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The Consumer Protection Model of Decisional Capacity Evaluation

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I. Background and Terminology

The medical profession in America during the 20th Century shifted from a paternalistic ethos to one committed to the value of patient autonomy. We find this trend to be commendable. To use the language of the courts, we hold that a strong "liberty interest" should be considered and respected in framing institutional policies.[1] This commitment to patient autonomy situates our standpoint in the liberal tradition. By 'the liberal tradition' we are referring to two broad families of political theories: the first family includes theories of justice that place a strong presumption in favor of liberty and the second includes theories of political legitimacy that give central emphasis to the importance of consent. The first is exemplified in the work of egalitarian liberals such as John Rawls and Thomas Nagel and the second is found in classical liberals such as J.S. Mill and F.A. Hayek.

One manifestation of the widespread commitment to patient autonomy that is expressed in contemporary medical culture is in the framing of the doctor/patient relationship as a health care provider/consumer relationship. We refer to this economic conceptualization of the relationship as 'the consumer model.' Setting aside our reservations with the consumer model and granting it for the sake of argument, we shall argue that valid informed consent and the accompanying practice of decisional capacity evaluations (DCEs) are essential to protecting the autonomy of health care consumers. We aim to defend the practice of DCE from liberal critics that may worry that DCEs are unjustifiable affronts to health care consumer autonomy.

Many philosophers in the liberal tradition hold that competent adults should be in control of medical decisions regarding their own medical care.[2] However, this commitment elides an important legal and clinical distinction between *competence* to make a decision and *decisional capacity*. These are contested concepts but we aim to clarify some of the key

conceptual confusions facing philosophical discussions of these concepts.[3] We shall argue that when a competent individual does not pass an appropriately conducted DCE regarding a particular medical decision, then that medical decision should be made by an appropriately selected surrogate decision maker.

Our argument rests on a distinction that is common in medical practice (Levenson, 2011, pp. 24-25). Global Competency Assessments (GCA) are legal judgments that an individual is no longer competent to make any further business, legal or medical decisions. When an adult is deemed globally incompetent, then that person is no longer authorized to make decisions on their behalf and a surrogate decision maker (technically, 'a guardian') is assigned to the individual. GCAs give *parens patrie* powers to a guardian to make decisions on behalf of the incompetent individual. In contrast with GCAs, DCEs are more localized: they are concerned with whether a health care consumer should make a particular medical decision about his or her own medical care. Buchanan and Brock (1989) aptly characterize DCEs as *decision relative*. A globally competent adult may fail a DCE and lose the authority to consent to or refuse medical treatment. DCEs are commonly performed in general hospitals, nursing homes and psychiatric hospitals every day.[4]

Someone, e.g., Charland (2011), might deny that this legal distinction is ethically relevant to medical practice and should not be considered to be the basis for ethical guidelines. We are not assuming that current legal and medical practice is sacrosanct. We hold that this distinction is ethically relevant because DCEs are morally justifiable components of the standard informed consent process administered in medicine (Levenson, 2011, pp. 25-26). As we argue below, both DCEs and the informed consent process are legitimate moral aspects of the medical transaction between health care provider and consumer.

Someone might reasonably object that the label "decisional capacity" is a misnomer. The DCE process does not involve determining whether an individual has the *capacity to make the decision*. In general, if something S partakes in an event ϕ, then S has the *capacity to* ϕ. To illustrate: if Smith falls to his death, then Smith has the capacity to fall to his death. There are few better ways to know whether S has the capacity to ϕ than to observe S ϕ-ing. In the context of a DCE, Jones may be refusing medical treatment because Jones claims that the voices on the radio command Jones to refuse treatment. Since Jones is refusing to have medical treatment, Jones has the capacity to refuse medical treatment. Therefore, DCEs are not primarily concerned with whether a patient *has the capacity* to make a decision. DCEs are concerned with whether the patient *should* make the decision

in that particular medical context. We hold that it is not a misnomer to characterize DCEs in terms of "decisional capacity," because DCEs are concerned with certain decisional capacities of the patient. DCEs primarily attempt to determine (1) whether the consumer has the legal capacity (global competence) to make a decision and (2) if the consumer is globally competent, then it needs to be determined whether the adult has the capacity to make an *informed* decision in this particular situation.

Within the liberal tradition, DCEs are usually justified with considerations of informed consent (see Kim, 2010; Levenson, 2011; Charland, 2011). DCEs historically emerged from the development of informed consent policies. Since the argument of this paper is concerned with liberal criticisms of the practice of DCE in the medical context, we shall assume both a strong principle of autonomy and a concern for informed consent in order to maintain common ground with these critics. A liberal critic of DCE may ask, "Given that a health care consumer is a competent adult, there is no justification for performing a test to determine whether that individual's medical choices are informed." This objection seems to assume that all health care consumers are informed about their health care choices. Often in circumstances where DCEs are triggered it has become clear to the health care providers that the consumer does not seem to fully understand the health care decision that they are making. The liberal critic may reply: consumers must accept the lion share of responsibility for their choices and absent fraud, buyer beware. So, given the consumer model, is there any justification for the informed consent procedure or DCE? We contend that there is.

Our argument in defense of the practice of DCE rests on a well-known distinction between human actions and behaviors.[5] We shall use the term 'mere event' to refer to events that are not human actions and we use the term 'behavior' to refer to mere events that involve the human body. Behaviors are non-agential events. We also use the term 'actions' to refer to events that are produced by human agency. To illustrate: if someone has a seizure, bites her tongue in half and drowns on her own blood, the event is best understood as a behavior and not an action. Arguably, autonomy is a property of actions and agents,[6] it is not a property of behaviors.

II. Actions, Behaviors and Consumers

In normal transactions in the medical marketplace, the consumer has a preference for a certain type of care and that preference is communicated with verbal or non-verbal indicators: speaking, writing, eye blinking, nodding, shaking one's head or so on. If the apparent communication of a preference is only a behavior, then, in general, that apparent communica-

tion should not be necessarily accepted as an expression of the consumer's preference for treatment. Apparent communication is not always a speech act.

If a health care consumer begins to spasmodically nod his head after being offered a form of medical treatment, it is not immediately obvious that the consumer is expressing a preference, especially if the nodding continues long after the question was asked or continues regardless of the nature of the follow up questions. The head nodding may be a behavior that is a result of massive stroke that has left the consumer encephalopathic. When a consumer appears to communicate a preference that is outside the statistical norm of what is expected for a given offer of treatment (e.g., an inexpensive, low-risk and fully curative therapy is rejected without explanation), then it is important for the health care provider to determine whether the consumer's apparent communication is a behavior or an action. Given that most people value longevity and well-being over shortened life and illness, when someone appears to communicate a refusal of a low-cost, highly reliable way to offer those goods, it may be an open question whether the apparent communication is a behavior or an action. This determination of whether the communication represents a behavior or an action is a critical component of the informed consent process. Likewise, in cases that involve the apparent communication of accepting a high-risk, low benefit, non-curative therapy with no explanation, it remains an open question whether the apparent communication is a behavior and not an action.[7] Here, again, the person is exposing themselves to decreased life or well-being and since that is statistically rare it should be determined whether the consumer's reply is an action or behavior. In cases of statistically deviant acceptances and refusals, DCEs are warranted. The minimal determination of whether the apparent communication is an action or behavior is a critical component to the informed consent process, which is in turn a necessary component of the healthcare transaction in the consumer model. To be clear, our view is that apparent communication that turns out after evaluation to be a behavior and not an action is sufficient to establish incapacity to make the medical decision under consideration. For the purposes of this paper, we are not going to explore what further criteria might establish, or be necessary for, determining incapacity.[8] It is a form of consumer protection to ensure that a medical transaction does not proceed if a presumably competent adult is apparently communicating a preference but those behaviors are not actions.

One virtue of this approach is that it provides a justification of DCE without appealing to a general principle of beneficence. A second virtue of this approach is that it clarifies an important set of conditions under

which a DCE is warranted. A third virtue of this approach is that it clarifies features of medical transactions that have been neglected by many proponents of the consumer model.

The consumer model should not assume that "anything goes" in the medical marketplace. Much to the chagrin of the small minority of anarcho-capitalists in the liberal tradition (e.g., Ayn Rand and Murray Rothbard), it is a fact that consumer protection is an important aspect of public policy. Consumer protection programs such as the Federal Trade Commission and the Food and Drug Administration provide important services to consumers, e.g., requirements that food ingredients are posted on food items. Many classical liberals and conservative economists admit the necessity of taxation on market transactions that have negative externalities. Sunstein and Thaler (2003; 2008) have proposed a form of "libertarian paternalism" that builds upon research from behavioral economics that suggests policies that do not undermine the autonomy of consumers but nevertheless nudge consumers in directions that may be in the service of promoting their own health or the efficient allocation of resources. Consumer protection is not antithetical to market-friendly solutions to social problems.

III. Objection and Reply

The Black Box Objection. One objection to our argument is that in economics it is commonly assumed that a consumer's true psychological motives and desires are in a black box. Economists have been bequeathed a large behaviorist inheritance. Revealed preference theory is the view that a consumer's preferences are determined by the output of their behaviors. This usage of 'behavior' is agnostic between whether the relevant events are, in our sense, behaviors or actions. According to revealed preference theory, the appearance of the communication of a preference is sufficient to establish that a preference has been expressed. Since the consumer's inner motives are opaque, it is reasonable to presume that all apparent communications of preferences are expressions of preferences. Nothing more is necessary to provide an adequate economic explanation of market transactions. Therefore, according to revealed preference theory, all apparent communication of consent and refusal will and should count as speech acts that express a choice.

Our Reply. It is implausible to presume that all appearances of communication in the medical marketplace are expressions of a preference and a choice. Once again, if a consumer has a seizure, bites her tongue in half and drowns in her own blood, then that consumer is not necessarily expressing a preference to bite her tongue and to die. This case

suggests a straightforward counterexample to revealed preference theory. The presumption that everyone is expressing a preference and a choice in their bodily movements may be justified in mundane, non-medical market transactions. However, in the medical context, many consumers will be afflicted with conditions that impair their capacity to make informed decisions about their medical care. Once again, consider the consumer who is an encephalopathic stroke victim and seems to be refusing the treatment when it is offered. The consequences of not administering a DCE in many of these situations would be extreme: the loss of bodily or psychological function, disability or death. The acceptance of every appearance of communication in the medical marketplace as the expressions of a preference is at odds with the need for valid informed consent. The behaviors (in our sense of *behaviors)* of consumers (especially ones in the grip of a major pathology or mental disorder) are not genuine speech acts in a sufficient number of health care transactions to justify a concern about informed consent to medical treatment in those cases and thereby merit the need for DCEs in those cases.

IV. Limitations to Our Approach

The conclusions of our arguments are limited in the following respects. We've limited ourselves to DCEs that involve cases of medical necessity. We have not focused on the general issue of whether all requests for medical treatment and surgery should be performed. Although we have focused on the role of the consumer in the medical marketplace, we are committed to an expert-based system (i.e., health care providers are experts that will determine which medical procedures are medically necessary). The information asymmetry between healthcare providers and consumers should not be ignored, or so we would argue. We have not rebutted all of the main objections that might be put forth by consumer models that require that consumers are granted any request for healthcare that they desire and can afford: these approaches would require the complete abandonment, or a significant modification of, the informed consent process for medical treatment. We would defend a consumer model that ethically requires that the informed consent process for medical treatment and the corollary practice of DCEs are a necessary regulation on the medical marketplace. Further argument would be needed for us to establish that no regulations on consumer choice would lead to significant problems in the medical marketplace. One last limitation of our argument is that we do not address how to perform an appropriate DCE (other than the first step of determining whether an action or behavior has occurred) or discuss the relevance of whether a category of "value" should be added to the standard criteria articulated by Appelbaum and Grisso (2001).

Notes

[1] Dworkin, et al., (1997) lucidly formulates the legal basis for this "liberty interest."

[2] This principle is central to the argument in favor of legalizing the practice of allowing physicians to prescribe lethal doses to dying patients in Dworkin, et al. (1997).

[3] See Buchanan and Brock (1989), Culver and Gert (2004), Charland (2011) for helpful overviews of the main conceptual questions facing legal, medical and ethical discussions of the relation between competence and decisional capacity.

[4] Kim (2010, pp. 27-40) presents occurrence rates of DCEs in the UK and USA.

[5] Our terminology borrows largely from Davidson (1990). However, our distinctions remain neutral with regards to the nature of human action.

[6] Christman (2009) maintains that autonomy is usually conceptualized as a feature of actions or agents.

[7] As Culver and Gert (2004) and Charland (2011) point out, there is disagreement about whether there are epistemic (and legal) asymmetries between apparently irrational refusals and apparently irrational acts of consent.

[8] Appelbaum and Grisso (2001) and Appelbaum (2007) present one of the most prevalent standards for how to conduct DCEs in the US. Kim (2010) expands upon those models and discusses them in their historical and legal context.

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Commentary on Daniel Moseley and Gary Gala's "The Consumer Protection Model of Decisional Capacity Evaluation"

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Moseley and Gala (2013) provide an intriguing approach to the decisional capacity evaluation (DCE) of patients. They accept a broadly liberal approach to this issue (one which they claim could include both classical liberalism and liberal egalitarianism). Even when adhering to this approach, they see likely pitfalls in allowing patients (or as they call them "health care consumers") a wide scope of decision making. Quick decisions by uninformed patients who demonstrate low degrees of decisional capacity may lead to unproductive medical team/patient encounters and costly, avoidable follow-up care.

While Moseley and Gala would agree that patient autonomy is important, they think that there are limits to that concept. They note that not enough care is taken to discriminate between the (presumably more general) competency of patients to make their global medical decisions and their decisional capacity for consenting to specific procedures. For instance, Moseley and Gala observe that it is consistent for a patient who has passed a Global Competency Assessment (GCA) to still not pass a DCE. Thus, a globally competent patient could still require that particular health decisions be made for them by a competent surrogate.

While I have no major objections to either their approach or to the substance of their claims, there are some issues about which I would like to hear more. For example, I would first like to better understand what Moseley and Gala's objections to the consumer model are in general. Secondly, it is not straightforward to me how one can be deemed to have appropriate competency and yet simultaneously fail to hold the requisite decisional capacity. I recognize that there is a legal distinction between global competency and specific decision making ability, but is this a fiction? Or is this distinction based on a philosophically tenable basis? Think of it from this perspective. In the health care marketplace, there is usually a gross informational asymmetry between health care practitioners and patients (as Moseley and Gala acknowledge near the end of their paper). This is often true even in cases where patients are relatively well-educated (but

perhaps not necessarily in medical studies or beyond the most basic ideas about science). If valid informed consent involves some sort of informational requirement (even assuming that the information is deemed good) what degree of expertise is required to be deemed such a decision-maker? Would my lack of a medical degree (even assuming that I was assessed to be globally competent) make me incompetent at determining particular health decisions for myself? And if this is too extreme an example, what makes it so? What is a non-arbitrary distinction between the sort of patient that Mosely and Gala have in mind and (perhaps) me?

Of course, I am not denying that there is a difference between competent and incompetent patients. I am left to wonder if we can really tease out global incapacities from specific ones to the degree that we can deem one to still be competent to make global kinds of decisions and more specific decisions in the health care context. Consider Mosely and Gala's example of the patient/consumer who is spasmodically nodding. Wouldn't this be a case of someone who should be classified as both globally incompetent and should also have a DCE?

Many of my questions, then, end up being definitional. What do Mosely and Gala mean by valid informed consent? Under what conditions does one have decisional competency and how is that isolated in global versus local decision-making? Does it simply rely on a patient being able to understand all of the relevant information (couldn't a substantial number of patients fall into this category)? Does it mean the ability for a patient to be able to sort through all of this information and then being able to consistently fit decisions together over time?

I recognize that Mosely and Gala say they adopt a robust notion of autonomy. To put my questions of autonomy in the proper context, we might appeal to the work of the political philosopher Adam Swift (2006). Swift notes several possible characteristics of a notion of autonomy that make it more robust as you stack them. One can do what they wish to do but still not be autonomous (he/she does not really rule him/herself) (2006, p. 59). Additionally, an educated person is freer than one who is not in two ways. The first way is that the educated person has more options available to him/her with respect to professions since presumably they have collected a series of skills germane to a wider range of occupations (2006, pp. 60-1). The second way comes via the ability to sift through information, process it, think independently, and to evaluate different courses of action (2006, p. 61). The person who has these abilities is more autonomous than the person who doesn't. Even if patient autonomy admits of degrees, I think we need to know what exactly Moseley and Gala mean by the concept. Accordingly, they would then need to apply the concept to specific cases.

I also think that if they are to continue their work into a more substantial article or book, they will need to also *defend* their notion of autonomy. Moseley and Gala are surely mindful that those with more libertarian sentiments to patient decision-making will pounce on their approach (not merely followers of Rand and Rothbard, but those of Nozick and perhaps even patient advocates for the Left as well). These critics might uniformly declare that too robust of a notion of autonomy conjures all of the pre-1960's medical paternalism in the United States that patient advocacy groups labored so arduously to overturn.

My final evaluation is that Moseley and Gala present a very worthwhile topic for further engagement. Their paper reveals some deep insights into the nature of this DCE's in particular and to more general considerations of patient autonomy in general. They have rightly alerted us to the limitations of this paper, which is perfectly acceptable given the restrictions of the conference forum. I hope that they continue their work on this important issue, not only addressing the limitations they admit, but several other questions that have arisen in this commentary, and will most surely arise during our discussion of this paper.

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