ETHICAL DILEMMA

A question of competence

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Introduction

Patients should be allowed to make decisions for themselves if they are mentally competent. However, the standards of mental competence vary, depending on aspects of the decision and on the patient.

Decisions that are complex require a high level of competence. Decisions in which the consequences are severe may also require a high level of competence and require that the examiner is more certain about the level of competence that the patient exhibits. There are some decisions in which patients require specific cognitive attributes (such as long-term or short-term memory).

We report our experience in dealing with an elderly woman who expressed a desire to return to her home after respite care, although evidence of self-neglect suggested that permanent placement in an aged-care hostel might be more appropriate.

Case report

Miss B was an 82-year-old retired clerical worker who had always lived alone. Local community groups helped her with washing, cooking, shopping and cleaning. Her general practitioner had seen her several times for ‘neglect’ and being ‘filthy’. Miss B had always refused to move from her home. Recently, her niece visited her from another state: she was appalled by her aunt’s situation and arranged to take Miss B to an aged-care hostel near the niece’s home for a ‘holiday’.

The local geriatric service was then asked to provide an opinion about Miss B’s suitability for permanent placement there.

On examination, her Mini-Mental State Examination score was 23/30—the 25th percentile for someone of her age and educational state [1]. A neuropsychology report revealed a range of cognitive impairments including disorientation, poor concentration, poor planning, impaired novel problem solving and severe memory impairments. Many of her other abilities were within the normal range.

The registrar who examined Miss B confronted her with evidence about the state of her house. She said that she would be quite all right there, as she had lived there without trouble for the last 50 years. She asked: “How would you like it, if a person turned up one day, took you away from your house, said you were going on holidays, and then flew you to somewhere like this, where you can’t even get away? You wouldn’t like that, would you?” The registrar felt that, despite some cognitive loss, Miss B had nonetheless demonstrated an ability to take in information about what had happened, process it appropriately and express a rational response. Since this indicated that she was competent, she should be able to return home if she wished, preferably with increased social support.

Her niece disagreed with this suggestion and requested a further opinion from the consultant geriatrician.

When the geriatrician interviewed Miss B, she had poor moment-to-moment recollection and repeatedly forgot names and topics of conversation. During the consultation, she lost her handbag and lost her way back to the consultation room. She said that she was only on holiday and was due to return home soon. The consultant noticed that her replies reflected her condition several years previously rather than her present state of health. For example, when he asked her how she would get food, she said she would walk down to the shop—although she had not done this for some years. These responses seemed to be consistent with her neuropsychological deficits. The consultant recommended that her period of respite care be increased, with the eventual aim of permanent placement in an aged-care hostel.
Discussion

Chronic self-neglect in elderly people has been labelled Diogenes' syndrome after the stoic Greek philosopher who lived his life wearing only a barrel. Patients with this condition have often had successful lives before their deterioration, and may only present to hospitals when they develop acute medical complaints [2]. When patients with severe self-neglect insist on returning home, this often meets with great resistance from both families and health-care professionals.

If doctors who care for such patients wish to override patients' decisions, then they must be certain that patients are not mentally competent, as there is a clear principle in ethics and law that competent patients are able to make decisions for themselves [3].

Assessment of competence

A general meaning of the word 'competence' is 'the ability to perform a task' [4]. Unfortunately there are no objective, universally defined standards for assessing patients' competence. Various criteria suggested include: evidence of rationality of choice [5–7], patient's understanding [8] or patient's appreciation of their situation [9]. Authors such as Pellegrino [10] have identified a number of capacities that contribute to competence (such as the capacity to receive, comprehend, retain and recall relevant information, the capacity to integrate the information received and relate it to one's own situation, and the capacity to evaluate benefits and risks). Yet there are no agreed standards for how such capacities are to be assessed or integrated into the overall assessment of competence [11].

The standard of competence may vary with the decision in question, yet it is unclear how this variation should be accommodated. Buchanan and Brock suggest that competence should vary with the risks of decisions: "The greater the risk relative to other alternatives ... the greater the level of communication, understanding, and reasoning skills required for competence to make that decision" [12].

However, it has been argued that: "It is confusing to blend the complexity or difficulty of a task with the risk of a decision. No basis exists for believing that risky decisions require more ability at decision-making than less risky decisions. To the contrary, a solid basis exists for believing that many non-risky decisions require more ability at decision-making than many risky decisions. These problems may be avoided by holding that the level of evidence for determining competence should vary according to risk, although competence itself varies only along a scale of difficulty in decision making" [4]. A difficulty with this view is that it may be more difficult to determine the complexity of a decision than its risks. For example, when deciding whether to choose one chocolate over another, the risks are easy to assess (i.e. nil), but the complexity of the decision is quite unclear.

Alexander [13] suggests that a number of different capacities define competent behaviour: the capacity to recognize that a purposeful decision-making response is required, the capacity to activate the cognitive mechanisms necessary to process the decision, and the capacity required to implement the decision's resolution. His view is that each capacity can be understood in terms of specific neurological capacities, and patients with specific neurological deficits may be incompetent to make some decisions yet not others, although the decisions may have equal risks or equal complexity.

This suggests that while patients require different levels of competence depending upon the complexity of the decision and its risks, they also require different types of competence for different types of decision.

Legal aspects

In law the assessment of competence has been approached in a number of ways. There is a general presumption that people are competent unless it can be shown otherwise. The High Court of Australia [Gibbons v Wright (1954) 91 CLR 423] addressed this issue by stating: "The principle ... appears to us to be that the mental capacity required by the law in respect of any instrument is relative to the particular transaction which is being effected by means of the instrument, and may be described as the capacity to understand the nature of that transaction when it is explained".

In the case of Re C [Adult: Refusal of Medical Treatment; (1994) 1 All ER 819] a paranoid schizophrenic patient who lived in a psychiatric facility refused to allow his gangrenous leg to be amputated. The court concluded that C's schizophrenia was irrelevant to his decision to refuse treatment. In Re T [Adult: Refusal Of Treatment (1993) Fam 95] Butler-Sloss commented: "(a) decision to refuse medical treatment by a patient capable of making the decision does not have to be sensible, rational or well-considered". This has been affirmed in Re MB (1997) (8 Med LR 217), in which the Court said that "panic, indecisiveness and irrationality in themselves did not amount to incompetence".

These sources suggest that competence should be established by deciding whether the person has the ability to understand the nature of the particular transaction. Once this is established, a person cannot be shown to lack competence simply because the decision itself is not sensible, rational or well-considered, or because the person has a diagnosis such as schizophrenia.

This approach to competence is most useful in simple decisions where the ability to understand the decision is easily assessed. For example, in the case of patients who require amputations for gangrene, there are only two outcomes that need to be considered—death from sepsis or survival with an amputation. If the patients are capable of understanding the nature of this choice, then they are competent to make the decision.
In more complex situations, different capacities may be required to understand the nature of the decision. Sometimes these are relatively easy to define. For example, in writing a will, patients require enough long-term memory to remember the claims of various heirs, enough comprehension and judgement to understand what a will is and enough immediate memory or registration to apply to the task of making the will [14].

In more complicated decisions, such as the decision to return to a disordered home, the exact capacities required to make the decision are not so clearly defined. A logical approach might be to carefully work through the decision with the patient, assessing his or her rationality at each point. Yet this may place a patient in an unfair situation as it leads to a type of circular reasoning. If a patient’s decision forms the sole basis of the examiner’s assessment of their competence, then the examiner might disallow decisions that he or she disagrees with.

Furthermore, while some decisions may be easy to work through, others lead inevitably to a range of further decisions. Decisions about accommodation may lead to further decisions about food, cleanliness, mobility, safety, finances and acceptance of services. These may, in turn, require many more capacities than can be easily recognized. In these situations, rather than working through each of these decisions, the assessment of patients’ global capacities (through neuropsychological testing) might become useful.

Testing for competence
Cognitive function is only one of the capacities required to make competent decisions. Yet, because cognitive deficits are common in elderly subjects, cognitive tests may be more reliable indicators of competence in this group [15]. However, Etchell et al. [16] found that neither clinical impressions or Short Mini-Mental State Examination scores were accurate in determining capacity.

Tests such as the Hopkins Competency Assessment Test [17] have been proposed for the formal testing of competency, yet it seems unlikely that any specific test is capable of integrating the wide range of defects that may challenge competency. In general, it appears that the assessment of competence should not be based solely upon cognitive assessments.

In the case of Miss B, the two clinicians took different views in assessing the degree of competency required for her to make decisions about accommodation. The registrar accepted a fairly low level of competency, which was assessed by talking through the particular decision at hand. The consultant required a high level of competency based upon both the decision at hand and an overall assessment of cognitive function by a neuropsychologist. These differences in approach reflect a lack of certainty that is found throughout the literature on competency.

Table 1 suggests a model for competency testing in which clinicians first examine qualitative and quantitative aspects of the decision to be made, then assess the patient’s reasoning in making the decision and finally attempt to place it within the context of the patient’s cognitive state.

It may also be possible to resolve such decisions without recourse to complex assessment of competence. In many circumstances it is possible to ‘defuse’ decisions, by reducing either their complexity or the severity of their consequences, hence reducing the degree of competence required. For example, if there is a risk of burning the house down that is not appreciated by the patient, removing unsafe stoves and heaters may decrease the chance of adverse events and make the environment more consistent with the patient’s own views of his or her safety. By defusing decisions in ways like this, patients’ decision-making ability may be accepted, even if they have low standards of competence.

In the case of Miss B, the patient saw the decision as straight-forward: she could return to her previous living situation (in which she had been living without problems for 50 years) or go to a hostel. Yet seen in another way, the decision was very complex and involved further decisions about a wide range of everyday activities. Miss B’s lack of short-term memory meant that she was unable fully to appreciate the difficulty of her present home situation and a further
examination of her cognitive status was therefore appropriate. Both registrar and consultant attempted to defuse the decision—by either improving services in her home or offering further respite care as a choice that was less confronting. Her final decision will eventually be between two less difficult choices—an aged-care hostel in which she already has experience or a more protected environment at home.

**Key points**

- When patients with severe self-neglect insist on returning home, this often meets with great resistance from both families and health-care professionals. If patients are competent, doctors must allow them to make their own decisions, even if these appear to be against their best interests.
- Different standards of competence depend on both the complexity and the consequences of the decision, and on the general cognitive state and specific cognitive defects of individual patients.
- The standards of competence required for a decision may sometimes be reduced, if its adverse consequences can be limited.

**References**