



The Narrative Coherence Standard and Child Patients' Capacity to Consent

Gah-Kai Leung

To cite this article: Gah-Kai Leung (2020) The Narrative Coherence Standard and Child Patients' Capacity to Consent, AJOB Neuroscience, 11:1, 40-42, DOI: [10.1080/21507740.2019.1704933](https://doi.org/10.1080/21507740.2019.1704933)

To link to this article: <https://doi.org/10.1080/21507740.2019.1704933>



Published online: 03 Feb 2020.



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husband” and a history of “intermittent [sic] depression” (7).

If Harriet fails to meet the criteria of appreciation and reasoning, as we have argued, the four criteria suffice to explain the reason that she lacks competence to consent to ECT. In this respect, the narrative coherence standard adds nothing at all.

FUNDING

This research is part of the international and interdisciplinary project ENSURE (2016-2019) and is supported by a grant from ERA-NET Neuron and the German Federal Ministry of Education and Research (grant number 01GP1623B).

ORCID

Matthé Scholten  <http://orcid.org/0000-0001-8000-8974>

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AJOB NEUROSCIENCE
2020, VOL. 11, NO. 1, 40–42
<https://doi.org/10.1080/21507740.2019.1704933>



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The Narrative Coherence Standard and Child Patients' Capacity to Consent

Gah-Kai Leung 

University of Warwick

Aryeh Goldberg (2020) compellingly argues for a Narrative Coherence Standard (NCS) to bolster existing methods of assessing patients' mental capacity. But his account fails to distinguish between the cognitive abilities of children and adults; consequently, worries

may be raised about the scope of the NCS, in particular when we consider child patients. In this article, I argue the NCS cannot plausibly apply to children. Since children's self-conception does not arrive fully formed—but rather is a product of both incomplete cognitive

CONTACT Gah-Kai Leung  Gah-Kai.Leung@warwick.ac.uk  Politics and International Studies, University of Warwick, Gibbet Hill Road, Coventry CV4 8UW, UK.

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development and socializing factors—I claim children may not possess a sufficiently intimate knowledge of self, and therefore a sufficiently coherent sense of self, as Goldberg demands. Therefore, we should either revise the NCS to accommodate children, adopt an incremental view of consent, or revert to the relevant form of the MacArthur competence criteria to establish children’s capacity to consent.

First, I want to clarify the meaning of “children”. Following common-sense usage, I define children as individuals below the standard age of majority of 18 years. By this, I do not mean to suggest a sharp distinction between the characteristics of childhood and adulthood (cf. Hannan 2018, 117); for example, in England and Wales the legal age of mental capacity is 16 rather than 18 (*Mental Capacity Act 2005*, 2). I merely suggest an upper limit beyond which my argument will not apply. Indeed, this essay may have implications for adults with a mental age comparable to young children. However, I do not discuss the implications of the NCS for such cases at length.

Now, we should review Goldberg’s argument for the NCS. This is meant to supplement the existing MacArthur competence criteria, which are: understanding of relevant information; communication of choice; rational assessment of costs and benefits; appreciation of consequences (Goldberg 2020). To motivate his argument, Goldberg presents the cases of Harriet and Jim to highlight deficiencies in the current medico-legal framework of mental capacity. On the MacArthur criteria strictly interpreted, Harriet and Jim could justifiably consent to refuse medical interventions; yet we intuitively believe that treatment ought to have continued for them. Thus, according to Goldberg, the MacArthur criteria are necessary but not sufficient to establish mental capacity. (See Goldberg 2020 for a fuller elaboration of these cases as I lack enough space here.)

Consequently, Goldberg adds an extra requirement: a Narrative Coherence Standard. This turns on the patient’s ability to develop an intimate conception of self through a narrative that extends over time (Goldberg 2020). This therefore enables the patient to develop mental states—beliefs, attitudes and desires—that are consistent and importantly *coherent* with that narrative conception of self. A patient passes Goldberg’s narrative coherence test when she shows how the mental states she has formed about herself—which fit with her intimate conception of self over time—are relevant to the medical decision at hand.

I will grant the force of Goldberg’s argument with respect to adults, but I am not convinced it holds when we consider children. The NCS demands we

clinically assess what Goldberg calls “the ability to govern along one’s own self-narrative” (Goldberg 2020, 11), which I interpret as an individual’s capacity to assemble the chain of events in one’s life experience into a fully-fledged coherent story. Such an ability to self-govern depends upon an intimate conception of the self for Goldberg. Yet children may not possess sufficient intimate knowledge of self as required for the NCS. Part of what it means for children to self-govern is for them to be able to self-reflect, since this enables children to reject views with which they do not identify and therefore author their own coherent self-narratives (cf. Clayton 2012, 354). But it is not obvious that children have a sufficient capacity for self-reflection. Furthermore, self-governance requires that children can distinguish the kinds of goods that they seek to value in life. The precise goods that children consider valuable will be derived from their intimate conception of self, but inevitably children will need some guidance as to what goods they ought to value in the first place (Hannan 2018, 120) and therefore they will need to be guided as to what conception of self is compatible with whichever goods they choose to value. If children lack the relevant developmental capacities for self-governance (such as the capacity for self-reflection or their ability to distinguish valuable goods), then we should doubt their ability to form coherent self-narratives.

Even if we accept children’s innate capacity for forming coherent self-narratives, as Goldberg’s standard suggests, we might worry about whether they are *independently* coherent self-narratives. I define an independently coherent self-narrative as one whose values stand apart from those transmitted through socialization and are cultivated through self-reflection. But children cannot form such independently coherent self-narratives because they are subject to powerful socializing forces, to the extent that they may even hold a false conception of self (Harter et al. 1996). One such force is parenting, which plays a crucial role in the values that children acquire (Brighouse and Swift 2006, 80, 104; Fowler 2014, 308) and therefore has enormous implications for children’s ability to form independently coherent self-narratives. Schools also exert coercive pressure on children’s worldviews and consequently help determine their adult life-projects (Schouten 2018, 351–35). Given the pervasive influence of parenting and education in molding children’s values, it is difficult to tell whether or not children are merely reproducing certain social norms through their self-narratives, especially if children do not possess the adequate self-reflection needed for their values to stand sufficiently apart from social norms.

Additionally, we should not assume that children can develop an intimate knowledge of self before they are actually ready to do so. If children can be wronged when they enjoy too little autonomy, they can also be wronged if we stray too far the other way and assume they are capable of making decisions to which they cannot yet reasonably consent (Hannan 2018, 119). This point is significant in the medical context, given that choices made in childhood can have wide-reaching implications when the patient reaches adulthood (Fowler 2014, 312). Decisions taken prematurely, especially those based on false or incomplete self-narratives, may lead to wrongful outcomes downstream.

Given the absence of a fully-developed sense of self in children, Goldberg might propose we should use a parent's or caregiver's assessment of a child patient's sense of self as a reasonable proxy. After all, it is widely understood that parents or caregivers have privileged access to the mental contents of children in their custody, such that they as proxies are capable of making decisions that will promote their charges' wellbeing (Fowler 2014, 307).

I have two responses here. First, it is not obvious that proxies have full unvarnished access to children's mental states. A proxy account of a child's mental state is even less likely to mirror that of the child concerned, as it may be affected by either: (a) ambiguity or insincerity on the child's part; or (b) erroneous memory or faulty perception on the proxy's part (Tribe 1974, 959). Second, even if it were true that proxies had full access to children's mental states, it is unclear how relying on proxy judgements of capacity would overcome the above worries about the ability of children themselves to self-govern. It is precisely that children are cognitive works-in-progress which motivated my initial objections concerning the NCS' applicability to children. These responses cast doubt on the ability of proxies to provide sufficient knowledge of a child's intimate conception of self, in order to meet Goldberg's test.

If my argument is persuasive, we should be skeptical of the NCS' applicability to children. What, therefore, should be done? We could revise the NCS to account for children, though it may face further objections not already mentioned. Alternatively, we might propose an incremental view of consent, whereby children may consent to an increasing range of things as their intimate knowledge of self develops. A third response would be to revert to a suitable version of the current MacArthur criteria. At least one study has indicated a minimum threshold of about 10–11 years old for competence, based on a modified MacArthur assessment tool (Hein et al. 2014). This suggests the MacArthur model, appropriately

understood, may already be sufficiently robust to assess children's mental capacity. I am somewhat sympathetic to the incremental view of consent, but I don't have the space to exhaustively discuss all these solutions.

I have argued the NCS currently encounters serious problems when applied to children. First, children lack the developmental capacities necessary to acquire an adequate capacity to self-govern. Second, children's intimate conception of self is subject to powerful socializing forces, which makes it hard to tell where such an intimate conception of self ends and begins. Either we should revise the NCS to better handle child patients, adopt an incremental approach or stick to the MacArthur model for now.

ACKNOWLEDGEMENTS

I am grateful to Peter R. Wilson and Daniel Muñoz for their helpful comments on this paper.

ORCID

Gah-Kai Leung  <http://orcid.org/0000-0002-9174-8844>

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