

Competence to Give Informed Consent for Medical Procedures

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Psychiatrists frequently are asked to evaluate patients' competence to give informed consent to medical procedures. However, there have been few studies of the types of patients referred or the degree of competence shown by these patients. Generally evaluations are made by psychiatrists with no special knowledge or training in forensic psychiatry. Moreover, the available criteria are somewhat vague, although papers by Roth¹ and Appelbaum and Roth² attempted to delineate some of these criteria.

A couple of related studies^{3,4} have shown there is severe impairment of competence to consent to voluntary psychiatric admission in newly admitted patients. Garnham⁵ showed that even in research subjects only a small number (all physicians) gave truly informed consent to a medical procedure and that the majority of subjects gave only partially informed consent or merely consent.

The doctrine of informed consent, of course, involves a sharing of decision-making power within the doctor-patient relationship and requires the doctor provide sufficient information so a reasonable patient could weigh the risks and benefits of a procedure.⁶ The patient, however, must be competent to make this decision, and the decision must be free and voluntary. Unless the patient is not competent to give informed consent, his/her refusal must be respected.⁷

Because informed consent has become a very important legal issue in all areas of medicine and because some courts are now making it an important issue even for psychiatric medication and treatment, we made a study of the types of patients referred to a psychiatrist for a determination of their competence to give informed consent to medical and surgical procedures. An additional focus of the study was to identify circumstances under which patients are referred. Such data could help in evaluating the relevance and meaning of competence to give informed consent. Sound competence assessments are essential because both consent and refusal are invalid in an incompetent patient.⁸

Theoretically, in the area of patient competence, the final decision maker is the court. In reality, however, such circumstances frequently do not occur. Often, the psychiatrist becomes the final and only decision maker because of emergency situations or because the patient may not know how to get a court hearing on this issue. Most psychiatrists who are asked to evaluate competence have no special knowledge or training in forensic psychiatry, and most forensic psychiatrists have tended to ignore the entire area of competence to give informed consent to medical procedures. Because of the relative scarcity of studies in the field and because of the increasing complexity of the issues involved, we evaluated and recorded the competence of patients referred to a psychiatric consult service.

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Method

All consultation requests made during the six months from October 1981 to March 1982 were examined where there was a request for competence when informed consent was an issue. A total of 33 consultation requests were thus obtained. After consultation, three requests were considered inappropriate in that no medical procedure was being contemplated, so 30 assessments of competence to give informed consent were made. All requests came from the nonpsychiatric wards at a Veterans Administration Hospital that is a major university teaching hospital. All patients were men; average age was 59.1 years. There was a total of 374 consults to psychiatry from these wards for all psychiatric purposes during this period. At this hospital, patients with a combination of medical and psychiatric problems generally were housed on a nonpsychiatric ward unless the medical problems were of a minor nature. If the patient was being held as an involuntary psychiatric patient or was a difficult psychiatric problem, special nursing was provided on the medical or the surgical unit. Such patients were therefore available to be included in our population. The majority of patients had a primary medical problem, but all consults were requested because of a possible psychiatric problem perceived by the referring physician. All consultations were performed by the authors, and the study was a prospective one. Although there was no formal reliability check, unclear consults were discussed among the authors.

In assessing competence, an attempt was made to apply the criteria described by Roth¹ and by Appelbaum and Roth,² but since they did not give an operational way to use these criteria or how to decide among them, some modifications were made. The criteria suggested by Roth were that a patient be determined competent by evidencing a choice, a reasonable outcome result from his/her choice, the choice be based upon "rational" reasons, his/her ability to understand, and his/her actual understanding. Appelbaum and Roth added criteria of an awareness of the stability of a patient's mental status over time, assessing the psychodynamics of refusal, and the effect of the setting. They also suggested that information provided by the patient could be incomplete as could information provided to the patient.

Since the criteria suggested by Roth and by Appelbaum and Roth were not operationalized, we used the following procedure in making the competence assessments. In accordance with Roth's suggestion, we decided on a threshold level for determining competence after considering risks and benefits of the contemplated procedure. Unless the situation were serious or life threatening, we assumed that a patient has a right to make unwise decisions and to disagree with his doctor if he is capable of weighing the risks and benefits. If the situation were life threatening and the procedure considered safe, there was presumption that a competent patient would accept treatment unless the patient could show us otherwise. Conversely, if the procedure were risky and the benefits dubious, it was assumed that a competent patient would refuse it unless the patient could give us good reasons otherwise.

Criteria for Evaluation

The elements used to assess competence were primarily those originally suggested by Roth: (1) the patient evidences a choice; (2) the choice be based upon "rational" reasons; (3) the patient's ability to understand the specific procedure being contemplated; and the present authors added (4) his ability to retain understanding. A patient who failed any of these four tests would be declared incompetent, and specific notes were written describing why we considered him incompetent. We modified the test of the patient's actual understanding in assessing incompetence as proposed by Roth.¹ Instead, without our explaining it to him, we first asked the patient to describe to us the procedure being contemplated and why it was necessary. If the patient did not understand, then we either explained the procedure to him or asked his doctor to do so, because we did not know whether the patient was incompetent or merely had received an inadequate explanation. If the patient did understand the procedure, it was considered a factor in the direction of competence.

The reasonable outcome criterion was included in determining our threshold for competence and therefore not repeated. We did consider instability of mental status, as proposed by Appelbaum and Roth,² a reason for frequent reevaluation of competence in a potentially changing patient and emphasized the nonpermanence of our assessment in such situations. Other factors, such as assessing the psychodynamics of a refusal and being aware of the setting and its effect, helped us in our consultation and sometimes in trying to change a patient's mind, but did not affect our judgments about competence. Since we had so few psychotic patients in our population, we did not have occasion to use our knowledge of a patient's psychodynamics to help change a patient's mind. We tried to cope with inadequate information provided by the patient by speaking to relatives whenever possible. We explained the procedure to the patient or asked the doctors involved to do so with us, in order to help with the not infrequent situation where inadequate information had been presented to the patient.

We did not expect the patients to be able to understand all the technical details of the proposed procedures, which included all types of medical and surgical procedures at a general hospital, but we did expect them to be able to understand the overall proposed procedure as well as the significant risks and benefits.

Results

During this study, as shown in Table 1, only patients with organic brain syndromes were found to be incompetent. Despite the differing criteria we were prepared to use, patients judged incompetent in our population were always

Table 1. Assessment of Patients Referred for Competence

	Competent	Incompetent
Organic brain syndrome	7	10
Depression	6	0
Schizophrenia	2	0
Personality disorder or no psychiatric diagnosis	5	0

found to be incompetent because they were unable to understand the risks and benefits of a procedure or to retain that understanding. Sometimes patients were judged incompetent because their choice was not based on rational reasons, but such patients in our population also always demonstrated an inability to understand or to retain that understanding. There were no patients in our population who based their decision on irrational reasons who did not also have an inability to understand or to retain that understanding. In other words, all patients judged incompetent because of psychotic reasoning or delusions had organic brain syndromes. All patients in our population evidenced a choice. There were a few cases where it was believed the patient's mental status could change with time and his competence could therefore also change in either direction.

A chi-square test was performed comparing patients with organic brain syndromes and those with all other diagnoses regarding competence, and it was found to be statistically significant ($\chi^2 = 3.83$, $df = 1$, $p < .05$). There was thus a significant difference between the competence assessments for patients with organic brain syndromes and all other patients.

As shown in Table 2, many more patients who refused medical treatment were referred for evaluations of competence than were patients who accepted treatment. Of the 23 patients who initially refused consent, 7 changed their minds and agreed after consultation. Diagnoses of those who changed their minds were: depression, 4; organic brain syndrome, 1; and no psychiatric diagnosis or personality disorder, 2. All these patients were considered competent. No originally consenting patients changed their minds and refused subsequent to consultation.

Case Examples

Patient A A 31-year-old quadriplegic psychotic patient was receiving Haldol for his paranoid schizophrenia. He required surgery for closing of a sacral sore resulting from a sacral decubitis. He was a patient of the spinal cord injury service. His schizophrenia was well controlled with Haldol, and he showed no abnormalities except for flattened affect. He was able to understand the circumstances requiring surgical intervention and could appraise the risks and benefits of surgery. Consultation had been requested to check out the patient's competence as part of clearing him for surgery. We considered him to be competent to give informed consent.

Patient B An example of a patient with a situational depression who was considered by us to be competent was a 60-year-old man with a severe peripheral vascular disease with resultant left below-the-knee amputation. He had had multiple cerebrovascular accidents with residual hemiparesis and expressive aphasia. He was admitted to a medical ward with congestive heart failure and pneumonia. Consultation was requested to determine the patient's competence to give informed consent to or to refuse treatment. He had been refusing medications and

Table 2. Acceptance of Treatment by Patients Referred for Evaluation.

	Refused Consent	Consented	Other
Number	23	5	5

therapy for his aphasia because he wanted to die. At first he refused to communicate, stating only that he wanted to die but later did cooperate when informed about the purpose of the interview. All questions had to be posed so the patient could answer "yes" or "no," because of his aphasia. He was eating during the interview and showed no signs of psychomotor retardation, although he did become tearful on occasion. There was no past history of depression.

The medical resident indicated that the patient's family had no interest in him and had requested "no code" on him. The patient appeared to understand the procedures the doctors wished to perform, but he merely wished to be left alone, didn't care whether he lived or died, but wanted an end to his discomfort. He appeared to understand the risks and benefits of treatment, not to be suffering from a major depression, and also not to be suffering from a temporary situational depression, having been in this state of mind for some time. His depression appeared reality based and not to involve an unrealistic appraisal of his situation. He was evaluated as competent to give informed consent to or refuse treatment.

Patient C Another example of a patient with depression who was considered by us to be competent is a 36-year-old man who had taken an overdose of Elavil 24 hours previously and was admitted to the medical intensive care unit. He described his suicide attempt as a means of getting back at a girl friend who had left him, but he now believed she was not worth killing himself over. He denied vegetative signs of depression or current suicide intent. We explained the desire of his physicians to observe him further and the risk of arrhythmias. He said he was feeling fine, had never really meant to kill himself, wished to take his chances outside the hospital, and would return for outpatient care. Under California law he was not eligible to be put on a psychiatric hold for involuntary psychiatric hospitalization insofar as he was convincing that he was no longer acutely suicidal. He also was competent to consent or to refuse medical treatment since he was able to weigh the risks and benefits. Although we thought his decision to leave was not wise, it was informed and not, in our opinion, based on his depression or other psychiatric illness. He was permitted to sign out against medical advice.

Patient D Consultation was requested for a 63-year-old man on a urology service because the patient kept pulling out his IVs and refusing therapy. The patient explained to us that he thought the IVs were causing his diarrhea. He said he had asked the nurse to pull it out the previous night and did so himself when she refused. He also was worried that he could have cancer, since he had had cancer of the prostate. There was no evidence that he had cancer, and he was merely being evaluated because of persistent infection. He responded well to reassurance and agreed to cooperate with the treatment. He was able to appreciate risks and benefits of treatment and had no mental disorder other than some anxiety secondary to hospitalization. We believed the patient to be competent and only in need of having his medical problems and treatment clarified by his physician.

Patient E An example of a patient with a mild organic brain syndrome who was considered competent is a 65-year-old man with cancer of the bladder, referred from urology for competence evaluation. He had refused an indicated total

cystectomy. We found he did not understand the alternatives. We explained that the best prognosis was with surgery and that radiation was possible but less ideal. After a full explanation, he consented to surgery. He knew the year but was off by one month on the date. He knew the name of the hospital and the general area but forgot the name of the specific city. He knew the President and could do serial sevens. Although he had some signs of mild dementia, possibly secondary to alcoholism, he was able to weigh the risks and benefits and was able to remember our discussion 30 minutes later.

Patient F A 55-year-old man from a medical ward suffered with aortic insufficiency, aortic stenotic heart murmurs, and a recent history of fever and upper respiratory symptoms. He was being worked up for subacute bacterial endocarditis. Consultation was requested to determine the patient's competence after he asked to leave the hospital. On mental status examination he was generally incoherent with nongoal-directed statements. He was oriented only as to person with clear sensorium without fluctuation. His recent memory was severely impaired. He did not comprehend the current facts of his case or his current medical condition, and he was unable to appraise possible outcomes. He was considered to have a dementia and to be incompetent to give informed consent or to refuse treatment.

Patient G Another example of an incompetent patient was a 61-year-old man from a medical ward who wanted to leave the hospital. Medical procedures were necessary to determine the possible presence of cancer of the lung. On mental status, the patient knew his name and the place but believed the year to be 1948 or 1949. He did not know why he was in the hospital and could not remember an explanation about possible cancer that had been given by us as well as by his ward physicians. He said he wished to leave because no one was doing anything for him. Our diagnostic impression was of senile dementia and that he was not competent to give informed consent or to refuse treatment. He was unable to weigh the risks and benefits of treatment because he could not understand the procedures or retain that understanding.

Patient H A different example of an incompetent patient was an 88-year-old man who was found to have a large left frontal mass. He also had Parkinson's disease, peptic ulcerative disease, as well as a history of a cerebrovascular accident. Consultation was requested by the surgery resident prior to surgery to remove the frontal tumor. This request was made even though the patient consented to surgery. The patient showed no ability to understand his current medical condition. He was not able to appreciate the risks of surgery in a man his age with his medical problems, even after they were carefully explained to him. He believed he would be fine without any evidence to support his optimism. He was oriented to person, place, and situation but was off on the date. Recent and remote memory showed some problems, but none that would be significant in an 88-year-old man. However, we believed he had a mild dementia interfering with his ability to appreciate the risks of surgery for him at his age. Because of the high risks and questionable benefits of the procedure, we decided there was a high threshold for competence to consent to this procedure. In our opinion, he did not meet this threshold and was incompetent to give informed consent to this procedure.

Discussion

This study indicates that in this VA population the overwhelming number of patients declared to be incompetent had organic brain syndromes. In fact, during the period under study, they were the only patients found to be incompetent. It surprised us that there were so few schizophrenic patients even referred for evaluations for competence to give informed consent, and there were no referrals with bipolar disorder. It also was striking that during the study, no schizophrenic or depressed patients were found to be incompetent. Both schizophrenic patients in our population consented to treatment and were referred only to check out their competence, and we found them competent.

Explanations of these findings include several possibilities. Perhaps schizophrenic, depressed, and bipolar patients may be more competent to consent to medical treatment than generally is assumed. Possibly it is not as common for their delusions (or denials) to affect their beliefs about medical treatment, although these delusions may frequently affect their beliefs about psychiatric treatment. Further study of this possibility is indicated. Perhaps there is a tendency for internists and surgeons to wait until a psychotic patient is under control before going ahead with medical and surgical procedures, which could account for the absence of referrals of incompetent psychotic patients. The findings cannot be explained by an assumption of an absence of psychiatric patients in this population since there were 374 consults during this period for some type of perceived psychiatric problem.

The authors have seen schizophrenic patients who were too delusional to give informed consent to medical treatment and also bipolar disorder patients who were too manic to give informed consent, but surprisingly no such cases were seen during the study. Such cases may be rarer than generally is supposed. It also is possible that the relatively advanced age of the VA population resulted in a large percentage of organic brain syndromes, but younger patients and patients with other psychiatric disorders were represented. Patients with psychiatric problems were present on the medical and surgical wards. All of the 374 consults to psychiatry were referred for some type of psychiatric problem.

Many more patients were referred who refused medical treatment than who accepted it. This finding implies either that incompetence leads to a much larger number of refusals than acceptances of treatment or (more likely) that referrals for psychiatric evaluation tend to be made primarily when a patient refuses treatment. Acceptances may be taken at face value as competence by internists and surgeons, without any attempt to look beneath the surface to see whether truly informed consent has occurred. As a result, we may have seen a biased sample that led to an underestimation of the number of truly incompetent though quietly consenting patients. Even if this possibility is so, it is remarkable that all the schizophrenic and bipolar patients in the hospital during this study consented to their medical treatment even if their consents were uninformed or merely passive.

Summary

This study shows that referrals to psychiatry for evaluation for competence to

give informed consent generally were made on patients who refused medical treatment. In this sample of referred patients, the only patients found to be incompetent to give informed consent were those with organic brain syndromes. No one with either schizophrenia or depression was found to be incompetent. It is possible that schizophrenic and depressed patients may generally be competent to give informed consent to medical treatment. This finding might be true notwithstanding the fact that many such patients have been found in other studies^{3,4} to be incompetent to consent to voluntary psychiatric treatment. For example, a patient may have delusions that others can read his mind and thoughts, but he still can understand that he needs dialysis for renal failure. Alternatively, it may be relatively rare that an emergency procedure is necessary before a patient's psychosis can be brought under control and consequently internists and surgeons themselves may prefer to wait.

The significance of the results is unclear. Because of active interest in the doctrine of informed consent for psychiatric and medical patients by both physicians and attorneys and the few studies within this population, there is a strong need for more study regarding competence to give informed consent. Further study is especially important for psychotic patients for whom psychiatric consultation is not requested. If it is true that psychiatric patients are more competent to give consent than is generally acknowledged, it would raise serious questions about states in which guardianships and conservatorships or involuntary hospitalization can automatically lead to considering patients incompetent to give informed consent to medical procedures solely because they are incompetent for other purposes (for example, providing food, clothing, or shelter).⁹ If it is true that many incompetent patients are not referred for psychiatric consultation merely because they passively consent to whatever the doctors suggest, it would raise further serious questions about the validity of so-called "informed consent" for these consenting patients.

Though this study cannot give definitive answers to these questions, or decide between the possibilities, it does highlight the need for more research so that policy and legal decisions can be based on factual information and not on legal fiction or misinformation. We need to obtain more data regarding the competence of psychiatric patients to consent to medical procedures so we can determine whether psychiatric patients are actually less competent than other patients to consent to such treatment, particularly when the medical illness does not fit into their delusions.

We also need further studies of the competence of consenting patients who are not referred for psychiatric consultation since it is possible that many quiet schizophrenics may passively consent to medical treatment but do so for psychotic reasons. Consequently, they may not truly be competent at all. Though our study cannot answer many of these questions, we have pointed out the substantial need for furthering their exploration. Forensic psychiatrists, in particular, should be addressing these matters although most competence issues currently are being evaluated by psychiatrists with no special knowledge or training in forensic psychiatry. Although routine determinations of the issues may be quite simple and

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not usually an area of special concern to forensic psychiatrists, we consider this situation not significantly different from other types of competence evaluations such as competence to stand trial or testamentary capacity, which frequently involve psychiatrists with special forensic expertise. Forensic psychiatrics can play an important role as consultant when frequent legal complexities arise, and thus help psychiatrists and other physicians deal with confusion about the issue of competence to give informed consent for medical procedures.

References

1. Roth LR, Meisel A, Lidz CW: Tests of competency to consent to treatment. *Am J Psychiatry* 134:279-84, 1977
2. Appelbaum PS and Roth LR: Clinical issues in the assessment of competence. *Am J Psychiatry* 138:1462-67, 1981
3. Appelbaum PS, Mirken S, and Bateman A: Empirical assessment of competency to consent to psychiatric hospitalization. *Am J Psychiatry* 138:1170-76, 1981
4. Olin J and Olin H: Informed consent in voluntary mental hospital admissions. *Am J Psychiatry* 132:938-41, 1975
5. Garnham J: Some observations on informed consent in non-therapeutic research. *J Med Ethics* 1:138-45, 1975
6. Meisel A, Roth LR, and Lidz CW: Toward a model of the legal doctrine of informed consent. *Am J Psychiatry* 134:285-89, 1981
7. Faden L and Faden R: False belief and the refusal of medical treatment. *J Med Ethics* 3:133-36, 1977
8. Stone AA: Informed consent: Special problems for psychiatry. *Hosp & Comm Psychiatry* 30:321-27, 1979
9. Morris G: Conservatorship for the "gravely disabled": California's non-declaration of non-independence. *Int'l J Law & Psychiatry* 1:395-426, 1978 □