Ethical issues and procedural dilemmas in measuring patient competence

Patients can be judged incompetent when they begin to refuse treatments and nursing interventions believed to be important for their health, but finding agreement among health care providers on the concept of competency is sometimes an arduous task. This article reviews competency measurement models from the disciplines of law, medicine, and philosophy and compares the usefulness of these tests and criteria. Conclusions are stated about the use of these models in nursing to evaluate the patient's autonomous state.

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IS THERE a line between competence and incompetence, or is the difference an arbitrary determination? Frequently, the determination of incompetence may appear arbitrary because the rationale for this decision making is not clear or not revealed. The definition of incompetence often varies from caregiver to caregiver within the same setting. Because nursing is concerned with ensuring the right of the patient to make decisions, uncertainty arises when there are questions about the patient's ability to make decisions or when the patient makes decisions that will not promote health and that predictably have serious sequelae. Some of the confusion in knowing how to intervene in these circumstances may relate to the fact that the concept of competence is multidimension-

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al; it is a social and legal concept as well as a medical and psychiatric concept. Divergent views can be seen in the models of competency measurement as found in the literature of law, medicine, and philosophy.

ALTERNATIVE CONCEPTIONS OF COMPETENCY

Models from psychiatry

Roth et al[1] reviewed competency tests as found in psychiatric literature and judicial commentary and organized them into five separate categories. Some of the categories showed overlap and some were inferred from the literature.

Test 1—Evidencing a choice. This test for competency requires the patient to show preference for or against treatment. The patient could be considered competent even if help is sought to make the treatment decision. When the patient is verbally silent, behavior is evaluated to judge the direction of the response; ie, if there is compliance with the treatment requirements when every opportunity is given for refusal of each modality offered, the patient is considered to be evidencing a choice and, therefore, to be competent. This test may not reveal the patient's understanding of the choice made; therefore, it is a low-level test in regard to determining if a patient makes an informed decision. Examples of patients who would be judged incompetent by this test are those who are unconscious, delirious, or psychiatrically mute.

Test 2—Reasonable outcome of choice. This test focuses on the outcome of the decision-making process, rather than the ability to make a decision. The test requires the patient to make the right or "reasonable" decision to be considered competent. The reasonable decision is the one that a reasonable person in like circumstances would make. Judicial decisions usually favor preservation of health, and that bias is commonly held by health care providers; thus, the patient whose outcome of choice is congruent with this bias is always considered competent. It is easy to see how this test could be used to determine that the patient is incompetent when there is refusal to acquiesce to treatment. With this test, the outcome of choice, not the patient, is evaluated. The circular nature of the test reduces its value for clinical use. It makes no contribution to an understanding of the decision-making process of the patient, and it has the potential to erode personal autonomy.

Test 3—Choice based on rational reasons. In this test the reasons for the patient's decision are evaluated to determine if they are "rational." Examples from the literature reviewed by Roth et al equated rational with the absence of mental illness, and Roth et al implied that mental illness is interpreted as disordered cognitive function, ie, delusion and/or delirium. Like the first test, this is a very low-level test of competence. Even for patients with mental illness, it is usually not possible to prove that the mental illness was responsible for the patient's treatment decision; for example, a delusional patient may reject extensive surgery out of fear, which is a normal reaction and not the result of the delusional state. This test offers little conceptual clarity about how to evaluate the quality of the patient's thinking. A decision in favor of treatment usually does not stimulate a concern for competence.

Test 4—Ability to understand. This test is most consistent with the current legal and ethical principles of informed consent and requires the patient to answer questions or show some understanding of risks, benefits, and alternatives to treatment. Understanding does not have to be perfect for the patient to be considered competent. The level of understanding required to pass this test cannot be precisely determined because few attempts at quantifying understanding have been made.[2] Meisel and Roth[3] reviewed numerous studies of informed consent to ascertain how the concept of understanding was made operational. Few hard data were found; the primary weakness of these studies was the limited reporting of the information given to patients when informed consent was obtained. Unfortunately, recall seemed to be equated with understanding by many investigators.

This test, like test 3, emphasizes only the cognitive ability of the patient to compre-

Table 1. Measurement of patient competency to consent to or refuse treatment

Test/criteria for competence	Criteria for incompetence
***Roth et al*[1]**	
Test 1—Evidencing a choice	No treatment choice is manifested
Test 2—Reasonable outcome of choice	Treatment choice is not like that of reasonable person
Test 3—Choice based on rational reasons	Cognitive disorder is present
Test 4—Ability to understand	Cognitive facts are not understood
Test 5—Actual understanding	Treatment situation is not completely understood or integrated
***Meisel*[2]**	
Status tests Permanent conditions Temporary conditions Transitory/subjective characteristics	There is deviation from hypothetical average person
Functional tests	
Absence of decision	No treatment choice is manifested
Nature of decision-making process	Unacceptable means of making decision are used
Nature of decision	Treatment choice is not in accordance with verifiable standard
Lack of understanding of informed consent	Information relevant to informed consent is not understood
***Beauchamp and Childress*[3]**	
Understanding the treatment	Rational reasons are not used to meet criteria
Weighing risks and benefits of treatment	
Making decision in light of such knowledge	

Table 1 *(continued)*

Test/criteria for competence	Criteria for incompetence
Culver et al[4]	
Patient knows—	Criteria are not met
Physician believes patient is ill and needs treatment	
Physician believes certain treatment will help illness	
Patient is being asked to decide about treatment	
Culver and Gert[5]	
Completely incompetent	Patient is an infant, severely retarded or senile, comatose, or can identify only immediate needs
Competent to give or refuse simple consent	Patient can comprehend only part of treatment situation
Competent to give or refuse valid consent	

[1]Roth L, Meisel A, Lidz C: Tests of competency to consent to treatment. *Am J Psychiatry* 1977;134:279–284.
[2]Meisel A: Legal overview, in Reatig N (ed): *Competency and Informed Consent*, US Department of Health and Human Services publication No. (NIMH) 81-23. National Institute of Mental Health, 1981, pp 32–71.
[3]Beauchamp T, Childress J: *Principles of Biomedical Ethics*. New York, Oxford Univ Press, 1979, pp 62–85.
[4]Culver C, Ferrell R, Green R: *ECT and Special Problems of Informed Consent. Am J Psychiatry* 1980;135:586–591.
[5]Culver C, Gert B: *Philosophy in Medicine*. New York, Oxford Univ Press, 1982, pp 42–63.

hend the treatment facts (or information of equivalent intricacy). No significance is attributed to the way in which the patient weighs the facts presented. Examples of patients who might be considered incompetent by this test are those with mental retardation of such a degree that they are unable to comprehend the situation, those with delirium, and those with levels of drug intoxication that would interfere with comprehension.

Test 5—Actual understanding. This test is similar to test 4, but it adds the obligation that the health care provider instruct the patient and then ascertain if the patient really understood the full meaning of the treatment information. Criteria for performance of this test are not defined; the health care provider is expected to make a genuine effort to educate the patient about the total treatment situation and its complexities. In general, the amount of understanding needed by the patient is potentially greater than that required in test 4. This high-level test of competence is important in situations when patients agree to treatment that carries high risk or when they refuse beneficial treatment with negligible risk.

Consider an alert, elderly cancer patient who requests the alleviation of suffering and support in maintaining respectability during the last days or months of life but who will not accept nursing interventions to meet these desires because of the presence and threat of pain. With the actual

understanding test, it is uncertain if the patient meets the requirements for competence. The patient appears to be sensitive to the realities of a fast-approaching death but will not accept measures to facilitate clearly stated goals. The omission of these nursing measures could cause significant harm to the patient. Test 5 highlights the conceptual difficulties in measuring the understanding of the patient and the personal meaning of that understanding. There is obvious potential for disagreement in patient evaluation. However, this test is intended to be comprehensive; it is meant to measure more than the patient's knowledge of the facts presented.

In summary, Roth and associates believe that the competency test used will often be some combination of these five tests, because no single test will encompass all biases held by the evaluator (Table 1).

Model from law

Meisel[4] provides a legal model regarding what it means to be competent to make treatment decisions as required by the doctrine of informed consent (Table 1). However, the focus of this model is incompetence and it is defined in terms of *status and functional tests.* A patient who has a certain status or lacks a certain functional ability would not be qualified to participate in the treatment decision-making process. Persons who deviate from the "average" and have one of the following characteristics would be considered incompetent: a permanent condition, ie, severe mental retardation; a temporary condition such as intoxication; or a transitory or subjective characteristic such as peculiar behavior or appearance. These status tests provide a quick but limited measurement of the patient.

The functional tests of incompetency specify the deficits in the decision-making process that prohibit the patient from making autonomous decisions. In the test for *absence of a decision,* the patient can be deemed incompetent when there is failure to make a choice about treatment, as in the test of Roth et al for evidencing a choice.

In the test for the *nature of the decision-making process* a patient is judged incompetent in the following circumstances.

- There is failure to give reasons supporting a treatment choice.
- No rational reasons are given to support a treatment choice. (Rational reason is defined as the use of reality-based information but may include nonobjective facts reflecting a patient's preference. This definition is different from that in the test of Roth et al of choice based on rational reasons.)
- There is no evaluation of risks versus benefits; this is similar to the test of Roth et al for *ability to understand.*

The test for the *nature of a decision* is used to evaluate the outcome of the decision-making process and determines the patient to be incompetent when the choice does not match certain standards, such as the physician's recommendation or the hypothetical standard of the reasonable person, like the test of Roth et al for *reasonable outcome of choice.*

Like the test of Roth et al for ability to understand, the test for *lack of understanding of informed consent* measures incompetence by (1) actual understanding (observation that the patient lacks cognitive ability to understand the information disclosed)

or by (2) ability to understand (inferential determination, perhaps from such sources as informal conversation or an intelligence score). These functional tests do not presume that a mentally ill patient is incompetent; rather, the test used determines the cognitive abilities to be assessed. The choice of a test usually reflects the tester's perception of what needs to be understood; thus, the tester's values significantly influence the determination of patient incompetence.

Meisel recommends starting with the test for the understanding component, when informed consent for research participation is sought. This test lacks the extremes of values intrinsic in the tests for the absence and the nature of a decision; is consistent with the implied meaning of consent; and meets federal regulations.[5] These functional tests have many of the same strengths and weaknesses as similar tests described by Roth et al, but Meisel's emphasis is to define incompetence as a means of knowing or presuming that persons outside this definition are competent to give informed consent.

Model from philosophy

Beauchamp and Childress,[6] who have philosophical interests in ethics, describe the concept of competence as it relates to informed consent in a biomedical context. They believe competence to consent is a precondition of acting voluntarily. Conditions external and internal to a patient may limit voluntary action, but it is usually the internal conditions that raise concern about competence. The investigators introduce the concepts of limited and intermittent competence, highlighting the fact that a person's ability to make decisions can vary over time and that an individual can be competent to make certain decisions but incompetent to make others. For example, a person with a delirium, a condition in which mental status characteristically fluctuates, might be intermittently competent, that is, competent during the periods of time when mental status was not impaired. A person who has generally exhibited normal behavior except in relation to circumscribed delusional thinking might have limited competence.

The choice of a test of patient competence usually reflects the tester's perception of what needs to be understood; thus, the tester's values significantly influence the determination of incompetence.

These authors cite an example of a man who behaves normally in most areas of living but engages in self-mutilating behavior because he believes God is asking him to sacrifice himself for the good of humankind. To determine that this individual or the delirious person is totally incompetent to make any treatment decisions limits the self-determination of both in unnecessary and unjustifiable ways; yet, both examples demonstrate a lack, at times, of the ability to understand sufficiently to give informed consent.

In recent years, there has been a major question in relation to determination of criteria for assessing competence. Beauchamp and Childress state that conventional criteria isolate various abilities to understand information and to reason about the consequences of personal

actions. Legal definitions of competency vary, but these authors point out that one or more of the following three criteria are generally considered to be essential by the courts[6(p59)]:

- "capacity to reach a decision based on rational reasons" (similar to test 3 of Roth et al);
- "reaching a reasonable result through a decision" (similar to test 2 of Roth et al); and
- "the capacity to reach a decision at all" (possibly related to test 1 of Roth et al).

Combining these criteria, Beauchamp and Childress state that a person is competent only if decisions are made on the basis of rational reasons and that in biomedical contexts this criterion subsumes that the person must be able to (1) understand the treatment, (2) weigh its risks and benefits, and (3) make a decision in light of such knowledge, even if the choice is not to use the information given. These authors do not identify the behaviors that demonstrate the evaluation of information in decision making, and they only imply that all three of their criteria must be met to judge an individual competent (Table 1).

Model from psychiatry and religion

Culver et al[7] are from the disciplines of psychiatry and religion, and they explain competence by the use of narrow behavioral referents. They say patients are competent to decide about treatment when the following minimal criteria are met: (1) the patient knows the physician believes he or she is ill and needs treatment, (2) the patient knows the physician believes that a certain treatment will relieve the illness, and (3) the patient knows he or she is being asked to decide about this treatment.[7] The patient's realization is primarily based on awareness of the current situation and the patient's ability to give and receive communication.

The authors point out that in clinical practice, the patient who refuses treatment believed to be necessary and/or beneficial by the health care professional often is deemed incompetent solely because treatment is refused. The labeling of incompetence allows the health care professional to think that it is in the best interest of the patient for the professional to insist on certain treatment for an individual who is unable to make decisions autonomously. Culver et al make a salient point: judgment about patient competence should be made independently of the patient's treatment decision. Because the determination of competence indicates how a discussion of treatment will proceed, it is essential that the health care provider recognize personal bias toward treatment and separate the evaluation of competence from a treatment decision.

These investigators recommend that once a patient has made a decision, the quality of the decision itself must be assessed to determine if it is rational or irrational. Except in unusual cases it would be considered irrational for the patient to act in a manner that is contrary to personal desires, in regard to such factors as freedom, pleasure, and suffering.[8]

Imagine that a post operative patient who has had no previous drug-related problems refuses to be medicated for pain following surgery. The patient rejects medication because of fear of drug addiction despite efforts at education about narcot-

ics. Although the criteria of the authors indicate that there may be no reason to question the patient's competence to make decisions regarding care, it is possible that the decision to reject pain relief results from an inappropriately strong fear, assuming there is no factual disagreement with the physician. According to Culver et al, the patient would be viewed as competent to make this decision, but the quality of the decision rendered would be considered irrational. Even when the quality of a decision is considered irrational, these authors say the decision should be respected, unless there are compelling reasons to override it, such as life-threatening or highly deleterious sequelae.

Professional behavior in relation to a patient's right to make a decision is generally clear when (1) the patient has been determined to be incompetent by most of the tests discussed here or (2) the patient is competent and making rational decisions. Competently made irrational decisions, though infrequently encountered by the health care professional, can present difficult problems. Culver et al offer clarification in this situation by making a distinction between incompetence and irrationality, allowing competent patients to make irrational decisions. It may be necessary and justifiable[9,10] to overrule some refusals of treatment, but it would not always be based on the grounds that the patient was incompetent (Table 1).

Model from psychiatry and philosophy

Culver and Gert[11] write primarily for people in medicine who have philosophical interests. They distinguish between two levels of incompetence in relation to valid consent (Table 1). The first category of patients would include those who are unable to give or refuse even simple consent (eg, infants, patients in coma, or severely retarded patients). The authors indicate further that it would be universally acknowledged as justifiable and even required morally for someone else to be appointed to make decisions for them.

Also included in this category are patients who are less than totally incompetent, who may be significantly limited in cognitive abilities but able to identify immediate needs and concerns such as hunger or discomfort. They would, however, not understand questions or concerns unrelated to immediate stimuli and therefore they would not understand that they are being asked for consent. Culver and Gert refer to patients in this category as being *incompetent to give simple consent.* This group of patients also would need others appointed to make their decisions for them.

The second category of patients these authors describe are those who are *incompetent to give valid consent.* These patients could understand that they were being asked to consent to a treatment and could actually give consent or refusal, but they would be unable to understand or appreciate the information necessary to give valid consent. Examples of patients in this category would be mildly delirious, mildly retarded, or mildly demented patients who may have only partial grasp of the situation or those who have delusions directly related to giving or withholding consent, eg, patients with paranoid belief that the health care providers are plotting to harm them. Culver and Gert describe these

patients as being incompetent to give valid consent but competent to give simple consent.

There is an important difference between the two levels of incompetence. For those patients incompetent to give simple consent, another person should be appointed to make decisions for them. The health care provider would not be in the position of overruling this patient's decision beca se nothing the patient does is viewed as giving or refusing consent. For those patients considered incompetent to give valid consent but competent to give or refuse simple consent, the situation is more intricate. Neither a consent nor a refusal of consent could be considered valid, since the patient lacks the ability to understand and appreciate the information being considered, so, again, a guardian should be appointed to decide on behalf of the patient.

Culver and Gert believe it is a very serious matter to give treatment without the consent of the patient, even when the patient is not considered competent to give valid consent.

A problem arises if the patient has given a simple refusal and the guardian disagrees with that refusal. These authors believe it is a very serious matter to give treatment without the consent of the patient, even when the patient is not considered competent to give valid consent. They advocate taking simple refusals of consent to treatment very seriously and overruling them only in special situations, when not treating the patient would involve significant harm. On the other hand, if the patient gives a simple consent to treatment and the guardian disagrees with that consent, Culver and Gert presume that the guardian is simply protecting the patient's interests.

To be competent to give *valid consent* the patient must be presented with sufficient information to make an informed decision and must be able to understand and appreciate that information. The aspect of understanding and appreciating the information is crucial. If anxiety results in inability to integrate all of the treatment information, the patient would not have adequate information and could not give valid consent. Because assessing the understanding requires being with and talking with the patient at some length, Culver and Gert suggest that, in an inpatient setting, the nurse is often in the best position to determine whether the patient has adequate information on which to base the decisions for treatment.

ANALYSIS OF MODELS

Major likenesses and differences are apparent in the preceding models. Tests 1, 3, and 4 of Roth et al are similar to the criteria used by Beauchamp and Childress to determine competence. In addition, Beauchamp and Childress recommend that judgments about competence take place within a specific context, so that an individual is not considered to be totally competent or totally incompetent. They encourage the establishment of criteria for determining competence, while recognizing that the initial choice of criteria establishes that certain abilities are essential.

The criteria of Culver et al show a

likeness only to test 1 of Roth et al. Culver et al do not specify the process that should be used to arrive at a treatment decision, because they assess competence prior to and independently of the patient's treatment choice. In addition, they define a difference between incompetence and irrationality. This adds precision to an understanding of the quality of the treatment decision because it allows the competent patient to remain competent, even when an irrational decision is made. This is a significant perspective because the patient judged incompetent would still be incompetent, even if there was subsequent consent to treatment.

Only Roth et al allow for test 2; this test evaluates the decision made by the patient but never evaluates the patient and would be regarded as a test of rationality, not competence, by Culver et al. Test 2 encourages the health care provider to enforce personal values instead of those of the patient; it assumes that the result is all-important. Content comparable to test 2 of Roth et al was found only in Meisel's test, nature of decision; however, Meisel comes from the discipline of law, in which it is common to measure action against a normative standard. Both tests appear to be inappropriate for use in the evaluation of patient competence.

Test 5 is thought to have the greatest reliability of the five tests of Roth et al, even though what constitutes the depth of actual understanding is not completely clear. Deficits in understanding could be ascribed to the health care provider as well as the patient. The explanation by Culver and Gert of competence for valid consent has a similarity to test 5; they specifically point out that valid consent means full attention must be directed to the patient to ensure that consent is truly informed consent, because it has been personalized. Culver and Gert expand the discussion of competence by specifying two levels of incompetence, a distinction not mentioned by the other authors. This distinction guides the health care provider in knowing that it is appropriate for some incompetent patients to make a treatment choice, even though the choice would not be truly an informed one, and in knowing what considerations should follow.

The lowest level tests of competency are test 1 of Roth et al; the minimal criteria used by Culver et al; and those tests used by Culver and Gert to determine competence to give or refuse simple consent. The highest level tests of competency are test 5 of Roth et al; the tests used by Culver and Gert to determine ability to give valid consent; and the three criteria of Beauchamp and Childress.

The bias of health care providers is slanted toward treatment; therefore, it is imperative that the competency test applied is not selected on this basis. In classifying competence to consent to or refuse treatment, Culver and Gert guarded against this bias by using specific competency descriptions to place the patient in one of three categories that determine whether the giving or refusing of consent will be valid. It is the classification of competence that makes the work of Culver and Gert more helpful than that of Culver et al; criteria of Culver et al for competence results in some ambiguities when competence is limited or fluctuating, and it is not clear how this should be evaluated when valid consent is determined.

The literature reviewed shows how diffi-

cult it is to have congruence on what it means to be competent, because of the variableness and doubtfulness of how incompetence is to be determined. Most efforts at defining competence have been directed toward consent to treatment rather than consent to research.[4,12-14]

NURSING AND COMPETENCY ASSESSMENT

Although nurses support and guide patients daily in fulfilling diagnostic treatment requirements, this is not done with ease when patients begin refusing to comply with protocols of health care. The nursing literature reveals no model to follow when there is a need to assess patient competence in order to know whether a paternalistic posture would be justified[15] or whether the patient's sovereign state should be respected. From a legal view, persons are considered competent until it is determined otherwise by a judicial hearing; however, clinical situations that require a nurse to make a competency assessment are a reality and are often of a pressing nature.

Illness does not necessarily distort the wishes of the true self; therefore, a person cannot be judged incompetent only because personal choices change after the start of a sickness. The autonomy of individuals is seriously respected by nurses, but a paradigm is needed for offering this protection when a patient's competency is being challenged.

Studies in nursing have not described the communication of nurses to patients about (independent) nursing treatments or the effects when these interventions are refused. This issue is complex because the nurse assists the patient with nursing prescriptions and the medical regimen, and the patient can refuse either or both of these, thereby risking detrimental consequences. This could result in the need to manage competing values of treatment, and it is uncertain if there is nursing consensus on the competency model to apply.

As the disease process may affect the patient's mental capacity, so also can interpersonal factors or the real or imagined features of a health care facility.[16] A high level of awareness is needed by the nurse to distinguish a competency assessment issue from these other effects. The preceding models of competency determination provide some conceptual understanding of how to act in a knowledgeable way, lifting moral choice out of an intuitive base. Judgments of patient competence can be based on understood concepts and are not to be confused with bias held by the health care provider. Although many patients are competent to make decisions about their nursing care and health care, it is important to address those borderline areas of competency that provoke uncertainty and need formulation by nursing.

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