Competence, Capacity, and Informed Consent: Beyond the Cognitive-Competence Model

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RÉSUMÉ

Seules les personnes compétentes peuvent fournir un consentement éclairé en matière de soins de santé. Les approches actuelles définissent essentiellement la compétence en termes cognitifs, omettant ainsi le fait que quelqu'un pourrait être compétent d'un point de vue cognitif sans pour autant avoir la capacité de fournir un consentement valide. Cette étude comporte une théorie plus solide de la compétence, qui comprend non seulement les paramètres cognitifs mais également les paramètres émotionnels et subjectifs. Par la suite, elle différencie la compétence de la capacité et elle indique le rôle utile que cette distinction peut jouer dans un contexte de soins continus et de longue durée. Elle démontre également la manière dont cette distinction concorde avec plusieurs décisions juridiques canadiennes récentes, et elle souligne l'utilité de celle-ci dans l'interprétation et l'application des lois provinciales pertinentes.

ABSTRACT

Only competent persons can give informed consent to health care. Current approaches define competence in essentially cognitive terms, thereby ignoring the fact that someone may be cognitively competent yet lack the capacity to give a valid consent. I outline a more robust theory of competence that includes not only cognitive but also emotional and valuational parameters. I then distinguish competence from capacity, and indicate the role this distinction can usefully play in the extended and continuing care setting. I also show how this distinction is consistent with several recent Canadian legal decisions, and outline its usefulness in interpreting and applying relevant provincial statutes.

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Over the last 30 years, the doctrine of informed consent has become a cornerstone of health care delivery in the English-speaking world. It is generally accepted that – within very narrow limits that centre in public safety and the competing rights of third parties – patients have the right to accept or reject any treatment and any intervention, even if this means less-than-optimal care or death. It is also accepted that unless there are reasonable indications to the contrary, patients must be presumed to be competent, that they will exercise the right to informed consent in their own person, and that in the case of incompetent patients this right will be exercised for them by a duly empowered substitute decision-maker (Beauchamp & Childress, 2001; Downie & Caulfield, 1999; Engelhardt, 1986; Fremgen, 2002; Garrett, Baillie, & Garrett, 2001; Picard & Robertson, 1996; Stauch, Wheat, & Tingle, 1998; Veatch, 2003). Since lack of information limits the ability to choose, most jurisdictions have developed explicit guidelines about the amount and nature of the information that must be disclosed and the conceptual level at which it must be

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pitched (Fremgen; Oates, 2000; Picard & Robertson; Stauch, Wheat, & Tingle).

Clearly, the notion of competence is fundamental to this doctrine. However, in its current form it assumes that competence can be defined in essentially cognitive terms that centre in the conceptual abilities of the individual. That is to say, it assumes that the central determinant in competence is the ability to understand the information that is given and to appreciate its implications. This view is well reflected in the professional literature (Chopra, Weiss, Stinnett, & Oslin, 2003; Earnst, Marson, & Harrell, 2000; Etchells et al., 1999; Grisso & Appelbaum, 1998; Moye, Karel, Azar, & Gurrera, 2004) and in the standard tools that are used to assess decision-making capacity (Folstein, Folstein, & McHugh, 1975; Grisso, Appelbaum, & Hill-Fotouhi, 1997). It is also integral to the law. So, for instance, the Alberta *Personal Directives Act*, which identifies decision-making competence in terms of capacity, defines *capacity* as ''the ability to understand the information that is relevant to the making of a personal decision and the ability to appreciate the reasonably foreseeable consequences of the decision'' (c. P), and Ontario's *Mental Health Act* defines an incompetent person as someone who lacks ''the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent'' (c. M; see also *Substitute Decisions Act*, 1992 S.O. 1992, c. 30). The Nova Scotia *Hospitals Act* is even more explicit, stating that

> in determining whether or not a person is capable of consenting to treatment the examining psychiatrist shall consider whether or not the person being examined (a) understands the condition for which the treatment is proposed; (b) understands the nature and purpose of the treatment; (c) understands the risks involved in undergoing the treatment; (d) understands the risks involved in not undergoing the treatment; and (e) whether or not his ability to consent is affected by his condition. (c. 7)

Legislation in other Canadian provinces is essentially similar.

This position ignores several other parameters of competence that are of central importance to consent, and in so doing fails to acknowledge that someone may be cognitively competent and yet lack the capacity to give consent. In what follows, I shall sketch a more robust theory of competence that includes not merely cognitive but also emotional and valuational parameters. I shall then distinguish competence from capacity, and indicate the role that this distinction can usefully play in the extended-care setting involving elderly persons with beginning dementia, or in situations involving individuals who are perfectly competent in the cognitive sense of the term but are volitionally compromised. I also show how this distinction is consistent with several recent Canadian legal decisions, and outline its usefulness in interpreting and applying relevant provincial statutes.

Competence in Decision-Making

Linguistically and conceptually, the notion of competence connotes having the qualifications that are necessary for performing a certain type of act (Buchanan & Brock, 1989; *Collins English Dictionary*, 1981; *Oxford Paperback Dictionary*, 1994). Thus, a lawyer may be competent in tax law, meaning that she is qualified in that area and is capable of providing sound taxation advice; a nurse may be competent in neonatal nursing, meaning that she is trained in taking care of severely disabled newborn children; a pilot may be competent to fly propeller-driven planes because she is trained to fly these types of aircraft. The point is that competence is always relative to a given undertaking, and that the individual who is judged to be competent is thought to meet the conditions necessary for being able to perform the relevant act in an acceptable manner.

However, there is a fundamental logical difference between something being necessary and something being both necessary and sufficient. The latter is the stronger condition, because it recognizes that what is necessary may be only one among several conditions that must be met conjointly in order for the conclusion to follow. For instance, to revert to the previous examples, the tax lawyer who is educationally qualified to give taxation advice may be unable to express that advice in a usable manner to a prospective client, the nurse who is a certified neonatal nurse may have suffered a stroke that interferes with the ability to actually perform the relevant nursing tasks, and so on. In each case the individual meets a necessary condition for the exercise of that competence but is incapable of exercising it because another condition is missing.

When the notion of decision-making competence is approached from this perspective, it becomes clear that the ability to understand is merely a necessary condition for competent decision-making and that several other factors are necessary; moreover, that all of them conjointly have to be met in order for decision-making competence to be present. These other factors centre in the conditions that are necessary for actual decision-making itself, and for the ability to translate that decision into practice. For clarity's sake, the first set of parameters may be

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identified as conferring decision-making competence, whereas decision-making competence together with the second set of parameters constitutes capacity.

Decision-Making Competence

Logically and conceptually, decision-making competence can be broken down into three distinct rubrics. They are, respectively, cognitive, emotional, and valuational competence. Each contains several sub-components.

Cognitive competence centres in what, loosely speaking, may be called the rational capacities of the individual. It can be analysed under three headings: conceptual, inferential, and mnemonic. Conceptual competence refers to the ability to grasp the concepts that are necessary for appropriate decision-making. However – and this is reflected in the leading case of *Reibl v. Hughes* (1980) – cognitive competence must be carefully distinguished from educational sophistication. Conceptual competence centres in a feature of the individual *as individual* – in the individual's ability to understand information that is presented at an appropriate level. By contrast, educational sophistication has nothing to do with an individual's inherent abilities, but instead with the training that the individual has received. Thus, medical information that is presented in language suited to communication among highly trained health care professionals will not be understood by the ordinary person, but not because the ordinary person is conceptually incompetent. It will not be understood because it is presented at an inappropriate educational level. It follows that conceptual competence may vary from case to case, depending on the complexity and sophistication of the concepts that are necessary for understanding the situation.

Inferential competence refers to the ability to discern the implications of the information that is presented and to appreciate their relevance to the process of choosing. Here again it is important to distinguish between competence and sophistication. Almost invariably, a highly trained health care professional will be able to identify more – and possibly different – consequences than the ordinary reasonable person who lacks such education. However, inferential incompetence will obtain if and only if the individual in question cannot discern the consequences and implications that a comparatively placed reasonable person would normally be able to identify as a matter of inferential capacity, given the available information.

Mnemonic competence refers to the ability to function in more than the immediate present. That is to say, decision-making is more than a momentary affair. It extends into the past because it draws on memories that lend conceptual significance to the data that are being presented, and it extends into the future because it requires the individual to project himself or herself into an expected future that is shaped by the decision-making at issue (Buchanan & Brock, 1989). Someone whose mnemonic capacity is so impaired that she lives only in the specious present – someone who lives only in a narrowly extended time frame where significant past decisions and experiences are not remembered – cannot adopt such a stance. Consequently such an individual is not mnemonically competent and cannot make appropriate decisions that have more than merely momentary significance. Alzheimer patients whose temporal awareness is confined to the specious present lack cognitive competence in precisely this sense, even if their conceptual and inferential competence is unimpaired.

Emotional Competence

The rubric of emotional competence acknowledges the fact that human beings are not automata but living beings who are embedded in psychosocial contexts and interact with other persons on more than merely cognitive terms. Further, it acknowledges that the choices we make, or indeed how we make them, may be influenced by the emotions that we experience on a particular occasion (Appelbaum, 1998).

Emotional competence has two parameters: appropriateness and strength. Appropriateness, as the term indicates, refers to the appropriateness of the emotions under the circumstances. Thus, all other things being equal, someone who expresses joy at the death of a beloved significant other from whose death she has nothing to gain, who was not ill and was neither hoping nor expecting to die, is expressing an inappropriate emotion. The individual is in what might be termed emotional shock, and is scarcely in a position to make a competent choice at that time. On the other hand, an emotion may be appropriate but may be experienced so strongly that it interferes with the ability to reason, to appreciate the implications of the options, or to make a choice at all. Expressions such as ''being overcome with emotion'' and ''being stunned'' capture this sort of situation fairly well. Usually such emotional incapacity is of short duration.

Valuational Competence

While cognitive and emotional competence are conditions necessary to make a decision, for decision-makers to be considered ethically competent, their decision must also be based on competent values. Perhaps an example will illustrate what is here at

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issue. Consider the octogenarian who is no longer a productive member of her family grouping and who decides to forego life-saving and/or sustaining medical treatment. While the values that ground her decision may be entrenched in the social or cultural grouping in which she is embedded, and while she may subscribe to these values – and even be able to defend them in rational terms – they are not values that acknowledge her as an entity with intrinsic moral worth as a person. In other words, they are values that are inherently in conflict with what the *Universal Declaration of Human Rights* (General Assembly of the United Nations, 1948) has characterized as the ''inherent dignity'' and ''equal and inalienable rights of all members of the human family''. To use the terminology suggested by Insoo Hyun, they are not *ethically authentic* values (Hyun, 2002).

So informed consent involves making decisions – which in turn involves making rational choices. Making choices, in turn, requires something that motivates the individual to actually select from the options that are available. This additional element is contributed by the individual's values. As Hodgkinson, building on the work of Kluckhohn (Parsons & Stills, 1962) has so aptly put it, values are ''concepts of the desirable with motivating force'' (Hodgkinson, 1996, p. 110) and thus function as action potentials. Absent values, choices cannot and will not be made.

To expand on this a little, values may be approached in different ways. For example, they may be analysed psychologically (Herzberg, Mausner, & Snyderman, 1959; Hodgkinson, 1996; Maslow, 1943; Urmson, 1968), socially (Durkheim, 1973; Peters, 1960; Steers & Porter, 1975), economically (Debreu, 1959; Pareto, 1909), and philosophically (Hall, 1952; Kant, 1785/1959; Moore, 1962). One of the more interesting approaches that straddles several disciplines has been proposed by Hodgkinson, who suggests that values are grounded in motivations and that they can be analysed as falling into three rubrics: values that are grounded in someone's emotional structure and derive from the individual's personal affect, emotions, or feelings; values that are rationally based and derive from the individual's understanding of social consensus and collective justification; and values that involve an acceptance of general principles and entail personal commitment and conviction (Hodgkinson).

On this understanding, not everyone will be valuationally competent all of the time. Thus, values may conflict with each other either on their own respective levels or with competing values of different types (Hodgkinson, 1996), thereby setting up contradictory action-potentials (O'Neill, 2001). For instance, the affect-based value of sexual gratification may conflict with the affect-based value of personal comfort, but it may also conflict with the higher-order consensus-based value of appropriate behaviour and with the still higher principled value of respect for others as persons. Unless the underlying motivations are of unequal strength or the individual has some means for resolving the valuational conflict, the individual cannot make a choice.

However, valuational competence requires more than valuational consistency or the ability to rank conflicting values. Values that change from moment to moment are not a secure basis for making decisions that have implications beyond the immediate moment. It is arguable, therefore, that while competent persons may change their values, their values must be more or less stable over a given period of time, since otherwise no consistent plans can be developed and the resultant actions may well be in conflict with each other (Buchanan & Brock, 1989; Elliott, 1998). This does not mean that the values cannot be changed, any more than it means that the world view cannot be changed; it merely means that any such change must be part of a more or less stable personality.

Moreover, one can distinguish between psychological and ethical valuational competence. Psychological valuational competence obtains when there is no conflict among the individual's values or when, given a value-conflict, that conflict can be resolved by some mechanism that prevents aporia. Here, the strength with which the respective values are held would constitute one among a variety of conflict-resolution mechanisms. In the presence of such mechanisms, aporia would be avoided and psychological valuational competence would obtain.

However, as several commentators have pointed out (Hodgkinson, 1996; Hyun, 2002) – and indeed as is obvious from the *Universal Declaration of Human Rights* – not all values are ethically acceptable values. To revert to the point that was made before, values that denigrate persons *as persons* – whether in the person of the value-holder or of those affected by the individual's decisions and actions (Hodgkinson) – and values that deny the inherent equality and dignity of all persons fall into this category.

In this context, the analysis proposed by Hodgkinson, although not without its own difficulties, nevertheless suggests a way of approaching the matter: In a valuationally integrated and competent person, the affect-based values (type I values) are trumped by consensus-based and collectively justified (type II) values, and these in turn are trumped by principle-based values (type III values). Therefore using this

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approach, someone is valuationally competent in the ethical sense if – over and above being valuationally competent in a psychological sense – he or she is able to rank values according to the above schema and is able to resolve valuational conflicts by subordinating the affect-based values to the rationally based values that derive from social consensus and collective justification and, ultimately, to the values that are principle-based and grounded in personal commitment and conviction (Hodgkinson, 1996). To adapt a phrase from Hodgkinson, someone who cannot do this suffers from ''value sickness'' or ''pathology'' (Hodgkinson, p. 187). This schema could further be integrated into Kohlberg's work on the evolution of ethical sophistication in individual persons; however, this would be beyond the scope of the present paper.

If this analysis is accepted, it follows that consistency in values or the possession of a conflict-resolution mechanism may not indicate ethical valuational competence. That is, someone's values may be consistent and stable, and the individual may possess an internal conflict-resolution mechanism; moreover, this mechanism may even give priority to principled, higher-order or type III values. Nevertheless, the individual may be valuationally incompetent precisely because these values denigrate the status of the decision-maker *as person*. This has nothing to do with how the values were acquired and/or validated, for it may occur even when the values have been acquired as a result of the social embedding of the individual, as it were through a process of social conditioning. Ethically, this may be the most insidious of all cases, because consensus will have taken the place of principled ethical evaluation and therefore undermine the role of type III values (Hodgkinson, 1996; Hyun, 2002). As the above example of the octogenarian illustrates, such cases are encountered in the geriatric setting when elderly persons who are embedded in a social context that measures their worth as persons on the basis of their ability to contribute to the economic well-being of the social unit as a whole, consider themselves as having no value because they are a drain on resources without compensating economic return. Their decision to forego life-saving and/or sustaining medical intervention will be cognitively, emotionally, and psychologically competent but, arguably, it would be ethically flawed.

Moreover, not all such values may be self-directed. There may be values that deny the personhood of *other* persons; for instance, when they deny equal status to persons who belong to different age cohorts or to ethnic or religious groupings. Ethnic cleansing constitutes an example of this issue. Again, as the *Universal Declaration of Human Rights* makes quite clear, such values are ethically unacceptable, their social validation notwithstanding, and persons who use such values are valuationally incompetent – at least in that respect.

The preceding analysis could be expanded further by suggesting that ethically competent values should also be appropriate for the developmental status of the individual. Thus, insofar as children are competent decision-makers (Harrison, Kenny, Sidarous, & Rowell, 1997), their values should be appropriate for children and not adults; likewise, the values of adults or of elderly persons should be in keeping with their situation and their abilities (Buchanan & Brock, 1989). However, the preceding will suffice as an indication of what is at issue in ethical valuational competence.

A Caution

At the same time, it must be admitted that there lies a danger in introducing a value component into competency assessment. Specifically, the danger is that only values that are consonant with the values of the assessor will be considered competent, and that all others will be rejected. This would make competence a function of the values of the assessor, and impose indefensible limits on the dignity of potential decision-makers.[1] There could be no worse an indignity for an elderly person than to be considered incompetent and to have her wishes discounted not because she was incompetent in any cognitive or other respect but because her values were not in agreement with those of the health care professional (Kirk & Bersoff, 1966).

However, this danger will materialize only by controverting and indeed ignoring the logic of the preceding analysis. The analysis does not require that there be valuational consonance between assessor and patient, that the decision be in what the assessor considers to be the patient's ''best interests'', or even that the decisions that are based on these values promote the ability of the individual to function as a ''normal'' member of society. Thus, on this proposal, the schizophrenic who refuses otherwise appropriate neuroleptic medication because he values his conceptual originality more than a symptom-free mental outlook will not therefore count as valuationally incompetent (*Starson v. Swayze*). His values, although perhaps not standard, do not denigrate him as a person and are therefore ethically quite acceptable. Instead, ethical valuational incompetence requires that the decision-maker's values deny or otherwise denigrate the status of the decision-maker or others *as persons* – as beings who have intrinsic and equal worth and dignity precisely because they are persons.

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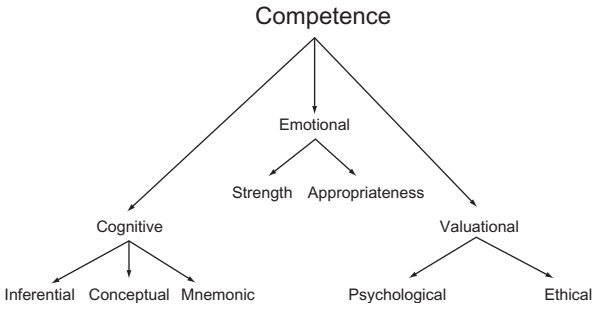


Figure 1: Schematic of logical structure of competence

There is no unique way in which ethical valuational competence can be achieved, and it certainly does not require that the values of the decision-maker must be consonant with the values of the assessor. However, if the values do not meet the basic ethical standards that are integral to the *Universal Declaration of Human Rights*, then they are ethically unacceptable. That applies to potential decision-makers as much as to assessors. Figure 1 schematically represents the logic of competence.

Capacity

There is one further aspect of competent decision-making that deserves consideration, and that is capacity: Competent decision-making involves more than being cognitively capable, emotionally uncompromised, and having appropriate values. It also involves the ability to make an authentic choice – to practise volition – and the ability to translate that choice into action (Roberts, 2002).

Internal Freedom-Impairing Parameters

This ability may be impaired in two ways. For lack of better terms, they may be referred to as internal and external freedom-impairing parameters respectively. Addiction is an example of an internal freedom-impairing parameter. Thus, some addicts clearly understand the implications of their substance abuse, are unhindered by inappropriate emotions, and use appropriate and authentic values in deciding to break their addiction, and yet are unable act on their decision to engage in and carry through an addiction-ameliorating treatment precisely because they are addicted (*Norberg v. Wynrib*).

Conditioning provides another example. Someone may be unable to choose authentically because she has been conditioned to accept a certain set of values. Consequently, even though such a person may be presented with a range of options, and even though she may fully understand and appreciate the implications of the various choices, she will inevitably select only a particular option because the value-set into which she has been conditioned effectively constrains her in that direction. People who have experienced abuse sometimes find themselves in this position.

Likewise, someone may be unable to make a ''free'' choice because of a mental illness, or be unable to act on a choice that he has rationally chosen. Kleptomania and gambling addiction here constitute examples. Kleptomaniacs and gambling addicts are not necessarily conceptually compromised. They may even share standard social values, intellectually reject their own aberrant behaviour, and be emotionally horrified by their own actions – and yet be unable to ''help themselves''. In these sorts of cases, internal conditions prevent the individuals from either making or acting on an otherwise competent choice.

External Freedom-Impairing Parameters

As for external freedom-impairing parameters, these are generally grounded in the situation in which the individual is embedded. Institutionalization – which is to say, being confined to a localized and organized setting where the behaviour of the individual is controlled by rules that are not set by the individual but are imposed by persons in authority – constitutes a frequently overlooked instance of this type of freedom-impairing parameter. A good example is provided by prisoners in jail or residents in a controlled residential facility. Such individuals may be perfectly competent and may even be free of internal freedom-impairing parameters. However, they may be volitionally compromised because the rules, regulations, and even physical restraints that they encounter prevent them from translating their decisions into action. It is an interesting question whether under such circumstances their choice for rehabilitative therapy or for adhering to the rules of the facility is volitionally competent. Unfortunately, to discuss this point with the attention that it deserves would go beyond the limits of this paper. Suffice it to say that, as a general principle, a choice whose purpose is to increase one's ability to function autonomously counts as indicating capacity in this regard, rather than volitional impairment.

Dependence and power-relationships may also constrain the will of the individual (Independent Task Force Commissioned by the College of Physicians and Surgeons of Ontario, 1991). Something like this occurs in the geriatric setting when an elderly person feels dependent on another individual – say, on a caregiver or on someone perceived to be in authority – or feels powerless when opposed to this other person and does not want to make a choice that might give

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offence. An example is provided by the case of the medically compromised elderly couple who live with their daughter and depend on her for assistance in their activities of daily living, where the daughter strongly rejects allopathic or ''Western'' medicine in favour of homeopathic and herbal health care. In order to retain the goodwill of their daughter and retain family solidarity (the couple is otherwise socially isolated), the father declines the surgical treatment that is indicated for his non-healing ulcerous leg, and the mother decides not to undergo the medically necessary cardiac bypass surgery that was recommended as a result of her heart attack.

Undue enticement constitutes still another example where the will of individuals may be overborne by the situation in which they find themselves (Annas, Glantz, & Katz, 1977; Freedman, 2005; Katz, 1972; Tri-Council, 1998; University of Arkansas for Medical Sciences Institutional Review Board, 2004). Thus, the elderly person in a long-term care facility who agrees to conform to certain rules that she would otherwise reject as demeaning (e.g., wearing prophylactic diapers) or to engage in activities in which she would otherwise not participate (singalongs at afternoon tea) may well be cognitively, emotionally, and valuationally quite competent, but her capacity to act in a truly authentic fashion may be compromised by the promised reward of being allowed to see her grandchildren.

It is interesting to note that the common law has long recognized some of these factors – in particular, the fact that someone's will may be overborne by undue pressure, or that a person may be overcome by undue enticement or be impaired by an unequal power relationship (*Norberg v. Wynrib*). In fact, the law recognizes that even though the will of the weaker party may not actually be dominated or overcome in any overt sense, the situation itself may be such that the consent is neither genuine nor authentic because the various factors constitute de facto freedom-impairing parameters. Mr. Justice La Forest stated it well in *Norberg v. Wynrib* when he said that ''consent must be genuine; it must not be obtained by force or threat of force'', and quoted with approval from Heuston and Buckley, *Salmond and Heuston on the Law of Torts* (*Norberg v. Wynrib*, p. 247): ''A man cannot be said to be 'willing' unless he is in a position to choose freely; and freedom of choice predicates the absence from his mind of any feeling of constraint interfering with the freedom of his will. A 'feeling of constraint' so as to 'interfere with the freedom of a person's will' can arise in a number of situations not involving force, threats of force, fraud or incapacity... It is presumed that the individual has freedom to consent or not to consent. This presumption, however, is untenable in certain circumstances. A position of relative weakness can, in some circumstances, interfere with the freedom of a person's will. Our notion of consent must, therefore, be modified to appreciate the power relationship between the parties... In particular, in certain circumstances, consent will be considered legally ineffective if it can be shown that there was such a disparity in the relative positions of the parties that the weaker party was not in a position to choose freely.''

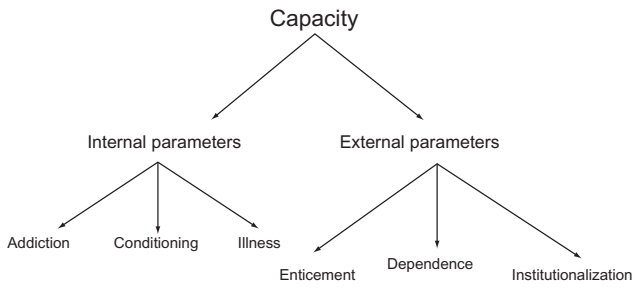


Figure 2: Schematic of logical structure of capacity

Correspondingly, the concepts of unconscionable action and of inequality have received detailed juridical examination in the courts (Cope, 1983; Klippert, 1983; Waters, 1986) and deserve further examination for the geriatric setting. Figure 2 schematically represents the logic of capacity.

Competence, Capacity, and Consent

When these notions of competence and capacity are combined, the result is a model that more accurately reflects the parameters involved in actual decision-making. However, competence and capacity, even when thus understood, are merely necessary features for informed consent; they are not sufficient.

That is to say, informed consent is the competent and unconstrained selection of a particular course of action from available options at a given time. However, one cannot select something of which one is unaware. It follows that, if even if competence and capacity are present, informed consent is impossible unless the available options are known to the individual.

At the same time, the fact that someone is aware of an option does not necessarily mean that he or she appreciates its nature or implications. It follows that informed consent also requires that the relevant options actually be understood, and that the decision-maker clearly comprehends their implications both insofar as individual well-being is concerned as well as for the lifestyle and life-plans of the individual in question. Again, it is worth re-emphasizing that

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a lack of understanding may not be a function of cognitive inability or emotional compromise but result from the fact that the option is not disclosed in a suitable fashion – which is to say, in a manner that is appropriate to the intellectual abilities and level of education of that particular person. Consequently, informed consent also requires that the relevant options be disclosed at a level that is appropriate for the individual who is supposed to give consent (Picard & Robertson, 1996). Of course, it may happen that the option cannot be disclosed at such a level because it cannot be translated to that individual's level of sophistication. In that case, the individual would still have capacity and otherwise be competent, but he or she would be unable to give informed consent in any ethically meaningful fashion on this occasion. Once more, it is interesting to note that the common law has long recognized this fact by acknowledging that someone may be capable of giving informed consent at one time and in one particular area but not in another.

Conclusion

It would be disingenuous to conclude this discussion without once more acknowledging the objection that the proposed extension of the notions of competence and of decision-making capacity in the context of informed consent is not without its dangers, and in particular, that the addition of valuational competence and of volitional capacity as additional assessment parameters threatens to turn back the clock to the paternalistic days of old.

There are two replies to this concern: One is the obvious reply that all assessment tools may be misused, and that this would be no exception. However, the more cogent reply is that this concern would materialize only if the stringent guidelines for using the concept of valuational competence that were insisted on above were to be ignored, and if the notion of capacity were to be extended beyond the limits that were indicated. To put it in a nutshell, valuationally the issue is not one of agreement or concordance but of respect for persons, and valuational differences between patients and professionals in themselves indicate nothing except difference. Likewise, power imbalances need not be volitionally compromising, and reward may be enticing without overbearing the volitional capacity of the individual. It all depends on the facts of the situation. As in any assessment, one has to look and see.

Informed consent has become the ethical cornerstone of contemporary health care delivery. This fact holds true in the extended and continuing care settings as much as anywhere else. By their very nature, these settings present a greater challenge because they frequently involve persons whose cognitive competence is relatively unimpaired, while their ability to make authentic choices is compromised by the situations in which they find themselves. I have argued that a properly structured theory of informed consent for the extended and continuing care setting must be alive to these possibilities, and must integrate them into an overall framework that captures its ethically relevant parameters. I have also argued that the standard approach fails precisely in this regard because it focuses on the cognitive aspects of competence to the exclusion of all others, and lacks the formal tools for identifying valuational incompetence and lack of capacity. This failure may carry a heavy cost for not only the care recipient but also for the health care professional. Specifically, it may result in situations where the professional knows that something is wrong, knows that something should be done, but cannot initiate the otherwise appropriate action because the formal tools that would allow third-party intervention do not exist – or exist only if supported by legal intervention.

However, legal intervention has its drawbacks and its limitations. For one thing, it is expensive and time-consuming. For another, engaging the law moves health care delivery into the legal arena and thereby fundamentally alters the nature of the health care professional–client relationship. Moreover, despite the increased juridical sensitivity to the different aspects of competence and to the distinction between competence and capacity, the legal process that adjudicates on these matters is subject to the vagaries of the judicial process itself.

Most important, however, is the fact that the law turns to health care when deliberating on these matters, and relies on clinical evaluations. I have tried to show that the clinical tools that focus on cognitive ability for evaluating competence are limited in their scope because they do not treat competence as the multi-modal entity that it really is, and because they contain no measures for assessing capacity. If this analysis is correct, then the current situation is logically and professionally flawed. It may be time to develop appropriate clinical tools to fill this gap and to integrate them into health care practice. The preceding discussion is intended as the outline of a theoretical framework within which such tools could be developed.

Note

1 I thank an anonymous reviewer for raising the need to explicitly address this point.

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