles, claiming that in this case it would really be better not to respect persons (but to, for example, act in their best interests as interpreted by someone else), is to miss the point both of informed consent and of respect for persons.

It may be that it is at least sometimes permissible to step outside the practice. In such cases one would admit that
there are principles other than respect for persons that must be considered. Then, although the practice of informed consent normally grants immunity to that appeal, in some cases that appeal is only one among many. Nonetheless, given the centrality of respecting persons to the entire moral endeavor, such cases will be rare and, as noted above, will necessarily include other very powerful moral appeals.

II. GLOBAL VS. SPECIFIC COMPETENCE

A. Understanding the Concepts

There is nothing particularly esoteric about global and specific competence; they merely constitute one example of the general/particular distinction found in common parlance. For example, a person might be a generally competent athlete; that is, she is capable of performing acceptably on the volleyball court, the tennis court, the running track, and the bowling lanes. She may, of course, perform some actions better than others. In fact, she may be quite good at some sports and quite poor in others, while at the same time being adequate at most athletic endeavors. To be generally competent is not to be perfect, but to be capable of performing adequately more often than not.

Conversely a specifically competent athlete is capable of performing satisfactorily in a particular sphere (for example, being a competent basketball player) without neces-
sarily being capable of extending that ability into other spheres (as, for example, also being competent to throw a discus). A specifically competent person is adept at one thing, but not necessarily at anything else.  

In medicine the global/specific distinction is acknowledged in the old saw that a generalist (i.e., a general—or, in today's vernacular, family—practitioner) knows less and less about more and more until finally she knows nothing about everything; while a specialist knows more and more about less and less until eventually she knows everything about nothing. Put another way, one might be a competent family practitioner, but not a competent cardiologist, and vice versa.

There are multiple variations on the conception of competence. Herein I follow Abernethy in understanding global competence to be functioning appropriately "in an array of cognitive and interpersonal domains" ([1], p.57), and Beauchamp [16] in assessing specific competence as "the ability to perform a task". We recall that global competence (GC) is schematized as

A person (P) is competent (C) for any task (T) if a standard (S) is met (or met to degree D)

while specific competence (SC) is

P is C for this T because S is met for this T (or met to D).

The concern in the present context is what it means to be globally or specifically competent with regard to consent.
The problem with either conception is one of specification, i.e., identifying what constitutes "functioning appropriately" or "ability to perform". Both phrases imply a capacity to get the job done, but what does this mean?

Most broadly a person is thought to be globally competent to consent if she is "informable and cognitively capable of making ordinary decisions on matters unrelated to the crisis at hand" ([1], p. 57)\(^{25}\). There are three components of this definition. The first is informability.\(^{26}\) To be capable of being informed, one must be able to acquire information. Thus a person must be able to receive data from his surroundings,\(^{27}\) to recognize information as information (both about the environment itself, i.e., that a choice is at hand, and about the facts themselves, i.e., to understand the content of incoming data)\(^{28}\), and to remember or retrieve it for use in the on-going process of decision making\(^{29}\). To do this one must be conscious, aware of the environment, educated (or educable), and aware that incoming data have a status beyond that of random stimuli impinging upon oneself and that may hence be ignored. One cannot be out of contact with reality for either physiological (e.g., coma) or psychological reasons (e.g., autism); suffer from delusions that radically interfere with one's relation to the world; nor be intellectually barren (i.e., unable to learn). To be informable, then, is to be able to receive, recognize, and remember facts.\(^{30}\)
Secondly, one must be "cognitively capable". This criterion is itself a conjunction of several distinct capacities which, taken jointly, imply the ability to assess and manipulate information. One must be able to consider how (if?) any information received relates to oneself, and to consider various choices with regard to how they might alter one's present or future status and plans. One must be able to examine how different responses would lead to different outcomes, and to assess which, based upon one's set of values, would be preferable. One must also be able to understand that different probabilities of success attend each of the different options and to include those probabilities in one's decision making calculus.

Based upon the above, one should be able to rank possible choices according to preference and the likelihood of outcomes. Thus a person must have the ability to see relationships between information and herself, the ability to weigh varying risks and benefits, and the ability to order prospects. Put another way, one must be able to relate to, reason about, and rank one's options.

Thirdly, one must be able to make a decision; that is, choose in light of his preferences. Moreover, a person must be able not only to actually select an option, but to psychologically respond to that selection (e.g., to embrace his choice wholeheartedly or to at least resign himself to its being the lesser of the evils). Thus one must be able to
resolve the situation and respond to the resolution.

In summary, global competence requires a variety of capacities: to receive, recognize, and remember information; to relate to, reason about, and rank alternatives; to resolve situations; and to respond to those resolutions. In health care settings it also requires, I submit, a fourth capacity to persist in one's decision and perhaps to recount this process to others so that they might have some evidence that the capacities are present. More will be said about this requirement later. One of the problems that attends competence assessment is confusion about justification of choices. To what extent need a person be able to articulate her choice and the reasons for her having made that particular choice, especially to those who will be instrumental in her realizing the chosen end? Put another way, how persuasive must patients (be able to) be about their choices?

Global competence, then, presupposes that persons are generally informable, cognitively competent, and able to make decisions. Too, it often presupposes that persons will be exercising these capacities under what counts in their lives as "normal" circumstances, i.e., those with which they have some familiarity. Applied to decision making, this would mean that so long as the four broad criteria are generally met, a person ought to be considered competent even when she appears to be incapable of making a particular decision, so long as it is sufficiently unlike the ones she usually faces. Then
for the patient who is having problems making a particular decision, but who has been able to make past decisions successfully or who is able to make other decisions in the present, the initial assumption should not be that she is an incompetent decision maker. Rather one probably ought to assume that she is experiencing an information deficit about the decision in question.  

So we see that on a global analysis of competence, "functioning appropriately" means being generally able to act to ensure the greatest probability of satisfactorily resolving those choice-requiring situations that a person faces. The idea is that, to be competent, persons must be able to choose those courses of action that seem most likely to promote outcomes that they determine will redound to their well-being.

It must be emphasized that the appeal here is not to outcomes but to an ability to complete a process that persons undertake to achieve those outcomes that they have themselves defined as desirable. We are all familiar with the havoc that chance can wreak upon schemes and dreams. If only outcomes are considered, the very lucky might appear to be competent decision makers, while the thoughtful but unfortunate may appear incompetent. This is why the appeal must be to a process that persons undertake to structure the way their lives will go rather than to results.

Such a process requires that persons be able to choose on the basis of a knowledge both of the facts of the matter
and of probabilities. This means they must know generally what their alternatives are. They must also be able to estimate what chance each has to secure the desired result.

Under this analysis, global competence will not require that all choices actually maximize or even promote one's well-being. What it does require is that decisions be made according to a procedure for acquiring information and exercising cognitive capacities so as to embrace the best foreseeable opportunity of realizing one's goals. Insofar as such things are under one's control, working according to such a mechanism insures that choices will best promote one's interests.

On this kind of procedural definition, where the task (T) is "making a decision", the standard (S) for global competence becomes: P can (or can to degree D) generally acquire information about options, weight them according to their probabilities of achieving his chosen aims, choose on the basis of that information and those estimates, and persist in that choice. Then GC, or,

A person (P) is competent (C) for any (T) if a standard (S) is met (or met to degree D)

translates to

P is C to make any decision if P can (or can to D) generally acquire information about options, weight them according to their probabilities of achieving her chosen aims, choose on the basis of that information and those estimates, and persist in that choice.
Conversely a person is thought to be specifically competent if she has "the ability to perform a task" [16]. For our purposes here she is specifically competent if she can give or refuse to give her consent to a particular treatment (where that includes reference to a particular condition, a particular practitioner, a particular place, and a particular time or span of time). The same three components of global competence exist, though with qualifications, for specific competence.

With regard to informability, one still must be capable of being informed, i.e., of receiving information from one's surroundings, of recognizing it as information, and of (actually or potentially) understanding the relevance to oneself of the data received. The difference lies in the fact that specific competence requires that one be capable of being informed about a particular project, of receiving some particular information from one's surroundings, of (actually or potentially) understanding the particular data received, and of recognizing it as information that is pertinent to one's present situation and that must be used to make a particular decision about a particular problem. That one was informable at some time in the past or will (again) be informable some time in the future is irrelevant; that one is able to do something else (say, ride a bicycle) is also unimportant. It is one's capacities to do some particular task--make this decision--that determine one's competence to
tender a specific consent. Lastly, informability again requires the capacity to remember; here, the facts pertaining to the particular decision at hand.

Again as with global competence, in specific competence the cognitively capable criterion implies an ability to manipulate information. But now one must be able to consider how (if?) this information received relates to oneself, and be able to consider how this information relates to and might alter one's present or future status and plans. One must be able to understand the probabilities of the different options and incorporate them into making this decision. And one must be able to examine how different responses to this information would lead to different outcomes and to decide which, based upon one's set of values, would be preferable. Again, previous possession of these abilities is not germane; one must have them at hand at the time this consent is sought.

Thus specific competence presupposes that persons are sufficiently informable, cognitively competent, and able to make and persist in decisions only within a very particular framework. What they have been able to do in what counts in their own lives as normal circumstances matters not at all (although, as noted above, a person's history will provide a useful guideline as to what one might reasonably expect from the person as decision maker). Nonetheless specific competence demands that persons have competence assessed on the basis of a performance under a very particular set of condi-
tions: the one that is at hand. Even if the four broad criteria are generally met, a person will not be considered competent unless she is capable of managing this particular situation.

As with global competence, it must be emphasized that assessments of abilities to give particular consents do not appeal to outcomes but to a process that persons undertake to achieve those states of affairs that they have themselves defined as desirable. Here again chance may play a part, and if only outcomes are considered, the very lucky might still appear to be more competent decision makers than are the thoughtful but unfortunate. This is why the appeal must be to a process that persons undertake to structure the way their lives will go, rather than appealing to an outcome. (See note 32.)

When the decision making framework is specific rather than global, the mechanism requires persons to know for this choice what the alternatives are and to be able to estimate what chance each has to secure the desired result. Specific competence will not require that a single choice actually maximize, nor even that it in fact promote one's well-being. What it does require is that this decision be made according to a process of acquiring information and weighting options that has the best foreseeable chance to realize one's goals in this case. Insofar as such things are under one's control, recourse to such a procedure should best insure that definite
choices will promote one's interests, broadly construed.

With such thoughts in mind, on a specific notion, where the task (T) is making this decision, standard (S) becomes: for this decision P can (or can to degree D) acquire information about options, weight them according to their probabilities of achieving her chosen aims, choose on the basis of that information and those estimates, and persist in that choice. Then SC, or,

P is C for this T because S is met (or met to D)

translates to

P is C to make this decision because, for this decision, P can (or can to D) acquire information about options, weight them according to their probabilities of achieving her chosen aims, choose on the basis of that information and those estimates, and persist in that choice.

B. Implications

Prior to discussing the disparities between the global and the specific analyses of competence, it is useful to note that the conceptions are more alike than they are different. On both accounts persons must be informable, cognitively competent, and able to make and persist in (some kind of) decision(s). Their differences do not lie in what must be done or in what abilities one must have; rather, they lie in the circumstances under which tasks must be executed. As a result, the analyses can affect different patient populations. I turn now to a consideration of these differences.
When consent is required, the task immediately at hand is to determine if the patient from whom consent is sought is competent to give that consent. On either conception the patient's decision making ability must be assessed. On a global conception the patient's general decision making capacities must be evaluated, while on a specific conception only the patient's ability to make a particular decision will be examined. For the former, the distraught or the merely recalcitrant person who fails to resolve a particular health care decision but who continues to make other sorts of decisions in a reasonably adept manner remains competent because her decision making capacities are, in general, functional. For the latter, the person would be deemed incompetent because, with specific competence, the patient's decision making abilities must be intact and the person must be actively using them at the time a certain consent is required. Past and potential decision making ability are irrelevant, as are present capacities that are not focused upon the relevant decision. This being so, concerns about global vs. specific competence arise in two groups of patients: those whose decision making abilities are usually above reproach (whether this refers to a general historic ability to make decisions or to a current ability to make most but not all decisions), but who now seem to lack the relevant capacities to give a particular consent; and those who now seem able to make the relevant decision, but who nonetheless
have difficulty with most others. Consider the following examples.

CASE I: Mr. Tsai is a 42 year old unmarried male who lives with his brother and sister-in-law in an inner city neighborhood. He is poorly educated, but able to understand most information that is presented to him in layman's terms. He has been hospitalized several times over the past six months with stiff neck, headaches and disturbances of balance. Repeated lumbar punctures have revealed persistent meningeal inflammation but all procedures to date have been unable to isolate the causative organism. A diagnosis of chronic meningitis has been made. Because several courses of broad spectrum antibiotics have failed to cure the disease, a cisternal tap has been recommended with the hope of being able to isolate the causative organism. Mr. Tsai understands what his illness is, why treatment has failed, and what his HCPs now want to do. He has consented to the procedure, but on two different occasions upon being taken to radiology for the maneuver he became quite agitated and adamantly insisted that he had changed his mind about having the procedure done. He admitted after the fact that he was worried about his revocation of consent, that he knew his "only chance" for cure
was to have the test; nonetheless, he stated he "just couldn't go through with it", an inability he himself was at a loss to explain. A work-up by psychiatry ultimately revealed that Mr. Tsai suffered from intermittent auditory hallucinations that told him "the doctors are trying to kill you". Even though the "voices" were not active during the attempted cisternal taps, Mr. Tsai was responding subconsciously to their warning.

CASE II: Ms. Smith is a 73 year old nursing home resident. She was admitted to the nursing home when a fixation about pursuing a career as a surrogate mother and suspicions that her nephew was trying to steal her money caused her to behave in ways that threatened her safety, as well as the safety and comfort of others. Now rather excitable and "nervous", Ms. Smith requires assistance in most activities of daily living. Her nephew, as her legally appointed guardian, makes all her financial and legal decisions. Diagnosed with a carcinoma of the cervix for which a hysterectomy has been recommended, Ms. Smith originally refused the operation because the surgery would "make it impossible for me to be a surrogate mother and help all those sad women who can't have children on their
own". However, after conferring repeatedly with her physician, primary care nurse, and her nephew, she is now able to understand that she is sick, that her life will be threatened if she does not have the surgery, and that her nurse and nephew will visit her daily during her hospitalization. She consents to the surgery.

We see that the crucial difference between global and specific competence is the extent to which the relevant capacities are operational with regard to a particular decision. Put another way, the presence of certain capacities allows a person to undertake a process by which decisions are made that, ceteris paribus, will lead to the person's well-being. These capacities may attend decisions generally or particular decisions. If they attend decision making generally, the person is deemed to be globally competent. If they attend the making of a particular decision, the person is considered specifically competent.

In some cases a person may be both generally competent and competent to make a specific health care decision about consent for treatment. In other cases a person may be capable of making most decisions, but incapable of making the specific health care decision (Mr. Tsai, the patient with meningitis). In yet other cases a person may be globally incompetent while being specifically competent for a certain health care
decision (Ms. Smith, the patient with cancer of the cervix). Finally, a person may be both globally and specifically incompetent (e.g., a comatose person). To illustrate these differences, let us consider three cases in which competence determination is a factor.44

Is (are) Mr. Tsai or Ms. Smith competent to consent to or refuse treatment? Mr. Tsai would seem to exemplify the first category—those able generally to make decisions, but hampered in making a particular choice. In his case, his hallucinations preclude his carrying out a program that, in his more controlled moments, he believes to be to his advantage (a belief with which his HCP's concur). Ms. Smith, on the other hand, seems generally incompetent to consent or refuse because she lacks the capacities necessary for self-sufficient decision making in the management of her life as a whole. Still, persistent attempts at explanation and reassurance have enabled her to understand the nature of the situation in which she now finds herself and, in virtue of that understanding, render her competent to make the concrete decision she now faces. As such, she represents the second class of patients—those who are generally incompetent while being specifically competent.45

The interesting question is whether, as does seem to be the case, different conceptions of competence will designate as competent different patients or patient populations. Mr. Tsai is globally competent but specifically incompetent; while
Ms. Smith is globally incompetent but specifically competent. If different conceptions designate different people as competent and incompetent, what are the implications of that fact? Does it matter that on a global conception of competence Mr. Tsai is competent while Ms. Smith is not, while on a specific conception the reverse would be true?

Mr. Tsai's case gives one pause because he seems to admit the importance of the same facts as do his HCPs. Moreover, he seems to value the same things and want the same outcomes as they do (e.g., his recovery). Thus his repeated last-minute revocations of consent are bewildering and lead his HCPs to suspect that something else is going on, that he might be less than fully competent. On a global conception, he qualifies as competent. On a specific conception his competence may be questioned.

Ms. Smith, on the other hand, has been unable for several years to manage any of the important decisions in her life. On a global conception she is clearly not competent. Still, on a specific conception, she seems competent to make this decision. Insofar as she understands what is wrong with her and what the recommended treatment entails, and insofar as she recognizes the pros and cons of proceeding with treatment and the effect of the surgery on her life, she will have grasped the important facts of the matter and thus be considered able to make a choice based upon those facts.
The upshot of these remarks is that on a global conception Mr. Tsai is competent and Ms. Smith is not, while on a specific conception Ms. Smith is competent and Mr. Tsai is not. Put more generally, with a global conception, persons who (more often than not) manage their lives successfully will be deemed competent to manage whatever health care situations they face.47 Patients who lack the ability to make most decisions will be required to turn to others to manage their medical decisions as well. Conversely, on a specific conception persons who manage their lives successfully will not necessarily be deemed competent to manage their health care situations (although they may be), while persons who depend upon others to manage their daily affairs may nonetheless be deemed competent to manage their health care situations (although they need not be). The problem lies in deciding which approach is properly ascribed to competence to consent.

C. Justification

The question naturally arises: How is it that conflicting conceptions have arisen? What is the moral justification for the use of each?

The most fundamental justification for a global conception of competence is the principle of respect for persons. The argument goes like this: Persons are special sorts of creatures, worthy of respect, because of certain sorts of abilities they have. One of these abilities is being
able to order their lives according to a mix of values, goals, and commitments that is unique to each person. One way of respecting persons is by refraining from interfering with their pursuits of their goals and commitments. Other things being equal, individuals know best what their own goals are and whether/to what extent participation in medical regimens promotes or obstructs those goals.48

It may appear possible to justify a global conception through an appeal to consequences. Here the claim would be that the person best knows what consequences are most desirable from her point of view. Then, assuming adequate information about alternatives and the probable results each would produce, she can choose the intervention (including no intervention) that will most likely produce the preferred outcomes. Regardless of which outcome seems most desirable to others, a well-informed person's choice will be most likely (have the greatest probability) to promote her best interests. Thus anyone interested in maximizing good outcomes will allow persons to choose according to their own lights.

All of these claims may, in fact, be true. Nonetheless I have argued that, at least within the practice of informed consent, one of the crucial implications of respecting personal choices in competent patients is that their decisions must be honored even if they do not redound to the best interests (as interpreted by others) of the chooser, i.e., when the best consequences (on some external estimate) would
not result. In such cases the appeal to consequences would require that the choice not be respected. Put another way, a consequential analysis would demand that the person not be respected.

In fact when the appeals to respect for persons and to consequences converge--i.e., when everyone, person and observers, agrees that the choice is in the best interests of the person making the decision--there is no need to appeal to consequences because the chooser is demonstrating in ways that are acknowledged by everyone else both her capacity to promote good consequences and to be the kind of person deserving of respect. When the two appeals diverge, the appeal to respect for persons would argue that this is just the type of situation--one in which the person is choosing in light of uncommon, unshared values--that the value of respect for persons demands be honored. This respect should be tendered even (and in fact especially) when the decision does not appear, from an external point of view, to redound to the person's well-being.

As a matter of fact, the freedom to march to the beat of different drummers is widely recognized and valued, at least within the United States. Persons who undertake risky behaviors (e.g., mountain climbing, motorcycle racing, etc.) are at least tolerated (if not encouraged) in such endeavors. It is generally admitted that such behavior may lead to "poor" outcomes (e.g., injury or even death) as assessed by others.
Indeed, the agent herself may likewise disvalue these possible consequences. Nonetheless, the value that accrues to one's life, all things considered, is thought to outweigh these appeals to consequences. Part of such freedom, then, is the freedom to fail to reach particular goals or to produce marvelous outcomes.\textsuperscript{49}

A second justification for a global conception, a right to privacy, is also derivative upon the principle of respect for persons.\textsuperscript{50} The assumption is that if there is anything over which a person has legitimate control it is what happens to his own body. This assumption protects that body from invasion by others in the absence of consent by its "owner". Thus persons have a right to allow or refuse access to their bodies.\textsuperscript{51}

Justification for a specific conception of competence also appeals to the principle of respect for persons. The claim is that one way of respecting persons is to act so as to foster their continued existence/well-being according to their own values and goals, even when they (appear to) request otherwise. Here the argument is: persons are special creatures whose decisions ought be honored; sometimes persons, due to a (temporary) loss of or reduction in capacity for principled decision making, make choices that are at odds with their own espoused values and goals; in such cases, respect for persons demands that we act to preserve/enhance/restore the capacities of individual persons, even if this means
(temporarily) usurping their decision making role.  

The appeal to respect for persons may powerfully serve the specific conception of competence to consent when persons want to pursue paths at variance with their own stated goals and values. Here the claim is that one's own definition of best outcomes are at least sometimes achieved by overriding a particular choice one might make regarding treatment. In the case of Mr. Tsai, for example, the claim might be made that his own strong preference for treatment is best served (and respect for persons best tendered) by performing the cisternal tap, even in the face of his adamant objection at the time the procedure is actually attempted.

Both global and specific conceptions have garnered tremendous psychological support. Consider the question: Did she do it? Each conception posits a different response, based upon a different emphasis, to this question. Globalism focuses upon "she" and appeals to the "Invictus" aspect of human nature, that part of persons that insists "I am the master of my fate: I am the captain of my soul" ([64], p. 375). Here the emphasis is on "she" and the appeal is to consistency of the psyche. The concern is not with the choice, but with the person choosing. In other words, did the agent control the activity, did she do whatever task (here, choose) was under consideration?

There is a tremendous force to the claim that as long as persons want and are attempting to choose how to manage their
lives, they ought to be allowed to do so. The thought is that those who will be most affected by a particular course of action ought to be the ones to select which course will be followed. Such considerations are central to one's identity, to who "she" is. And there is no compelling reason to limit such choices to the realm of the "reasonable" or to "what's good for you". If one is genuinely the master of one's fate, that mastery extends to the eccentric and the harmful.

Proponents of specific competence are likewise buttressed by psychology. But here the emphasis is upon "do", and the concern is to show that the agent was acting, as opposed to merely reacting or unthinkingly going through the motions of, and hence merely appearing to be, acting. To actually do the task of choosing requires that certain capacities be in place (i.e., those that constitute informability and cognition) and that they are being applied to the task at hand. Persons with such capacities are the sorts of beings whose choices are worthy of respect.

If, on the other hand, these capacities are not intact and at work, the patient is not doing the task, but is doing something else (merely responding to stimuli). As such there is no reason to respect what may appear to be a choice but is, in reality, something else (an automated or unthinking movement). This is because a "pseudo-choice" is not a reflection of the capacities that motivate respect for persons. We respect persons secondary to capacities. Absent
the capacities, there would be no (or less) reason for that respect. Thus when the capacities inherent in competence are absent or diminished, the choices made do not carry the same moral mandate for non-interference.56

Nonetheless I believe an argument can be made that competence, at least as it applies to decision making and informed consent, refers to a person's capacity to make a specific decision rather than to those capacities, all things considered. That argument is this: When HCPs seek a person's consent, what they are seeking is his permission to intervene in his life in a very particular way and for a very particular purpose. It is not that they are unconcerned with how this will affect his life as a whole; indeed, it is often because they are greatly concerned to restore him, as fully as possible, to that life that intercession is contemplated. The patient's life as a whole will hopefully inform his choice and, to the extent that it is known to HCPs, their assessment of whether the choice is consistent with that life. As noted above, choices that seem odd herald the need to explore further why patients have made them.

Nonetheless, when HCPs seek a patient's informed consent, they do so under the aegis of a practice (in the technical sense of that term as discussed above). That practice demands that the person be competent to give this consent. The practice decrees that it is this consent and the capacity to give it to which HCPs must attend. It is competence to give
this informed consent that must be assured. For it is only competent persons whose consent is valid, and if the patient is not competent to make this decision, he cannot validly give this consent for this intervention.

If the patient is both generally and specifically competent, there is no problem. If she is generally competent but incompetent for this decision, transferring decision making capacity to someone else should be the best way to enhance (restore/prevent diminution of) her greater decision making capacity.\textsuperscript{57} Put another way, it should be the best process for respecting the patient as a person. And, it will be recalled, one purpose of the practice of informed consent is to tender respect for persons.

D. Critique

Even with this hard choice settled there remains the problem of testing for the presence/absence of decision making capacities. As Chapter I, Section II.B. illustrates, the tests currently available for these capacities suffer from multiple design problems that impugn their reliability. This discussion has presupposed that a person must have some capacity for manipulation of information, a presupposition that derives both from the nature of persons and from the practice of informed consent. The former includes the special abilities of people, as opposed to other animals, for rational consideration of data as an essential element for planning their lives, ordering priorities, constructing personal
values, and the like. The latter looks to the nature of the practice itself: informed consent just is the presentation and consideration of data that attend different alternatives in particular situations and the analysis of which results in one's making a decision.

Nonetheless while these considerations provide good reasons for requiring the inclusion of a certain (but how great?) capacity for information management, they do not provide equally good reasons for limiting the requisite capacities to these skills alone. There are also reasons (to be discussed in Section V of this chapter) for demanding the presence of non-cognitive, affective capacities.

Which of these capacities are necessary (and, perhaps, which must be absent) has not been determined. This compounds the problem of how to test for whatever capacities a conception includes. Even if the necessary abilities were limited to information processing skills, testing for their presence remains problematic. Since the stress of illness often impairs attention, concentration, and memory, the patient's informability and cognitive capacity are often impaired (See note 82 infra). It thus becomes imperative to assess the extent of such impairment but, again, no reliable tests exist.

Not only is there a problem in determining how much impairment exists, there is as well no definition as to how much is too much. Moreover, such designations may also be
affected by value judgments. The concerned clinician or family member whose primary motivation is to control or cure the patient's specific pathology may be reluctant to accept a patient's refusal of treatment. It then becomes tempting to associate an unwanted decision with stress-related reduction of capacities, and to charge that if the patient were truly informed she would decide as her caregivers and others recommend rather than as she has chosen. The question remains: is a patient who is somewhat impaired competent on a specific conception of that concept?

E. Summary

Both GC and SC appeal to common sense, as well as to respect for persons for justification. Nonetheless the fact that competence to consent is located within a practice allows us to argue that a specific rather than a global conception of competence is what is required. Still requiring resolution are the problems of delineating the requisite capacities and of constructing a reliable test for their presence/absence. Clearly choosing between GC and SC will not resolve all the problems surrounding the concept of competence.

III. THRESHOLD VS. DEGREE COMPETENCE

Regardless of its having been resolved that competence is a specific rather than a global notion, the conception of competence remains incomplete. Still to be addressed is the
question of threshold vs. degree, i.e., of how to qualify whichever conception obtains. This is the issue of what the standard for decision making should be. Just as the GC vs. SC dichotomy raises the question of the appropriate context for decision making, the TC vs. DC dichotomy poses the question of just how the capacities under discussion apply to determinations of competence. It is to an extended consideration of this next distinction that I now turn.

A. Understanding the Concepts

The distinction between threshold and degree is analogous to that between all-or-none and more-or-less. The degree, or more-or-less, approach operates on the assumption that competence (more specifically, the capacities that constitute competence) lies upon a continuum. The end points of this continuum are "fully competent" and "fully incompetent" [51]. Between these ends lie infinite points according to which persons may be designated as possessing greater or lesser competence. Persons are, on this approach, more or less competent. A degree notion of competence, then, asserts that different persons possess in varying amounts the capacities required for competence, according to which they are considered more or less competent.

The threshold, or all-or-none, concept incorporates a point or line of demarcation that runs through competence determinations. On this system the continuum still exists, but a certain value along the progression is designated as a
cutoff point. Persons whose capacities fail to reach this point are deemed incompetent; those whose capacities reach or exceed the level are deemed competent. The cutoff point allows, at least in theory, clear cut designations to be made, such that persons either are or are not competent. A threshold notion of competence, then, is a construct by which a level of capacities is established by fiat as definitional of competence. Recalling the schemata from Chapter I shows that on a degree conception (DC)

\[ P \text{ is C to D for this } T \text{ because S has been met to D,} \]

while according to TC, the threshold conception,

\[ P \text{ is C for this } T \text{ because S has been met.} \]

The athletic metaphor used above helps illustrate the difference. On a degree notion a basketball coach might decide that her team of players will be good enough to make the finals if, on average, the team as a whole shoots at least 85% from the free-throw line, 78% from the field, and scores 60 points a game. Of course individual team members will be more or less competent free throw shooters, more or less competent shooting field goals, and better or worse defensive players.

On the other hand a coach may select a team by demanding that each player be capable of performing satisfactorily at particular levels or thresholds. That is, each player must
be able to shoot at least 85% from the free-throw line, 78% from the field, and score 10 points a game to be deemed a competent basketball player.

In medicine the degree/threshold distinction may be found in the literature on severity of illness indices and the management of seriously ill patients. Patients can be classified as more or less sick on the basis of the scores they receive on such systems as APACHE II [82], TISS [38], [77] or APS ([86], [88], [89]). For example, patients with APACHE (Acute Physiological and Chronic Health Evaluator) scores in excess of 40 are considered to be very sick, while those whose scores are 5 or below suffer minimal physiological derangement.61 Individual patient's scores fall on a continuum between zero (no pathology) and, for example, 50 (major, widespread pathology). The patient who scores "one" (i.e., who is virtually normal) is less sick than is the person who scores "41" (i.e., is critically and irreversibly ill). Likewise for patients with scores of "7" vs. "40", "10" vs. "30", "20" vs. "21", ad infinitum. For institutional populations, within which some patients are more and some less sick, one can set a threshold that will determine treatment loci and modalities. For example, patients with APACHE scores in excess of 22 may be decreed sufficiently sick to require intensive care; i.e., they meet that institution's threshold for admission to ICU. Likewise the patient whose APACHE score is greater than 40 may be, again according to a particular
institution's policy, defined as too sick to recover. Because these patients reach a threshold that indicates an inability to benefit from ICU care, their admission to ICU may be barred, even should they or their families request such care.

The concern in the present context is what it means to be competent to consent on threshold and degree notions. Again the problem with either conception is one of specification, here of specifying which capacities at what level constitute the threshold (i.e., Standard S) and how these differ from the number or level of capacities that make up different degrees (D) of competence.

As with global and specific competence to consent, the presumption is that the threshold and degrees bear some relationship to informability and cognitive capability in making decisions. Thus the components discussed above (i.e., informability, cognitive capability, and the abilities to make and persist in a decision) form the basis for assessing further qualifications of the conception. Turning again to informability, the concern now is with the extent to which a patient must be capable of receiving, recognizing, and remembering data to be considered competent.

Regarding the second, third, and fourth criteria, cognitive capability (manifested as some ability to manipulate information) and the abilities to resolve a situation and persevere in that resolution will still be required. Persons must still be able to recognize to some extent situations in
which a choice is required, as well as be able to some extent to identify and choose between alternatives and to endure in such choices. Thus on a threshold conception the standard (S) becomes "possesses to extent E the capacities to make this decision because P has to E the capacities necessary for decision making (i.e., she can acquire to E information about options, weight them according to their probabilities of achieving her chosen aims, choose on the basis of that information and those estimates, and persist in that choice). Then TC, or,

P is C for this T because S has been met

translates to

P is C for this T because she possesses to E the capacities for decision making (i.e., she can to E acquire information about options, weight them according to their probabilities of achieving her chosen aims, choose on the basis of that information and those estimates and persist in that choice).

Conversely on a degree notion of competence a person is rarely (if ever) said to be fully competent or fully incompetent. When she attains (or fails to attain) a particular level of capacity, she is competent to that extent. Thus if she is informable and in possession of cognitive capacity and decision making ability to degree D, she is competent to degree D. Here capacities are ranked according to their locations along the continuum. Thus if one can be accurately informed about six situations in ten, or capable of making decisions in half the situations with which one is presented
(or, perhaps, six out of ten times one faces a specific situation), then one is capable to degree 6 and 5 respectively.\textsuperscript{63}

Thus on a degree conception of competence S becomes: possesses to degree $D_x$ the requisite capacities for decision making. And DC, or

P is C to D for this T because S has been met to D, translates to

P is C to $D_x$ for this T because P possesses to $D_x$ the requisite capacities for decision making (i.e., she can acquire information about options, weight them according to their probabilities of achieving her chosen aims, choose on the basis of that information and those estimates, and persist in that choice).\textsuperscript{64}

B. Implications

Again it is worthwhile to note that the conceptions of threshold and degree are more alike than they are different. On both accounts persons are evaluated according to the same criteria: informability, cognitive competence, and the abilities to make and persist in decisions. Here the differences lie not in what capacities are present, but in whether/to what extent the level of capacity present constitutes competence.

When consent is required, certain determinations must be made. For both threshold and degree conceptions the patient's decision making ability must be assessed. Additionally, for both systems the patient's level of capacity must be located upon a continuum. In this respect the implication is the
same: neither system will function without a reliable method for assessing a patient's capacities. Moreover, both demand some way of evaluating examination results, i.e., a method for scoring capacities that will permit their being placed upon the continuum. This is to say that these conceptions require a list of capacities, a test for capacities, a method for scoring capacities, and a method for assigning the scores along the continuum.

From here on the implications diverge. On a threshold conception the requisite level of competence (i.e., the threshold) must be set. This means that there must be some determination of what level of capacity is consonant with a declaration of competence. Whatever level is chosen will require some justification as to why everyone below the level will be, at least for purposes of consent, incompetent, while everyone above it will be competent to guide her own medical course. Of course once these points have been established, anyone falling on or above them will have her decision respected; anyone failing to attain the level will have her decision set aside. (See note 23 supra.)

It is difficult to say, especially given that competence will be determined in specific situations, how thresholds might be set. Surely a patient will need to understand that he is sick, what (at least in a general sense) is wrong with him, the nature (again, at least in a general sense) of the recommended treatment, and what chance it has for success.
What, if anything, beyond that ought to be included would need to be determined on an individual basis. In fact, the particulars of even those components might need to be much more precisely specified.

It is just such particularization that a degree conception of competence seems better able to accommodate. As a matter of fact, individuals can and usually do understand the particulars of those components to greater or lesser degrees. Where one patient will realize only that she is "sick", another will understand her diagnosis anatomically, physiologically, and biochemically. Where one patient will recognize only that her doctor wants to do surgery, another will be able to articulate with precision the actual details of the surgical procedure. Where one patient knows only that treatment will "probably" make her better, another will appreciate the probability for complete vs. partial cure, with and without complications. The latter patient in each case can surely be said to be more competent to consent than the former. To the extent that greater competence is present, the patient will have a greater claim to having her decision respected.

To illustrate the difference between these approaches, let us consider two cases.

CASE III: Mr. Simmons is a 47 year old street person who was brought to the emergency room by police officers who discovered him, collapsed and
confused, in an urban alley. Physical examination reveals a poorly nourished, dirty, dehydrated man who is oriented to person only. He has an 8 X 10 cm. coccygeal ulceration extending into the gluteal crease. The ulcer is draining a purulent material, and blood cultures reveal a gram negative septicemia. After three weeks of hospitalization, adequate nutrition and hydration, antibiotics, and debridement of the ulcer, Mr. Simmons is alert, oriented to time, place, and person, comfortable, and requesting to be released. His ulcer is clean and healing nicely, though it will continue to require thrice daily sitz baths and antibiotic ointment applications. Upon questioning, Mr. Simmons states that he "got sick because I was on the street". When questioned as to how he plans to care for himself after discharge from the hospital, he replies he will "soak in water sometimes and put the medicine on my sore". He is, however, unable to remember the specific details of his wound care. Still, when reminded, he is able to complete the procedure satisfactorily. When asked where he plans to carry out these measures, he says only "I have friends to help". He is, however, unable or unwilling to provide their names, and states he cannot remember their address or phone number. Thus
they cannot be reached to receive instructions about his post-discharge care, or to take him home from the hospital. He knows he has to "take care of my sore or it will get bad again" and that if that happens "I have to come back to the hospital." When asked why he wants to leave the hospital and what he plans to do after discharge, he replies, "Just hang out."

CASE IV: Mr. Able is a 32 year old homosexual male with AIDS. He is in the emergency room with respiratory distress, diagnosed as having Pneumocystis pneumonia. His failing health forced him to resign from his job as a Registered Pharmacist six months ago. The loss of his job resulted in the loss of his insurance. He has exhausted his savings and is unable to pay his rent, for life's necessities (food, medicine), and to pay for any further medical care (especially if he were admitted to the hospital). Nonetheless he has two close friends who have welcomed him into their home and, moreover, arrange their work schedules so that one of them is always available to tend to his needs. Mr. Able understands that he has a terminal illness, that with medical care his life can be extended for some brief but unspecified period of
time, that he has at least a 50-50 chance of recovering from this bout with pneumonia but that without treatment this particular illness will probably result in his death. Nonetheless he requests that his friends (whose names, address, and phone number he gives for the record as persons to be notified in case of emergency) be allowed to take him back to their home and keep him as comfortable as possible. He wants to spend his "remaining time saying good-bye to friends and family", and tells his HCPs that he has "gotten all my affairs in order". He requests that he be given a prescription for injectable Morphine Sulfate to minimize his respiratory distress.

Mr. Simmons seems to fulfill the minimum criteria for a threshold conception of competence. He knows what is wrong with him: he has a sore (it is unclear whether he truly can relate this to his lack of access to facilities for personal hygiene). He knows what the recommended treatment is: bathing and medication. He knows his prognosis: if he fails to care for it, he will get worse. Nonetheless his HCPs are genuinely concerned that this minimal understanding of his condition and its contributing factors are insufficient to deem him competent to be released and to be responsible for his continued care. They fear that his low level of
understanding, especially when coupled with limited access to facilities for personal hygiene (or, as is more likely, no access to such facilities), will virtually guarantee that his wound will shortly become re-infected and he will again require hospital admission for sepsis (if, indeed, he does not die before he can receive medical care). They want to declare Mr. Simmons incompetent and admit him to an extended care facility with a court-appointed guardian to make decisions about his care.

In contrast, Mr. Able's HCPs are inclined to honor his requests for non-hospitalization and for the morphine. He fully understands what his disease is, what his treatment options are, and what his prognosis is with and without therapy. His friends are available and reliable in ways that Mr. Simmons' friends apparently are not. He understands his entire situation as Mr. Simmons does not. He is prepared to accept the consequences as Mr. Simmons is not. He has planned for his (admittedly brief) future in ways that Mr. Simmons has not. Mr. Able clearly has a greater (both qualitatively and quantitatively) understanding of the facts of his illness. Moreover, he has more of those traits that we value in persons (e.g., abilities to plan for his future, to revise those plans when needed, to form close interpersonal relationships) and in view of which we deem them worthy of respect. Put another way, Mr. Able seems both more competent and more deserving of respect than does Mr. Simmons.
The interesting question is which of these patients is (are) competent according to a threshold conception. Absent designations of such a threshold, it is impossible to answer this question with certainty, but some speculations might be made here. If one rules out appeals to "more or less" (which is, after all, what setting a threshold does), then one must seek some sort of minimal set of criteria by which persons are designated competent decision makers. On a baseline assessment of informability, Mr. Simmons seems to be competent. He knows what is wrong with him (a "sore") and what the treatment is ("soak in water sometimes and put the medicine on"). He has displayed at least rudimentary cognitive competence in that he knows what his prognosis is with and without treatment (recovery vs. rehospitalization). Moreover he knows that his street life contributed to his illness and that he may have to come back to the hospital if his symptoms exacerbate. One might also argue that he is cognitively competent insofar as he recognizes that he has to convince his HCPs that the latter is unlikely to happen, and that this is why he insists that he has friends (albeit so far as his HCPs know they are faceless, nameless, addressless, and telephone numberless) who can give him the help he needs. He has consistently expressed a preference—for discharge and "hanging out" on the city streets—and has persisted in that preference.
Given the paucity of detail that attends his information level, as well as his manipulation of that information, his HCPs are concerned about his competence to make this decision. Nonetheless, he does fulfill a minimalist set of criteria for a threshold conception of competence. If this conception is adopted, HCPs will have no recourse but to honor this clearly and repeatedly stated decision. The patient has attained the threshold and, hence, is designated as the appropriate decision maker for choices surrounding his care.

This is problematic because, if respect of patients' choices is accorded or denied on the basis of respect for persons, then the respect for the one should vary directly with respect for the other. This is why Mr. Simmons' case is somewhat unsettling: he seems to have qualitatively and quantitatively fewer of those qualities that we respect in persons. He has no well established life plan (other than to "hang out"), no well developed interests (other than to get out of the hospital), no strong interpersonal relationships (as attested to by his inability to give even the names of friends), and, hence, no (or at best a limited) frame of reference for making the current decision he faces. Moreover, he seems unable to assess risk/benefit ratios or to attend to the different outcomes that different interventions would promote; i.e., he seems deficient in the cognitive aspects of competence. Put another way, his decision seems somewhat but not very worthy of respect and he seems somewhat but not very
competent.

We can make sense of this evaluation on a degree notion, but respect that is conferred on the basis of a cutoff point or threshold denies this. Unlike a degree version of competence, a threshold version does not accord well with the concept of respect for persons or with common sense and experience (see below). That this is so follows from the basis of respect for persons. These foundations will be discussed in detail in Section V. of this chapter. For now I will just briefly explicate the thesis as follows: We value persons, and deem them worthy of respect, in virtue of certain capacities they have: the capacities for rational thought, for selecting from a plethora of goals and values those that are important to them and on the basis of which they construct both a unique personality and a life plan, and for relating to others in significant ways, to name but a few. The better developed, both qualitatively and quantitatively, these capacities are, the greater the worthiness of the person for respect. Put another way, more and better capacities demand more and better respect for particular human beings. It is this continuum of respect that is acknowledged by a degree (and submerged by a threshold) notion of competence. Thus, its correlation with the principle of respect for persons provides additional support for a degree notion of competence.67
One would like some sense of how/if these two options will affect differing patient populations. Unfortunately, absent a conception of the threshold and degrees, no such determination is possible. It seems safe to say, however, that patients who meet the threshold will acquire a designation of "competent" and, hence, of decision-making authority (otherwise what purpose would be served by a decision-making threshold?). On the other hand, on a degree notion of competence patients would be more or less competent and, hence, will labor under greater uncertainty regarding the status of their authority to be respected decision makers with changing circumstances.

C. Justification

The findings of the previous section may appear to give small comfort to advocates of either notion. The question naturally arises: How is it such conflicting conceptions have come into use? What is the moral justification for the use of each? The fundamental moral justification for both conceptions would seem to be the principle of respect for persons. Recall that persons are special sorts of creatures, worthy of respect because of certain sorts of abilities they have. One such ability is being able to plan their lives according to unique values, goals, and commitments. Such persons deserve respect, one instantiation of which is freedom from interference in their decision making. The converse of this is that persons without such capacities need not be
respected. In fact, the proper approach to those people would seem to be protection of their best interests, regardless of their preferences (should they be the sorts of creatures capable of expressing any) ([47], [74]).

Thus the desirable approach for patients in consent-requiring situations is to respect the decisions of competent persons and promote the best interests of incompetent persons. To achieve this end requires some means of ascertaining which patients belong in which group. There are two options: 1) pick a cutoff point; persons whose decision making ability exceeds the point are competent; persons whose decision making ability fails to reach the point are incompetent; or 2) consider patients as more or less competent and allow them greater or lesser participation, as accords with their greater or lesser abilities, in decision making.

The justification for a threshold conception (based, it is recalled, on the principle of respect for persons) then runs as follows: Persons who are deserving of respect have certain capacities; Moreover they possess them to certain extents; The persons worthy of having their decisions respected display decision making capacities to (at least) Extent E. Accordingly, to respect those persons who have E-decision making ability, as well as to protect persons whose decision making ability falls below E, E is set as the threshold for competence. Persons whose capacities fall at or above E will have their decisions respected; persons whose
capacities fall below E will have decisions made by a surrogate.

This approach has two advantages. First it settles, at least for purposes of decision making within health care settings, the question of which patients are and which are not competent. Second, it is easier to assess patients according to single values (i.e., according to which they either pass or fail) than to assign them along a continuum and then decide, on the basis of a potentially infinite number of values, whether patients are competent.68

On the other hand, a degree conception of competence is not without its attractions.69 To begin, people really do seem to fall many different places along a continuum of competence. One person may be more or less competent for a single task at different times or for different tasks at a single time. Different people are differently competent to perform a given task. This variation should be recognized and managed in consent contexts, as it is in other spheres. That way respect for persons is tendered insofar as it is appropriate, while best interests are promoted or protected by not allowing patients to overstep their decision making capacities, thereby causing harm to themselves and others. In addition, a degree conception of competence has the further advantage of according so well with common sense.

This finding correlates nicely with the belief that respect is due a person in proportion to the extent to which
certain characteristics are present in that person. If persons are worthy or respect because they possess certain valued traits, then persons possessing more of such traits or possessing them to a greater extent are more worthy of respect than persons possessing fewer traits, or the same traits to a lesser degree.

Moreover, the logistical advantages that a threshold conception would confer do not alter the fact that any threshold is artificial and, at least in that sense, arbitrary. That the question of competence is settled by fiat is, and ought to be, disturbing if we have reason to suspect that the fiat does not accord with the facts of the matter. And the fact of the matter is that people are more or less competent to manage particular situations. Likewise the ease of assessing patients according to a single value is, and ought to be, distressing if there is reason to believe that a single value fails to reflect the complexity of the evaluation being performed. The fact that competent persons deserve respect because of a panoply of abilities (and those in varying degrees) requires recognition. The better way to admit such respect will be through a degree notion of competence.

D. Critique

As with global vs. specific competence, threshold and degree notions of competence suffer from the problems of delineating the capacities that comprise competence and
testing for the presence/absence of those capacities. A person must have some capacity for manipulation of information. The problem lies in determining which capacities are necessary and to what degree. This analysis will encounter problems identifying and justifying the requisite capacities, both those to be included and those to be excluded.

Again there is the problem of establishing a test for whatever capacities are included. The same problems discussed in the section on global vs. specific competence apply here, as does the fact that value judgments may dictate when respect is tendered or withheld.

Although a degree conception of competence correlates nicely with the belief that respect is due a person in proportion to the extent to which certain characteristics are present in that person, it is nonetheless often difficult to determine that extent with precision. Other factors can legitimately play a part in the evaluation (for example, in patients with clearly reduced decision making capacity in whom one is reluctant to vest decision making authority, one may rightly inquire as to probabilities of promoting, protecting, or restoring those capacities through a particular intervention, as well as about how greatly different interventions might benefit the patient). All these factors will need to be considered and an estimation of their weight in the resolution of the situation will need to be given.
Most people will be able to reach a solution with which they are reasonably comfortable, although disagreement may occur. The unease that one feels at such a prospect will vary, no doubt, with how uncomfortable one is at the thought of a messy universe and with the thought that some assessments must be made on the basis of judgments rather than measurements. The imprecise nature of the world extends into the medical arena in particularly unsettling ways and, while this fact will give no one comfort, its recognition might at least avoid futile searches for a single right answer. Such imprecision should lead to the recognition that there is more to decision making than the problem of determining competence. It might, in fact, make one suspect that other moral considerations might attend decision making situations. This is not, however, a question of competence; it should not be confused with being so.

E. Summary

Understanding competence as a degree notion will require a listing of the requisite capacities and justification for that listing. Additionally, the relationship of differing levels to designations of "more", "less", "too little", etc., must be worked out. Again, both must be justified. Until such tasks are completed, it is impossible to say how people would be affected by the different conceptions. Both TC and DC appeal to respect for persons as justification. But TC is
arbitrary as DC is not, and DC accords much more fully with the facts of human nature (hence, with common sense). The fact that it is less amenable to testing than TC will be considered more fully later. (This is surely cause for some discomfort.) Clearly choosing DC over TC, as choosing SC over GC, also fails to fully solve the spectrum of problems surrounding competence.

IV. CONSEQUENCE-DEPENDENT

VS. CONSEQUENCE-INDEPENDENT COMPETENCE

Regardless of whether competence is global or specific, of whether it is a matter of threshold or degree, its complete analysis must indicate to what extent, if any, consequences will participate in competence determinations.

A. Understanding the Concepts

The distinction between consequence-dependent competence (CDC) and consequence-independent competence (CIC) is the difference between including an appeal to consequences in assessing competence and declaring that consequences have no place in such determinations. As Drane puts it, "...as the consequences flowing from patient decisions become more serious, competence standards for valid consent or refusal of consent become more stringent" ([43], p. 18). This means that as the consequences that attend choices become more sobering, as more can be gained or lost, the definition of competence
should change. Either more capacities are required or the extent to which capacities must be present changes.

Like degree competence, CDC operates on the assumption that competence (or the capacities that constitute it) lies upon a continuum. But instead of the end points being "fully competent" and "fully incompetent", the end points are "minimal (or no) chance of catastrophe" and "maximal chance of catastrophe". Between these extremes lie, at least in theory, an infinite number of points by which competence may be designated according to greater or lesser chances for optimal and catastrophic outcomes. Here again persons can be designated as more or less competent, but instead of this determination's depending upon a person's capacities to manage the situation, the designations vary with the nature of the projected outcomes of particular choices. That is, P may be C for T because T may have a minimal impact for P; but that same P may be incompetent for T, if the projected consequences of T, are profound.

The CDC notion of competence may but need not recognize that different persons possess required capacities in different amounts. It is the anticipated impact of particular choices (where those projections may but need not include an assessment of the person's capacities for decision making) that determine competence. At any rate, a consequence-dependent conception of competence is really a series of definitions along a continuum: where the consequences of
intervention (or non-intervention) are insignificant, the degree of competence required is minimal; where the consequences of intervention (or non-intervention) are significant, degree of competence required is maximal.

The other possibility is consequence-independent competence. Its conception merely specifies that consequences will not be included as a component of competence. Put another way, the choice will be between global and specific, threshold and degree, cognitive and affective. Once those choices have been made, everything that needs to be said will have been said.71

The schema show that a consequence-dependent conception (CDC) states

\[ P \text{ is } C \text{ for this } T \text{ because } \text{varying } S \text{ is met for this } T, \]

while according to CIC

\[ P \text{ is } C \text{ for this } T \text{ because } \text{nonvarying } S \text{ is met for } T. \]

The concern in the present context is what it means to be competent to consent on consequence-dependent and consequence-independent notions. Regarding CIC this question is quickly dispatched: it means whatever it means on whichever other notions are chosen and nothing more. Thus \( S \) becomes whatever specific and degree notions determine, and

\[ P \text{ is } C \text{ for this } T \text{ because } \text{nonvarying } S \text{ is met for } T \]

translates (given the discussions of the two preceding sections) to
P is C to D, for this T because P possesses to D, the requisite capacities for decision making (i.e., she can acquire information about options, weight them according to their probabilities of achieving her chosen aims, choose on the basis of that information and those estimates, and persist in that choice).

With CDC the problem is again one of specification, now of specifying both capacities and magnitude of consequences for differing situations. Here a person is competent if she possesses the particular capacities or level of capacities that correspond to the magnitude of the potential consequences of the options about which she must decide. If the outcome is potentially catastrophic, she must be highly informable and in possession of advanced cognitive capacity and decision making ability. Because capacities and outcomes are ranked along a continuum, a CDC conception of standard S becomes: "possesses the requisite capacities for decision making in a situation of Magnitude M". Then CDC, or

\[ P \text{ is } C \text{ for this } T \text{ because varying } S \text{ is met for this } T \]

translates to

\[ P \text{ is } C \text{ for this } T \text{ because } P \text{ possesses the requisite capacities for decision making in a situation of Magnitude M and this situation's magnitude is } M. \]

B. Implications

Unlike the previously considered conceptions, CIC and CDC are more different than alike. On the former, the implications are those discussed in Sections II and III of this chapter. As such there are no further implications that
attach to CIC uniquely.

For CDC, persons will still be evaluated according to the criteria of informability, cognitive competence, and ability to make and persist in decisions. For situations having potentially maximal or minimal effects, more or fewer capacities may be required. If so, these must be identified and justified. Additionally, the level of capacity present will need to be assessed, as will the level of the potential effects of postulated actions. Both values (capacities and effects) must be located upon a continuum. Again we face the need for a reliable method for assessing a patient's capacities. Here, however, another method is required: some way of valuing consequences so as to place them upon a continuum. CDC's requirements include a test for capacities, a method for scoring capacities, a method for assigning the scores along a capacity continuum, methods for scoring situations and placing them along an effects continuum, and a method for correlating the two continua.

Should it be possible to achieve all the aforementioned methodological requirements, there should be no further problem as to whose consents/refusals ought be respected. Persons who have the capacities necessary for particular tasks may competently make decisions regarding those tasks (though not, by extension or without further evaluations, to others). Whatever choices they make regarding such tasks are competently made and, hence, ought to be respected. Of course a great
deal of time—that of HCPs and patients alike—will be taken up by grading situations and by competence testing. Whenever a new task presents, a new scoring procedure, relevant to that task, will need to be undertaken.

There is one further implication that needs to be considered, should a CDC conception of competence obtain. Presumably whatever criteria and the testing methods ultimately prevail will be either constructed solely by or have significant input from HCPs. As the bias of HCPs is generally for rather than against treatment ([34], [49]), it is quite possible that an ascending scale of criteria can be established that will effectively preclude self-determination for any serious or major therapeutic intervention. This threat may in fact be inherent in this approach. Eth, for example, has argued [49] that a consequence-based sliding scale notion presumes incompetence, in that patients must prove that they are able to handle risky decisions. This is because criteria can be demanded in so great a number and at so high a level that very few, if any, persons already under stress from illness could be judged competent. Such a system would effectively undercut both the procedure of and the rationale for informed consent. After all, the concept was established as a way of enhancing and protecting the self-determination that, in part, grounds respect for persons. Should consequences become a part of a definition of competence, it will be important to take precautions against
unbridled enthusiasm for treatment and, derivatively, against personal choice and respect for persons.

A single case here should illustrate the difference in the two approaches. Consider

CASE V: Ms. Meyer is a 58 year old insulin dependent diabetic who has developed end stage renal disease. She has been on hemodialysis for fifteen months, and has begun to have complications associated with that treatment. She has just been notified that a donor kidney is available for her and that she must come to the hospital immediately for transplantation. Ms. Meyer replies that she has given this matter a great deal of thought and has decided against having the transplantation. Her reasons include 1) that she has lived a full life and she would prefer that the kidney go to a younger person who has "more time"; 2) that as full as her life has been, she is ready for it to be over; she has no family, and few friends, and she has grown weary of the restrictive life style her disease has imposed upon her; 3) she plans also to discontinue dialysis; she recognizes that this will result in her death, and that the process will be, at least for part of the time, uncomfortable; nonetheless she has thought about her options for some time now and her choice is termination of treatment.
On a CIC conception, Ms. Meyer appears to be competent to a high degree to make this decision. She understands her illness, the various possible treatments, the prognoses with each, what her future holds psychosocially as well as physiologically, and she has made a choice based upon those facts and her personal values.

On the other hand, on a CDC conception the magnitude of her decision is sufficiently great that it is at least an open question as to whether she would be deemed competent to make this decision. One might want to argue that she is competent to make this choice if she chooses to undergo therapy because then her death and suffering would (probably) not occur; i.e., the nature of the consequences would change. But this seems both an arbitrary and unacceptable way of circumscribing options that are open to patients. It seems, as a matter of fact, to effectively close off many options to virtually all seriously ill patients who choose to forego treatment. On the other hand, to argue for expanded capacities in serious circumstances also circumscribes patients' options in that many persons in such circumstances also suffer some impairment of the capacities requisite to competence. To require a varying standard is but another way of imposing a threshold (actually a number of thresholds) which, for the reasons noted in the last section, is problematic. What CDC entails is that, whenever the case is serious, the ante is upped and the patient thereby more frequently excluded from the decision
making process.

C. **Justification**

We again consider the etiology of such conflicting conceptions and ask how each might be justified? Once more, the justification for CIC will be that for the preceding options that have been adopted. But for CDC the primary moral justification is, obviously, an appeal to consequences. There is of course reasonable concern that decisions of major import should be approached by people who have their "eyes wide open" and are fully aware of the ramifications of their choices. At such times, when the results of letting impaired persons make decisions seem especially threatening, the consequentialist approach is to act in whatever ways are necessary to encourage better anticipated outcomes. One such method is through an increasingly stringent definition of competence.

As plausible as this approach may seem, it clearly has great potential for encouraging actions that are not respectful (that in fact may be blatantly disrespectful) of persons. As was noted above (Chapter Two, Section I), respect for persons is grounded in their capacities, one of which is the ability to plan one's own life by choosing a unique mix of values, goals, and means. Nothing has been said to indicate that this mix must include any particular content, nor that any particular content is necessarily excluded.

In fact there are a number of reasons why appealing to content should be forestalled. First, it is often the case
that people can agree upon the facts of a matter and yet recommend diametrically opposing actions. This may be because they rate the importance of individual facts differently.\textsuperscript{72} Or they may rank outcomes differently.\textsuperscript{73} They may reason with varying degrees of facility \textsuperscript{105}, or they may differ about what or how to reason. (Hahn \textsuperscript{61}, for example, notes that some cultures do not contain, conceptually or pragmatically, risk/benefit analyses.) Or different people may be operating under different value systems. But respect must be tendered to all persons, even those whose values, goals, and means fall outside the mainstream (assuming, of course, that these do not fail to respect other persons). To insist upon a more rigorous definition for competence, whether in number or degree of capacities, because certain choices are seen as riskier (if not inherently improper) by a majority of the citizenry or by a group of professionals flies in the face of respecting persons. Such evaluations may give good grounds for more rigorous attempts to inform patients to insure full understanding, and they may require, when the "wrong" choice is made, intensive efforts to understand why the patient chooses as she does. But any movement that inherently restricts the range of genuine choices fails to respect persons. As noted in the preceding section, there may be legitimate appeals to overriding a "less" competent person's choice.\textsuperscript{74} It is very likely that these would include appeals to consequences. Such appeals are not, however, the same
thing as calling a competent person incompetent, and they should not be confused with that ploy.

Part of the temptation to appeal to consequences no doubt originates within the medical community under the justification of professional commitment. HCPs are dedicated to doing for persons their good, for acting in such ways as help patients return to their previous healthy (or less unhealthy) states. They are committed to "doing something" for their patients. Moreover, HCPs generally have very specific ideas of how to do a patient's good for her--e.g., to treat her.

In this day and age there is much that can be done to patients.75 These interventions have varying probabilities of success; they also have varying costs. How one weights the benefits, the costs, and their relationship to each other varies between individuals and is largely dependent upon one's previous goals and value structure. The personal systems that go into decision making are unique, so it should come as no surprise that different people, presented with the same facts, come to different decisions.

It should also come as no surprise that part of the system of values and goals of most HCPs is a commitment to do the best thing possible for their patients. Problems arise when the HCPs' appraisal of the best thing to do is at odds with the patient's appraisal. With the HCPs' bias toward treatment, the patient laboring under an ascending scale of competence runs a significant risk of being treated when,
given her personal value system, treatment is genuinely not in her best interests. Moreover patients and HCPs may disagree about the "facts" of the matter (e.g., how distressing a correctable condition will be to the person afflicted with it) or about what sort of treatment would be most compatible with the patient's expressed values or goals. Each might try to persuade the other to her point of view, but agreement will not always be possible.

HCP's who are unaware of or cannot accept a patient's value structure or who disagree with patients about the facts of the matter may be able to mount some other justification for treating a patient against her will. But the justification for overriding a person's choice should not be a spurious label of incompetence.

D. Critique

As with previous notions of competence, CDC suffers from the problems of delineating the capacities that comprise the conception and of testing for the presence/absence of those capacities. CIC will suffer from the problems that attend specific and degree notions (and, as the next section will show, both cognitive and affective components).

CDC, as noted above, faces an overwhelming number of determinations: a test for the presence of capacities, a method for scoring capacities, and a method for assigning the scores along a capacity continuum, methods for scoring
situations and placing them along an effects continuum, and a method for correlating the two continua. Each must be constructed, justified, and validated--perhaps not impossible, but sufficiently staggering to give one pause. The same problems discussed in the section on global vs. specific competence apply here as, of course, does the fact that value judgments can dictate the number and level of capacities required in any particular situation. 77

It is quite possible that any effort to analyze competence in relationship to consequences is misdirected. Competence is, after all, dependent upon a set of capacities that persons possess. It is not about what decisions they reach while using those capacities. Put another way, competence is about procedures, not about results (although, of course, it is to be hoped that the former will permit some control over the latter). Since competence has to do with how people choose rather than with what they choose, the reasonable approach requires that competence be construed without recourse to outcomes.

This does not, however, mean that patients or HCPs will cease to be concerned with outcomes. Results are and will surely continue to be a serious concern of all parties involved in health care decisions. The point is that concerns about consequences are different concerns from those surrounding competence. Incompetent patients may accidentally choose "correctly" and competent patients may choose
"incorrectly", as assessed by others. When a competent person chooses to enhance the likelihood of bad or even disastrous results, concerns about that outcome does not disappear merely because the choice was competently made.

Insofar as we are concerned about the seriousness of results, we might want to construct a series of tests in ascending order of difficulty and apply the more difficult examinations in those circumstances wherein outcomes are especially worrisome. That is, the worse the consequences, the tougher the test one must passed to be allowed single-handed decisional authority. But note: this would not be the same thing as saying a person was incompetent; it would rather be saying that there are competing values at work in the health care decisional arena; competence counts as one value, outcomes as another.

I am not advocating this approach, but merely drawing a distinction between theory and practice that is often overlooked. The theoretical analysis of competence does not include appeals to consequences; the test(s) for competence might. In the health care arena where decisions are often weighty and where the time for consideration is often abbreviated, one can understand the temptation to elevate the standard for the purpose of insuring that only those persons who are unusually capable will meet the criteria and, hence, be designated as competent. This, it might be thought—perhaps correctly—will minimize the number of untoward
outcomes. The point remains that such a maneuver is separate from the concept of competence.\textsuperscript{78}

E. \textbf{Summary}

Assessing competence in terms of consequences poses the same problems--listing characteristics and qualifications, justifying them, and finding a reliable test--that the previous choices faced. This is true by definition for CIC which, as we have seen, reverts to the analyses of earlier options. CDC faces the additional problem of protecting patient autonomy in high-risk situations, where HCPs will often see treatment as the only logically defensible choice and who may therefore want to construe competence so as to ensures the preservation of professional rather than personal values.

V. \textbf{COGNITIVE VS. AFFECTIVE COMPETENCE}

A. \textbf{Understanding the Concepts}

The components of cognitive and affective competence were discussed extensively in Chapter I and so will only be briefly reviewed here. Cognition in a broad sense refers both to the information handling system of the brain and to cognitive capacities per se. Thus a cognitive analysis of competence is one in which the requisite capacities include attention and perception, language usage (fluency, articulation, and comprehension), memory (recent, short-term, and remote), and
cognition itself (intelligence, calculation, insight and judgment, manipulation of data, and abstract thinking).

Affective competence addresses a person's abilities both to internalize and to cope (for lack of a better word) with the information she processes. Affective capacities include feelings, motivations, and behavioral control ([91] p. 12). They refer to emotionality, or those activities of the mind that determine how persons feel; motivation, or those activities of the mind that determine what stimulates people to action; and control, or how and to what extent people respond to feelings, especially when the feelings are strong. The cognitively competent person is able to acquire information from the world and to utilize it to increase both her knowledge and control of her environment. The affectively competent person is able to respond in emotionally and behaviorally appropriate ways to that information, and to be moved to pursue and accomplish those tasks that are important to her survival and enjoyment of life.

Cognitive and affective competence both play crucial roles in the day to day activities of health care. The patient who is sick or in distress almost always suffers some impairment in both realms. (See note 82 infra.) Illness often both reduces cognitive abilities and provokes affective responses (e.g., depression, anxiety). Cognitive and affective capacity are contained implicitly in all schema mentioned in the previous sections; their status ought to form
part of any standard (S) by which competence is judged. For clarification, however, we can think of the standard specifying cognitive competence (CC) as stating

**P possesses to Dx for this T the requisite cognitive capacities for decision making** (i.e., she can acquire information about options, weight them according to their probabilities of achieving her chosen aims, choose on the basis of that information and those estimates and persist in that choice)

which, it will be noted, is merely a restatement of the capacities enumerated earlier.

Likewise the standard will specify affective competence (AC) as

**P possesses to Dx for this T the requisite affective capacities for decision making** (i.e., she can respond in emotionally appropriate ways to information and be moved to pursue those desires whose satisfaction she deems important.

**B. Justification**

Unlike the first three options discussed in this chapter, cognitive and affective competence are not mutually exclusive. Rather they are mutualistic. Healthy persons function effectively in both intellectual and affective spheres, exercising their rational and emotional abilities with facility.79

There are two separate arguments why any analysis of competence must attend to both the cognitive and affective systems. The first is that the two systems are so functionally intertwined (unconsciously if not consciously) that anything that affects one affects the other.80 When one
system is impaired, the other system malfunctions as well. For example, any situation that provokes a strong emotional response affects, in virtue of that response, the cognitive system as well.°1 (Consider how little one remembers of information offered in times of stress.°2)

Just as excessive emotionality induces aberrant responses, so excessive rationality can impair one's ability to successfully manage one's experiences. If only reason's input is recognized, the emotions can wreak havoc with the body in the most subversive of ways, both physiologically (e.g., ulcers) and psychologically (e.g., nightmares). Human intelligence is more than the ability to calculate. It turns in part upon the capacity to recognize and take appropriate note of all important data (e.g., feelings) ([30], [132], [161]). Moreover, emotional responses are important signals to persons that certain situations or persons are important to them. When emotions are suppressed, the information carried by these signals goes unrecognized, leading persons to make decisions without complete information.°3

The point is that thinking and feeling are intimately related. When one malfunctions so, to some extent, does the other. Anyone interested in insuring competence is well advised to consider both systems in the assessment and conception of that concept.

The problem, as noted in Chapter One, Section II, is that this relationship is poorly measured by such tools as are
currently in use for competence testing. The inability of tools such as the MSE to assess most of the affective capacities assures that they will be of little help. Moreover, the import of the affective system is often entirely overlooked, as is the case with the Mini-Mental Exam [53] or the Cognitive Status Exam [80] which are explicitly advertised as tools for cognitive assessment. That the MSE and its miniaturized progeny have been pressed into service as tools for competence assessment indicates a serious lack of awareness of the import of the affective system and of its interaction with cognition. Yet the fact that affect and intellect effect each other is sufficient reason to include both in a conception of competence.

The second and more compelling reason for including both the affective and cognitive systems in a conceptual analysis of competence is that each contributes to the composition of those unique beings so worthy of respect: persons. The argument goes like this: persons are worthy of respect in virtue of a variety of capacities they possess. Some of these capacities are cognitive in nature (e.g., the capacity to consider differing values and goals, and to choose among the many which we will adopt). Some, however, are affective in nature (e.g., the capacity to enter into personal relationships or, put another way, to feel warmth and affection for others). It is not the case that we only value the cognitive abilities; we in fact value all the abilities
that constitute a person's identity. Therefore, in showing respect for persons, we admit as important (i.e., to their being the kind of creatures worthy of respect) all the capacities that they possess. This means that both cognition and affection deserve attention.

Part of the motivation for individuals' embracing different goals and means is that they feel differently about options. Two persons presented with the same choice will sometimes identify the same facts of the matter but nonetheless choose different options because their feelings, desires, and values are different. Even people who share goals may, because of different feelings, adopt different means toward those goals. This is part of the etiology of their uniqueness and, derivatively, part of their worthiness of respect. Put another way, the sorts of beings worthy of respect are those with both cognitive and affective capacities intact.

1. A Brief Reminder

Let us review a few facts regarding the MSE. First, recall that it is variously asserted that the MSE was established to describe and manage psychoses; to pinpoint areas of dysfunction with sufficient precision to direct further diagnostic efforts; and, following therapeutic intervention, to monitor the patient's response to therapy. By no account was the MSE established for the purpose of assessing personal competence, either generally or for particular tasks. Also
we must remember that, at present, direct evaluation of mental function is not possible. We infer that certain mental functions are occurring from the behavior that we observe in ourselves and in others.

For example, if two people are debating in animated fashion about possible flaws in a lecture on theoretical mathematics that occurred yesterday and they are in agreement about the facts of that event, we can infer that each has a normal level of consciousness and attention; that each is drawing upon some store of information that includes a knowledge of math; that they are remembering correctly (or, by strange, unlikely coincidence, their memories are identically impaired); that their language faculties are healthy; and that they are calculating with facility. It is possible to test each of these suppositions and verify, we will stipulate, each of these assumptions. We might further infer, from the enthusiasm and intentness of expression of the debaters that they are strongly interested in the topic at hand, and that each is concerned to persuade the other of the wrongness of her interpretation. From the fact that the dispute is not being settled by force we may infer that each is in control of her emotions and behavior. We infer these things, but the inferences might, for all we truly know, be wrong.

The MSE simulates this type of encounter, albeit artificially. Again, the MSE checks level of consciousness, attention and concentration, language, memory, and higher
cognitive functions (to include storage and manipulation of a fund of information, social awareness and judgment, insight, and abstract thinking). Without a doubt the MSE is heavily weighted toward assessment of the intellectual realm, at the expense of emotionality and control. Its emphasis is almost exclusively upon evaluation of information processing. What might the implications of this emphasis be for competence?

2. Cognition and Competence

Let me say at the outset that my remarks in this section are intended to apply only to the MSE as it relates to competence determinations. I am not concerned to consider the philosophical underpinnings of its use in "purely" diagnostic or therapeutic circumstances. Rather I am concerned to assess the MSE in its extended use of appraising the competence of persons in the medical setting. It is the philosophical foundations of the MSE in this circumscribed setting--i.e., why the MSE is thought to be helpful in competence determinations and what must be presumed about the nature of patients in these settings--I will discuss.

Questions of competence most often arise within the medical setting when there are decisions to be made regarding treatment options. A great many treatments may not legally be initiated unless someone gives consent. Consent is valid only if three requirements are fulfilled: it is given voluntarily, it is informed, and the person giving it is
competent ([39], [33], [127], [51]). All things equal, consent must be obtained from the person to whom the treatment will be administered. Assuming this person has been adequately informed regarding the nature of her illness, the treatment options, their risks and benefits; and assuming her consent is uncoerced; then it only remains to show that she is competent. Lack of any superior method, the MSE has been pressed into service for competence determinations.

Assuming there may be some reason for confidence that the results of the MSE are reliable, the results do indicate something about the efficacy of mental functioning. Then, recalling the emphasis of testing is predominantly in the intellectual realm, we find that the MSE results that relate to competence are the results within the cognitive realm.

Put another way: the MSE largely tests cognitive function; if the MSE is used for competence determinations, then competence must be considered to be (largely) effective cognitive functioning. That is, if the MSE is given to a patient to see if she is competent, and she passes the test (i.e., performs well cognitively), then the presumption is that to be cognitively effective is to be competent. To perform poorly (i.e., to [appear to be] cognitively ineffective) is to be, presumably, incompetent.

In one sense a normal MSE might be reassuring. Insofar as an affective malfunction can impede cognitive functioning and vice versa, a normal MSE gives some evidence that both
systems are healthy. However it might be that a normal MSE only gives evidence that, however unhealthy one system is, it is not (for whatever reason) drastically interfering with the other, or that the other is compensating for the diseased processes. Since the MSE most directly tests cognitive function, it is likely that disorders of cognition would be more easily identified. That is, a normal MSE might, of course, reflect that both systems are in fact healthy. But it might, in fact, be so imprecise that it merely fails to reflect disorders of the affective system until the impairment is profound. This being possible we must ask, is it acceptable?

It is surely an open question as to whether the person who can reason, but whose reasoning is fully controlled by a compelling emotion, is competent. The woman who genuinely understands the risks, but still adamantly refuses a hysterectomy for an (easily cured) cancer in situ of the cervix because she has a white hot hatred of surgeons will make us wonder if her decision ought to be respected. Equally suspect will be the person whose emotions are in fine shape, but whose capacity for reasoning is diminished. If a patient is told that treatment A has an 80% chance of cure while treatment B has a 10% chance and responds "Well, I guess it doesn't make much difference," this, too, ought give us pause.

It is possible that further investigation will lead to a decision to weaken the testing for competence by requiring
that only the rational or only the emotional capacities to be intact. This, however, seems unlikely. It seems more probable that competence will be found to turn upon a healthy nature of both. That, of course, must be argued for. It is to that task that I now turn.

C. Justification

1. Competence and Respect for Persons

What would it mean to consign competence exclusively to the intellectual realm? That is, what kind of beings would and would not be competent? The history of philosophy reveals two major conceptions as to who "counts" as a person worthy of respect. The first school of thought deems that only those beings capable of rational thought warrant respect. The second school acknowledges the importance of rationality, but insists that persons to whom respect is due have other, equally important (for respect), attributes. Both traditions will be considered.

2. Persons as Merely Rational

The first concept of personhood is traditionally represented by the Aristotelian "rational man" or the Kantian "autonomous agent". On this account persons are worthy of respect in virtue of their capacity for rational thought. It is this capacity--and this capacity alone--that sets persons apart from other living things and entitles them to special treatment.
Aristotle is an early proponent of the persons-as-rational theory to be discussed here. In Book III, Chapters 10 and 11 of De Anima he describes the unique nature of human beings in terms of their particular mental capacities. Human nature, like that of other animals, contains an appetitive element. This element's function is to indicate objects of desire, positive and negative (i.e., things to be pursued and avoided). In addition, the human mind possesses capacities for calculation and speculation. The former serves to determine means to the appetitive ends, while the latter allows the person to consider ends that might better be sought or eschewed, regardless of the thinker's desires (De Anima, 433a, 10-20, [12], p. 238).

It is in speculative reason that Aristotle grounds the special status of human beings, for it is this capacity that allows persons to lead the contemplative life. Such a life is possessed not merely of desires and schemes to satisfy them, but also of rational reflection upon what kinds of desires are best suited to beings with reason (De Anima, 433b, 30-434a, 20, [12], pp. 240-241). Because such beings speculate upon not merely what people do or want to do, but also what they ought to do, their reasoned beliefs and actions are such as others should adopt and copy.

The idea of man-as-rational is further explicated in Nichomachean Ethics where Aristotle states:
...we are seeking what is peculiar to man. Let us exclude, therefore, the life of nutrition and growth. Next there would be a life of perception, but it also seems to be common even to the horse, the ox, and every animal. There remains...an active life of the element that has a rational principle... And, as 'life of the rational element' also has two meanings, we must state that life in the sense of activity is what we mean... Now we state the function of man to be a certain kind of life, and this to be an activity or actions of the soul implying a rational principle... *(Nichomachean Ethics, 1098a, 1-15, [13], pp. 356-357).*

In *Nichomachean Ethics* Aristotle was concerned to describe the "virtuous man", he who should be emulated (and ought not be opposed or thwarted) because his words and deeds were true and right. In virtue of this truth and rightness, this man was responsible for his actions. As such his "right action" would not be "involuntary"; that is, it would not take place under compulsion or owing to ignorance; and that is compulsory of which the moving principle is outside, being a principle in which nothing is contributed by the person who is acting or is feeling the passion, e.g. if he were to be carried somewhere by a wind, or by men who had him in their power *(Nichomachean Ethics, 1109b, 35--1110a5, [13], pp. 385-386).*

As the product of a reasoned choice, right action was not motivated by appetite, emotion, wish, or opinion *(Nichomachean Ethics, 1111b, 1-30, [13], pp. 390-391).* Rather it "involves a rational principle and thought" *(Nichomachean Ethics, 1112a, 15, [13], p. 392).* For Aristotle,
The origin of action...is choice, and that of choice is desire and reasoning with a view to an end. This is why choice cannot exist either without reason and intellect... (Nicomachean Ethics, 1139a, 30-35, [13]. p. 463).

In summary, Aristotle claimed that only human beings were capable of virtuous choices and actions. This is because only humans, as beings with reason, were capable of choosing not only the right means to their ends but also the right ends. Action without reason is the province of animals, i.e., of creatures that are merely acting upon instinct. Humans differ from animals in their capacity to reason, and it is just because of this difference that humans are special. Their other (animalistic) attributes, such as desires and emotions, are not germane to this special status. They may, in fact, detract from it.

Like Aristotle, the eighteenth century German philosopher, Immanuel Kant, finds the distinctive nature of human beings to derive from their capacity to reason. In an age of scientific revolution, Kant sought to revolutionize psychology and morality by proving, with the certainty heretofore reserved for scientific endeavors, that man could know truly. In his Critique of Pure Reason Kant describes the structure and function of the mind in its quest for certain knowledge. Though his concern is with "pure" activities, Kant acknowledges the interplay of sensation and cognition:
...experience contains two very dissimilar elements, namely, the matter of knowledge [obtained] from the senses, and a certain form for the ordering of this matter, [obtained] from the inner source of the pure intuition and thought...(Critique of Pure Reason, A86=B118, [73], p. 121).

Although both sense and reason participate in experience, only that part of experience acquired through reason (i.e., "the inner source of the pure intuition and thought") is veridical. The validity of knowledge acquired through the senses is always dubious, and one should never rely upon information attained through sense perception.

There are at least two reasons for making this claim: 1) The sense organs can suffer a primary malfunction and 2) perceptions can be contaminated by wishes, needs, or other secondary conditions. Since humans are sensual creatures, it is natural for them to use reason to ascertain how best to meet the needs and desires of the body. But such use does not exhaust the realm of reason. And it is reason in its "pure" form that elevates its bearer to an exalted status (Critique of Practical Reason, 61, [72], p. 63).

Unlike information acquired through perception, information gained through reason is indubitable. It is genuine knowledge, not tainted by the untrustworthy senses. As reason is not (inherently) contaminated by mundane conditions, it can know universally; that is, achieve knowledge recognized as true by all persons of reason.
For Kant, as for Aristotle, reason's power lies in its ability to ignore or override sensuous influences. Because reason can abstract from the particular, reason can determine what ought to hold for all persons. Free from the pull of feelings and desires, reason can legislate universally; it can prescribe ends as well as means for humans. It is reason by which man "distinguishes himself from all other things, even from himself so far as he is affected by objects" (Foundations of the Metaphysics of Morals, 452, [74], p. 70).

Kant insists that rational beings are inherently worthy of respect because only that which is an end in itself—i.e., is prized for its own sake—has intrinsic worth, or dignity. Such beings Kant terms "persons". Persons are capable of morality, and "...morality and humanity, so far as it is capable of morality, alone have dignity" (Foundations of the Metaphysics of Morals, 435, [74], p. 53). This is because reason alone, uncontaminated by sense-inspired data, can know truly (albeit only in the realm of morality).

A summary of Kant's position says: Beings possessed of the faculty of reason are capable of prescribing to themselves the universal law of morality (i.e., the categorical imperative). Insofar as they are capable of motivating themselves to action in accordance with this law and solely because reason demands it (i.e., not because they stand in any way to gain), they may be said to have a "good will". Any being capable of doing this—determining herself to action on
the basis of laws that reason gives to itself--is a being who possesses dignity, is a being inherently worthy of respect. Persons also happen to be possessed of a sensual nature. This nature is irrelevant to the value of persons and, in fact, can thwart personhood. Only reason determines personhood and its value.

Following in the tradition of persons as (merely) rational is the twentieth century philosopher H. T. Engelhardt, Jr. For Engelhardt, as for Kant, a person is not necessarily a human being, nor are humans necessarily persons. The Engelhardtian "person" is "self-conscious, rational, free to choose, and in possession of a moral sense" ([47], p. 105).

On this account persons (and only persons) are worthy of respect. This is because persons (again following Kant) have a capacity for self-reflection that allows them to see beyond their particular circumstances to mankind as a whole. Thus persons can see not only what states of affairs do exist, but also those that ought to exist. This capacity for rational self-reflection permits persons to praise/blame actors and actions alike and, therefore, to prescribe changes. Without this capacity there is no special status nor any reason to respect a creature.

There is no denying that human rationality is an extremely important factor to be taken into consideration in
discussions of competence. As Aristotle, Kant, and Engelhardt show, it is rationality that allows us to evaluate situations from a wide (rather than a merely personal) variety of perspectives. Persons can abstract from their particular circumstances and view the world more objectively. Of an anticipated undertaking, persons can consider the present situation, the desired situation, the odds of all interventions moving one from present to desired state of affairs, and the risks involved. Reason can best evaluate whether a given action is "worth it". Moreover, reason can give the answer in a universal sense; that is, whether any person in similar circumstances would consider the contemplated action advisable; whether the answer is "yes" or "no", reason can tell us why.

Whatever we want to include under the concept of competence, we will need to include rationality, if only because it is this capacity that permits us, in a very real sense, to make decisions (i.e., to choose in the Aristotelian sense described above). It is reason that allows us to survey the past, assess the present, and project into the future; reason that permits the weighing and evaluation of options; reason that guides decision. Absent rationality, creatures follow instincts or act randomly. They do not so much decide issues as respond to stimuli.

3. Persons as More than Rational
As important as rationality is to the concepts of personhood and respect, it is nonetheless an open question as to whether only reason is necessary to worthiness of respect. Reason, being a necessary condition of respect, may not be a sufficient one. Throughout history there have been alternative accounts of personhood, accounts that claim that there is more to personhood than a capacity for rational thought. On this alternative account, possession of qualities beyond rationality (e.g., emotional capacity, personal interests, unique histories, etc.) is required for personhood and respect.

One of the more compelling accounts of persons as more than rational comes from the Eighteenth century Scottish philosopher, David Hume. He is perhaps best known, in this regard, for his seemingly outrageous statement that "Reason is, and ought only to be, the slave of the passions, and can never pretend to any other office than to serve and obey them" ([68], p. 127). Hume recognizes that this claim challenges a regnant ideal, and he acknowledges that reason has long been deemed the dominant faculty, stating:

Nothing is more usual in philosophy, and even in common life, than to talk of the combat of passion and reason, to give the preference to reason, and assert that men are only so far virtuous as they conform themselves to its dictates. Every rational creature, it is said, is obliged to regulate his actions by reason; and if any other motive or principle challenge the direction of his conduct, he ought to oppose it, till it be entirely subdued, or at least brought to a
conformity with that superior principle. On this method of thinking the greatest part of moral philosophy, ancient and modern, seems to be founded... ([68], p. 125).

Hume's epistemology might be considered a case of putting the traditional cart before the traditional horse. A strong empiricist, he contended that it is the "passions" rather than reason that both motivate people to action and designate those ends for which people should act. Reason functions only to consider the relation of ideas to each other. This function may be abstract, as in the case of mathematics and logic where truths are intuited or demonstrated from such truths, or experiential, as in the relation of ideas that are acquired through experience.

Since knowledge is acquired only through experience, experience grounds all reasoning. People have experiences, then they think about them. Moreover, experience shows which sorts of events lead to pleasure and which to pain, and people learn through experience which sorts of events they prefer. On the basis of experience, agents determine the types of goals or states of affairs to seek or avoid.

Hume admits that many preferences are socially determined. They result from habits and customs peculiar to individuals' geographical locations, social status, upbringing, and the like. As such, were persons born into different circumstances, they would have different experiences and, hence, develop different preferences. This is one reason why
he would see no need for reason to legislate universally—because there is no such thing as universal experience. Rather, each person has her own unique experiential history; and it is just from such a particular past that a person comes to know her own preferences and how to order her own life.

Absent experience and its derivative preferences, reason would have nothing about which to reason. Reason's only task is to determine the means to preferred ends; that is, to calculate the most efficacious method for achieving goals. As such, the only way to be unreasonable it to mistake a non-existent object as a possible goal or to be confused about how to achieve a genuinely possible goal ([68], p. 128).

The Humean position may be summarized thus: Humans are sensate creatures. Through the senses they experience pleasure and pain. The goal, throughout life, is to acquire pleasure and avoid pain. Reason is the faculty by which people can determine which categories of experiences will yield pleasure, which pain. Reason also functions to postulate and evaluate various methods by which this goal can best be achieved. Without the data provided by the senses, reason would have absolutely no data to ponder. Because of each person's unique experiential history and its role in assigning goals, there is no need for a faculty that functions as a universal end setter.
Consider next the philosophy of John Stuart Mill. Less iconoclastic than Hume, he is nonetheless keen to carve out a place for the affective realm in the constitution of the value of persons.

Mill was the son of James Mill, a political reformer, and the intellectual heir of the great nineteenth century political philosopher, Jeremy Bentham. Raised to continue the efforts of these brilliant and ambitious men, Mill was schooled from the crib in the activities of reason. By his twenty-first birthday he had become a scholar, philosopher, logician, reformer, writer, and linguist. Yet, as he notes in his *Autobiography*, intellectual capacity alone did not make a full life; feelings were necessary as well. Moreover, intellectual endeavors carried to extreme may thwart the development of a full life (and vice versa, as Aristotle and Kant were concerned to show). His record of discovering this impediment is worth quoting at length:

For now I saw...what I had always before received with incredulity—that the habit of analysis has a tendency to wear away the feelings: as indeed it has, when no other mental habit is cultivated, and the analysing spirit remains without its natural complements and correctives ([103], p.96). ... All those to whom I look up, were of opinion that the pleasure of sympathy with human beings, and the feeling which made the good of others, and especially of mankind on a large scale, the object of existence, were the greatest and surest sources of happiness. Of the truth of this I was convinced, but to know that a feeling
would make me happy if I had it, did not give me the feeling. My education, I thought, had failed to create these feelings in sufficient strength to resist the dissolving influence of analysis, while the whole course of my intellectual cultivation had made precocious and premature analysis the inveterate habit of my mind. I was thus . . . left stranded at the commencement of my voyage, with a well-equipped ship and a rudder, but no sail; without any real desire for the ends which I had been so carefully fitted out to work for: no delight in virtue, or the general good, but also just as little in anything else. The fountains of vanity and ambition seemed to have dried up within me, as completely as those of benevolence.

...neither selfish nor unselfish pleasures were pleasures to me. And there seemed no power in nature sufficient to begin the formation of my character anew, and create in a mind now irretrievably analytic, fresh associations of pleasure with any of the objects of human desire ([103], pp. 97-8).

Mill goes on to say that he "never turned recreant to intellectual culture", but that "The maintenance of a due balance among the faculties, now seemed to me of primary importance" ([103], p. 101).

Mill's point is, in some respects, similar to Hume's: life's goals are, at least in an important part, the product of feelings (Hume's "passions"). Unlike Hume, Mill does not claim that only feelings can motivate; he does claim that they help to motivate, and most certainly that they accompany the pursuit and attainment of goals. In fact a crucial part of goals, considered in their entirety, is the feelings that attend their achievement; for without feelings both goals and
efforts are hollow and, hence, incomplete.\textsuperscript{96}

Like Hume, Mill recognizes the diversity of goals and the fact that a person's goals are often the product of her environment. As such, goals are not necessary (universalizable in a Kantian sense), though they may be, given one's circumstances, inevitable. With changing circumstances, goals can change. He further notes in \textit{On Liberty} ([104], especially pp. 13-15), that so long as no one else is harmed, whatever ends a person adopts may not be interfered with. One may try to dissuade or educate others, but if they persist in striving for seemingly unacceptable goals, they must be permitted to do so. Put another way, one of the ways of respecting persons is allowing them to make their own mistakes.\textsuperscript{97}

To summarize Mill's remarks: People are composite creatures. They have reason and feelings. Each is important to the well-being of the person as a whole and should be cultivated; the output of each should be acknowledged and respected. To the extent that only one of the faculties participates in a given event, that event should be suspect.

The persons as more than rational account includes, in considering worthiness for respect, more qualities than rationality. This is because, as Mill and Hume point out, persons are in fact more than just their capacity for rational thought. Humans are to be prized not merely because they
can reason, but because they can participate in other encounters as well. The abilities to respond in social situations, to develop personal bonds, to be an active member of a society and of a moral community, are as important as the ability to calculate. Twentieth century philosopher Baruch Brody offers an elegant description of this concept of persons:

We think of persons as having the potential to perform a wide variety of actions whose performance we value greatly. These include the potential to make rational (and especially principled) choices, the potential to engage in a variety of interpersonal relations, the potential to appreciate beauty, and the potential to desire to know the truth. We therefore value the person who has those potentials ([22], p. 33).

Here the key point is that it is not only rationality that we value in persons, but other characteristics as well. It is not only the capacity, in virtue of rationality, to participate in a Kantian moral community (i.e., a community where reason legislates universally), but the capacities to participate in social, aesthetic, religious, and scholarly communities as well. Part of the value that attends individuals is their ability to interact with other persons and with their environments in ways that provide mutual satisfaction. When persons behave in ways that are informed by other valued characteristics, we ought to support (or at least not interfere) with such behavior. Reason is not the only source of value.
Consider, by way of example, the autistic person: some autistic persons have an uncanny capacity for such "rational" activity as mathematical calculations. They can compute in seconds problems that would take most persons minutes (if not hours or days, and for some it would be impossible). Nonetheless, given their near-total inability to interact with the world around them, these persons are considered impaired. Their affective impairment, in Brody's terms, decreases their value and, hence, the respect due to them as persons.

Brody's position, then, is much like Mill's: Persons to whom respect is owed are those possessing a composite nature that includes both the abilities to reason and to participate affectively in their world. To the extent that they possess all such characteristics, they are valued; if they suffer a reduction in or lack of characteristics of any sphere, that value is lessened.

4. Respect for Persons and Competence to Consent

What has all this to do with competence to consent? It is surely the case that anyone who has a claim to be respected as a person has a similar claim to have his decisions respected. The question is: What sort of person can claim that respect? If we follow the persons-as-rational tradition, we must say that persons who are (merely) rational will have their decisions, medical or other, respected. Absence of impairment of their affective capacities is
irrelevant.

If, on the other hand, we are persuaded by the persons-as-more-than-rational account, we will demand not merely the capacity to reason, but also the capacity to function well affectively. Then persons who decide predominantly on the basis of affect will not, for that reason alone, be denied respect (assuming they are not completely irrational). There are good reasons for affiliating with the latter school of thought, rather than the former—especially in a health care setting. As examples might illustrate these reasons more clearly, consider

CASE VI: Ms. Green, a 46 year old research chemist, has just been admitted to the hospital for a biopsy and frozen section of a lump in her left breast. She is extremely apprehensive, not only about what the biopsy will reveal, but about the fact that her surgeon has recommended a modified radical mastectomy should the frozen section reveal the lump to be malignant. Ms. Green's apprehension in this regard stems from the fact that both a mother and a sister died during operative procedures (one during a mastectomy). As a result, Ms. Green has an enormous fear of surgery and has vowed to avoid any operative procedure that is not positively required to save her life. She has consented to the biopsy and a lumpectomy on that basis, but has made it quite
clear to her surgeon, internist, and all the nursing staff that she refuses a mastectomy and wants only the lump removed. Following her recovery from the procedure she plans to undergo radiation therapy. At the time she is making this decision, there are neither five-year nor long term statistics comparing differences in outcomes between the two approaches, but preliminary results indicate that the outcomes will not be radically disparate. Ms. Green understands this; she adds that, even were the outcomes significantly different, she would rather take her chances with radiation therapy than subject herself to the overwhelmingly frightening (to her) experience of surgery. She admits that many people would find her choice indefensible, but she is not bothered by that fact. It is, she notes, her choice and she willing accepts its consequences.

CASE VII: Ms. Evans is a 42 year old housewife admitted for an emergency appendectomy. At the time of her admission, she is extremely depressed. Her husband has been recently diagnosed as having amyotrophic lateral sclerosis (Lou Gehrig's disease), and her only child was recently killed in a motorcycle accident. She has stated to her friends that she has begun to question whether her life is
still worth living, now that the two people nearest and dearest to her will soon both be dead. What, she queries, is to be gained by her own continued existence? Psychotropic medications have been initiated to relieve Ms. Evans' symptoms. In the process of obtaining her consent for the appendectomy, her surgeon informs Ms. Evans that one in every 10,000 persons having anesthesia dies as a result of an untoward reaction to the anesthesia itself. Ms. Evans replies, "I hope I am the one."

The common salient feature of these examples is that they display factors beyond rationality that are applicable for the patient who finds herself, quite particularly, in a situation in which she must make a medical decision. Here the particulars, as her particulars, have very real import. The rational may, quite appropriately, give way to the emotional. In fact, recognition of the import of the emotional aspects might be the rational thing to do. Of course, the rational may give way to the affective inappropriately. Both of these possibilities need to be examined.

It might be possible to defend a particular treatment decision from a purely rational, impartial, or universal perspective. But it might nonetheless be impossible, given the circumstances unique to a certain patient, to defend that treatment choice as best for him, especially if he has
strong feelings for or against various options. The person who, like Ms. Green, has an enormous fear of surgery may be fully justified in choosing radiation therapy rather than a mastectomy for her breast cancer, given the debate over which treatment is most successful. If her fear is sufficiently great, the choice is probably justified even if the most reliable data show some disparity in the five-year survival rates, so long as that disparity is not exorbitant. In fact one could argue that, even in the face of an exorbitant disparity the patient, so long as she understands the increased risk, can choose because of her strong feelings about the matter, the riskier procedure. Not everyone is risk averse and, moreover, strong feelings are often considered sufficient justification for unusual, atypical, or risky behavior in other facets of life. (People are, for example, allowed to marry even when virtually everyone who knows the parties involved agrees that the marriage is mistaken. Concerned parties do not intervene because a strong emotion, love, is often thought to forestall unwanted intrusion [15].)

Consider affection and cognition as lying on a five-value scale. Four indicates excessive presence, three indicates an increased presence, two indicates "normal" presence, one indicates reduced presence, and 0 indicates the total absence of affective or cognitive components (i.e., to be 4+ affective is to have the affective components excessively involved; to be 1+ rational is to have rationality playing a reduced role
in decision making).

On such a system Ms. Green has a 3+ affective level and a 2+ rationality level. Her affective components are more involved than is usual in making this decision. But her rationality seems in no way impaired. In fact, she admits that her choice is at odds with the statistical norm, a fact that she accepts and is prepared to defend by claiming that, in this particular case, she chooses to embrace her strong feelings and act in accordance with them.\textsuperscript{101} Ms. Green is surely more competent than not to make this decision.\textsuperscript{102}

It is, of course, important that the affective not completely overpower the rational; i.e., being 4+ affective and 0 rational. In such cases persons are not choosing (in the Aristotelian sense explicated earlier), but merely reacting to stimuli (here, affective stimuli). If the regimen which a patient finds loathsome has a good chance of cure while the one she chooses is quackery (e.g., mastectomy versus Laetrile for breast cancer), her choice of the latter probably indicates a failure of rationality. This is as unacceptable as a failure of (or failure to incorporate) the affective components. Nonetheless, one shows respect for individual persons by allowing them some latitude in balancing the rational and the affective. It may be that if the patient is not fully rational at a particular time, her capacity for intermittent or partial rationality will still provide some reason for respecting her choice. Thus, patients with 3+
affective components and 1+ rationality, or 3+ rationality and 1+ affective components would, in virtue of participation of both systems, be competent.

This, of course, does not settle the crucial question of whether patients are incompetent when either of the systems completely fails. For the reasons discussed in the preceding sections of this chapter, I deem it to have been settled that a level of 0 rationality renders a person incompetent to make a decision. This stems from the fact that respect for persons requires that they be able to participate in the structuring and restructuring of their lives. Anyone in whom cognition is absent cannot be so involved because he cannot fulfill the cognitive analyses that are necessarily a part of decision making (or choosing rather than merely reacting). Hence, such persons cannot be for that decision someone to whom we tender respect vis a vis that decision (although, for a variety of reasons, we might want to respect the person in other ways).

Of course, the presence of strong emotions does not, in an of itself, imply irrationality. Aristotle and Kant would certainly agree that reason is quite capable (absent acrasia) of overpowering the emotions to determine actions (and that it should do so). Hume and Mill would insist that emotions are a valid and important aspect of the human experience that may (indeed, should), ceteris paribus, help to direct that experience. And it is certainly true that Mill\textsuperscript{103} does not demand abrogation of the rational aspects of decision making;
he only demands concomitant attention to the affective components.

Importantly, it might be not only possible but imperative to include non-rational aspects in the decision making process. Our woman who has an enormous fear of surgeons might be justified in electing to pursue a medical rather than an operative therapeutic regimen. But if this same woman, hampered by illness and fear, should be "cognitively impaired" according to the MSE—and recall that strong emotional states can interfere with performance on nearly all components of the MSE\textsuperscript{104}—this cognitive "impairment" would deem her "incompetent" to make this decision, and a surrogate would be appointed to make the choice.

To pursue this line of thought a bit further, it should be noted that the circumstances surrounding decision making by most sick people are just such states of affairs as have been shown to impede maximal cognitive performance upon the MSE.\textsuperscript{105} Such states as fear, anxiety, depression, pain, fatigue, unfamiliar surroundings—all usually present to some degree in illness—have been shown to inhibit cognition, at least as it is measurable by the MSE. If competence correlates with higher cognitive functioning as tested by the MSE, the noxious circumstances under which many patients take the MSE will undoubtedly result in many of them being labelled incompetent. And this in situations where those same factors might be legitimate sources of input that ought to be factored
into any decision about further treatment. But if affective components of competence are admitted, they may have the power to make up or correct for cognitive deficits.

That leaves us with the difficult question of how to consider a person who has a 0 level of affective components. I am not quite certain how numerous such persons are. There are certainly people who keep their emotions under such rigid control that they rarely intrude, at least in a conscious way, into decision making. The crucial question is, are such people competent. The answer is, yes and no. Let me explain.

There certainly are unemotional people in the world. Most people can count among their acquaintances at least one person who "never lets her feelings get in the way", the truly and fully cerebral person when it comes to decision making. 106 Such persons would, on the scale, register a 0 affective assessment. Are these people competent? Yes, if this is a typical pattern of behavior, and for three reasons. First, the person who has "always" squelched emotional response cannot be expected, under stress, to change her personality. Stress often precludes any response other than those which are "automatic". 107 Second, it should be possible to ascertain if there are feelings present—we could ask the person—which are now being and which have been habitually intentionally excluded as relevant to decision making. If so, the person is acting in character and at least some attention is being paid to the emotions—i.e., that which is necessary to exclude
them. Third, there are the control and motivational factors to be considered. That the person is very much and, for her, very typically "in control" and moving ahead with the decision making process gives evidence of an involvement of at least part of the affective system. To override this person's typical response is failing to respect her as a person.

If, on the other hand, the person usually both perceives and attends to his emotions but in a particular situation is doing neither, there is cause for concern. In this person an affective rating of 0 is evidence of incompetence. This is because the person has blackballed a portion (for him) of a normally functional aspect of his decision making system. To permit him to make decisions without the sorts of advice he normally deems to be important and worthy of attention is to permit him to go astray from the structuring and restructuring of his life plans. This is failing to respect him as a person by permitting what is, for him, incompetent behavior.

The final issue that remains to be addressed is what a process of affective competence might be like. This is a tricky issue, as we do not normally think of the affective components as tracking through a process. Somehow feelings seem to spring full blown from we know not where. Still, if we are committed to the idea that to be competent one must demonstrate conformity to an acceptable process, it behooves us to try and delineate such a process for the affective components.
Just as cognitive competence turns upon the possession of certain capacities, so affective competence depends upon an analogous set of abilities being in place and functional. We recall that, to be cognitively informed requires that the person be able to receive, recognize, and remember certain facts, so to be affectively informed requires that the person be able to receive, recognize, and remember certain affective facts. These include an awareness of the emotional events that attend any decision making event. For example, we want persons to be aware of (receive) feelings they experience, recognize that they constitute an integral part of the situation in which the person now finds himself, and remember, during the on-going process of making the decision, that one has certain feelings that attend (albeit with varying intensity at different times) this decision.

Next, as she must be cognitively competent, a person must be affectively competent. For the former this involved the abilities to relate to, reason about, and rank alternatives. For the latter, the same criteria apply; she must relate the feelings she is undergoing to her present situation, reason about how different feelings attend different therapeutic options, and incorporate these feelings into the ranking of alternatives from which she must ultimately choose.

Just as she must be able to actually make a decision, so must a person be able to square her emotions with that decision, once made. This does not mean, of course, that she
must be happy about her situation or about the choices she must make. It does, however, mean that she must acknowledge the emotional responses that accompany her choice, that she not allow such responses to block her making of a choice, and that, at least in the presence of negative emotions, she must work toward acceptance of her situation, if not delight with it.

Finally, as the cognitively competent person must be able to recount the process by which he arrived at his decision, so must the affectively competent person be able to indicate the role his emotions played in his choice. He is not required to bow to their dictates; he may, in fact, admit that he had to put them aside in order to make a decision. Or he may instead ruefully confess that they played a greater role than he would have liked.

Harry Frankfurt's concept of "second-order desires" is helpful in explicating this notion of affective competence. On his analysis there are first-order desires, the desires to do or have something; all animals have these sorts of wants. But there are also second-order desires, or the desires to have (or not have) certain kinds of desires. These latter sorts are present only in rational animals who have the additional capacities for being able to envision how their lives would go differently, depending upon the extent to which they control their first-order desires and for preferring that their lives go one way rather than another.
It is this sort of discrimination upon which affective competence depends, for this further capacity allows people to say "I am giving free rein to my emotions because I want to" or, conversely, "My emotions are compelling me to act in this way, and I would rather I felt otherwise", of "I have strong feeling about this, but I am ignoring them". In all cases the person has acknowledged the input of his affective components as important to his decision making process. The point is that the affective components do, in the normal person, play a role in important decisions (like it or not). The process that attends affective competence thus requires that this role be admitted and incorporated into decision making.

The critic will charge that the process I have just outlined is not an affective process at all, but a process of reasoning about feelings. This is true, but it does not disturb me much. The idea of affective competence is to get one's feelings out into the open so that they can be managed during decision making. This process accomplishes that end.

My dismissal of this criticism is undoubtedly too glib. In one sense, to ignore it is to ignore the entire dispute between the cognitivists (such as Aristotle and Kant) and the non-cognitivists (such as Hume and Mill) by conflating the issues. Put another way, it would be saying that the inability of reason to ground morality is yet another topic that reason must consider. The implication is that it is
still only reason that can ultimately justify morality. Analogously, my claim that affective competence is acquired only through a process of reasoning may seem to collapse the two types of competence, such that ultimately only reason can serve as the final arbiter for competence.

To some extent this charge is correct. Nonetheless, I do not think the conflation of affective and cognitive competence constitutes total surrender. Although it does relegate affect to the domain of reason, it also demands that affect be included in that domain. For that reason, it assures that the feelings that traditionally accompany decisions of any moment will be assayed and included (if only to the extent necessary to suppress them or, ala Frankfurt, to recognize that they are something one wishes would go away) in one's final choices. This seems, at least to me, to be an acceptable compromise. As such, it counts more as a truce than a surrender.

The critic will also charge that no one does (no one can?) undertake such a process during decision making and to insist upon it is a useless academic exercise. This I am less certain about. It is probably the case that it is rarely performed in so precise a manner. Moreover, such processes may only be available for conscious consideration retrospectively. However it seems possible that it might be employed as a guide to help persons who are stumped, either because they are having trouble containing their emotions or
because they are refusing to acknowledge them, to more effectively bring the affective components into the making of decisions. Once this is achieved, HCPs and patients can address them within the relevant context, just as they do the components of cognitive competence.

E. Summary

We find that to be a being worthy of respect is to be a particular sort of creature—one who reasons, to be sure, but also one who experiences certain sorts of feelings and who interacts with the world in certain ways. This being so we understand that, while reasoning capacity is a necessary condition for respect, it is not a sufficient condition. Just as acting from emotion without the benefit of reason or acting without control are acting inappropriately, so to act from reason without counsel from the affective components is to act in ways that diminish one's worthiness of respect. Persons to whom we owe respect are persons who are whole, in the sense of accepting counsel from all mental spheres. They are the persons Plato described in The Republic as harmonious.

The discussion of cognitive and affective competence, then, tells us a number of things. We respect persons in virtue of all their capacities, affective as well as cognitive. Because this is so, we insist that both systems be recognized in competence assessments. Both can be more or less present and both must be present at least to some extent for a person to be considered competent.
VI. IMPLICATIONS FOR A NEW UNDERSTANDING OF COMPETENCE

Where does this leave us with regard to analyzing competence? Are we better off, or worse, after considering all the above? Probably both, for although our understanding of the concept should be richer and more extensive, the problems of choosing from among all four (rather than merely one) paired alternatives has enormously expanded the difficulties surrounding the analysis of this concept.

And yet that is what is required if a genuinely inclusive appraisal is sought, because each of the paired alternatives addresses an aspect of competence that the others leave untouched. A complete conceptual analysis of competence cannot afford to omit any of the options; a choice between each pair is required. A brief review should make this clear.

First, competence has been determined to be a specific notion. Global assessments of competence may be useful insofar as they give evidence as to what a person has been like in the past. This gives HCPs a rough but useful standard against which to compare the patient's current behavior. But competence to consent will always be determined from the point of view of a particular situation. This tells us that

P is C to make this decision because, for this decision, P can (or can to D) acquire information about options, manipulate that information according to a process that maximizes the probabilities of achieving her chosen aims, choose on the basis of that information and those estimates, and persist in that choice.
Second, competence is a matter of degree. This is to say that people can be more or less competent; it is also to say that attempts to decree that persons are or are not competent with regard to a threshold are misdirected. The threshold may be a convenient fiction, but it fails to respect persons and the uniqueness of each person's choices. This tells us that

P is C to D, for this decision because for this decision P possesses to D the requisite capacities for decision making (i.e., she can acquire information about options, manipulate that information according to a process that maximizes the probabilities of achieving her chosen aims, choose on the basis of that information and those estimates, and persist in that choice).

Third, the assessment in Section IV makes a strong argument for omitting consequences from the logic of competence, because such appeals stand in opposition to respecting persons, even (and especially) in idiosyncratic and tragic choices. Since competence is consequence-independent, the considerations of CIC vs. CDC do not change this conception.

Finally, both cognitive and affective capacities are necessarily included in the conception. The arguments of the last section make clear that both are integral to our understanding of what makes a person and of what grounds a worthiness of respect. This dual nature of persons has significant implications for the understanding of competence since affective components have not traditionally played a central role in competence assessments (except, of course, when blatant emotional states are thought to preclude the
possibility of competent decision making). This tells us that P possesses to \( D \), for this \( T \) the requisite cognitive capacities for decision making (i.e., can acquire information about options, manipulate that information according to a process that maximizes the probabilities of achieving her chosen aims, choose on the basis of that information and those estimates, and persist in that choice) and \( P \) possesses to \( D_\star \), for this \( T \) the requisite affective capacities for decision making (i.e., can respond in emotionally appropriate ways to information and be moved to pursue and accomplish those tasks that are important to her survival or enjoyment of life).

The upshot of this is that competence is much more involved than has been previously imagined. What has been thought to be a single-faceted issue is now seen to be multi-faceted and, hence, much more complex. Thus, merely fleshing out the particulars of the conception will be no mean feat (especially given that when only faced with a single-faceted choice no clear understanding has been forthcoming!).

Given the increased complexity of the concept, it can be expected that the notion of competence to consent will be much more restrictive than it has been in the past. Part of this, of course, lies in the simple fact that there more aspects of a person's mentation that will have to be assessed; as such, evaluations will themselves be more complex and it will become more difficult to say with any certainty that persons are or are not competent. But greater disquietude may stem from the fact that, because there are more components to competence, there are more things that can go awry. Put another way,
there are more ways to fail to be competent.

In a more positive vein, it is possible that appealing to a degree rather than a threshold notion will counteract some of this tendency. That is, we might say of people not that they are incompetent, but that they are less competent than they were previously or will be in the future, or than someone else is. This will have different implications than would declaring them to be fully incompetent.

There are (at least) two philosophical implications that flow from an expanded concept of competence. Both are somewhat disturbing. The first is that, the more complex the conception of competence, the tougher it will be to fulfill all the criteria (i.e., the tougher it will be to be competent). Assuming that criteria are included because they are themselves or are somehow related to the capacities that we value in persons, one has no choice but to conclude either that there are fewer persons who are worthy of respect than one might have otherwise thought, or that such persons as are generally worthy of respect are nonetheless worthy less often or to a lesser degree. This leaves one with some sense of confusion as to who is worthy of respect, or when.

Second, appeals that one might otherwise lawfully make to consequences will be reduced. If I am right about the foundational nature of respect for persons to the concept of competence, invoking consequences as grounds for declaration of incompetence will be illegitimate. One might, of course,
make such appeals in attempts to persuade competent persons to re-evaluate their choices when those choices seem not to redound to their well-being. However further recourse to outcomes is prohibited. From a practical aspect, the threat of really noxious consequences might serve as a mandate to further investigate a patient's data base, to make certain he has all relevant information and genuinely understands the ramifications of his choice. But so long as a person is competent, appeals to any horrible results that might follow from his choice are forestalled (at least so far as competence is concerned). There is, nonetheless, the worry that allowing preventable tragedies may somehow fail to respect persons.  

This prospect certainly has practical implications for what it means to be a good health care practitioner. Insofar as competence can be defined (and tested for), its presence in a person will usually serve to make her the court of last appeal in the health care decision making process. The goal of health care has long been to secure for patients their good. Traditionally this good has been defined (almost) solely according to the guidelines for successful medical practice. (In the crassest sort of way, such securing of the good is recognized in the old saw, "The operation was a success, but the patient died".) The justification for such practice was often based upon claims that patients were, if not incompetent, at least suffering from a reduction in competence. Disproving such claims has been difficult and,
in the absence (although sometimes in the presence as well) of strenuous resistance on the patient's part, the recommendations of the HCPs were generally followed even when the patient expressed some reticence or dissatisfaction. Such scenarios ought to disappear with a reliable and thorough analysis of the conception competence. We turn now to Chapter Three which will provide such a conception.

NOTES

1. This formulation is the second of three different, but purportedly interchangeable, ways in which Kant expressed his categorical imperative. There has been much debate among Kant scholars as to just whether the three formulations did indeed make the same claims. This controversy need not concern us here since, whatever Kant may have meant by the first and third formulations, he surely meant in the second that persons ought always to be respected.

2. For Kant, "person" is often thought to be a technical term that designates one who possesses the capacities for rational thought and, hence, for universal moral legislation. Under such an interpretation, persons need not be humans. God and the angels would be Kantian persons, as would intelligent extraterrestrials.

The more interesting question is whether, within a Kantian framework, all humans are persons. In his discussion of personhood found in the Foundations of the Metaphysics of Morals [74], Kant often seems to use the terms "person" and "human" interchangeably. In his second formulation of the categorical imperative, cited above, he speaks of treating "humanity, whether in your own person or in that of another" (Foundations of the Metaphysics of Morals, 429, [74], p. 47). In this and other such phrasings, the terms appear both to be and to be used as synonyms.

Likewise, in a passage on a discussion of duty, Kant notes that "[duty] must...hold for all rational beings...and only for that reason can it be a law for all human wills" (Foundations of the Metaphysics of Morals, 425, [74], p. 43, emphasis added). The suggestion here is that duty, as a
prescription for "all rational beings" is, for that reason, a prescription for all humans. Similarly, he notes that "...man and...every rational being exists as an end in himself and not merely as a means to be arbitrarily used by this or that will" (Foundations of the Metaphysics of Morals, 428, [74], p. 46). Again, the implication is that all humans (as well as other non-human rational beings) are worthy of respect.

Nonetheless, confusion arises on this question. Such ambiguity no doubt results from other passages wherein Kant is keen to stress the importance (for morality) not of human beings per se, but of reason. For example, "...morality and humanity, so far as it is capable of morality, alone have dignity (Foundations of the Metaphysics of Morals, 435, [74], p. 53, emphasis added). Likewise, he speaks of the "dignity [of every rational being]...over all merely natural beings (Foundations of the Metaphysics of Morals, 438, [74], p. 56, emphasis added). Passages such as these seem to imply that it is not humans per se that are worthy of respect, but only those humans who also possess the capacity for rational thought.

If this is his meaning, that is, if Kant (as seems to be the case from his critical work taken in its entirety) genuinely believes that only rationality grounds respect, humans who lack the ability to reason (e.g., the severely demented, infants) are humans but not persons worthy—or at least not inherently worthy—of respect. There may be other good reasons for treating all humans respectfully, but such treatment would then derive from those other reasons rather than from the rational nature of the humans in question.

If, on the contrary, Kant thought humans, regardless of their particular capacities to reason deserved respect, then it is unclear why he speaks specifically about that capacity. It seems likely, given his casual use of the terms, that Kant simply presumed that all humans were at least potentially if not actually capable of reason and, hence, were worthy of respect.

3. See, for example, [47].

4. I have been tempted to say that reason, while not on all accounts a necessary condition for worthiness of respect is nonetheless a sufficient condition for that worthiness. That is, so long as one is rational, one is deserving of respect (and, for purposes of the present discussion, is a being who is competent and whose decisions ought therefore be respected). I now believe that this assessment is incorrect, and rather, that reason is a necessary but not sufficient condition for being respected (both in oneself and with regard to one's decisions). This means that persons who are worthy of respect must be possessed of reason, but that they must also
be possessed of other capacities as well. This claim will be defended below.

5. See, for example, [22], [67], and [68].

6. One upshot of renouncing a restricted definition of personhood is that the scope of moral worthiness is thereby extended. On a restricted definition, it would be tautologous to claim that persons (in the technical sense) are the foundation of morality. Without such persons, there would be no moral sphere; for morality just would be the set of concerns of beings interested in right and wrong or in what is good or bad. It would then be safe to say that there would be no moral concerns that failed to relate (albeit to varying degrees) to persons, and that only persons would have claims to moral treatment.

I take this conception to be false, at least in part because of the widespread belief that there are, in fact, beings other than those who are rational to whom morality applies and who do have (regardless of whether they can themselves articulate them) moral worth and some moral claims upon individuals and societies. Examples of other creatures with (at least some) moral worth or claims include the irretrievably comatose, the anencephalic neonate, and animals. Of course not everyone shares this belief, but many do (Cf. [131]); and the question seems sufficiently far from being settled to require that the dialogue continue.

On the other hand, there might be rational beings who are uninterested in the moral realm. (Kant, of course, would claim that such a being is conceptually incoherent). Such "outlaws" might eschew all forms of social enterprise, of which morality is an instance, preferring instead to lead an amoral and isolated existence. One might then charge (Cf. [47]) that such persons would be unable to make any moral claims upon their fellow men to be treated in morally acceptable ways.

This claim also seems false. While an outlaw might not be entitled to make particular moral claims upon particular moral communities, so long as he possesses some of those characteristics which are valued in persons, his absence of the sense of community usually found in humans in no way undercuts the respect granted to other (i.e., to morally involved) persons (assuming he does not, by his behavior, forfeit this respect).

7. I am not fully comfortable with potential capacities, largely because so many things can obstruct their realization and, hence, at least some of their holders' worthiness for respect. Still, part of the value of persons is that at least most of them can throughout their lives become something other/more than what they are at a particular time. Then, too, there is the necessity to behave appropriately with
regard to persons who are asleep, narcotized, anesthetized, etc., even though they are not at those times actually exercising the valued capacities though presumably have the potential for doing so. So in these senses it seems appropriate to speak of "potential" (viz., for continued exercise in the future) capacities, while at the same time recognizing that such moves may provoke strong rebuttals (see, for example, [168]. especially Chapter 6).

8. See, for example, [24], Chapter 2.

9. For an intensive analysis of the variations on the theme of personal identity, see [119], Part Three.

10. I should add that I am not here taking a position on the question of materialism (i.e., that the mind just is a series of physical--biochemical, neurophysiological--events) versus idealism (that there is only mind (i.e., disembodied spirit). In the event that either of these positions is the correct one, we would surely have to revise our theoretical conceptions of personal identity. I suspect, however, that these revisions would not demand any serious revisions in our practices.

11. Different versions of this theory give different accounts of what it means to have one's life go well. The major contenders are the hedonistic theories (i.e., my life goes well insofar as I am happy), desire-satisfaction theories (i.e., my life goes well insofar as my desires are satisfied), and objective good theories (i.e., there are certain things that are good and bad and my life goes well insofar as I achieve the good things and avoid the bad, independently of whether this makes me happy or satisfies my desires). Different versions of this theory also give different answers to the question: May I ever act against my own self-interests? On some versions, it is irrational to act to thwart my own good. On others, acting against my own good for the sake of another (e.g., acting altruistically or morally) is permitted but not required.

12. Under the aegis of morality, it is at least sometimes permissible to further one's own interests, viz., whenever one is in a situation about which morality makes no demands. Different theories have various descriptions about the characteristics of situations in which there are no moral demands. One of the charges against act utilitarianism, for example, is that there cannot be a situation in which morality does not exert demands.

13. For a fuller discussion of this problem, see [21].
14. For a full explication of this theory, see [119], Parts I and II.

15. As a matter of fact, this is what HCPs generally assume. See, for example, [1], [2], [9], [19], [59], [106], [108], and [115].

16. See note 15, supra. Moreover, Faden and Beauchamp ([51], pp. 287-288) argue that one of the things we want from competence assessments is a determination of who is the decision maker in health care settings; i.e., whether HCPs should be giving information to and seeking consent from the patient herself or to some surrogate decision maker.

17. Two points need elaboration. First, it is crucial to distinguish between being the best judge of one's goals, values, or desires and being the best judge of how to achieve these. The best judge of the former is not necessarily the best judge of the latter. That is, a person may be the best judge of her goals while, at the same time, someone else (e.g., her HCPs) may be the best judge(s) of the means to those goals. It is possible to want something, even quite badly, and be completely at a loss as to how (best) to realize that ambition. This scenario is, in fact, quite a common one in health care settings. Persons want, for example, a long and healthy life; that is the goal. They seek advice from HCPs who counsel them regarding appropriate diets, exercise regimens, medications, etc.; these are (some of) the means. In persons who are afflicted with life- or health-threatening illness, these goals are in even greater jeopardy. Then the person even more needs the advice of HCPs regarding how best to conquer or control her pathophysiology. The person who fails to solicit such input may actually thwart the achievement of her self-determined projects or outcomes.

Second, the critic will charge that patients may literally have no idea what it will be like to live with particular afflictions and, hence, how their goals or values will be affected. This is, in one sense, trivially true; i.e., until I have diabetes, I do not know subjectively what it means for me to be a diabetic. This point is often made (illegitimately, in my opinion) to buttress arguments that HCPs are better positioned to make decisions than are individual patients, because the HCPs have seen lots of diabetics and can generalize from that experience. These claims are true; they are also beside the point. This is because HCPs' knowledge of diabetics cannot necessarily be reliably extended to my diabetes. Put another way, HCPs know nothing of the subjective experience of my diabetes.

It is true that HCPs can draw upon a wider range of individuals with diabetes. On that basis they can make predictions and recommendations that are statistically respectable for diabetics in general. But I can draw upon a
wider range of my individual experiences (e.g., how I manage stress or disability; what I take to be legitimate causes for revisions of my goals and values; and so forth). HCPs have a statistically significant n secondary to a large number of particular different individuals. I have a statistically significant n secondary to a large number of particular different experiences—mine. The former qualifies them to give advice; the latter qualifies me to accept or ignore it, in my case. They know more about diabetes; I know more about me. Which of us knows more about my diabetes is at least open to discussion.

18. There is an important caveat that attends this point. It is the acknowledgement that the individuals are not the only persons with any capacity for making choices, medical or otherwise, that are important throughout their lives. Most persons have close relationships to other persons, and part of such relationships is that values and goals are shared or at least discussed. This sharing often puts other persons in a position of being able to attest, often with a great deal of accuracy, to what their family members and friends would want to do or have done for them when those people are unable to speak for themselves.

It is this intimate knowledge of others that has allowed the practice of "substituted judgment", both formally and informally, to be adopted as one form of decision making within society. When a person is unable to speak for herself, both medicine (See, for example, [127], [27], [28]) and the law (See, for example, [25], [37]) have traditionally turned to those closest to the person who is unable to make her own decision, to determine what she would choose, were she able. Such examples formalize the common and helpful approach to decision making of inquiring "What do you think Mary would want us to do?" when Mary is not present.

19. This claim obviously presupposes that the criteria for informed consent--information, competence, and voluntariness—are met.

20. At this point it may be useful to note that on a self-interest theory we might often be required to override a patient's choices. If present choices seem to conflict with past beliefs, goals, and desires, and assuming that good evidence for this claim could be presented, HCPs might legitimately act in paternalistic ways to protect the former attitudes. On a present-aim theory, however, this move is blocked unless, of course, the patient is deemed to be incompetent, in which case one moves to promote her best interests insofar as they can be determined. Then one piece of evidence of those interests would probably be the protection of long-held values. (I say "probably" because when those values are at odds with strongly held values of
HCPs or family members, they are often ignored ([10], [11], [28], [32], [90], [135], [141], [151]).

21. Pernick notes ([122], p. 11), however, that HCPs generally did not override objections on the part of patients, probably because of the tenuous positive link between cause (e.g., health care) and effect (e.g., recovery) that attended medicine before the mid-twentieth century.

22. In discussing a "practice" I am following the description of Rawls ([130], Section III). Rawls notes, correctly, that it is often the case that trying to decide how to handle cases on an individual basis, without formal guidance, can be confusing and frustrating. Moreover such an approach often leads to unwanted, untoward results.

A more efficient method for decision making is to establish a "practice" that lays out rules of behavior for the management of recurring situations. The characteristics of a practice include:

1. The rules of the practice are logically prior to the particular cases that it address;
2. The practice changes the degree of authority each person has regarding unilateral resolution of particular cases;
3. The rules of the practice are not merely guidelines or suggestions for case resolution, but are instructions for those purposes; and
4. The rules will more often than not lead to the correct decision's being made.

Under a practice decisions are made in accordance with whatever rules the practice includes. One learns the rules, then applies them to cases, rather than generalizing from case management to the construction of rules. Moreover, once the practice has been established, anyone operating within the confines of the practice no longer has leave to ignore its rules, but must use the rules for decision making.

Rawls' example of a practice is the game of baseball. One of its rules is that each batter is allowed only three strikes. Were a batter to ask for a fourth, on the grounds that in his particular case it would really be better to ignore the three-strike rule, no one would seriously consider the request. Rather we would claim that this batter simply does not understand the game.

I take informed consent to be another example of a practice. Among its rules is one that states that consent will only be elicited from persons who are competent. But more important is the rule that competent persons will be the only source from whom consent is elicited. In other words, one who claims that in this instance, even though the patient is competent, it would really be better to accept the judgment
of some other person, simply does not understand the nature of the practice of informed consent.

Similar notions of practice are discussed by MacIntyre ([97], Chapter 14) and H. Brody ([24], pp. 30-34).

23. For further argumentation that competent individuals' decisions ought to be respected, see [16], [27], [108], [125], [127], [135], and [172].

24. Of course, the globally competent athlete is also specifically competent in more than one particular sphere. This claim, however, presupposes a particular interpretation of global incompetence. On one interpretation, "global incompetence" means that a person is not competent to do any task. However an alternative interpretation of "global incompetence" is that a person is generally but not completely incompetent to perform tasks. It is within this latter interpretation that one can be globally incompetent but specifically competent. Within this work, "global competence" and "global incompetence" will presume the second interpretation unless otherwise specified.

25. I take consent to be a form of decision making. By this I mean that competence to consent is competence to make decisions, or to undertake a process in which alternatives are considered as mutually exclusive options. (For a similar analysis, see [28], [51], [76], [83], [94], [115], [127], and [128]. This contrasts with unconsidered reactions (i.e., mere responses) to situations, in which a person behaves in a particular way without considering different courses that might be taken. Put another way to consent is to act and not to merely react.

26. In discussing the importance of being informative, I am addressing something quite distinct from the importance of being informed. The former is a capability, the latter is a state of affairs. It is widely recognized that within health care settings it is, ceteris paribus, highly desirable for patients to be informed about their diagnoses, prognoses, treatment, etc. The information allows patients to understand, accept, and cooperate with the therapeutic course. (See, in this regard [3], [11], [15], [28], [34], [50], [75], [84], [92], [101], [127], [134], and [138].) The importance of being informed is crucial to moral responsibility [110], and is recognized in the law as well ([31], [35], [107], [114], [137], [144], [147], and [169]).

27. Discussion of and support for this criterion may be found in [7], [8], [16], [17], [27], [34], [71], [80], [102], [121], [125], [127], and [141].
28. Discussion of/support for this criterion may be found in [8], [121], and [141].

29. Discussion of/support for this criterion may be found in [6], [7], [27], [28], [34], [41], [53], [59], [71], [80], [102], [106], [121], [127], [160], and [174].

30. It is important to note that to be informable is not the same thing as being informed. One might choose, for a variety of quite legitimate reasons, to forego being informed. Some patients, for example, specifically request that their HCPs not given them information about diagnosis, prognosis, or treatment. Rather they instruct the HCPs to "do what you think is best".

The extent to which HCPs are comfortable with this "carte blanche" approach to patient care varies a great deal among practitioners. However one feels about operating within a patient's informational void, one is probably well advised to check with the patient periodically to make certain he still wants not to be informed.

Interestingly enough, many people circumscribe information input in a variety of other ways that have little to do with medical decision making. For example, Jehovah's Witnesses do not want to hear about therapeutic options that require the use of blood or blood products because, given their religious beliefs, these are genuinely not options for them.

The more interesting question is to what extent such "immune" beliefs ought to be subject to the same sorts of scrutiny that attend other aspects of health care choices. Can one, for example, weigh the risks and benefits of continuing to be a Jehovah's Witness or consider what is the probability that so continuing will promote one's other values, beliefs, and goals, when one is actively hemorrhaging and the most effective treatment is to accept a blood transfusion? Perhaps not, given the dire stress of the moment. But then ought such risks and benefits be incorporated into decision making much earlier, for example, when one is deciding whether or not to embrace the Jehovah's Witness faith? It seems odd to think that decisions of faith would turn upon consequentialist or risk/benefit calculations. Traditionally the answers to such questions are thought to be "revealed" more than arrived at by calculation.

My own thinking is that, in such circumstances, religious beliefs impose the same sorts of constraints as do practices (in the technical use of that term as was described in Chapter Two, Section I). Insofar as one embraces a practice, to that extent are certain estimates precluded as a part of one's decisional calculus. Nonetheless just as one can step outside a practice in certain extenuating circumstances so, presumably, can one step outside one's religious beliefs. This giant step would, however, seem warranted only in very
unusual situations. In one sense, of course, threats to one's life seem to be situations of sufficient magnitude to allow radical reinvestigations. In another sense, maintaining one's commitment to religious beliefs in times of ultimate peril seem to be what is meant by religious integrity and fidelity. Suffice it to say that the question admits of no quick and easy answer.

Because the Jehovah's Witness sect is well established and has been much discussed, their more unusual tenets no longer seem so bizarre as to require that they be rejected out of hand. But many people have equally unusual beliefs that may not be shared by a larger group, nor widely publicized. Then, when they intrude into the decision making process, others may be more reluctant to admit their credence. What if, for example, Ivan Illich (of Medical Nemesis fame; not Dostoevski's character) were to be inadvertently brought to the emergency room and then to regain his capacity to articulate his beliefs? Ought we respect his statements that technological medicine invariably does more harm than good and that, moreover, people can always bear what they are determined to bear so that treatment is more often than not unnecessary? Would we?

If the logic of decision making legitimately admits those beliefs, goals, and values that persons define for themselves, then there seems to be no in principle reason for ignoring or overriding those which are genuinely unique to particular individuals.

31. Many consider informability to be a component of "cognitively capable". (For a representative sample of this position, see [116] or [80]. While this is a traditional structure, I split the concept into separate (albeit related) constructs, since one can be informable without being otherwise cognitively capable. One case in which these characteristics can be distinct is that of pathological indecision. (For concerns about pathological indecision, as well as "normal" ambivalence, see [7], [42], [108], [127], and [139].) Here persons would be capable of being informable and yet be cognitively incapable (in the sense to be described) because of an inability to weight various options, see the relationship between those options and one's own expressed values, appreciate how different choices would achieve different outcomes, assign probabilities to projected outcomes, or perform some combination of these activities.

32. Discussions of/support for this criterion may be found in [7], [8], [16], [17], [19], [27], [34], [59], [61], [90], [102], [106], [121], [125], [127], [141], [143], [151], and [174].
33. Discussions of/support for these criteria may be found in [7], [8], [16], [17], [19], [27], [28], [34], [59], [71], [80], [87], [102], [106], [121], [125], [127], [141], [143], [151], [160], [166], [174], and [175].

34. Discussion of/support for this criterion may be found in [8], [27], [28], [57], and [151].

35. Discussion of/support for this criterion may be found in [7], [8], [16], [17], [28], [34], [71], [94], [101], [106], [121], [125], [127], [141], [143], [151], [164], and [175].

A word of caution is in order here. One needs to take care not to confuse the person who is especially careful in making decisions and who may, therefore, take an inordinate amount of time in choosing among options, from the person who is genuinely unable to make a choice. For concerns about pathological indecision, as well as "normal" ambivalence, see [7], [42], [108], [127], and [139].

36. Discussion of/support for this criterion may be found in [8], [16], [17], [27], [28], [42], [43], [59], [90], [106], [121], [125], [127], [148], and [164].

37. Of course persons in abnormal or extraordinary situations may still perform in satisfactory fashion. The point is that their competence cannot be assessed on the basis of performance under aberrant conditions.

38. One might suppose that global competence refers only to historical abilities. Then the fact that a person is unable to perform a task under present conditions would not count against his competence. In decision making this would imply that if the four criteria have generally been met in the past, a person must be considered competent even when he appears to be incapable of choosing in this particular situation (so long as the choice does not differ sufficiently from those he has faced throughout his normal life).

However it is also possible to consider a person globally competent if he is able to perform all (or most) of the tasks facing him at a particular point in time. This would indicate nothing about his past performance, but only that he can do all (or most) things now. Such an interpretation stands in opposition to the case where he has historically been able to do a particular task--e.g., make decisions--but cannot now do so.

On the former interpretation his historical abilities would transfer to the present, making him competent to perform, even though the necessary capacities are not now present (or are present in a diminished degree). On the latter interpretation his historical abilities would provide evidence of what we might expect him to be able to do, other
things being equal. They would not, however, count toward as assessment of his current competence.

We do not have to settle this issue here. As will be shown below, competence applies to particular situations. As such, a patient's history will be germane in that it will provide a yardstick against which his current abilities can be compared ([8], [59], [142]). Thus, HCPs should not be surprised (nor overly dismayed and concerned) when a patient who has been chronically unable to make decisions cannot make the one he now faces. On the other hand, patients who have not been but now are incapacitated warrant further investigation to determine the cause of the current deficits so that they might be eradicated or compensated for.

39. For other accounts of the importance of appealing to a process, rather than to a result, [28], [108], and [125].

40. For discussion of competence to consent as a specific notion, see [8], [17], [27], [28], [29], [39], [42], [43], [59], [71], [108], [121], [127], [135], [142], [143], [157], and [175].

41. Some specific consents will necessarily be less precise. For example, execution of an advance directive, such as a natural death act or living will, must omit reference to particular practitioners, places, and times. They may or may not omit reference to particular treatments (e.g., no CPR but do continue nutrition or fluids), though presumably they will designate particular conditions (e.g., being terminally ill, or that death be imminent). An interesting variation on the last theme is persons who to refuse treatment for even more particular conditions. For example some cancer patients consistently refuse further therapy with a negligible chance for cure (and, in some cases, even for palliation) of their cancers, but continue to actively seek treatment for other concurrent diseases that may or may not have resulted from the cancer or its treatment (e.g., cardiomyopathies that result from chemotherapy).

42. Of course, if the decision need not be made immediately, that one will be informable at a later date is not only relevant but important for determining when the decision should be made. For an excellent article advocating a program of delayed decision making, especially for patients with chronic or recurring illness, see [34].

43. It might be that HCPs need to ascertain if the patient, rather than some surrogate, is the person to be approached for consent [51]. Or it might be that HCPs need to ascertain if the decision needs to be made now or if, in cases where the patient's competence is diminished, the decision might wait
until the patient's competence can be restored or enhanced ([32], [34], [92], [108]).

44. Additional works on this interesting conceptual disparity may be found in [8], [16], [17], [28], [34], [39], [59], [71], [141], [142], [143], and [175].

45. I omit discussion of persons who are comatose and thus both generally and specifically incompetent since no one argues that they are, under any definition, competent decision makers.

46. The presumption here is that Ms. Smith does in fact understand her illness, what is involved in therapy, and the pros and cons of the various therapeutic alternatives (including that of no treatment at all). She may, of course, merely be passively agreeing; but that is a different case entirely. The example assumes that in this case she is in fact exercising capacities for knowing and for cognitive competence.

47. In truth this position is less pure than it may appear. Persons who have been competent but are no longer are not usually allowed decision making freedom. They would probably not, for example, be allowed to handle their financial affairs or enter into contracts. Persons who anticipate their future incompetence may instruct others regarding their wishes as to how their affairs are to be managed, either through a durable power of attorney or, in a more limited way, through a Ulysses contract (cf. [43]). These mechanisms are not the same thing, however, as being allowed to make decisions at the time of incompetence.

If health care decisions are respected in the previously competent, now (i.e., for this decision at this time) incompetent, this would constitute a middle position between fully competent and fully incompetent. There is, however, another option: to delay decision making insofar as possible until suitable measures can be instituted to restore or enhance the competence of the person to make her own decisions (see note 18, supra).

48. Various accounts of why this would be the case may be found in [26], [27], [90], [108], [122], [125], [143], [166], and [172]. Hahn [61], for example, notes that assuming a "patient knows best" stance is the best way to assure that particular cultural backgrounds and biases are acknowledged as relevant and are admitted into decision contexts. Recall, however, that being the best judge of one's own goals is not necessarily the same thing as being the best judge of what are the best means to promote those goals.
49. See, in this regard, [28], [49], [104], [125], [149], and [175]. Too, for at least some persons, controlling one's own life is thought to be intrinsically valuable quite independent of any assessment of consequences.

50. In the United States this right is guaranteed through the fourth amendment to the Constitution which assures persons freedom from interference in determining what can and cannot be done to their property. Since one's body is construed as being one's property, it cannot be touched without one's permission. This important right is recognized in both statutory and constitutional law. For further discussions, see [31], [35], [107], [137], [144], [147], and [169].

51. For elaboration see [2], [19], [26], [32], [36], [47], [101], [104], [115], [147], and [171].

52. This argument may also be presented to the choosers themselves. One may attempt to convince them that choices that fail to protect their lives or well-being themselves fail to show respect for persons. See, in this regard, Kant's arguments regarding duties to oneself ([74], pp. 39-41, 37-39). While this approach may be successful, there are conceptual difficulties with its use. At least one scholar has argued that the idea of a duty to oneself is a conceptual confusion. Just as I can always excuse others from duties they owe me, so (the argument goes) I can always excuse myself from duties owed myself. This being so, there would seem to be no duties to myself that are binding upon me in any serious way. For a fuller discussion of this argument, see [153].

53. Of course, whatever action one undertakes in attempting to respect a particular person in a particular situation, one must recognize that one is acting upon a probabilistic best guess. The best estimates may be beset by bad luck, while the worst estimates may, through sheer good fortune, succeed in protecting a person's self-stated goals and interests. (See note 39 supra.) It is this possibility that ought to make HCPs especially wary of imposing their own demands upon patients who have strong conflicting preferences. Nonetheless there do seem to be cases where the best information available argues for overriding a patient's refusal as a way of showing a fuller, more inclusive respect for the person.

In some sense the dispute over where these principles lead would seem to be amenable to empirical investigation—take two sets of n patients each, matched for personal, psychological, pathological, etc., characteristics; subject one set to decisions based upon a global definition, the other set to decisions based upon a specific definition, and see which group fares better. Unfortunately, while theoretically intriguing, the well known problems of identifying, predicting, and weighing effects rule out such empirical examina-
tions. We seem to be left with both definitions appealing to the same principle, and no immediately obvious way to adjudicate between their claims.

54. See note 42 supra.

55. See, regarding freedom to fail, [49], [104], [125], and [149].

56. This is not to say that when the capacity for competent decision making is lost, there is necessarily no further reason to respect persons. Recall that we respect persons on the basis of a number of traits they possess, only one of which is the capacity for competent self-governance. Persons lacking this capacity may still possess others and, to that degree, be worthy of respect ([22], [23], [135], [145]). This will have implications for how we otherwise treat such persons, but these questions will be separate from the question of whether their decisions ought to be respected because they are competently given.

57. Surrogate decision makers can acquire that status formally or informally. In the first instance, the surrogate decision maker is appointed by the courts and the appointment carries such legal rights and responsibilities as the decision specifies. More commonly in the health care setting, family members step into the breach when patients are unable to make their own decisions. The assumption is that family members best know the patients goals, values, and desires, and that they will act in concert with and to protect and promote them. Put another way, it is assumed that family members are most likely and best able to decide as the patient himself would choose. Any or all of these assumptions may be erroneous in particular cases. The nuclear family with shared values is considerably less common than in previous times. Nonetheless, to rely on the already overburdened judicial system to assume decision making responsibility for patients whose inabilities may be minimal, intermittent, or brief would be an exercise in futility. The informal method, while not unproblematic and without risk, seems far preferable. For further discussions of surrogate decision making, see [8], [28], [121], and [127].

58. There are a number of biases that can intrude upon judgments of competence. Some may be professional, as when HCPs have a bias toward treatment ([34], [49], [75]). They may be culturally motivated, as when orientals prefer acupuncture to surgery ([2], [16]). Or, of course, they may be personal, as when a practitioner assumes that particular classes of patients (e.g., women or minorities) are inherently inept.
59. As Faden and Beauchamp note [51], cutoff points are often established for legal or policy reasons, largely as a matter of expedience. As such, these points are convenient fictions that allow the law to say with certainty who is considered capable of self-determination and who is not. In the clinical setting where off-the-cuff assessments are often made, there is no such distinct delineation unless the institution has itself established criteria or watershed points to be used in competence determinations within its confines. The danger, both in the clinical and in the legal setting, is that the establishment of such cut-off points may be arbitrary. They may be designated as markers solely in virtue of bureaucratic convenience rather than because they are reliable indicators of competence in any objective sense. (See also [16], [17], [27], [59], and [175].)

60. Recall that arguments in Chapter Two, Section II, supported a specific rather than a global definition of competence. That being so, these and successive schema will be presented with that in mind. Thus they will refer to an agent's being competent "for this T" rather than "for any T".

61. In theory it is possible to get an APACHE score of 128, but scores over 50 are rare and are considered to be incompatible with life.

62. As on the threshold definition, degree assessments apply across the board. For each decision with which a person is presented, she is competent to a particular degree. Because she may possess different degrees of the required capacities for different situations, she may be competent to different degrees for different tasks.

63. The values of 5 and 6 are illustrative only. They do not represent any actual measurement procedure by which degrees of competence are currently (or even potentially) assessed.

64. It is worth noting here that a degree definition of competence is incompatible with a global notion of competence. When a person is said to be competent to D, to make a particular decision he faces, an inherent aspect of the concept is that persons are more or less competent for a given decision. One can envision persons who are, on a degree definition, one hundred per cent incompetent (e.g., the permanently comatose). And while there presumably could be, at least in theory, some persons who are always one hundred per cent competent, these are somewhat harder to imagine. It is much more likely that, as common sense attests, persons are more or less competent decision makers, depending upon the person and the decision. At any rate, if people are more or less competent for given decisions, they are not globally competent. Conversely, if
they are globally competent (i.e., competent for all decisions), they are not more or less competent.

65. One ought to anticipate slippery slope arguments against whatever definition of the threshold is ultimately adopted.

66. A "minimal" set is needed for the following reasons: What we are seeking is a cut-off point below which persons are deemed unable to make decisions. Said another way, what is wanted is the least restrictive set of criteria a person can possess and still be competent to make her own decisions. When persons possess qualitatively or quantitatively additional criteria, HCPs might feel more comfortable honoring their choices, but that is not what is at stake in setting a threshold. Rather the goal is to include in (as well as to disenfranchise from) the decision making process the appropriate classes of patients. Given that the most basic principle that underlies the entire exercise is respect for persons (as will be shown in Section 5 of this chapter), one is rightly concerned not to inappropriately usurp decision making authority in the competent, self-determining person. Hence, the threshold will be set in the least restrictive way that protects such persons.

67. Larry Temkin has pointed out to me that it is impossible to correlate a degree notion of competence (or of anything else, for that matter) within a Kantian framework because Kant had very much a threshold notion of personhood, upon which respect was based. It is certainly true that Kant had a single standard, that of being able to prescribe for oneself the moral law. There were, for Kant, no degrees to the matter; either one could or one could not use one's reason to be a universal lawgiver. If one could, then one was infinitely worthy of respect; one had, in Kant's term, "dignity". And it was persons with such dignity that grounded the whole moral enterprise.

If this is all and only what is meant by a Kantian concept of personhood, then Professor Temkin is quite right to express dismay at the move I am making here. But my interpretation of a Kantian conception of personhood is a broader one in this sense: there are persons who ground the entire moral enterprise and whom we deem worthy of respect. (These factors are surely crucial components of Kant's position.) I take exception with Kant in the criteria these persons exhibit in virtue of which respect is due to them. The criteria I have put forth are both more numerous and admit of degrees. As such the respect that is due to them (as well as their competence) need not be a threshold notion, such as Kant postulated.

This seems to me not to be terribly iconoclastic. It admits the moral realm is grounded in personhood. It grants respect to persons on that basis. If the criteria for moral
agents is not purely Kantian, it is because I differ with Kant's psychology rather than with his principles of moral theory.

68. Advocacy of a threshold conception of competence is found in [8], [16], [27], [28], [59], [121], and [174].

69. Advocates of a degree conception include [7], [17], [59], [108], [133], and [175].

70. Two scholars who reach a similar conclusion are Baruch Brody and Sir David Ross. Brody's theory, the Model of Conflicting Values, is applied to decision making within the health care environment (see his Life and Death Decision Making, [22]). Ross' approach is applied to "pure" ethical theory in his The Right and the Good [140]. Likewise, Roth, Meisel, and Lidz [143] claim that, given the complexities of consent-requiring situations, the search for a single test for competence is a "search for a holy grail" (p. 284).

71. CIC is defended in [49] and [121].

72. See, in this regard, [61], [161], [166], and [170].

73. See, in this regard, [9], [34], [57], [121], [135], [139], [161], [166], and [170].

74. It would be impossible to do justice here to the role of competing values within decision making contexts. This is, however, a vitally important issue. For further discussions and suggestions regarding the adjudications of non-commensurate and competing values, see [2], [16], [22], [23], [25], [27], [28], [32], [34], [43], [44], [56], [60], [100], [106], [110], [115], [120], [121], [135], [143], [149], [150], [151], [171], and [175].

75. Note that doing something to a person is not necessarily the same thing as doing something for a person. The former implies a manipulation; the latter, a benefit or at least that one is following the instructions of the person upon whose behalf one is acting.

76. In fact it is not uncommon for patients' specific and clearly articulated preferences or instructions to be flagrantly ignored or even overridden ([10], [11], [28], [32], [90], [135], [141], [151]), especially when the patient makes the "wrong" choice ([2], [28], [29], [49], [71], [135], [143]).

77. In spite of a host of theoretical and logistical problems, the inclusion of appeals to consequences in competence assessment continues to attract wide-ranging support. See,
for example, [11], [27], [28], [42], [43], [56], [59], [71], [118], [120], [127], [143], [175], and [175].

78. I am indebted to H. Tristram Engelhardt, Jr., for discussions on this point.

79. This is not to say that both systems functions equally well in all persons. It is quite often the case that one system will predominate. When this is the case the person may be labelled "rational" or "emotional". Nonetheless it is rare to find only one of the systems functional, and when that is the case, there is always pathology present.

80. See, in this regard, [9], [16], [28], [30], [33], [34], [42], [53], [62], [65], [70], [75], [78], [90], [95], [135], [151], and [172].

81. The effects of emotional states on cognition is extensively documented. For representative discussions of this relationship, see [9], [20], [28], [30], [34], [53], [61], and [172].

82. Many early studies on informed consent discovered that the stresses of illness and of the foreign hospital environment sometimes left patients who had no history of cognitive impairment with a drastically reduced ability to absorb the information necessary for giving consent ([76], [69], [84]. But others have suggested that external factors which can be compensated for if not overcome make this less problematic that was first thought to be the case (cf., [85], [75], especially Chapter 5).

83. Discussion of support for affective constituents within competence include [2], [30], [34], [42], [50], [69], [85], and [90].

84. For discussion of testing tools and their limitations, see [6], [53], [70], [80], [124], [143], [146], [161], and [176].

85. In some sense, of course, this statement is false. CT scans and cerebral angiography, for example, can provide us with quite detailed information about the geography of the brain. Then, too, PET scans give increasingly precise measurements of the brain's physiological activity. But none of these data can tell us just what the brain is doing when it is 'thinking' or, for that matter, precisely how the brain goes about 'thinking'. About the particulars of thinking, our knowledge is woefully inadequate.

86. This claim can also be made of the more psychiatrically oriented version of the MSE. These variations are particularly interested in aberrant mental functioning and
look for such mental events as delusions, hallucinations, etc. Such events are considered to be disorders of thought content and information processing and, hence, are variations of the intellectual theme of the MSE under consideration. See, in this regard, [48] or [85].

87. Competence determinations are not routinely part of the consent process. They are only performed where suspicion of incompetence has been raised.

88. But see [28], [70], [78], [161], and [167].

89. Here I must set out a caveat. It seems intuitively appropriate to question the competence of persons with altered levels of consciousness or impaired attention. Such persons, in virtue of those afflictions, are unable to fully interact with their environments and thus unable to effectively amass data upon which decisions are based. Likewise, persons whose language capacities are so reduced as to prohibit all communication with others (e.g., autistic but not necessarily aphasic persons), or those who cannot remember facts pertinent to giving consent will be unable to efficiently manipulate data or demonstrate that they have done so. Such impairments may lead to a diagnosis of incompetence. These concerns will have to be considered much more fully later. This initial intuition is offered as a way of explaining my concentration here upon cognitive functions.

90. Although Aristotle usually speaks of the "soul" rather than the mind, it is clear that his "soul" and the modern term "mind" are interchangeable.

91. Although it would be anachronistic to attribute discussions of competence to Aristotle, his discussion of choice and of the choices of the virtuous man provide a compelling analogy for discussions of competence. Like the modern requirements for persons giving informed consent, the Aristotelian agent has to be informed and uncoerced. His further emphasis upon choice informed by reason might be interpreted to mean that the chooser had to be competent.

92. It is impossible to explicate the theses of the First Critique in the space of this work. For a reasonably short discussion of why true knowledge is not possible in other realms the reader is referred to Critique of Pure Reason, A236=B295--A260=B315, [73], pp. 257-275.

93. For Kant rational beings are inherently worthy because of their capacity to articulate for themselves the moral law (Foundation of the Metaphysics of Morals, 412-441, [74], pp. 29-60; Critique of Practical Reason, 41-106, [72], pp. 43-110).
94. By "passion" Hume means 1) sense impressions or 2) reflections upon these sense impressions. My concern is limited to the latter, or the "secondary, or reflective impressions" ([68], p. 3). These are divided into "direct passions", or "such as arise immediately from good or evil, from pain or pleasure" and "indirect passions" that are direct passions accompanied by "other qualities" ([68], p.4). Only the "direct passions, desire, aversion, grief, joy, hope, fear, despair, and security" ([68] p. 4) are considered here.

95. This, of course, is not the source of Hume's anti-rationalism. That stance is the product of his concerns regarding motivation. The argument, briefly, runs like this: Morality is concerned to motivate people to certain kinds of action. Reason can never provide a motive force; only the passions can do so. Therefore, morality is not the product of reason.

96. In his acknowledgment that emotions motivate to action, Mill does not differ from Aristotle or Kant. It is his claim that they should do so that distinguishes his position from theirs.

97. See note 55 supra regarding the importance of the freedom to fail.

98. See note 23 supra.

99. For a discussion of a similar case, see [143].

100. This is, actually, a fair description of the Kantian problem of finding the relevant description.

101. For a further discussion of actual desires and preferred desires, see [55].

102. The affective-cognitive dichotomy gives, I think, further testimony to the wisdom of a degree (rather than a threshold) notion of competence. While Ms. Green has good cognitive skills, not all patients are so fortunate. Then the question of trade-offs between cognition and affection arises. In such cases it is often difficult, if not impossible, to determine if patients have reached a threshold. It is not nearly so difficult to determine if they are more or less competent.

103. Given Hume's radical epistemology, I except him from this position.

104. See note 81 supra.

105. See note 82 supra.
106. I omit discussion of whether these people really "don't feel a thing". My thinking is that if they genuinely feel nothing, there is serious psychopathology going on. If, as seems more likely, they merely do not show what they are feeling, that will be problematic for assessing their affective components, but is not necessarily indicative of psychopathology.

107. Although, of course, stress often does stimulate changes in personality or at least in behavior. Then we say, "Joe must really be under stress; he is not acting like himself."

108. For a further discussion of these concepts, see [55].

109. Perhaps some concerns might be assuaged by remembering that respecting persons is only one of the moral appeals that are available to agents. Certainly in cases where competence is "less", a possibility that the degree analysis permits, other appeals will be more compelling and may, in fact, permit others to override the competent (albeit less so) person's decision. In fact, in cases where other appeals are unusually powerful it will be possible, at least in theory, to override the decision of a highly competent person. Historically the courts have made just such a move in overriding the refusal of blood by admittedly competent Jehovah's Witnesses who have minor children. The argument is that the needs of the children for their parents and of the state not to be avoidably burdened with the responsibility for these children outweigh the competent refusal of life-saving treatment. Note well, however, that parents are not decreed incompetent so that they may be displaced from the decision making process. Their competence and rights to make decisions are explicitly recognized, but only as two among a panoply of competing concerns that bear upon the situation considered as a whole. In certain cases, it is claimed, the rights of competent decision makers to be self-determining may be outweighed. See, in this regard, [117] and [126].
CHAPTER THREE

I. THE NECESSARY CONDITIONS FOR THE POSSIBILITY
OF COMPETENCE TO CONSENT

We turn now to completing the conceptual analysis of competence to consent, that is, to determining the necessary conditions for the possibility of competence to consent. In so doing, we remember that competence must be framed so as to apply to specific contexts because, at least insofar as informed consent is concerned, it is the person's ability to make a particular decision that is relevant. Moreover, the meaning of competence to consent will be fashioned according to a degree, rather than a threshold, notion because, as preceding arguments proved, persons can be more or less competent to make particular decisions. There will be no appeal to consequences because such appeals pose a real and serious threat to respecting persons. Lastly, because both cognitive and affective faculties are constitutive of persons' worthiness of respect, both will be included within the constituents of competence.

We further recall that competence for any undertaking must be assessed in terms of capacities. This follows from the fact that competence to perform a particular task requires that one possess the capacities necessary for that task's completion. Competence to consent/refuse, being no exception,
will be explicated in terms of the capacities required for
decision making, of which consent/refusal is an instance.
The requisite capacities have been mentioned briefly in the
previous chapters. It remains to elaborate upon these
discussions, showing the relationship between the possession
of such capacities and one's being the sort of person whose
decisions are worthy of respect.

In the preceding chapters the point was made that the
criteria for competence to consent, while numerous, could be
assembled under the four broader categories of informability,
cognition, choosing, and persisting in one's choice. This
model will be continued throughout this chapter, and the
particular capacities that jointly comprise competence to
consent will be considered individually within this broader
framework. These particular capacities include 1) under
informability: the abilities to receive information, to
recognize information as information, and to remember or
retrieve information; 2) under cognition: the abilities to
relate situations to oneself, to reason about alternatives,
and to rank alternatives; 3) under choosing: the ability to
pick among options; and 4) under persisting in one's choice:
the abilities to maintain one's resolve (withstand the
criticism of others) and to resign oneself to one's decision
(withstand self criticism). Each will now be considered more
fully. In an attempt to clarify the concepts under
discussion, reference will be made to the various cases
elaborated in Chapter 2.

I turn now elaboration of the individual capacities necessary for competence to consent.¹ The format for this examination will be to explain each capacity and appraise its correlation to decision making in particular situations. Following this, each capacity will be explicated in terms of a degree notion of competence. The overarching tenet that informs this discussion, it will be remembered, is that respect for persons turns upon the ability to engage in certain types of activities. Most crucial for this undertaking is the ability to plan their lives according to goals and values that they have embraced as their own.

Prior to undertaking these explications, some clarifying remarks about the degree notion are in order. Clearly it will be impossible within the scope of this work to fully expound upon all possible degrees of competence. I will, therefore, limit discussion to three such degrees: maximal, minimal (adequate), and inadequate competence. The maximally competent person is one in whom most components are present to a high degree.² The inadequately competent person is one in whom most, but not all, components are largely, but not entirely, absent.³ The minimally (or adequately) competent person is one in whom enough of the components are sufficiently present to enable the decision maker to grasp the prominent facts of the situation, and to examine them so as
to come to a conclusion. The meaning of these distinctions vis a vis the individual components of competence will become clearer as each is addressed.

II. INFORMABILITY AND DECISION MAKING

The component capacities of informability are the abilities to receive information, to recognize data received as information, and to remember or retrieve information. At the most fundamental level, each of these is important to decision making for the simple fact that decisions are made on the basis of information and, absent these capacities, the person would be unable to acquire the necessary data.

A. The capacity to receive information

1. Its meaning

The capacity to receive information is the ability to acquire facts about the world. This is the most primitive of the requisite capacities in that it is merely the requirement that one have intact certain sensory and neurophysiological skills. The ability to procure data presupposes that a person can see, hear, smell, taste, and feel; that his peripheral nervous system is capable of transmitting these stimuli to his brain; that he is conscious, i.e., (potentially) aware of the stimuli; and that his central nervous system is unimpaired, so as to permit his brain to receive the impulses.
This is to say that one must be able to see, hear, feel, smell, or taste. It is also to say that the stimuli can get from the point of impact, through the peripheral nervous system to the central nervous system, making them available for analysis and interpretation. It means that the person can (although he may not choose to) perceive the stimuli that impinge upon his sense organs, and has the neuroanatomical and neurophysiological integrity to assess them.

2. Its relationship to decision making

One's ability to navigate effectively through the world derives from the successful interplay between self and environment. For the most part, that success will turn upon decisions one makes about how to structure particular actions and, more crucially, how accurately one has assessed one's circumstances. This requires a capability for gathering facts about both self and other (not-self), because it is on the basis of such data that one makes decisions about how to act. (It is true that one can merely react to stimuli, but then one is not making decisions; one is only responding.)

One first needs to assess the nature of one's state, to identify the particulars of one's circumstances. Next one must determine whether or not one is happy with the situation. By being "happy with the situation" I do not merely refer to some free-floating positive emotion (although a sense of well-being or pleasure may be present), but to a sense of satisfaction that this situation conduces to the realization
of one's life plan or lifestyle, whether in the short or in the long run (or, if one is unhappy with the situation, that it fails to so promote one's aims).

If such happiness does attend one's circumstances, one wants to know how best to maintain the state; if not, how best to change it. Either way, knowledge of options for action, options that are at least in part determined by one's starting point, is necessary. The more one knows about both internal and external environment, the more fully one understands one's starting point and, thus, the better one may project how the situation may be manipulated to increase the possibility of achieving one's goals. But, of course, one only can know about the environment if one can acquire information about it. This is why the ability to receive information necessarily plays a part in competence.

3. Its degrees

What does it mean to be maximally, minimally (adequately), or inadequately, informable? Since "informability" depends upon sensory, neurophysiological, and neuroanatomical integrity, I will discuss its degrees with reference to these same characteristics.

The first characteristic, sensory intactness, is dispatched with relative ease. One is maximally sensorily competent if the capacities for sight, hearing, touch, taste, and smell are all present and are either naturally functioning at full levels or have been corrected to permit such optimal
functioning (as, for example, through use of eyeglasses or a hearing aid). One is, of course, sensorily incompetent if none of these senses is working. The person who is deaf, blind, and unable to smell, taste, or feel any sensory stimulus would have no way of getting information. Any serious discussion of decision making necessarily presumes the presence of some sensory capacity through which information can gain entry to the conscious awareness of the decision maker.

For the purpose of informed consent the more appropriate focus is upon sight and hearing because, while it is true that information is obtained via touch, taste, and smell, the relevant data that HCPs must provide for patients' consents can only come in the form of explanations. Because explanations can only be given orally or in writing (i.e., explanations are not received by touch, taste or smell), patients must be able to hear or read them; they cannot be deaf and blind. Thus the minimally competent person must be able to see or hear well enough to read printed instructions or hear the instructions when presented verbally.

It is likewise non-problematic to analyze consciousness in terms of degrees: The maximally competent person will be alert and attentive to details of explanations. The minimally competent person may be lethargic and initially inattentive, but will be able to be aroused and stimulated into attending to an accounting of the facts. The inadequately competent
person will exhibit deficient consciousness (be obtunded, stuporous, or comatose) and, therefore, unable to attend to the discussions at hand.

In similar fashion neuroanatomical and neurophysiological competence can be addressed. The maximally competent person has no impairment in either sphere, the result being that all stimuli initiate a neurological process, the result of which is that stimuli travel, unimpeded, from their points of origin to the brain. In the inadequately competent person, this progress is interrupted such that stimuli do not travel (or do not travel the appropriate route) from impact to destination. The minimally competent person will be the one in whom the process is delayed (e.g., a person with early multiple sclerosis where impulse transmission is retarded but not qualitatively altered) or pathologically altered, but in way(s) that do not affect receipt of information (e.g., Erb's palsy).

4. A recapitulation

People want to manage the way their lives will go. Toward that end they need to know the state of their internal and external environment, and how that state circumscribes their options for action. Knowledge of self and other is required to orchestrate their interaction with any proficiency. Persons can acquire the knowledge for making decisions about their lives only if they are at least minimally competent to receive information about their
situations. This means that they must be able to read or hear the relevant information; that they must be actually or potentially aware enough to be able to attend to this information as it is presented to them; and the stimuli must be able to ultimately get into the central nervous system (higher brain centers) to permit consideration of the information those stimuli carry.

Let us relate this analysis to the cases discussed in Chapter II. In fact, all the patients discussed in that chapter are sensorily intact. All are fully conscious and able to attend to explanations. All are neurologically intact. Thus any differences that lie in their degrees of competence do not stem from differing abilities to receive information. We turn, therefore to the second component of informability, the ability to recognize information as information.

B. The capacity to recognize information as information

1. Its meaning

The capacity to recognize information as information is the ability to screen out "noise" from the salient data. Not everything that impinges upon body and mind needs to be incorporated into the decision making process—nor can it. At each moment we are subject to James' "blooming, buzzing confusion". The richness of the world, internal as well as external, must be attended to selectively to permit any
management of it at all. Decision makers must pick and choose from stimuli those that have personal import. They must determine what is important to them—what is truly information—and what is irrelevant—what is "noise". This ability to separate information from noise is what is meant by the capacity to recognize information as information.

2. Its relationship to decision making

The first step in culling from among this surfeit of riches is to recognize that one is in a position in which choice is required. Decision makers are persons who want to control the directions their lives take, and such control demands that decisions be made. So there is the requirement that one recognize when it is necessary to make a decision. This is the first piece of information that must be recognized as information.

Toward that end one must be able to sort from among the plethora of stimuli those pieces that genuinely inform the choice at hand. Only facts that are useful to making the decision count as information, so these must be identified. Likewise, facts that impede the decision making process, facts that are only noise, must be screened out. If they are erroneously entered into the calculus, they may delay the decision or lead to a decision that is inappropriate.

This ability to sort random stimuli into categories relevant to individual choices is essential to the capacity to recognize information as information. It requires that the
decision maker be able to attend to stimuli selectively and to selectively perceive the importance of various stimuli.

3. It degrees

What does it mean to be maximally, minimally, or not competent to recognize information as information? This question will be answered in terms of its components, i.e., in terms of the ability to recognize that one is in a situation in which choice is required and to separate relevant information from "noise".

The maximally competent information recognizer will realize that her situation demands that she make a choice. She will be able to identify and selectively attend to data that apply to the choice to be made. This means that she will understand the content of incoming data. She will recognize certain of those facts as salient and certain as extraneous; the former will be understood to be necessarily included, the latter as necessarily excluded from the decisional calculus. Moreover, she will recognize this information as relevant to her life either in part or as a whole; i.e., the data is information for and about her. Importantly, she will accomplish these tasks independently. This is not to say that she will not require assistance from others, nor that others may not serve as resources in her considerations. Rather it is to say that she works through the process on her own.

The minimally (adequately) competent information recognizer may not initially realize that her situation
demands a choice; she will, however, admit that this is the case once it has been pointed out to her by someone else. She may be unable to identify and selectively attend to data that apply to the choice to be made but, again, will recognize their applicability after others bring their importance to her attention. She may generally understand the content of incoming data, but have some difficulty perceiving the salience or nonsalience of individual facts. Thus she may be unable, without guidance to understand which are necessarily included, which necessarily excluded from the decisional calculus. Again, however, she will comprehend their import once it is presented to her. She will be able to appreciate another's assessment of how this choice applies to her life as a whole.

The primary difference between the minimally and maximally competent person is the independence with which these activities are carried out. The former requires explication by others for much of her understanding; the latter does not. However, dependent though he is upon others to direct his attention to decisional components, once these have been addressed the minimally competent person can perceive their importance. Moreover, he is then motivated (reminded, perhaps) to consider these and further aspects of the state of affairs. He can also, once the process has been initiated, bring in further applicable data for consideration. Lastly, he can come to a decision. Like the maximally
competent decision maker, the minimally competent person requires assistance from others. But, for him, others are not merely resources for information; they are intimately involved in mobilizing or directing his involvement in a particular choice. He cannot fully work through the process on his own. Nonetheless, he can embrace the process and its components once their importance is made clear to him by others. Moreover, once started he can bring further relevant data to the undertaking.

The incompetent information recognizer will never realize that she is in a situation that demands a choice. She may not be able to understand the content of incoming data, or she may be unable to identify (i.e., differentiate between salient and extraneous facts) or attend to relevant data. Thus she will be unable to construct a decisional calculus. She will be unable to locate this choice within her life as a whole. Unlike the adequately competent person who could make a decision once provided with assistance, the incompetent person will be unable to come to a decision (other than, perhaps, in the arbitrary fashion of merely "pointing" in one direction or another). Most importantly, even with assistance she will be unable to accomplish these tasks. She will be unable to complete the decision making process.

4. A recapitulation

If people want to manage the way their lives will go, they must be able to make choices. Toward that end they must
be able to recognize data that inform that endeavor. They must be able to recognize that a choice is required, to identify what counts as information about that choice, to understand explanations about that choice, and to correlate the choice with their lives as a whole. They may be able to do these things independently, in which case they are maximally competent. They may be able to do them with assistance, in which case they are minimally competent. They may be unable to do them, in which case they are incompetent.

How does this analysis relate to the cases discussed in Chapter Two? Consider first Mr. Able, the AIDS patient with Pneumocystis pneumonia. He recognizes that he must make a choice. He can screen out irrelevant material (e.g., the high cost of hospitalization, since that is an option he wishes to forego). He can locate his situation within his life as a whole (e.g., he desires to spend his remaining time with his significant others rather than in a hospital).

Contrast Mr. Able with Ms. Smith, the woman who initially refused a hysterectomy for cancer of the cervix because she wanted to be a surrogate mother. She also recognizes that she must make a choice, but is unable to rule out irrelevant data (e.g., that her post-menopausal status precludes her being a surrogate mother). Nor is she, at least at the outset, able to see the relevance of the life-threatening nature of her disease. Nonetheless she can understand, at least with help, the explanations about her disease and its prognosis; and,
ultimately, her nephew and HCPs are able to promote her understanding of her disease and the relevance of its threat to her life. Interestingly, she is able to locate her decision within her life plan. She realizes that a hysterectomy makes her goal of surrogacy impossible. But it is only with assistance that she comes to appreciate the importance of this choice for her life as a whole, specifically for her continued physical health and well-being.

None of the patients whose cases were elaborated in Chapter Two is fully incompetent on the criterion of recognizing information as information. However we can demonstrate such incompetence by considering

Case VIII: Mr. Grey is a 58 year old electrical engineer who suffers from advanced Alzheimer's Disease. Once a brilliant man who headed his own firm, he has deteriorated to the point of needing constant supervision and assistance in all activities of daily living. He is unable to feed himself, dress himself, or manage any of his personal care; consequently he is in a nursing home. He does not recognize his three children with whom he had a strong and loving relationship; although he occasionally smiles when his wife of thirty-five years comes to visit. His speech consists of a few garbled words, but is mostly mono-syllabic grunts. He apparently understands nothing of what is said
to him and cannot (or will not) follow simple commands. He can still walk, and he wanders aimlessly most of his waking hours. He has been diagnosed as having leukemia, and a decision must be made regarding whether or not to give him chemotherapy.

Mr. Grey is surely incompetent. He cannot recognize anything about his current circumstances, therefore he cannot recognize that he (or someone) must decide about chemotherapy. He cannot recognize any stimuli; certainly he cannot sort facts into salient and extraneous classes with regard to his leukemia. He can neither understand nor execute any verbal communication. And he has no remaining social awareness (with the possible exception of a remnant of affection for his wife), judgment, insight, or capacity for abstract thought. It is not only that Mr. Grey cannot undertake these activities independently; he cannot participate in them when they are instigated by others. As such he is totally incompetent.

The differences in the degrees of competence experienced by Mr. Able, Ms. Smith, and Mr. Grey stem from qualitative differences between Mr. Able and Ms. Smith, and from quantitative differences between Mr. Grey and the other two patients. Mr. Able and Ms. Smith have differing abilities to recognize information as information. These persist Mr. Able to function as an independent decision maker, while Ms. Smith
requires assistance. Mr. Grey, lacking this ability completely, cannot function as a decision maker. We turn next to the third component of informability, the ability to remember (retrieval) information.

C. **Remembering or retrieving information**

1. **Its meaning**

Because most decisions are not made instantaneously but over time, it is essential that persons have recurring access to material that informs the pending decision. Since some of this material (e.g., its relationship to one's previously established life style) has been acquired in the past (i.e., the life style), it is essential to be able to call up old information for consideration of its relevance to new choices. This capacity to bring previously stored facts before one's consciousness for reconsideration is what is meant by remembering.

2. **Its relationship to decision making**

Even if a person has been able to receive and recognize facts as pertinent to a decision, these facts are unhelpful in making choices if the person cannot remember them for repeated consideration. One needs to be able to ponder facts in diverse combinations and within miscellaneous (perhaps hypothetical) scenarios in order to understand fully their meaning or to appreciate their gravity. This type of leisurely examination cannot be carried out if the person
cannot remember the facts to be examined.

Moreover many persons need time for quiet reflection on the details of situations about which they are expected to make decisions. They do better if they can retreat, temporally or geographically, from events that demand a ruling. This approach is only helpful if, after achieving the needed distance, they can then remember the details of the case upon which they must deliver a verdict. This is another reason why memory is important.

3. Its degrees

It is an all too familiar and maddening fact of life that memory is temperamental. Moreover, memory often becomes less reliable with age. Memory is classified with reference to time. There is short-term memory, or memory for immediate (within the past hour) event; recent memory, or memory for events of the last few weeks or months; and long-term memory, or memory for anything that occurred prior to the last few months. The memory impairment that occurs with age is often a selective impairment. That is, short-term and recent memory often are more impaired than long-term memory. This is problematic because people develop values and goals over a life time, but have to make health care decisions on the basis of data that are (or should be) stored in their short-term or recent memory banks. Thus the relevant data may be only variously available to them. Put another way, a patient might well recall that she decided long ago never to end her life
in a nursing home, while being unable to recall the salient fact that a particular condition requires a brief (only) stay in such a facility.

What does this mean for maximal, minimal (adequate), and inadequate competence? The maximally competent patient will be able to remember the salient facts in all three memory banks. He will have access to all (or most) applicable memories so that he can consider the important data that attend a decision. Moreover, his access will be largely independent of the prompting of others. He will be able to recall the facts at will and examine them at his leisure and convenience.

The minimally competent person will have a less facile but nonetheless functional memory. She may require frequent repetition of data, to compensate for deficits in short or recent memory. However her long term memory will be easily accessible, so as to permit her to see the relevance of current events to her chosen values and goals. Oft-repeated reminders will help to overcome memory ineptitude, either by exercising the pathways needed for information retrieval and thereby facilitating unassisted memory, or by helping her to relate her present situation with her past choices.

The incompetent patient will suffer not only from short-term or recent memory loss, but from long term memory deficits as well. Presented with the facts of the matter, she will be unable to remember them, even after prompting. Nor will she
be able to remember values and goals that have been important to her in the past. As such, she will lack access to all information that are germane to the decision at hand.

4. A recapitulation

Patients who must make choices within a health care setting need to thoroughly consider the different risks that attend different options—their nature, their likelihood, their impact upon lifestyle. All of this takes time and will require that they be able to recall the details of each facet in turn. This requires that short-term and recent memory—i.e., memory for the recently acquired information—be intact. Long-term memory must also be functioning efficiently, to permit the person to locate this situation in his life as a whole, to determine how this choice will fit with his previously espoused goals and values. The maximally competent person will have easy, independent access to all three memory banks; the minimally competent person will have access to these banks with assistance. The incompetent person will not be able to access them at all.

Absent memory it would be difficult to make any genuine choice or live any sort of integrated life. Consider Ms. Green, the chemist with a breast lump who elects a lumpectomy and radiation therapy over a radical mastectomy. She exemplifies maximal memory competence. She can recall the just-learned facts about her case as well as her previous negative experiences that motivate her to refuse any surgery
that is not immediately life-saving.

Compare Ms. Green to Mr. Tsai, the man with the chronic meningitis. It was only with capable prompting from a psychiatrist that Mr. Tsai was able to remember his auditory hallucinations that led him to refuse the cisternal tap as the procedure was about to begin. As such, he is adequately competent, once this information has been brought to light. Likewise for Mr. Simmons: his inability to remember the address and phone number or his friends or the details of his wound care are cause for concern. The fact that he can perform his wound care with prompting would make him minimally competent if (and this, it is recalled, is one source of his HCP's concern) anyone were available to remind him.

Contrast these two patients with Mr. Grey, who remembers nothing at all. He is surely an incompetent rememberer. The difference between these three patients again lies partly in the degree of dependence required in the exercise of the capacity for memory. But there are additional qualitative and quantitative differences in the nature (recent vs. remote) of facts recollected as well as in how much data are recalled.

The criterion of informability is crucial to competence to consent, because it is through its capacities that persons are able to acquire the data upon which decisions are based. It is, however, only the first set of capacities upon which competence to consent depends. We turn now to the second
major criterion, cognition, and to the analysis of its components.

III. COGNITION AND DECISION MAKING

The component capacities of cognition are the abilities to relate the current situation to one's life as a whole, reason about the various possible courses of action, and rank the possibilities. Each of these is important to decision making because it is by means of these faculties that one evaluates the wisdom of pursuing different alternatives, and correlates past, present, and future aspects of his life.

A. Relating Situations to Oneself

1. Its meaning

Just as we are besieged with many random, individual stimuli, so we are involved in multiple situations. From these we must choose those in which to participate and those to avoid. It is impossible to be involved in every possible opportunity with which one is presented; there is neither the time nor effort to fully pursue every association conceivable between oneself and the world. One must be able to assess options to determine which are (the most) germane. This ability to discern which situations have personal import is the capacity to relate situations to oneself.
2. Its relationship to decision making

Possibilities can be evaluated as more or less important on the basis of one's previously espoused goals and values. Details that relate to these concerns are compelling; details that do not are at best merely interesting, or at worst interferences. To structure one's life in an on-going, satisfactory manner requires an ability to make these distinctions. Otherwise the inundation of information will cause persons to overlook factors that are meaningful to causes and concerns they hold dear. This will mean that at some time hence they will make decisions on needlessly incomplete information, information that would have been available had they screened out the trivia. Or they might be unable to make decisions in virtue of being overwhelmed with data. Appropriate circumscription of one's relationship to one's world requires the ability to embrace relevant and eschew irrelevant options.

The ability to relate possible actions to oneself, then, requires that one be able to identify the opportunities with which one is faced, to distinguish the values or goals that are at stake, and to recognize which actions (or inactions) will promote or obstruct those values and goals. Those that promote them will be pursued; those that obstruct them will be avoided.

3. Its degrees

How, then, is one maximally, minimally (adequately), or
not competent to relate information to oneself? The maximally competent person will be able to identify, within his environment, those opportunities that have personal import. He will be aware that his decisions have an impact on his various espoused goals and values, and will understand that the former affect the latter in diverse ways. And he will be able to distinguish which options will affect which values. As with the foregoing capacities, the maximally competent person will be able to undertake these evaluations independently.

The minimally competent person will, again, be able to complete such evaluations, but not without assistance. She will need, perhaps, help in identifying which options have personal import; or she might require aid in understanding the relationship between her values or goals and her options.

The incompetent person will be unable to complete the evaluation process, either because he is unable to identify or understand the relevant options, or because he is unable to relate them to his life as a whole. Or, at the extreme, the incompetent person may be unable to recall the goals and values that have been important to him.

4. A recapitulation

The competent decision maker must be able to relate her current circumstances to herself as a person and to her life as a whole. This requires the ability to identify the pertinent options at any given time, the values and goals that
these potentially affect, and how different decisions will influence different goals and values.

Recall Ms. Meyer, the diabetic who refuses a kidney transplant and who discontinues renal dialysis, even though she knows her choices will hasten her death. She has identified three options: transplant, continuing dialysis, and no further treatment. She has identified two values: altruism, by which her failure to accept the kidney makes it available to "a younger person who has more time"; and a certain quality of life (one with family and friends and without the restrictions placed upon her by her disease) below which life is not worth living. And she understands the relationship between her options and her values: if she accepts the kidney, she forgoes an opportunity for altruism; if she continues dialysis, she forgoes the quality of life she desires; if she forgoes treatment, she honors her values of altruism and commitment to a particular quality of life. This thorough-going understanding of these factors and their inter-relationship makes her maximally competent. And, of equal importance, is that she has reached her decision independently.

Ms. Smith exemplifies minimal (adequate) competence. She has come to understand that she has two options: a hysterectomy and no treatment for her cervical cancer. She appreciates that two important values are involved: her desire to be a surrogate mother and her continued existence.
She has come to comprehend the fact that her continued existence requires her to forfeit her (imagined) opportunities for being a surrogate mother. She was unable to identify or appreciate these factors without assistance from her HCPs and her nephew. Nevertheless, through their efforts she has achieved this awareness. Her need for help and her ultimate successful completion of the process qualify her as minimally competent.

Incompetence is, once more, personified in Mr. Grey. His profound cognitive deficits preclude his awareness of options, values and goals, and their correlation to each other.

B. Reasoning About Alternatives

1. It meaning

Reasoning about alternatives means explicating and assessing information. The capacity to reason about alternatives is the capacity to examine the disparate outcomes that attend specific choices, to determine how each would influence one's life, to consider these factors from a variety of perspectives, and to make predictions based upon those considerations. Assuming one can successfully receive information, recognize its pertinence to one's current state of affairs, remember it, and relate it to one's life as a whole, one then needs to be able to assess the sundry risk/benefit ratios and to determine the respective probabilities of each option's occurring. To be able to do
these tasks is to be able to reason about alternatives.

2. Its relationship to decision making

These activities, coupled with the assessment of the relationship of various options to one's life as a whole (as discussed in the preceding section), allow a person to make predictions about what different choices would mean to her life in its entirety. Most people want their lives to go, on the whole, as well as possible. Facility in reasoning about alternatives is one of the skills that helps to achieve that goal. The endeavor proceeds thus: One first identifies the different outcomes that might ensue from one's current situation. Having identified A, B, and C as legitimate options, one will want to assess the differing risk/benefit ratios that attend each. Likewise, one would want to postulate the various impacts that each avenue would have on one's life as a whole. This will necessarily include the chances that each has for achieving the desired outcome, as well as how one's options would change in case of failure. The outcome of this process is a rough guide to the value and likelihood of the options--e.g., A has 2 moderate benefits, 2 minor risks, and a 50% chance of realizing its predicted and desired outcomes; B has 3 major and four minor benefits, 3 major risks, and a 60% chance of realizing its predicted outcomes; C has....

The whole affair is somewhat messy, by which I mean it is rarely the case that there will only be one possible
acceptable outcome and only one possible acceptable route toward realizing it. Rather, the entire undertaking will more likely than not require tradeoffs. Mr. Able, for example, will have to compare the outcome of an early death at home that may greatly distress his significant others who may feel incapable or hard pressed to manage his symptoms, against a longer but more constrained life, some of which is spent in the more restrictive health care setting. Each has a different risk/benefit ratio. Each has, in fact, different risks (distress of loved ones in the former, more episodes of pain and loss of freedom in the latter) and different benefits (better quality of last days of life in the former, possible longer life in the latter).

This toting up of factors is anything but easy. It is, however, important to decision making because it is just this activity that provides decision makers with full and complete information about choices to be made. HCPs can provide details about diagnosis, treatment alternatives, risks and benefits of the options, and estimates of prognosis. They cannot, however, provide information about the acceptability of each of these to individual patients. Patients alone, after examining these data in light of their own goals and values, can make those assessments.

It is, in fact, at this point in the decision making process that persons are able to insert their own idiosyncratic beliefs into the value calculus. Recall Ms.
Meyer. If the only data factored into the estimates were the medical risks and benefits, the only acceptable outcome would be for her to undergo kidney transplantation, for this route would offer the best chance of eliminating (or at least reducing) the pathological effects of her diabetes. She would no longer suffer from end stage renal disease. It would also offer the best chance of reducing her untoward, distressing symptoms—the nausea, malaise, hypertension, prostration, etc.—that attend renal failure. Moreover, the transplant would restore much of her independence; she would no longer be required to restrict her diet and her fluid intake, nor schedule her life around dialysis treatments (although she would be required to take expensive immunosuppressants).

What the medical risk/benefit ratio fails to take into account is Ms. Meyer's other, personal values. These estimates do not acknowledge her altruistic desires nor the diminished value her life, absent friends and family, holds for her. These idiosyncratic values are what she brings to the calculus, and it is their introduction at this point that permits her to make a decision that is best for her, all things considered. Without these evaluations, patients are operating in a partial information vacuum which, if not corrected, jeopardizes the very goals and values that people seek to protect through medical interventions. This, then, is why this step is important for decision making: it admits the vital information needed to maximize decision making.
success for the person, considered as a whole.

3. Its degrees

The maximally competent person will be able to complete the calculations of risks and benefits, determine probabilities, and speculate about the effects different choices would have on her life, all things considered. She will, of course, need to be provided with the baseline technical information about medical risks, benefits, and probabilities. But, having received such data, she will be able to work through the remaining calculations on her own. Ms. Meyer displays such capacities, as do Mr. Able and Ms. Green.

The minimally competent person will also be able to complete the appropriate calculations but, again, will require assistance from others. He will still need to be provided with the technical information but, additionally, this information will need to be available to those persons who will help him with his assessment. He may, for example, be unable to independently weigh risks and benefits or to assign probabilities. This ineptitude may result from a difficulty with the mathematical concepts themselves or because he is unable to integrate this information into his own system of goals and values. Or he may suffer from an inability to project himself into the future, to imagine what his life would be like as a result of his choosing one option over another.
There is, additionally, the problem that certain false beliefs may interfere with the decision making process. Patients may, of course, merely misunderstand information. When this happens, efforts to correct these misconceptions should allow the process to move forward in a satisfactory fashion. On the other hand, persons who suffer from fixed inappropriate beliefs need a different kind of assistance. Mr. Tsai, for example, believes there is one overriding risk—that his physicians are trying to kill him. Were this true, he would be foolish to submit to their interventions. Since it is not, he can profit from therapy that results in his relinquishing the delusion (or, perhaps, in his agreeing to allow someone else to make the relevant decisions for him so that his delusion will not thwart his primary goal of restoration of health).

The upshot of this discussion is that, so long as the minimally competent person has an assistant who can help him to perform these necessary assessments, he will be able to understand the actual or anticipated scenarios so that he can come to appreciate how certain choices will better promote his goals and values. He differs from the maximally competent person, then, in his ability for independent decision making based upon appraisals of risk/benefit ratios and predictions of success. Ms. Smith, like Mr. Tsai, embodies these characteristics.
The incompetent person will never be able to complete the process. He will not only not be able to perform some or all of the required calculations; he will be unable to understand that there is a choice to be made and that his life will go differently, depending upon which option is selected. He may also be unable to realize that his goals and values are at stake, or the importance of this decision to his life and beliefs. Once again, Mr. Grey fits this description.

4. A recapitulation

The capacity to reason about alternatives is the ability to construct personalized risk/benefit ratios for each option, to assess the probability that each will occur, and to foresee how one's life would be variously changed by each possible action. The procedure is imprecise. It is, nonetheless, what falls under the rubric of a capacity to reason about alternatives. Assuming the capacity is intact, the decision maker will be ready to exercise the next capacity.

C. Ranking Alternatives

1. Its meaning

The person who has the capacity to rank alternatives is one who can make a list based upon non-arbitrary reasons. Using the sort of reasoning just discussed, a decision maker should be able to come up with at least a rough hierarchy of preferred choices. This follows from one's ability to make sense of all the manipulations performed when one is reasoning
about options. In spite of the imprecision that accompanies alternatives, one can say, "I choose B, then A, then C, in that order". This means that B is designated as the preferred solution and the one which, other things being equal, the decision maker favors. If for some reason B becomes unavailable, the person may then endorse A; but he may embrace only B and deem all other options unacceptable. Then, if B is not available, he may see inaction as his only acceptable alternative, choosing thereby not to act on A or C. The ability to place options in a preference hierarchy, then, is what is meant by the capacity to rank alternatives.

2. Its relationship to decision making

The goal of decision making is, tautologically, making a decision. This means that one alternative is embraced and the others foregone. Selecting one possibility and committing oneself to its course of action signals the end of the process. Therefore, persons must be able to determine that one option is preferable (or which are at least tolerable). This endpoint results from a person's being able to rank opportunities. Once they ascertain that there is a "first choice", they are able to select that option and proceed accordingly. The ability to rank alternatives assures that the decision making process can be completed.

3. Its degrees

The maximally competent person is able to place possible actions along a continuum. He sees one act as being, given
his goals, values, and circumstances, as being optimal. He sees others as being less likely to promote his chosen preferences (though, to the extent that they are able to do so, they are at least permissible), and sees some as being either unlikely to do so or as being (again, given his personal situation) unacceptable. As before, he is able to make these determinations without assistance (other than, of course, that which is required for him to possess the data which inform his options). This capacity is illustrated by Mr. Able, Ms. Meyer, and Ms. Green.

The minimally competent person will have some difficulty constructing a hierarchy of choices. This may be a result of aforementioned difficulties with relating alternatives to herself or with reasoning about them. But it may also be that she cannot make the precise distinctions that differentiate (very) similar options. She should, however, be able to distinguish between classes of actions; i.e., she should be able to assign actions to "favorable", "flawed, but acceptable", and "unacceptable" categories. This having been done, the ultimate choice can be made by someone else; her family might determine which option from the "favorable" class seems best to promote her interests, all things considered. Or, perhaps her HCPs can choose, again from the "favorable" group, that action which is attended by the best medical risk/benefit-probability statistics. As before, the minimally competent decision maker requires the assistance of others to
complete the evaluation process. We see how this approach would work in the management of the care of Mr. Tsai, Ms. Smith, Mr. Simmons, and Ms. Evans.

The incompetent person will be unable to organize her options in any fashion. This being so, she will be unable to construct the "favorable", "acceptable", or "unacceptable" designations. She may fail at this task in virtue of an inability to relate options to herself or to reason about options. This incapacitation will persist, in spite of attempts on the part of others to help her to organize choices on the basis of her goals, values, and desires.

4. A recapitulation

The capacity to rank alternatives is the final step in the evaluation process that attends decision making. It requires that persons be able to assess personalized risk/benefit ratios and to determine the various probabilities of actions' promoting and protecting their values, goals, and desires. It is unavoidably imprecise. The extent to which persons are able to grapple with this inexactness and come to a conclusion separates the maximal, minimal, and incompetent decision maker.

D. Addendum

The criterion of cognition is crucial to competence to consent because it is through its capacities that persons are able to correlate facts in the world with how their lives will
go. Cognitive competence is necessary for a person to successfully integrate her past, present, and future lives, in the sense of protecting and promoting values, goals, and desires through time. Moreover, without these skills there would be no decisions made (although there might be mere "pointing" to one act or another), because data could not be fully considered from unique personal perspectives. It is cognitive competence, then, that makes it possible to reach an endpoint in the evaluation process.

IV. RESOLUTION AND DECISION MAKING

1. Its meaning

Resolution comes with choosing and "choosing" means actually picking, in an informed and reasoned fashion, one of the available options and abiding by that selection. Resolution, then, means making a choice.

2. Its relationship to decision making

To choose is to settle the question of what one will do, and to indicate one's commitment to a particular course of action. It signals that one has put an end to the vacillation that attends a panoply of choices, each with pros and cons. Put another way, resolution marks the completion of the formal or structured decision making process. It is related to decision making in signalling its successful completion.
3. Its degrees

The maximally competent person makes an independent choice. She receives information throughout the process, but her consideration of it and her ultimate decision are independent ventures.

The minimally competent person also makes a choice. His consideration of relevant information and his ultimate decision are guided by others.

The incompetent person is never able to choose. Others must determine the course of action for her. This inability may derive from incompetencies in the aforementioned capacities, but it may also be an independent incapacitation; i.e., she may only be unable to choose. ¹²

4. A recapitulation

Resolution is the skill by which a conclusion is attained (even if only temporarily) in the decision making process. It is the ability to reach an endpoint. The acquisition of an outcome provides, in a very concrete sense, closure to the decision making process. Absence of this capacity leads to failure of the entire decision making project. There are, however, other on-going activities that attend choice and are important to it. It is these further enterprises to which we now turn.
V. PERSISTING IN ONE'S CHOICE AND DECISION MAKING

The fact that one ultimately chooses does not commit one to being happy about that choice. Many people genuinely wish that other choices had been available. All of the patients in the cases we have considered undoubtedly wished they had not had to make health care choices at all; i.e., all wished their lives had not included serious illness. But beyond that fact, most wished their circumstances had been qualitatively different in other important ways. Ms. Meyer, for example, wished her opportunity for transplantation had come several years earlier, when she was younger and when she had family and friends who could have supported her through the surgery and its post-operative course. Ms. Green would have preferred to have information available on the comparative long-term morbidity and mortality rates of lumpectomy with radiation vs. radical mastectomy.

The point is this: It is almost never the case that one faces a situation in which there is a perfect choice. Rather, people have to make "the best choice, all things considered". This means, among other things, that they may harbor doubts that their choices really were the best ones. Moreover, when they make unpopular choices, there may be on-going efforts on the part of others to persuade them to reconsider. It is in light of these possibilities that the last two capacities are considered. What choice does bind one to is, at least, a
commitment to a course of action. This requires one to persist in one's decision, both to oneself and to others (when others are involved) so that all parties may get on with what needs to be done. This persistence will now be considered.

A. Maintaining Resolve: Withstanding Criticism from Others

1. Its meaning

Insofar as other people will be affected, directly or indirectly, by one's choices, those choices must be communicated to and, hopefully, accepted by them. Were respect for persons and, derivatively, for their decisions the only relevant factor, competent choice would be sufficient to preclude interference and to insure cooperation. However it is often the case the one's choices make impositions on other persons. They may then be reluctant to render aid, may even threaten to interfere with the patient's chosen course. The ability to persist in one's choice, even in the face of such obstruction, is what is meant by withstanding the criticism of others.

2. Its relationship to decision making

Others may be the agents of one's choices; or they may be affected, emotionally or practically, by the events that follow one's choices. (Mr. Able's friends, for example, will probably experience distress and some inconvenience as a result of his choice. As his primary care givers, they will have to participate in his experience with disease and
disability and, ultimately, in his death.)

Others are affected, sometimes unfavorably, by our choices. Yet we often expect them nonetheless to assist us in the processes by which our goals are realized. So it becomes necessary to impart a sense of importance regarding those choices to them so that they can understand and aid, or at least not hinder, us in our efforts. Part of being respected as a person is not having one's decisions ignored or thwarted. Part of respecting others as persons is recognizing that, when they do not share our goals or our means, they deserve explanations that can help them understand our choices. At best, this will mean sharing, in as articulate a fashion as possible, the reasoning process that preceded the decision—recounting what factors were considered, how various alternatives were weighed, what personal values were pivotal to the process.

But sometimes so thorough a description will not be possible, either because the decision maker is not, by nature, very articulate, or because she cannot at that time muster the energy needed for a complete recapitulation. Then others must settle for an abbreviated justification, perhaps a simple but firm "It's the best thing for me".

Worse yet, decision makers may be totally at a loss to articulate justifications for their choices. They may not fully understand these themselves; they may be unable, for whatever reasons, to express them to the satisfaction of
others. Yet the importance to the chooser of the choice may be testified to by her perseverance in that choice. The fact that in the face of persistent opposition she remains constant in her decision gives evidence of its gravity and of its worth to her as a person worthy of respect.

Nor can the distress she would suffer, were others to act against her best interests as she herself has defined them, be discounted. One way of showing respect for persons is to not subject them to pain and suffering to which they have not consented.\textsuperscript{13} Decision makers may need to appeal to this value to enlist others to their cause. Absent the ability to coherently argue for protection of this value, their persistence in acting in concert with the choice will perhaps serve as an eloquent, if less articulate, expression of it.

The relationship of withstanding the criticism of others to decision making, then, is that via this capacity a person testifies, whether verbally or non-verbally, to the importance of the decision to the well-being of the decision maker as he himself has defined it.

3. Its degrees

The maximally competent person is able to recount the process by which she arrived at her decision. She will be able to argue persuasively about why that decision should be honored, even when others are reluctant to accept it. She may appeal to the considerable effort she has expended in making
what is, for her, an appropriate choice. She may also appeal to respecting her decision as a way of respecting persons. Regardless of whether others are persuaded, she will continue to embrace her decision.

The less articulate person is minimally competent. He may be, at best, able only to state that the choice is very important to him. At worst, he may be able only to persevere in spite of efforts to dissuade him or interfere with his plans. His diminished verbal skills, rather than his determination, serve to distinguish him from the maximally competent. He is behaviorally as adamant in his choice as is the maximally competent person. Mr. Tsai fits this description; although unable to give reasons for reneging on his consent once in the radiology suite, he is nonetheless fervent and constant in his refusal, thereby conveying the importance, to him, of his decision.

The incompetent person fails to display either of these criteria. She perseveres neither verbally nor behaviorally in her choice. She either cannot or will not explain her decision; and she either cannot or will not insist that it be honored.

4. A recapitulation

Competent persons persist in their choices over time. This sense of purpose is necessary to complete many tasks, especially the more unpleasant ones. Because completion of these tasks often requires the participation or understanding
of others, it is necessary for the chooser to be able to convey to others why or to what extent his choice is important to him. Maximally competent choosers can give both verbal and behavioral testimony to the worth to them of their decisions. Minimally competent choosers can only give behavioral evidence. Incompetent choosers can give neither.

B. Resignation: Withstanding Criticism from Oneself

1. Its meaning

It is sometimes the case that the chooser himself is not enthusiastic about the his choice, but sees it as a necessary evil. Nonetheless to proceed with the tasks ahead, he must persevere in his choice, if only because it is the best option available. This is particularly difficult if the ensuing course is in any way onerous, because it will require him to undergo disagreeable experiences. Such adventures are best undertaken with a sense of purpose and of commitment to the designated end. They are more likely to succeed if one can dedicate himself to a course of action, if he can make a decision and follow through. This resolution, especially in the face of uncertainty or dismay at what may follow, is what is meant by withstanding one's own criticism.

2. It relationship to decision making

It is helpful to remember that many, if not most, choices are only one among many possibilities. Often estimates of the risk/benefit ratios and probabilities of success are
uncertain, and often the data base is incomplete. There is, therefore, a certain amount of hesitation that any serious decision is the correct one. To such extent as is possible, the information deficits ought to be corrected; but it is probably never possible to eliminate them completely. Thus ultimately it becomes necessary to proceed in spite of these limitations. That one makes a choice does not, however, in and of itself, erase the concerns that attend it. As a result, persons may find themselves in the position of having to reassure themselves on an on-going basis about their choices.

It is sometimes helpful for the decision maker to review the process that led to his making the decision he made, to recall the factors that told both for and against the ultimate choice. Clearly this will require that the same capacities that went into making the decision persist over time—at least long enough to undergo review(s). The ultimate capacity, and one that will emerge as one convinces oneself of the necessity of proceeding according to plan, is resignation to that plan, such that one is motivated to undertake the tasks required for its successful completion.

The relationship to decision making of withstanding one's own criticism, then, is that this capacity gives a person the resolve to move forward with the actions that are required by one's decision. Persisting in one's choice allows its implementation and, hence, the promotion or preservation of
the values, goals, or desires that are the aim of the decision.

3. Its degrees

The competent person is one who proceeds with the execution of her decision. The incompetent person is one who is unable to do so. This capacity seems not to admit of degrees in the same ways that the others do, probably because there are really only the two outcomes: acting upon one's decision and failing to do so.

It might be possible to distinguish between maximal and minimal competence on the basis of how enthusiastically persons pursue a goal, or with how much dispatch. But, since part of the meaning of resolve is that one proceeds in spite of a lack of enthusiasm or in the face of outright distaste, basing a distinction on this characteristic seems unhelpful

4. A recapitulation

Withstanding one's own criticism means that one can overcome one's own doubts and uncertainties about a choice and proceed with the actions that it dictates. Without this ability, this courage of one's convictions, people would be unable to act except when they were certain that they had absolutely all relevant information and had analyzed it correctly. Since these conditions rarely are the case, it is important for decision makers to be able to move forward in the face of doubt. The competent person can do so; the incompetent person cannot.
VI. CONCLUSIONS AND NEW DIRECTIONS

A. The Conceptual Analysis of Competence

In this chapter competence has been explicated as the possession of the capacities to receive information, to recognize information as information, to remember/retrieve information, to relate information to oneself and one's circumstances, to reason about one's alternatives, to rank alternatives in order of one's preference, to resolve situations through choice, to withstand the criticism others, and to withstand one's own criticism of one's decision.

These abilities must, for the reasons discussed above, be intact for a person to be maximally competent to give or refuse a consent that will, ceteris paribus, be respected by other persons. The hallmark of the maximally competent person is the possession of these capacities to the extent that they may be exercised independently. Absence of or inability to exercise these capacities renders a person incompetent to give or refuse consent. Decisions regarding the incompetent person will necessarily be made by others.

Between the maximally competent and the incompetent are the minimally (adequately) competent persons. They differ from the former in that they require the assistance of others to reach a decision. They differ from the latter in that, given time and assistance, they can reach (or agree with) a decision.
Persons who competently reach decisions should generally have these decisions respected. This is because persons who are able to competently decide are the types of beings who are worthy of respect. That they are turns, at least in part, upon the ability to plan the way they want their lives to go. Decisions competently made are one of the ways they work to assure success of those plans. Not interfering with those decisions is one way of respecting them as persons.

B. Implications for Future Research

There are, of course, a number of questions that remain unanswered. The predominant problem that this thesis has not addressed is how to test for competence. While in one sense a test for competence is just another theoretical exercise, it is, from the perspective of the clinician, the most important question that attends the entire field. Located in the day to day demands of health care, in which the practice of informed consent requires that a person's competence (or lack of same) be established, the clinician needs a tool by which she can determine who can and cannot give valid consent. Thus, the first project ought to be the application of the theory developed here to the construction of a test that measures the capacities discussed herein.

A second, related project would be the application of these concepts to children. One problem that has plagued pediatrics is the question of competence of non-adults. The
law, of course, is quite clear in its statement that anyone below the age of majority is not legally an adult. But the question of competence, turning as it does upon the possession of capacities, ought not be decided by fiat in non-legal settings. In particular, given that the cooperation of children is often essential for successful completion of particular therapeutic ventures, it becomes important to understand how competence applies to children in health care settings. This is practically important in those cases in which there are disputes between children and their parents or guardians about how best to proceed with the management of the child's illness.

Of course, in a broad sense this project is an extension of the project of constructing a test for competence. Then children who pass it would also be deemed competent decision makers. But there will be more to such an investigation, in that the question of who is the appropriate decision maker in a health care setting, will also be addressed. This is an interesting sociological, as well as philosophical, question.

Both these projects are clinical in nature. There is, however, another theoretical topic that this research bears upon: the question of what counts, within the practice of informed consent, as a voluntary consent. (It will be recalled that a valid consent is informed and voluntarily given, as well as being competently given.) The same sorts of concerns that attend determinations of competence attend
determinations of voluntariness. For the practice to stand on solid foundations requires the explication of this concept as well.

It seems to me that many of the capacities that inform determinations of competence—most notably informability, cognition, the ability to withstand criticism of self and others—also inform determinations of voluntariness. The practice of informed consent can only profit from further analysis in this area, and the analysis of competence may be able to provide a structure for that analysis.

NOTES

1. For the initial discussion of these capacities, see Chapter Two, Section II.

2. It is at least theoretically possible for a person to be in complete possession of all possible components. This person should then be designated "perfectly competent" and would, of course, be competent to consent.

3. It goes without saying that the person in whom all components are totally absent—e.g., a comatose person—is "perfectly incompetent", and would, of course, not be competent to consent.

4. There are, of course, many other sorts of knowledge involved in decision making. One might profit from knowing, for example, what other options are available; the risks and benefits of each; the likelihood of achieving each and the costs involved in trying to attain one over the other; which, if any, options one finds inherently preferable and which are preferred given one's other projects and goals; which option is first choice, which is second, third, an so on. Some of these other instances of knowledge will be considered later on. The point here is that, to begin the decision making
process requires that one know where one is and how one feels about being thus positioned.

5. There is one obvious exception to this claim, that being that explanations might be quite effectively given in Braille to a person who is both blind and deaf. In such situations the sense of touch would have to be intact for a person to be informable. Thus the blind, deaf, paralyzed person would be unable to receive information that would be accessible to the merely blind, deaf person. The upshot of this is that the superimposition of paralysis upon a blind, deaf person would serve to render that person incompetent for decision making because the paralysis eradicates the person's last available route for information.

6. We do not need here to discuss the various pathologies by which the process may be interrupted. In, for example the blind, deaf, and paralyzed person, the stimuli do not arouse the appropriate sensory peripheral receptors. In the comatose person the central nervous system does not perceive the stimuli. Either way, as well as in all other procedural interruptions, the appropriate information is unavailable to the person by, for, or about whom a decision must be made. Suffice it to say that when this is the case then the person is, regardless of the etiology, incompetent to make decisions.

7. This is especially problematic, given the demographics of patients. As the population itself gets older (i.e., a greater percentage of the population is over 65), a greater number of people can be expected to be beset with, among other things, difficulty remembering.

8. There is clearly some overlap between this capacity and the preceding one of relating situations to oneself. In practice distinguishing between the two is difficult, if not impossible, since both involve evaluating actual and potential situations with an eye to how they influence the course of one's life. However there is at least this theoretical distinction: the former requires a person to recognize that her current circumstances include a choice that must be made and why, given her present state of affairs, that is the case; the latter demands recognition that different choices will change her life in different ways, how those changes differ, and why that is the case.

9. I take it that one benefit would be the promotion or preservation of goals or values that one holds dear. Likewise, one risk would be that these goals or values are jeopardized or overtly obstructed.
10. I do not mean to suggest that most people go through this process in so formal or structured a fashion. Still, they do make lists of pros and cons for various options, and often discount the longer list of pros in favor of a shorter one when the chances of success are remote for the former and near for the latter.

11. This does not mean that persons cannot reconsider their decisions or that they cannot have second thoughts or worries about actual choices. What it does mean is that they must, ultimately, bring closure to the process, even if that closure is attended by some uneasiness and even if there is recognition that such closure may be, in fact, only temporary.

12. There are persons who are affected with pathological indecision. Put simply, they are quite unable to make a choice, even if they have been able to construct personal risk/benefit ratios, assign probabilities, and relate options to their present and future selves. Part of the pathology in such cases seems to be an unusually strong concern that important data may have been overlooked and, hence, that any decision will be made on the basis of incomplete evidence. Insofar as choice eliminates at least some opportunities from further consideration, there is an accompanying fear that one will have made the wrong choice. If this choice is such as commits one to any sort of "irreversible" action, the person worries over potentially missed opportunities and the fear that one's life is irretrievably ruined.

I do not mean to imply that one ought not to worry about these possibilities. Nonetheless, it is quite probable that one never has absolutely all the information that applies to a particular situation. And one needs to be aware of this probability, so that one remains open to information that would be relevant to a decision to change one's plans and adopt different approach when it becomes apparent that doing so is preferable. The point is, this probable information deficit ought not obstruct decision making entirely.

13. Persons can, of course, elect to undergo misery (and, sometimes, a great deal of it) to accomplish goals that they have chosen. That is, however, a different situation, one in which they volitionally undertake to suffer for the sake of a chosen purpose.
BIBLIOGRAPHY


147. Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92, 93 (1914).


