Defining a Clinically Useful Model for Assessing Competence to Consent to Treatment

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Burdened with the responsibility of making an initial assessment of their patients' capacity to make treatment decisions, clinicians need a sound clinical assessment model. Drawing on ethical, legal, and clinical sources, the author reviews the appropriateness of existing models and standards and describes why each fails the needs of the clinician. The patient's ability to form a therapeutic alliance is shown to be a valid assessment model for defining a treatment decision-making ability threshold because it adheres to widely accepted ethical and legal standards. Using this model to set a threshold for the decision to bring cases to the attention of a court or administrative body, the therapist arrives at a satisfactory balance between competent treatment, patient autonomy, and judicially mandated due process imperatives while providing a forum for patient education and assessment of the clinician's technical skill. Explanations of case examples illustrate the use of the therapeutic alliance for this purpose in a variety of clinical situations. Specific recommendations are made on what may be represented to court in cases in which the patient's competence appears to fall below this treatment threshold.

Seventy years ago, Judge Cardoza proclaimed all people of adult years and "sound mind" are competent to make decisions concerning their bodies in the situation of medical treatment,[1] This principle has been affirmed in modern writings.[2,3] Unfortunately, there has not been a scholar of jurisprudence, medicine, or ethics who has usefully described what constitutes a sound mind for treatment decision making.

The clinician must raise the initial question of the patient's capacity to make treatment decisions. This is a distressing task for the clinician in view of the present lack of clinically useful criteria, models, or instruments for ascertaining a patient's capacity. Lacking guidelines, a clinician wanting to be certain a person is competent to make treatment decisions may seek judicial review for every patient. This would be unwieldy at best. Alternatively, the clinician might assume a completely "libertarian" approach and regard every person as competent. This approach leaves the clinician open to legal action because he or she may be held liable if a patient is treated as competent and a court later declares that the patient was *de facto* incompetent at the time of consent.[4,5] Neither extreme approach ill do.

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It is necessary to identify a model that can be applied by a clinician to assess a patient's decision-making capacity. This initial clinical assessment will only serve a "threshold" function. Adult patients should be assumed competent. Therefore, patients assessed to fall below the threshold of decision-making capacity will be referred to a court or administrative body for a formal determination of treatment competence. I recently articulated a clinically useful model for defining this threshold.[6] Here, the ethical and legal foundation for using the model is explored in more detail, the model is shown to provide the ancillary benefit of assisting in the assessment of the clinician's competence, and the explanations in the case examples illustrating how the model can be used are amplified.

Ethical Considerations

Two ethical approaches are commonly cited as being basic to a decision-making process.[7] The deontological approach considers a correct final decision to necessarily follow from a correct reasoning process. The other pertinent concept is the utilitarian approach, which asserts that one should determine what constitutes a desirable outcome and then act in a manner that allows one to reach it.

If the assessment of competence to make treatment decisions is based on the deontological concept, judgments will need to be made about what is rational or irrational about the person's reasoning, about the quality of the person's fund of knowledge, and about one's idiosyncratic beliefs. When the utilitarian approach is used there is a strong tendency to assess the person's competence by considering whether the treatment decision allows for an outcome that the examiner determines to be in the patient's "best interest."[8] In either case, personal autonomy is undermined under the guise of assessing competence; the patient is told which attitudes or treatment decisions are acceptable.

In 1983 the Supreme Judicial Court in the Commonwealth of Massachusetts articulated a view relating to patient treatment decisions[9] that affirms the dictum of Judge Cardoza and has recently been echoed by other state courts.[10,11] The court held that each person has a right to make treatment decisions according to his or her own values and asserted that a person has the right to make "wrong" choices concerning medical treatment. Although one may feel uneasy about having the court shape the ethics of our society, these judicial views imply a third ethical approach to the assessment of a decision-making process. In the circumstance of making treatment decisions, a decision should be assessed according to the person's particular system of personal, cultural, and social beliefs and not by the value system of the observer.

In the health science literature the individual's array of personal, cultural, and social beliefs is known as the person's health belief system.[12] If the person is able to express his or her health belief system in the context of making treatment decisions, it is appropriate, based on this third ethical approach, to assume

that the patient is competent even though we, as professionals or humanitarians, may consider the person's reasoning faulty in some way or dislike the outcome of the treatment decision.

This concept provides the ethical foundation for a model that can be used by the clinician to identify a treatment decision-making ability threshold. A model based on this ethical approach will tend to enhance patient autonomy and guard against paternalism without precluding genuine compassion on the part of the clinician.

Existing Legal Assessment Criteria

In general, the legal criteria advanced for the assessment of treatment decision-making capacity does not guide the clinician with precision. Judicial opinion and laws concerning the person's competence in treatment decisions as well as other functions include vague terms such as "understand," "have a rational understanding," or a "clear capacity."[13,14] Basing their opinion on the findings of various courts in a variety of cases requiring a judicial determination of competence (contracts, wills, refusing treatment, standing trial), two authoritative authors[15] in the legal perspectives of determining treatment decision-making competence conclude ". . . the most precise concept of competence that we will be able to develop (is whether or not a person has) the capacity to understand and appreciate the nature and consequences of one's acts . . ." (p. 153). The inherent vagueness in this definition is acknowledged as the authors note that the determination of competence, although purported to be a question of fact (that is, an issue to be determined by a judge), is ". . . likely to be based upon a value judgment (of the court)" (p. 154). If a clinician were to use the vague standards of the court to identify a patient's decision-making ability threshold, the clinician would be treading dangerous ground. He or she would, in effect, be obliged to judge the person's treatment decisions by his or her own value system.

It appears that the court is reluctant to define the clinical parameters of treatment decision-making capacity. The Massachusetts Supreme Court decision discussed earlier[9] does not define what constitutes treatment decision-making competence even though the whole decision is driven by this concept. The court appears satisfied to let the clinician determine the threshold that will define which patients should be referred for judicial assessment of competence.

Some legal criteria for the evaluation of competence to make treatment decisions are clearly irrelevant. In a memorandum from the Chief Justice of the Probate Court of the Commonwealth of Massachusetts[16] and in the *Rennie v. Klein* decision,[17] the "dangerousness" of the person was cited as one element to be considered when assessing the patient's capacity to decide treatment. This is a distressing example of the court using an issue—here, competence to make treatment decisions—to exercise its police control power.

The legal system has identified a standard for the assessment of one form

of competence that can be applied to the present question. Consider the legal criteria advanced for the determination of a defendant's competence to stand trial. In *Dusky v. US*[18] it is stated that a defendant is competent to stand trial if he or she can consult with his or her attorney in his or her own defense. Being able to stand trial is an important function. It is a serious mistake to try a defendant who is really not competent. I suggest that the liberty and autonomy interests involved in the issue of competence to stand trial (guilt, incarceration) are at least as great as those involved in the administration of treatment (including antipsychotic medication). Therefore, the ability of a patient to consult with his or her doctor on his or her own treatment should represent a satisfactory standard for treatment competence because a defendant's ability to consult with his or her attorney in his or her own defense is taken as a standard for competence to stand trial in the serious situation of criminal proceedings.

From a legal perspective, the threshold that can be used by the clinician in the initial assessment of treatment decision-making capacity may legitimately be founded on a standard that related to the patient's ability to consult with the doctor (clinician) in his or her own treatment. This standard requires that the treatment decision-making capacity threshold assures that the patient has the ability to express his or her health belief system. By doing so, the patient will be able to define the parameters of his or her health problem and the treatment goals and strategies will be mostly free from the value judgments of the clinician.

Existing Clinical Assessment Criteria

Laudable attempts to organize a conceptual framework for the assessment of competence include that of Roth, Meisel, and Lidz.[13] The standards proposed by these authors were discussed, slightly refined, and generally supported by Beauchamp and McCullough.[19] The least rigorous standard for determining competence is that of "evidencing a choice." This standard is immediately seen to be inappropriate for the process of treatment decision making. Suppose a person grunts and smiles when shown a blue, but not a yellow, pill. Being stimulated by blue rather than yellow hardly indicates the patient possesses a treatment decision-making capacity. Another standard of assessment requires the patient to make a decision leading to a "reasonable" outcome. Such a standard is based on an assessment of the person's decision outcome. If the clinician used this standard to set a threshold, he would be judging the patient's competence by substituting his or her values (health belief system) concerning a "good" outcome for those of the patient. Three other suggested standards for determining a patient's competence are based on the assessment of one's "understanding" or "ability to understand" or on whether the decision is based on "rational reasons." These standards require an assessment of the "goodness" of the person's decision-making process and therefore will once

again cause the clinician to impose his or her health belief system on the patient. In addition, assessing a person's competence by considering undefinable terms such as "understanding" and "rational" or by considering what constitutes sufficient "ability" forces the clinician to enter the "nonmedical" (unpsychiatric) realm of values, mortality, and arbitrary thinking.[20]

Accepting that any criteria relating to treatment decision competence will require some brush with caprice, it is necessary to minimize the use of undefinable terms.

Recently, some authors have suggested the standard used by the clinician in the initial assessment of the patient's capacity to make treatment decisions should change in relationship to the gravity of the decision being made and the clinical condition of the patient.[21,22] By doing this, the clinician will multiply the places in which he will necessarily inject the values of his own health belief system into the system of the patient. The clinician will necessarily make a (nonmedical) value judgment concerning the goodness of the patient's decision-making process and about what constitutes a "grave" and what a "not so grave" outcome. Assessing the patient's capacity to make treatment decisions according to a varying standard is tantamount to changing the rules in the middle of the game. Changing the level of competence needed in this manner allows the clinician, court, family, or "advocate" to intrude in the person's life virtually on whim. A valid model for the clinician in the initial assessment of treatment decision-making capacity must be based on an invariable standard.

The extant clinical assessment models and the standards on which they are based cause clinicians to overtly or subtly superimpose their value systems on those of their patients' by requiring that judgments be made concerning the rationality of the decision or the acceptability of the decision outcome. A suitable clinically useful standard and assessment model must rest on the legal and ethical standards for the assessment of treatment decision-making competence as described earlier in this article.

Defining the Required Features of an Assessment Model

I have shown that ethical and legal perspectives support the use of a clinical model for determining a threshold of treatment decision-making ability based on an unvarying standard comprised of two moieties. The legal component requires that this standard reflect the person's ability to consult, or work with, a doctor (clinician) in the business of treatment. The ethical component demands that the standard assess patient's treatment decision-making capacity by considering their ability to express their individual desires concerning treatment goals and strategies (i.e., their health belief systems) even if these beliefs lead to outcomes that the clinician considers unfortunate.

The clinically useful assessment model must allow only very few false-positive determinations of competence and it must allow the clinician to view the patient's treatment decision capacity

as not being solely related to factors of the patient because factors arising from the clinician, patient-therapist relationship, and the general environment have been shown to lead to errors in the assessment of competence.[23,24] The model must provide the patient an opportunity to trust the therapist to the degree the patient deems appropriate while clearly establishing that "trusting" is not synonymous with "submission." Cognitive functions (intelligence, memory, attention, concentration) and emotional factors (hopelessness, grandiosity, paranoia, rage), and the effect their complex interplay will have on the person's ability to engage in treatment decision making must be assessed through the model. The chosen model must allow the assessment of capacity to be documentable and explainable to the court or administrative body that will render the final determination of treatment decision-making competence. The model must address the dilemma of patients who, because of their illness, deny they suffer a problem or illness of any sort.[25]

The clinically useful model that allows for the definition of a treatment decision-making capacity threshold and is based on the legal and ethical standards previously described is the evaluation of the patient's ability to form a therapeutic alliance.

Therapeutic Alliance as a Treatment Competence Assessment Model

The therapeutic alliance may be defined as the interactive process between the patient and therapist that develops from the patient's need or desire to solve a health problem and the therapist's need or desire to assist the patient in this endeavor.[26] The therapist works to assist the patient to identify and solve problems. Treatment alternatives cannot be usefully considered by the patient without the establishment of this alliance.

Although the therapeutic alliance was initially described in outpatient psychoanalytic relationships, the importance of the constituent elements of the alliance (real relationship and working alliance between the patient and therapist) has been appreciated by a wide array of schools of therapy.[27] An alliance with some combination of real relationship and working relationship elements must be formed before any treatment can occur regardless of the site (inpatient[28] or outpatient, public or private), length of treatment (brief term, psychoanalytic, or pharmacology consultation), type of therapy (dynamic, cognitive, psychopharmacologic, or general medical), or therapeutic issue, including an assessment of dangerousness.[29]

There is no need for the therapist to substitute his or her values for the patient's treatment decisions when using the therapeutic alliance to define the competence threshold. The therapist will only be evaluating the patient's ability to engage in the process of identifying a health problem, deriving a treatment strategy, and working toward a treatment goal. The successful development of a therapeutic alliance will imply the patient has one of an infinite number of combinations of quantity and quality of

information and the general cognitive and emotional functions sufficient to decide which health problems and treatments are worth pursuing. Delusions, paranoia, ambivalence, and withdrawal as seen in schizophrenia; grandiosity as seen in bipolar illness; constant rage, projection, and denial as seen in borderline personality disorder; denial and irritability as seen in dementia; or hopelessness as seen in depressive syndromes may possibly (but certainly not necessarily) result in a patient being unable to form an alliance.

A therapeutic alliance is not synonymous with the patient's complete passivity in accepting the clinician's pronouncements. Such passivity would suggest the patient is not competent to make treatment decisions. A good alliance is in evidence when the patient is able to question and disagree with the therapist and free to decide how much to trust or accept the therapist's recommendations.

Another benefit realized by using the formation of an alliance as a model of competence is that it allows a process to develop through which the patient can become better informed about the treatment proposed by the therapist and thus enhance informed consent.[30,31] All existing competence evaluation models, in my opinion, strongly urge the therapist to view consent/competence assessment as "one-shot" affairs.

If a therapeutic alliance fails to develop, it is important to recognize that this may be due to some factor from the therapist, the environment, the patient-therapist relationship, or the patient.[26] The clinician will consider that the patient may not have sufficient treatment decision-making capacity only if the failure to form a therapeutic alliance is mainly due to some factor of the patient.

Using the formation of the therapeutic alliance as the model for determining a threshold level of treatment decision-making ability provides a method of assuring that the therapist has the requisite skills needed to engage and assist a patient. The therapist's skill in working with the patient to develop an alliance can be tested through a variety of valid and reliable instruments. These tests demonstrate education can improve the ability of the clinician to work with the patient. Thus, it can be documented that a particular therapist has an excellent ability to form an alliance with patients in general.[32] This will add credence to a clinician's assessment that a particular patient's inability to form an alliance is most likely due to some factor of the patient's character rather than that of the therapist.

It is often assumed that psychiatric patients are not as capable as medical patients to make such decisions simply due to the nature of their illnesses.[33] There is strong evidence, however, that psychiatric patients, as a population, acquire information as well or as poorly as other medical and surgical patients.[23,34–37] As elucidated in studies of hospitalized medical[38] and psychiatric[39] patients, the vast majority of medication refusals in these settings are due to some strain in the therapist (doctor, other staff)-patient interaction. Psychiatric patients do not refuse medications more frequently than

medical patients. Treatment refusals by psychiatric patients are only infrequently a substantial or direct result of their mental dysfunction.[39] By using the development of the therapeutic alliance as the model of assessment, attention will be drawn to the importance of the clinician-patient relationship. This will certainly serve to ensure that effective, humane treatment occurs in an atmosphere of respect and opened communication.[32]

Practical Application of the Model

The theoretical basis for using the formation of the therapeutic alliance as a model to define a treatment decision-making ability threshold has been outlined in some specific terms. Some case examples will help illustrate how the alliance provides a useful practical model for this purpose.

Case 1 A young man was admitted for hostile outbursts in his community residence. He started to refuse his medication regime after a trusted staff member left. When approached by the psychiatrist, he yelled threats of physical assault and proclaimed that the staff was changing his medicine into poison. After six attempts to establish an initial alliance, including two by another psychiatrist, the primary psychiatrist concluded that the patient was not capable of establishing a working relationship that would allow the patient to consult the doctor in the business of treatment. In court, the patient's threatening, verbally aggressive behavior was described. It was pointed out to the court that more than one psychiatrist was unable to engage the patient in a meaningful discussion of the problems experienced by the patient or of the goals or possible strategies of treatment.

The person's ability fell below the necessary threshold of treatment decision-making capacity as defined by the therapeutic alliance model. His behaviors prevented him from expressing his health belief system and from consulting with the psychiatrist in the tasks that were relevant to his treatment. The behaviors, physical and verbal, could be concretely documented in the chart. It would be noted in the record's progress notes that the person stated his problem was that the staff at the residence was changing his medicine into poison, that his goal was to purify his body, and that he wished to accomplish this (strategy) by bringing the residential staff to justice in the Lord's court. His angry, threatening manner and inability to talk to anyone for more than a few minutes should be recorded. Because more than one psychiatrist failed to establish an alliance it can be suggested that the situation is due to the state of the patient's mental functioning rather than to some particular personality conflict between the psychiatrist and the patient or to the technical ineffectiveness of the doctor.

Case 2 A 26-year-old woman was admitted after police brought her to the emergency room. She was found huddled on a doorstep during a frigidly cold night and would not respond to the police officer's query about her present well-being. Alcohol use was not in evidence. She was pleasant and exhibited some loosening of her thought associa-

tions during the interview. She denied living in the doorway and denied all problems. She simply stated that there was nothing wrong and that there was therefore nothing to talk about. At the very least, she should have mentioned that there was a problem about her situation in the street that caused the police to interfere in her life. It would have been sufficient for her to state that all she wanted was to be able to stay out of the way of the police. Alternatively, she might have focused on her need for shelter or food.

After a number of attempts, and assessment by another psychiatrist, the primary psychiatrist concluded that the patient was not able to engage in an exploration of her situation. The woman's treatment decision-making capacity fell below the necessary threshold ability. Therefore, the woman should be brought to court for a determination of competence. The court might decide that her apparent denial and refusal to engage in an exploration of the problems she faces is really an expression of her appreciation and understanding (the commonly used legal criteria for competence) of her situation and of the consequences of her decision. The court would then find her competent. Alternatively, the court might agree that her behavior indicates an inability to assess her situation and declare her incompetent to make treatment decisions. The decision rests with the court. The apparent failure of the woman to establish a therapeutic alliance due to her psychiatric illness only provides a threshold for the clinician to use in deciding which patients to bring to court for a competence determination. The threshold, when properly applied, is not too high, which would negate the presumption that most adults are competent, or too low, thereby assuring that patients who are really not competent are not being treated.

Case 3 A 36-year-old man had a variety of bizarre thoughts concerning his powers to communicate with aliens. His manner of dress was odd and he was withdrawn from most social interactions. He had not worked for eight years and lived with his mother. Hospitalization occurred for want of an alternative place to live when his mother died. After a few days, he was able to talk rather openly with the therapist. Many of his bizarre thoughts came to light. There was no evidence to suggest that he was bothered by his lifestyle. He felt it was not in keeping with his message from the universe to take medication on a continuous basis although it was all right to take a short course of antibiotics or an occasional aspirin. The psychiatrist suggested that medication might help improve his ability to negotiate the demands of living independently. The patient refused such treatment, remarking that he would rather stay in the hospital if necessary than take the medication on a long-term basis.

A person can harbor all sorts of strange ideas and fears and retain the ability to make treatment decisions. What is important is whether the person can define and express his or her desires concerning treatment decisions and engage in a working relationship with a

therapist around the issue of possible treatment goals and strategies. This patient clearly remained above the treatment decision-making ability threshold defined by the formation of the therapeutic alliance. He was able to engage in an alliance with the psychiatrist that allowed for an exploration of his health problems, possible treatment goals, and alternatives. It was appropriate to consider his treatment decision to refuse medication a competent one even though the therapist opined that it was plausible even probable that the medication would improve his opportunity to function independently.

Discussion

Mental health professionals have the responsibility of making an initial assessment of their patient's capacity to make treatment decisions. Existing models are not clinically useful. The patient's ability to form a therapeutic alliance is shown to be a valid assessment model for defining a treatment decision-making ability threshold because it adheres to widely accepted ethical and legal competence assessment standards. Using this model to set a threshold for the decision to bring cases to the attention of a court or administrative body, the therapist arrives at a satisfactory balance between competent treatment, patient autonomy, and judicially mandated due process imperatives while providing a forum for patient education, informed consent, and assessment of the clinician's technical skill. The case examples illustrated how the clinician should use the therapeutic alliance for this purpose and what may be represented to court in those cases in which the patient appears to fall below the competence threshold as determined by the model. This clinically applicable model releases the therapist from the burden of making impossible legal or ethical decisions concerning the patient's capacity. The ethical dilemma remains, however, of how and when, if ever, the state should exercise its *parens patriae* or police powers in the situation of medical treatment.

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