

Competence to Consent

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Psychoiatrists and mental health care settings sometimes seem inordinately concerned with the concept of consent for things: hospital admission, medication, procedures, release of information. It often appears (and is sometimes true) that our general medical colleagues don't have to worry nearly so much about consent; they just seem to do what they need to do and there's rarely a problem. Their patients are assumed to be competent to understand what is explained to them without reams of paperwork and multitudes of lectures and memos about the rules that apply to consent or refusal of this or that. The law is certainly interested in medical consent, but competence is rarely the headline topic that it has become in psychiatry.

Psychiatrists and other mental health professionals are often personally involved in the consent process, getting it, documenting it, and reviewing it, or documenting that the patient was competent to provide adequate permission for whatever is contemplated. The existence of a great many government rules and statutes—and even hospital or agency policies and ethical guidelines—concerning consent seems to reflect a relative distrust by the public, which has been (largely unfairly) visited upon the mental health professions by some groups.

Be that as it may, in this month's column, I will focus on an important element of consent: competence.*

The Elements of Consent

A valid medical consent has three basic requirements: *knowledge*, *competence*, and *voluntariness*. Knowledge refers to the information supplied. Competence refers to the patient's ability to understand and use that information to make a reasonable decision. Voluntariness to the absence of undue coercion.

Note that "coercion" is not the same as a professional recommendation. The information supplied to the patient can (and should) contain *facts* such as "the medicine is likely to help with your symptoms so that you won't have to stay in the hospital so long" or "it would be best if you enter the hospital voluntarily, but I am so concerned about your safety that we must consider involuntary hospitalization if you don't." One should not, however, make

threats (such as "if you don't sign the admission form, we'll have to send you to the locked ward against your will"). It's a fine line, I know, but one that should be addressed with the patient's safety and clinical interests in mind.

Knowledge (or information) is important, but to give truly "informed consent" the patient must be able to use that information adequately to make a rational decision on his or her behalf. "Adequately" is a key word here. Patients should understand and be able to use the information supplied to the extent necessary to make a reasonable decision, but they are almost never required to understand it in great depth.

No doubt some readers are thinking about the issue of withholding information or details that might make the patient unreasonably anxious, and thus unreasonably prone to make a bad consent decision. There is a difference between the level of information needed to assess risk and benefit adequately and that which—perhaps varying among different kinds of patients—brings up rare possibilities that may be unduly frightening (especially to an obsessive or paranoid patient). The law and the standard of care recognize that some risks are so remote that to enumerate all of them would be onerous and largely pointless. There is also a small body of law and experience that describes how much information a physician may omit when it would unduly frighten a patient or otherwise interfere with a rational decision. This does not mean, however, that doctors may hide relevant information from patients.

Notice I didn't say anything about *written* consent. Most simple consents aren't written at all, and many aren't even spoken (see below). Getting it in writing is not part of the legal picture unless a government or agency has a rule about the procedure for obtaining and documenting some particular consent. There is nothing magic

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*I like the word "competence" better than "competency." The latter sounds like bad grammar to my ear but is widely used in legal circles.

about writing; it is merely documentation that the consent took place in some acceptable format (e.g., that it included certain explanations and understandings or a witness if needed). Consent may be documented in other ways, such as by simply describing it in the patient's record. Whether or not such documentation is sufficient for legal or risk management purposes is up to statute or agency rule, but it's not basic to the concept of consent.

Competence to Consent in Medical Settings

Competence is the capacity to understand something and act reasonably.¹ It is a legal, not a medical, concept. In the United States, almost all competencies are assumed for adults unless some legal action (e.g., guardian appointment or court directive) has abridged them. Although doctors should not take it upon themselves to say that a patient is "incompetent" (judges are the arbiters of legal competence), we should be generally aware of when to question it, and avoid relying on the patient for consent to elective risks if he or she seems unlikely to understand them. Doctors may be involved in recommending that a court limit a patient's competence; that's not the same as finding the patient incompetent.

In many states, doctors are allowed to find a patient clinically "incapacitated" (or some similar term) and act on that finding without invoking the legal concept of "incompetence." One may determine, for example, that an unconscious or delirious patient cannot make medical decisions for himself in some acute situation, and (depending on the applicable state's laws) act in the patient's interest. Note that the use of such terms as "incapacitated" in a clinical setting may or may not comport with their meanings in legal settings (or those of similar terms, such as "lacking capacity"). As we've said here before, common medical usage often differs from legal definition.

Not all "competencies" are the same. In fact, most are quite different from each other. This discussion refers to a narrow area of competence related to medical consent. We'll soon see that even within that topic the threshold for competence changes with things such as *level of risk, simplicity of decision, and discrepancy of risk and complexity among the different possible decisions.*

As we have discussed in columns on trial competence, the ability to make reasonable decisions is a functional condition, not directly attached to diagnosis. It is a relatively acute concept, which applies to the person's ability—or "capacity"—at a particular point in time. Past functioning or competence is often not directly relevant. For some patients, the level of competence is quite stable from day to day. Others have varying capacities which depend on their illness (e.g., waxing or waning psychosis or dementia), treatment compliance, or even the treatment or procedure being employed (cf. patients who become briefly incapacitated because of anesthesia, pain medication, or electroconvulsive therapy).

Competence Versus Level of Risk

The law places great weight on a person's right to decide what happens to his or her body, and is reluctant to remove or usurp a patient's individual control. In that light, it tends to assume that a person is competent unless there is good reason to assume otherwise (such as a judge's finding of incompetence). Interventions that are not likely to harm the patient or that involve a great preponderance of benefit and very little risk are not generally seen as matters that justify much testing of competence. The level of competence required for consenting to them is often very low.

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Buying a pair of pants doesn't carry much risk. A clothing store is not required to assess each customer's competence to decide how to spend money, even for really loud golfing slacks. The customer's ability to express a choice and pay the bill is sufficient.

Similarly, almost any adult, even those with substantial psychiatric symptoms or mental retardation, may often be allowed to consent to low-risk procedures and treatments by simply expressing agreement, and sometimes by merely expressing a choice or participating voluntarily. The risks of, say, simple venipuncture, a physical exam, or participation in activities-of-daily-living classes do not reach the threshold necessary to require some competency test.

Competence versus Complexity of Procedure or Decision

Some procedures have very significant consequences but the decision process involving them is pretty simple. My favorite example involves a comparison of two surgical situations. In one, a 35-year-old accident victim with mild mental retardation has developed severe traumatic gangrene of her foot and is virtually certain to die without a below-knee amputation. In the other, a similar 35-year-old

patient with mild mental retardation has breast cancer which may or may not have spread to her axillary lymph nodes.

The decision to amputate one's leg in the former situation is a major one, but is also simple. There is a yes-or-no question and the possible outcomes are fairly clear. One may choose death, or life without the lower leg (assuming for the moment that the surgery is likely to be straightforward and relatively free of complications). A decision to amputate (see below for the alternative) requires only a fairly low level of competence in order to arrive at a reasonable conclusion.

The cancer patient, on the other hand, is faced with a far more complex set of decisions. There is no "yes-or-no" agreement among physicians, and there are no similar patients or even controlled studies that shed light on her particular situation. She must take into account the pros and cons of lumpectomy, simple mastectomy, radical procedures, chemotherapy, and/or radiation, as well as issues related to appearance and self-image, future fertility, the probability and possible manner of death, probability and duration of life, and quality of life given the various treatment options. The level of competence required to contemplate any of the possible treatment options and compare them to the others is substantial.

The consequences of consenting to something are often quite different from the consequences of refusing. Refusal may require a much higher level of competence than consent.

In the first example (trauma-related gangrene and amputation), the law may allow considerable mental incapacity before questioning the patient's competence (but see below). In the second (complex breast cancer), some substitution of judgement (e.g., by a guardian) is likely to be required.

Competence to Consent versus Competence to Refuse

But what if the person in the gangrene scenario above wants to refuse the amputation? The consequences of con-

senting to something are often quite different from the consequences of refusing. Refusal may require a much higher level of competence than consent. It makes no sense to use the same competence criteria for consenting as for refusing if the applicable levels of risk or benefit are significantly different.

Voluntary psychiatric hospital admission is a good example of this principle. The combination of low risk and simplicity of consequences means that consent to be admitted requires only a *low* threshold of competence in order to achieve understanding adequate for the decision. Most severely mentally ill patients (even many who are psychotic) are able to understand the general risks and benefits of hospitalization, what is likely to occur while there, and the reasons admission has been recommended. The "downside" risk of admission is quite low (very few patients are injured by hospitalization) and the "upside" potential for benefit is usually high (i.e., both a strong probability of benefit and the fact of benefit itself).

Refusing admission, on the other hand, usually has much worse consequences (e.g., danger of further decompensation or suicide, less efficient evaluation and treatment, worsening social/vocational conditions), which are also more complicated for the patient to contemplate. This combination of much higher risk and more complex consequences means that refusal to be admitted often requires a *much higher* threshold of competence (than does consent for admission) in order to achieve understanding adequate for the decision.

The same principle of uneven risk and complexity can be applied to many other consent decisions with varying thresholds of competence, including consent for (versus refusal of) medications, other treatments and procedures, and authorization to contact third parties for important clinical information.

The Last Word

Competence to consent is only one of many kinds of capacity, and itself has different thresholds for decisions that involve different levels of risk and complexity. Consent and refusal are not equivalent processes, in part because they are associated with different kinds and degrees of risk. In psychiatry, refusal is usually the riskier choice, and thus usually demands a higher threshold of competence before the patient's decision should be accepted at face value.

Reference

1. Gifis SH. Law dictionary. Woodbury, NY: Barron's Educational Series; 1975.