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## AUTONOMY, COMPETENCE, AND INFORMED CONSENT IN LONG TERM CARE: LEGAL AND PSYCHOLOGICAL PERSPECTIVES

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### I. INTRODUCTION

#### A. *Autonomy and the Elderly*

**P**ROTECTING the “autonomy” of older people has recently gained greater attention among policy makers, legal commentators, medical ethicists, psychologists and others.<sup>1</sup> Increasing focus has been directed at long term care settings such as nursing homes, which are thought to inhibit the free exercise of autonomy, particularly with regard to residents’ participation in decisions about their own care.<sup>2</sup> Indicative of this trend, the United States Congress recently passed legislation to require institutions to enhance autonomous decisionmaking for nursing home residents.<sup>3</sup>

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1. See, e.g., Marshall B. Kapp, *Medical Empowerment of the Elderly*, 19 *Hastings Center Rep.*, July/Aug. 1989, at 5. (discussing importance of having elderly persons make their own decisions while ensuring that they can transfer decision-making power to others if transfer made voluntarily and with caution).

2. See Alan Steinberg et al., *Patient Participation in Treatment Decision-Making in the Nursing Home: The Issue of Competence*, 26 *GERONTOLOGIST* 362 (1986) (“Recent reports have suggested that the frail elderly are a population particularly vulnerable to being denied participation in the treatment decision-making process.”); Alexander J. Tymchuk et al., *Medical Decision-Making Among Elderly People in Long Term Care*, 28 *GERONTOLOGIST* 59 (Supp. June 1988) (“There has been increasing concern that the rights of all people, and especially those of elderly and other vulnerable populations, be adequately protected.”).

3. Omnibus Budget Reconciliation Act, Pub. L. No. 101-508, § 4206, 104 Stat. 115 (1990) [hereinafter OBRA 1990] (commonly called “Patient Self-Determination Act”). For discussions of the Act, see American Bar Association, Commission on Legal Problems of the Elderly, *Patient Self-Determination Act* (1991); Alexander M. Capron, *The Patient Self-Determination Act: Not Now*, 20 *HASTINGS CENTER REP.*, Sept./Oct. 1990, at 35 (criticizing effect of Act); Margot L.

(1671)

In substance, this trend grows out of time-worn perspectives on autonomy and health care decisionmaking embedded in the doctrine of “informed consent”—the legal idea that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”<sup>4</sup> Inherently intertwined with the notions of autonomy and informed consent is the concept of “competency,” for informed consent law primarily protects those capable of making decisions on their own behalf.<sup>5</sup> Yet beyond this firm grounding in legal theory, the law continues to search for a workable application of the informed consent doctrine to avoid inappropriate denial of decisional autonomy while at the same time intervening on behalf of those unable or unwilling to make decisions for themselves.

Given psychology’s immediate relevance to the complex conceptual and diagnostic issues involved, it is surprising that the law has not drawn more explicitly upon psychological perspectives in evaluating autonomous decisionmaking under the informed consent doctrine. This article considers how psychological perspectives on autonomy and competency might improve application of the legal doctrine of informed consent to facilitate autonomous decisionmaking among elderly nursing home residents. We argue that psychology’s process orientation and focus on the complex interplay between personal, environmental and social factors can help expand the otherwise rigid and narrow elements of informed consent. Incorporating psychological perspectives may help the law distinguish between those situations in which an elderly person’s decisions should be implemented and those in

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White & John C. Fletcher, *The Patient Self-Determination Act: On Balance, More Help than Hindrance*, 266 JAMA 410 (1991) (summarizing effect of Act).

4. *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.), *overruled by* *Bing v. Thwnig*, 143 N.E.2d 3 (N.Y. 1957); see RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 24-30 (1986) (discussing history of informed consent doctrine beginning under battery theory of liability); see also PAUL S. APPELBAUM ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 35-36 (1987) (“Law’s concern for the bodily integrity of the individual . . . can be traced to . . . [civil] assault and battery and to the criminal law proscription of homicide, battery and mayhem.”).

5. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 79 (3d ed. 1989) (“Competence to consent . . . might be . . . described as a presupposition of the practice of obtaining informed consent . . .”). The law may implement decisions of patients who now lack competency but expressed preferences about care prior to becoming incompetent. In addition, in some instances, the law permits surrogates to make decisions on behalf of the incompetent person. See Paul B. Solnick, *Proxy Consent for Incompetent Non-Terminally Ill Adult Patients*, 6 J. LEGAL MED. 1, 16-29 (1985) (discussing legal and ethical issues surrounding selection of surrogate decisionmaker).

which paternalistic intervention is justified. Moreover, psychology can help identify intervention techniques designed to facilitate competent decisionmaking in the elderly and can help make informed consent a workable standard in clinical practice.

## B. *Nursing Homes as a Context for Autonomy and Competency Concerns*

### 1. *Demographics and Patient Characteristics*

Nursing homes are important settings for autonomy and competency issues for three reasons: (1) the projected increase in the number of elderly needing nursing home care; (2) the substantial individual lifetime risk of institutionalization; and (3) the functional abilities and disabilities of nursing home residents.

Over the next fifty years, the nursing home population is projected to triple, with an especially dramatic increase in those over eighty-five years of age.<sup>6</sup> These statistics suggest that many Americans and their families will have personal experiences with nursing homes. In fact, although only a small percentage of older adults reside in nursing homes at any point in time, a greater proportion will have spent some time in a nursing home before they die.<sup>7</sup>

The salience of autonomy and competency concerns in nursing homes becomes clear when these lifetime risks are considered together with depictions of the functional capacities of nursing home residents. Nursing home residents present a complex constellation of physical, psychiatric, psychological and functional limitations that call into question the capability of many to mean-

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6. U.S. SENATE SPECIAL COMM'N ON AGING, DEVELOPMENTS IN AGING: 1986, S. DOC. NO. 8, 100th Cong., 1st Sess. (1987). These projections assume no major shifts in health care delivery, efficacy, or public policy incentives for use of nursing homes. *Id.*

7. See Jersey Liang & Edward J. Tu, *Estimating Lifetime Risk of Nursing Home Residency: A Further Note*, 26 GERONTOLOGIST 560 (1986) (statistical study determining odds of individuals spending time in nursing homes); Erdman Palmore, *Total Chance of Institutionalization Among the Aged*, 16 GERONTOLOGIST 504, 505-06 (1976) (outlining factors that increase chances of institutionalization); see also Christopher M. Murtaugh et al., *The Risk of Nursing Home Use in Later Life*, 28 MED. CARE 952 (1990) (estimating probabilities of nursing home use).

Almost a third of men turning 65 in 1990 and just over half of women can be expected to use a nursing home sometime before they die. . . .

[A]bout seven out of ten couples turning 65 in 1990 can expect that at least one of the two will use a nursing home sometime before death.

Nine out of ten married children with four parents turning 65 can expect to have at least one parent use a nursing home.

*Id.* at 960.

ingly participate in decisions about their care.<sup>8</sup> Recent psychological research also reveals that staff perceptions about patients' ability to comprehend information and make informed decisions often does not conform with more objective measures of patients' actual ability.<sup>9</sup> Thus, while it is laudable to enunciate principles of autonomy and enact laws designed to facilitate patient participation in care decisions, to secure meaningful participation from a population characterized by high levels of disability requires careful analysis and perhaps a reformulation of traditional notions of informed consent.

## 2. *Regulatory Reform, Nursing Homes and Autonomy*

The difficulties of facilitating autonomous decisionmaking in elderly nursing home residents form a context for recent legislative and regulatory interest in residents' rights to self-determina-

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8. See Tamra J. Lair & Dons C. Lefkowitz, *Mental Health and Functional Status of Residents of Nursing and Personal Care Homes*, DHHS Publication No. (PHS)90-3470, at 6 (Washington, D.C. 1990) (estimating prevalence of mental disorders, problem behaviors and self-care deficits among nursing home residents).

40.9 percent of nursing home residents were without a mental disorder. Another 28.7 percent had dementia only, including chronic or organic brain syndrome, and 13.7 percent had dementia in combination with one or more other mental disorders. A similar proportion (15.5 percent) had a mental disorder or disorders, but no dementia. . . . Slightly less than half of all nursing home residents exhibited problem behaviors such as wandering, yelling, and hurting themselves or others physically. The most prevalent behavior problem was getting upset and/or yelling (31.1 percent), followed by wandering (11.1 percent), and physically hurting others (10.9 percent).

*Id.*

9. *E.g.*, L. Jaime Fitten et al., *Assessing Treatment Decision-Making Capacity in Elderly Nursing Home Residents*, 38 J. AM. GERIATRICS SOC'Y 1097, 1100 (1990). Fitten and colleagues presented three hypothetical treatment vignettes to residents in a Veterans Administration nursing home and compared objective measurements of the decisionmaking capacity of the residents with physician assessments of the residents' decisionmaking capacity. *Id.* at 1098-1100. The gap between the residents' performance and their physicians' assessments of their capacity for consenting to treatment was astounding. *See id.* at 1100. "Although about three out of four nursing home residents (77%) were judged by their physicians to be capable of consenting to dental treatment, only one third (33.3%) achieved a perfect score on the [consent capacity measure]." *Id.*

In another study, Terrie Wetle and colleagues highlighted the gap between perceptions of residents and nursing staff members in nursing homes. Terrie Wetle et al., *Nursing Home Resident Participation in Medical Decisions: Perceptions and Preferences*, 28 GERONTOLOGIST 32, 36 (Supp. 1988). When they asked about the information provided to residents regarding health information and involvement in medical treatment decision making, they found that "nurses (63.8%) were much more likely to believe that the resident was told all there was to know than were residents (28.3%)." *Id.*

tion.<sup>10</sup> Essentially, these laws require that residents be afforded the opportunity to participate in care planning and treatment decisions and be given adequate information to make decisions about their future care. For example, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) required that each nursing home resident have the right to: (1) choose a personal physician; (2) be fully informed in advance about care and treatment that may affect his or her well-being; and (3) participate in planning care and treatment or changes in care and treatment, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state.<sup>11</sup> The right to refuse treatment is a major focus of the relevant portions of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), commonly referred to as the "Patient Self-Determination Act."<sup>12</sup> Under OBRA 1990, institutions that receive Medicare or Medicaid funding must provide written information to each individual concerning his or her rights, under state law, to participate in care decisions, to execute advance directives such as living wills and to refuse treatment.<sup>13</sup>

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10. See Marshall B. Kapp, *Decision Making by and for Nursing Home Residents: A Legal View*, 4 CLINICS GERIATRIC MED., 667, 668 (1988).

These decisions may concern matters of mundane living, such as what clothes to wear, what food to eat, what television show to watch, and in what activities to participate. These decisions may also involve difficult and fundamental medical issues, such as which physician to select, whether to take one's medicine, whether to submit to a transfer to an acute care hospital so that aggressive life-sustaining treatment may be initiated, whether to permit intravenous feeding tubes to be inserted, whether to assent to the imposition of restraints or room transfers, or whether to agree to behavior control interventions such as electroconvulsive therapy (ECT).

*Id.* at 668.

11. Omnibus Budget Reconciliation Act, Pub. L. No. 100-203, § 4201, 101 Stat. 160, 165-66 (1987) [hereinafter OBRA 1987]; see generally Michael A. Smyer, *Nursing Homes as a Setting for Psychological Practice*, 44 AM. PSYCHOLOGIST 1307 (1989) (presenting extensive discussion of OBRA 1987).

12. See OBRA 1990, *supra*, note 3.

13. Specifically, § 4206 of OBRA 1990 requires that institutions that receive Medicare or Medicaid funding must maintain written policies and procedures:

- (A) to provide written information to each . . . individual concerning—
  - (i) an individual's rights under State law . . . to make decisions concerning . . . medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives . . . and
  - (ii) the written policies of the provider or organization respecting the implementation of such rights;
- (B) to document in the individual's medical record whether or not the individual has executed an advance directive;
- (C) not to condition the provision of care or otherwise discriminate

Several themes are important in considering the impact of OBRA 1987 and OBRA 1990 in the context of autonomy and competent decisionmaking. First, the legislation and subsequent regulations acknowledge the importance of state laws in shaping the rights of nursing home residents. Second, each act emphasizes the importance of assessing the competence of nursing home residents and allowing their full participation within the limits of their competence. Finally, both acts emphasize—either implicitly or explicitly—the concept of informed consent: In order to participate in medical treatment decisions, the nursing home resident must exhibit the competence to understand and act upon complex information.

## II. THE LEGAL DOCTRINE OF INFORMED CONSENT

### A. Introduction

Despite the broad principles of autonomy enunciated in recent legislation, the informed consent doctrine has been criticized as an unattainable legal and ethical ideal.<sup>14</sup> This section provides an overview of the legal informed consent doctrine, considers its limitations as applied to the elderly and suggests ways in which integration of psychological perspectives into the legal doctrine can facilitate autonomous decisionmaking among elderly nursing home residents.

With certain exceptions,<sup>15</sup> the law of informed consent re-

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against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law . . . respecting advance directives at facilities of the provider or organization; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

*Id.*

All three branches of the federal government have recently focused attention on residents' rights and the responsibilities of nursing homes to provide meaningful involvement for residents in this range of decisionmaking. See Kapp, *supra* note 10, at 667; see also Marshall B. Kapp, *Limiting Medical Interventions for Nursing Home Residents: The Role of Administrative Law*, in 1 *ADVANCES IN LONG-TERM CARE* 109 (Paul R. Katz et al. eds., 1991) (discussing influence of various types of law, especially administrative law, on nursing home residents' ability to participate in their care).

14. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 1-4 (1984) (discussing inconsistency between theory of having patients share decisionmaking and medical practices); Jay Katz, *Disclosure and Consent: In Search of Their Roots*, in *GENETICS AND THE LAW* II 121, 128 (Aubrey Milunsky & George J. Annas eds., 1980) (arguing that implementing doctrine of informed consent in context of genetic counseling will require many changes in existing practice).

15. See Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a*

quires health care providers to disclose sufficient information for patients to make informed decisions about medical care. Informed consent encompasses the gamut of treatment decisions: "do not resuscitate" orders, execution of living wills, refusal of treatment, or even termination of treatment (commonly referred to as the "right to die"). Failure to provide sufficient information or to obtain consent prior to treatment has historically subjected providers to liability for assault and battery<sup>16</sup> and, more recently, for negligence.<sup>17</sup>

The legal doctrine of informed consent, as gleaned from a patchwork of state judicial opinions and statutes, contains three essential elements: patients with *decisionmaking capacity* must be provided *sufficient information* to make an informed decision *volun-*

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*Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 431-33 (discussing various situations where there are exceptions to general rule requiring disclosure). Many states have enacted statutory exceptions to the requirement of informed consent, some of which are framed in terms of "defenses" to an informed consent action. See Theodore R. LeBlang, *Informed Consent: Common Law and Statutory Considerations*, 1-18 (ABA National Institute on Medical Malpractice 1991) (reviewing state statutes and case law on informed consent); see also Theodore R. LeBlang & Jane L. King, *Tort Liability for Nondisclosure: The Physician's Legal Obligations to Disclose Patient Illness and Injury*, 89 DICK. L. REV. 1, 45 (1984) (specifically discussing limits on duty to disclose).

Possible exceptions to the duty to disclose include the following: (1) where an emergency situation exists that precludes the ability of a patient to give consent, or the opportunity for a provider to secure consent, see ARTHUR F. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION* 355-57 (2d ed. 1988) (discussing emergency exception to informed consent); (2) where the patient does not desire to be informed or would have wanted medical care despite the known risks, e.g., ALASKA STAT. § 09.55.556(a)-(b)(2) (1983); (3) where the risks are known by the patient, are commonly known, or are too remote or insubstantial, e.g., N. Y. PUB. HEALTH LAW § 2805-d.4(a) (McKinney 1985 & Supp. 1992); and (4) where there is a "therapeutic privilege" such that a provider may use reasonable discretion in deciding to refrain from a full disclosure in order to avoid negatively affecting the patient's condition, e.g., ALASKA STAT. § 09.55.556(b)(4) (1983). In addition, a signed consent form may create a presumption that information was disclosed. See, e.g., GA. CODE ANN. § 31-9-6.1(b)(2) (Michie 1991).

16. See, e.g., *Pratt v. Davis*, 79 N.E. 562, 563 (Ill. 1906) (operating without consent gives rise to "an action for trespass to the person"); *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.) ("[A] surgeon who performs an operation without his patient's consent commits an assault . . ."), *overruled by Bing v. Thwnig*, 143 N.E.2d 3 (N.Y. 1957); *Rolater v. Strain*, 137 P. 96, 99 (Okla. 1913) (stating that physicians will be liable for damages if during surgery they go beyond that to which patient consented).

17. See, e.g., *Salgo v. Leland Stanford Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. Ct. App. 1957) (stating in medical malpractice suit based in negligence that "[a] physician violates his duty to his patient . . . if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment"). *But cf. Moure v. Raeuchele*, 604 A.2d 1003, 1008 n.8 (Pa. 1992) (stating that in Pennsylvania, lack of informed consent gives rise to action for intentional tort of battery, not action for negligence).



tarily, or free of undue influence or duress.<sup>18</sup> Stating the legal elements so tersely perhaps raises more questions than answers. How much and what type of information must providers disclose? Should providers be obligated to ensure that patients understand the information? When is consent truly voluntary, especially in an institutional environment and with a dependent, often acquiescent group, such as the frail elderly? Perhaps most difficult, how does the doctrine apply to those with transient or waning competence? Are providers obligated to facilitate competence through therapy or environmental manipulation? The complexity of these and similar issues will be highlighted as we turn to an analysis of the three elements of informed consent.

## B. *Analysis of Informed Consent Elements*

### 1. *Decisionmaking Capacity*

Consent can be informed only if exercised by a patient of "sound mind" or, in more contemporary parlance, with "decisionmaking capacity."<sup>19</sup> Hence, decisionmaking capacity is a precondition to informed consent.<sup>20</sup> Given the complexity of the determination, it is not surprising that no standard legal definition of capacity has emerged. Instead, each state develops its own definition through limited judicial precedent and, in some instances, by statute.<sup>21</sup> Courts have spoken in vague generalities that make consistent application difficult at best. Some commentators have suggested that judicial decisions on the issue can be broken into three standards: (1) capacity to reach a decision based on rational reasons; (2) capacity to reach a reasonable result through a decision; and (3) capacity to make a decision at all.<sup>22</sup> Because of their generality, these categories offer little gui-

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18. See MARSHALL B. KAPP & ARTHUR BIGOT, GERIATRICS AND THE LAW: PATIENT RIGHTS AND PROFESSIONAL RESPONSIBILITIES 23-32 (1985) (outlining elements of valid consent); see also BEAUCHAMP & CHILDRESS, *supra* note 5, at 78 (listing elements of informed consent).

19. See PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH I, MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 15, 55 [hereinafter PRESIDENT'S COMMISSION] (Washington, D.C.: U.S. Government Printing Office, 1982).

20. BEAUCHAMP & CHILDRESS, *supra* note 5, at 79.

21. For a 50 state review of competency standards used in guardianship proceedings, see STEPHEN J. ANDERER, DETERMINING COMPETENCY IN GUARDIANSHIP PROCEEDINGS 3-15 (American Bar Association, 1990).

22. BEAUCHAMP & CHILDRESS, *supra* note 5, at 83.

dance in evaluating individuals' capacity to make health care decisions.

Despite lack of uniformity and specificity, several important legal trends are noteworthy. First, it is generally recognized that informed consent law requires a determination about specific capacity to make a particular health care decision, rather than an evaluation of overall competency.<sup>23</sup> Thus, courts have recognized that although a patient may be declared legally incompetent to handle her affairs—for example, in a guardianship proceeding—she may nevertheless retain cognitive capacity to decide whether to have her leg amputated.<sup>24</sup>

Second, the law increasingly recognizes that competency is not an all-or-nothing phenomenon. Instead, decisional capacity is viewed along a continuum as a matter of degree. One court recently noted that “there are degrees of incompetency; some individuals are more incompetent than others.”<sup>25</sup> Some state statutes define decisionmaking capacity in terms of patients who, while lacking complete capacity, nevertheless are able to understand and appreciate the consequences of proposed medical treatment and communicate a choice about their preferences.<sup>26</sup>

Third, courts and legal commentators increasingly require assessment of patients' “functional capacity” to make decisions, rather than an evaluation of the reasonableness of their decisions or an assessment of status (such as old age or medical diagnosis) that is purported to interfere with decisional capacity.<sup>27</sup> Thus, an “unreasonable” decision such as refusing medications may nevertheless be implemented if the patient has the functional capacity to make such a decision. As one commentator noted: “The most important task for the legal standard of competency is to distinguish effectively between foolish, socially deviant, risky, or simply ‘crazy’ choices made competently, and comparable choices made incompetently. Although incompetent behavior may be restrained, identical competent behavior may not.”<sup>28</sup>

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23. PRESIDENT'S COMMISSION, *supra* note 19, at 3, 55; *see also* ANDERER, *supra* note 21, at 13-14 (discussing trend in guardianship law toward evaluation of specific decisionmaking capacities).

24. *Lane v. Candura*, 376 N.E.2d 1232, 1233-34 (Mass. App. Ct. 1978).

25. *In re Guardianship of Ingram*, 689 P.2d 1363, 1371 (Wash. 1984).

26. *See, e.g.*, IDAHO CODE § 39-4302 (1985) (“Any person of ordinary intelligence and awareness sufficient for him or her generally to comprehend the need for, the nature of and the significant risks . . . is competent to consent . . .”).

27. *See* ANDERER, *supra* note 21, at 8-10 (discussing trend in guardianship law toward functional definitions of incompetency or incapacity).

28. Paul R. Tremblay, *On Persuasion and Paternalism: Lawyer Decisionmaking*

In articulating such standards, the law has borrowed from the burgeoning ethical, medical and psychological literature on decisionmaking capacity.<sup>29</sup> Though no widely accepted standard has emerged, some commentators have identified factors that should be accounted for under such an assessment: "1) evidencing a choice, 2) 'reasonable' outcome of choice, 3) choice based on 'rational' reasons, 4) ability to understand [the implications of the choice], and 5) actual understanding [of the implications of the choice]."<sup>30</sup> Others question measures that include "rationality" of the decision and instead suggest that capacity depends on an individual's ability to understand the nature of the treatment choice presented, appreciate the implications of the various alternatives, and make and communicate a reasoned choice.<sup>31</sup> Finally, several commentators have suggested a risk-benefit analysis, where the amount of capacity required should depend in part on the gravity of the decision at hand; the more serious or life-threatening the decision, the greater the capacity courts should require of the decisionmaker.<sup>32</sup>

While there is no shortage of literature identifying standards for decisional capacity, several problems in application persist. First, little progress has been made in identifying specific psychological, environmental, social or other factors that mediate between mental status and decisionmaking capacity. The law's focus on the individual's decisional capacity gives short shrift to

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*and the Questionably Competent Client*, 1987 UTAH L. REV. 515, 537-38. As former United States Supreme Court Chief Justice Warren Burger noted, the right to self-determination is so important that it protects even "a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk." *In re President & Directors of Georgetown College*, 331 F.2d 1000, 1017 (D.C. Cir.) (Burger, J., dissenting from denial of rehearing *en banc*), *cert. denied*, 377 U.S. 978 (1964).

29. For a critical review of recent medical, psychological and legal literature on defining and assessing decisionmaking capacity, see Marshall B. Kapp, *Evaluating Decisionmaking Capacity in the Elderly: A Review of Recent Literature*, in PROTECTING JUDGMENT-IMPAIRED ADULTS: ISSUES, INTERVENTIONS AND POLICIES (Edmund F. DeJowski ed., 1990).

30. Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 280 (1977); see also, Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 NEW ENG. J. MED., 1635, 1635-37 (1988) (offering standards similar to Roth's for functional assessment of decisional capacity).

31. PRESIDENT'S COMMISSION, *supra* note 19, at 57-59.

32. See, e.g., James F. Drane, *The Many Faces of Competency*, 15 HASTINGS CENTER REP., Apr. 1985, at 17-21 (recommending use of sliding scale to determine competency whereby required level of competency increases as risks of treatment increase); Robert Weinstock, *Informed Consent and Competence Issues in the Elderly*, in GERIATRIC PSYCHIATRY AND THE LAW, 49, 61-64 (Richard Rosner & Harold Schwartz eds., 1987).

the array of external factors that could facilitate or inhibit exercise of such capacity.<sup>33</sup>

Second, despite near universal recognition that specific decisional capacity be assessed, some persist in deferring to general competency evaluations to determine specific capacity. For example, even OBRA 1987, the seminal legislation designed to enhance the autonomy of nursing home residents, implies that patients' rights to participate in treatment decisions could be abrogated by a judicial determination of incompetency.<sup>34</sup>

Third, legal precedent rarely views decisional capacity as a dynamic process involving the interplay of a variety of variables that constantly change over time. The element of time is crucial to the extent that external events—for example, moving into a nursing home—might cause temporary incapacity that could be restored over time.<sup>35</sup> Indeed, OBRA 1990 codifies the law's tendency to neglect time by requiring providers to educate and discuss advance directives with nursing home residents upon admission.<sup>36</sup> Yet psychologists argue that a one-time discussion of such matters during such a tumultuous time may inhibit rather than facilitate competent decisionmaking.

Finally, and perhaps most importantly, current legal informed consent applications do not recognize the interrelationships among all of the elements of the doctrine. Instead, the law typically requires an initial evaluation of whether a patient possesses decisional capacity pursuant to the factors described above, and then separate assessments of whether adequate information was provided and whether the decision was made voluntarily.

33. In particular, the law has not attempted in any significant way to assess the relationship between the environment and the person's capacity to make decisions, a relationship that psychologists view as paramount in assessing decisional capacity. For a discussion of this relationship, see *infra* notes 55-58 and accompanying text.

34. Section 4201 of OBRA 1987 states that a nursing home resident has the right to participate in care decisions except with respect to "a resident adjudged incompetent." OBRA 1987, *supra* note 11, § 4201. Perhaps unintentionally, the legislation adopts a presumption that a judicial finding of incompetence means that a nursing home resident is incapable of participating in health care decisions. This deference to general competency determinations stems, in part, from the absence of available frameworks to identify those factors that facilitate or inhibit specific decisionmaking capacity.

35. See L. Jaime Fitten & Martha S. Waite, *Impact of Medical Hospitalization on Treatment Decision-Making Capacity in the Elderly*, 150 ARCHIVES INTERNAL MED. 1717, 1719-20 (1990) (reporting study suggesting that presumably competent elderly persons may be at risk for developing decisional impairments during hospitalization for acute illness).

36. OBRA 1990, *supra* note 3, § 4206.

More contextual psychological perspectives view the elements as interrelated such that a patient's decisional capacity could be facilitated (or inhibited) by the manner in which the information was conveyed or by the circumstances under which the information was presented.<sup>37</sup> Thus, contextual psychological perspectives suggest that informed consent doctrine should view decisionmaking as an ongoing process and should recognize the importance of individual characteristics of patients, the relevance of environmental influence, and the reversibility of apparent defects in the decisionmaking process.

## 2. *Informed*

The second element of informed consent requires that patients be provided with adequate information to enable them to make an informed decision. Courts and legislatures have developed three standards to determine whether a decision is "informed;" each reflects the law's primary concern with guaranteeing that relevant information is disclosed, rather than that it is understood and assimilated by the patient.<sup>38</sup>

The traditional standard requires disclosure of information that "reasonable" health care providers would disclose in similar circumstances.<sup>39</sup> This provider-centered approach has been rejected in numerous jurisdictions. Instead, these jurisdictions adopt a patient-centered standard, requiring that providers disclose information that "reasonable" patients in similar circumstances would want to know in order to make informed decisions.<sup>40</sup> While this enhances individual autonomy to a de-

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37. For a discussion of how the circumstances under which information is presented affect decisional capacity, see *infra* notes 71-83 and accompanying text.

38. See KAPP & BIGOT, *supra* note 18, at 25-27 (discussing standards for disclosure).

39. See, e.g., *Fain v. Smith*, 479 So. 2d 1150, 1152 (Ala. 1985) (stating that in deciding whether disclosure of risks was adequate, objective standard used is whether physician disclosed all risks that reasonable physician in same or similar circumstances would have disclosed); *Doctors Memorial Hosp. v. Evans*, 543 So. 2d 809, 811-12 (Fla. Dist. Ct. App. 1989) (stating that expert witness required to establish standard of care of similar prudent health care provider that radiologist should have met in disclosing risks); *Leiker v. Gafford*, 778 P.2d 823, 830 (Kan. 1989) (standard is what "a reasonable medical practitioner would [disclose] under the same or similar circumstances"); *Foard v. Jarman*, 387 S.E.2d 162, 164-66 (N.C. 1990) (holding that physician who acted in accord with community standard of disclosure made sufficient showing of informed consent).

40. See, e.g., *Hartke v. McKelway*, 707 F.2d 1544, 1548 (D.C. Cir.), *cert. denied*, 464 U.S. 983 (1983) (stating that physician should focus on "patient's position" in determining what information to disclose); *Canterbury v. Spence*, 464

gree, some courts have gone further and adopted a purely “subjective” test that requires providers to disclose information that the individual patient at issue would want to know.<sup>41</sup> It generally is recognized that legal informed consent requires, at a minimum, disclosure of information “about the nature and purpose of the proposed treatment, its risks and benefits, and any available alternatives.”<sup>42</sup>

More recent commentators argue that informed consent also should require that the patient demonstrate actual understanding of the information presented.<sup>43</sup> However, this suggestion has been slow to infiltrate legal or clinical practice. The law continues to be preoccupied with the quantity and quality of information disclosed rather than with the format of the disclosure or the comprehension and assimilation of information by the patient.<sup>44</sup> In clinical practice, information is often disclosed via written consent forms, especially when advice has been sought from legal counsel.<sup>45</sup> Simply providing information may be ineffective in securing meaningful consent with nursing home residents whose comprehension is impaired by a variety of physical, emotional and psychological factors.<sup>46</sup>

As noted earlier, the information disclosure element typically is analyzed separately from the other elements of informed consent. This overlooks the fact that, especially for elderly people, the manner in which information is disclosed can dramatically af-

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F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (risk must be revealed if material to patient’s decision); *Cobbs v. Grant*, 502 P.2d 1, 11 (Cal. 1972) (“In sum, the patient’s right of self-decision is the measure of the physician’s duty to reveal.”).

41. *See, e.g.*, *Scott v. Bradford*, 606 P.2d 554, 558 (Okla. 1979) (requiring disclosure of risks “likely to affect patient’s decision”); *see also* BEAUCHAMP & CHILDRESS, *supra* note 5, at 90-91 (discussing advantages and disadvantages of subjective standard). *But cf.* *Barclay v. Campbell*, 704 S.W.2d 8, 10 (Tex. 1986) (using “reasonable person” standard).

42. APPELBAUM ET AL., *supra* note 4, at 49 (detailing the elements of disclosure).

43. *See* BEAUCHAMP & CHILDRESS, *supra* note 5, at 99 (“[U]nderstanding is a more important element than disclosure and may be the most important element in . . . obtaining an informed consent.”).

44. *See* Lori B. Andrews, *Informed Consent Statutes and the Decisionmaking Process*, 5 J. LEGAL MED. 163 (1984) (“Judicial opinions . . . focus on the standards of disclosure and causation rather than the content or format of the communication . . .”).

45. *See, e.g.*, SOUTHWICK, *supra* note 15, at 299 (recommending use of written consent forms).

46. *See* Lair & Lefkowitz, *supra* note 8. For further discussion of information processing in the elderly, see *infra* notes 69-81 and accompanying text.

fect the patient's capacity to make decisions.<sup>47</sup> As we shall argue at length in a later section, viewing the capacity and informed elements as interrelated encourages consideration of intervention techniques to help even cognitively impaired residents understand the relative risks and benefits of various decisions facing them. In this way, autonomous decisionmaking can be facilitated.

### 3. *Voluntary*

Informed consent also requires that competent patients making health care decisions do so voluntarily. From the law's perspective, any element of force, coercion, fraud or duress may render a decision void.<sup>48</sup> Voluntariness should be viewed as a matter of degree; it can be compromised by overt force or more subtly by coercion or manipulation.<sup>49</sup> Nursing home residents may be particularly susceptible to subtle influences, in part because of the psychological effects of institutional living.<sup>50</sup> However, the "voluntariness" requirement may be difficult to enforce, because health care decisions are ordinarily questioned only when residents disagree with proposed treatments.<sup>51</sup>

Although the law has difficulty enforcing this element, it is an important aspect of informed consent both legally and psychologically. Psychological theory underscores not only the centrality of voluntary action to psychological adjustment, but also the importance of viewing the voluntariness element as interrelated with the other informed consent elements. Psychological perspectives can help identify those situations and those decisions in which elderly residents are at risk of being unduly influenced. Psychological perspectives also can facilitate competent and voluntary

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47. For a discussion of how the circumstances surrounding the disclosure affect the patient's decisional capacity, see *infra* notes 71-83 and accompanying text.

48. See BEAUCHAMP & CHILDRESS, *supra* note 5, at 106. Voluntariness of consent requires "absence of psychological compulsion, and the absence of external constraints." *Id.*

49. See KAPP & BIGOT, *supra* note 18, at 23-24 (discussing interferences with voluntariness of patients' decisionmaking).

50. For a discussion of the particular susceptibility of nursing home residents to interferences with the voluntariness of their decisionmaking, see *infra* notes 84-94 and accompanying text.

51. See THOMAS GRISIO, *EVALUATING COMPETENCIES: FORENSIC ASSESSMENTS AND INSTRUMENTS* 315-16 (1986) (stating that "the question of competency simply might not be raised if the patient does not refuse the proposed treatment"); GARY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* 251 (1987) (suggesting that where patient assents to treatment, competency is likely to be questioned only when physician is concerned about potential tort liability).

decisionmaking by providing guidelines for presenting information in a non-threatening manner.

#### 4. *Conclusion*

In summary, the law recognizes the importance of informed, competent and autonomous decisionmaking in health care settings but has yet to identify rigorously those factors that inhibit or facilitate such decisions. Part of this failure stems from the law's tendency to analyze the elements of informed consent in a rigid manner, searching for objective tests against which to measure individual performance. In so doing, the law views the elements of informed consent in a piecemeal manner. The elements identified by informed consent doctrine provide a useful analytical framework to address the issue, but the elements must be viewed as inherently interrelated—that is, as aspects of an ongoing, dynamic process wherein a person's capacity to exercise decisional autonomy depends on a variety of impinging environmental, psychological and social factors. It is by facilitating this view that psychology can contribute most strongly to the legal understanding of decisional autonomy. Thus, the following section reviews psychological perspectives on competency, autonomy and informed consent, and identifies areas in which psychology can contribute directly to clarification of legal issues.

### III. PSYCHOLOGICAL PERSPECTIVES ON COMPETENCY, LEGAL COMPETENCY AND INFORMED CONSENT

#### A. *Psychological Conceptions of Competence*

For psychologists, the term competence is multidimensional, encompassing a range of impinging intrapersonal, interpersonal, social, psychological and environmental factors.<sup>52</sup> This multidimensional characterization of competence is conceptually consistent with legal conclusions that competency is difficult to define and should be evaluated from a variety of vantage points. Psychological conceptions of competency can help legal decisionmakers identify the range of factors relevant to evaluating decisionmaking capacity.

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52. See, e.g., Martin E. Ford, *Processes Contributing to Adolescent Social Competence*, in HUMANS AS SELF-CONSTRUCTING LIVING SYSTEMS 199, 205-06 (Martin E. Ford & Donald H. Ford eds., 1987) (discussing variety of ways concept of competence has been used in psychological literature).



### 1. *Competence From a Motivational Framework*

One school of psychological thought approaches competency from a motivational framework: “[C]ompetence [is] an organism’s capacity to interact effectively with its environment. . . . [I]t [is] necessary to treat competence as having a motivational aspect, and . . . the motivation needed to attain competence cannot be wholly derived from sources of energy currently conceptualized as drives or instincts.”<sup>53</sup> For elderly nursing home residents, the need to evaluate motivational factors that relate to decisional capacity seems paramount. An elderly person reluctantly placed in a nursing home who also is experiencing serious physical and mental problems may lack the motivation to participate meaningfully in decisions about medical care.<sup>54</sup> Though the decision not to participate in medical decisionmaking deserves respect, perhaps some attempt should be made to address the motivational inhibition on autonomy through therapy or counseling.

### 2. *Competence From a Contextual/Environmental Perspective*

In addition to examining the motivational aspect of competence, psychologists focus attention on competence as the organism’s capacity to interact effectively with its environment.<sup>55</sup> Recently, psychologists have focused on cognitive competence, and have highlighted a useful distinction between *competence* and *ability*:

[C]ognitive ability . . . refer[s] to the individual’s intellectual level as measured by conventional tests of intelligence and cognitive functioning. Cognitive competence is more difficult to define, but it can be loosely interpreted as the utilization of one’s abilities—cognitive, interpersonal, and others—in adapting to particular situations.<sup>56</sup>

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53. Robert W. White, *Motivation Reconsidered: The Concept of Competence*, 66 PSYCHOL. REV. 297, 297 (1959). White asserted that much of human behavior occurred in service of the attainment of competence and the corresponding “feeling of efficacy.” *Id.* at 329.

54. See Conrad M. Swartz & Carole Stewart, *Melancholia and Orders to Restrict Resuscitation*, 42 HOSP. & COMMUNITY PSYCHIATRY 189 (1991) (discussing impact of depression on decisionmaking regarding do not resuscitate orders).

55. See White, *supra* note 53, at 297, 323-30 (defining competence as “an organism’s capacity to interact effectively with its environment” and elaborating upon this definition).

56. Timothy A. Salthouse, *Cognitive Competence and Expertise in Aging*, in HANDBOOK OF THE PSYCHOLOGY OF AGING 310-11 (James E. Birren & K. Warner

In the legal context, evaluators might find this distinction between underlying cognitive ability and competence in actual performance useful. Too often, those evaluating competency for legal purposes have relied on purportedly objective psychological measures of intelligence or cognitive ability which are not designed to measure the degree to which individuals use their abilities to act autonomously or to make competent decisions. Commonly used tests are not designed to distinguish between cognitive ability and competent performance.

Other specific problems in using standard psychological tests to measure competence in the elderly are that most of the tests were not constructed specifically for this age cohort, the reliability of many such tests is suspect, most of the tests lack ecological validity, and finally, the tests are not capable of resolving the problem of differential diagnoses in the impaired elderly.<sup>57</sup> Accordingly, despite the allure of using objective, easy to administer psychological tests to determine competency in legal settings, many limitations exist which must be considered. Although there is a clear consensus that decisionmaking capacity is an essential element for assessment in long-term care, there is also a consensus that there are no generally accepted reliable, valid and simple assessment techniques for use in long-term care settings.<sup>58</sup>

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Schaie eds., 1990). A similar theme is echoed by Robert Sternberg and John Kolligian, who stress the multidimensional nature of competence:

[T]here are different dimensions of competence, and [competence] manifests itself in different ways. For instance, behaviorally, competence may take the form of maintaining control over external events; neuro-physiologically, competence may be achieved through the brain's ability to establish order among the disparate stimuli received by the senses; sociologically, competence may consist of a healthy adaptation to an environment or social context; and psychologically, competence may be experienced through the ways in which one perceives, judges, and evaluates oneself.

Robert J. Sternberg & John Kolligian, Jr., *Preface to COMPETENCE CONSIDERED AT IX* (Robert J. Sternberg & John Kolligian, Jr. eds., 1990).

57. For a more complete discussion of the limitations of psychological tests used to assess competency, see William M. Altman & Patricia A. Parmelee, *Discrimination Based on Age: The Special Case of the Institutionalized Aged*, in *HANDBOOK OF PSYCHOLOGY AND LAW* 408, 416-17 (Dorothy K. Kagehiro & William S. Laufer eds., 1992).

58. See L. Jaime Fitten et al., *Assessing Treatment Decision-Making Capacity in Elderly Nursing Home Residents*, 38 *J. AM. GERIATRICS SOC'Y* 1097, 1103 (1990) ("In the absence of full psychiatric, neurologic, and legal evaluations . . . it may be insufficient to explain to the [elderly] resident the nature of the medical problem, to outline treatment options, to offer a recommendation, and to accept his or her decision. . . . [U]nder such conditions, clinicians can and should more systematically and directly probe the patient's understanding of the issues involved and the reasoning underlying his or her treatment decision."); see also Kay Weiler, *Functional Assessment in the Determination of the Need for a Substitute Decision*

### 3. *Competence as a Labeling Phenomenon*

While acknowledging the importance of context, psychologists also emphasize the evaluative component of competence—evaluation by both self and others:

Clearly, competence and incompetence involve, at a minimum, an interaction among person, tasks, and situation. But more important, competence and incompetence are ascriptions to performance. They represent a labeling phenomenon. Thus, it is not the same thing to understand *performance* in, say, mathematics as to understand *competence* in mathematics. Performance pertains to how well a person does, whereas competence (in one of its meanings) refers to how well that person is perceived to do by someone, whether the self or another. To understand competence or incompetence is to understand a labeling phenomenon.

. . . .  
. . . [C]ompetence is not a maximum level of performance nor incompetence a minimum level, but, rather, both are prototypes—i.e., profiles based on people's conceptions of a construct.<sup>59</sup>

Conceptually, this characterization of competence is compatible with legal notions that evaluators should measure competence to perform specific tasks, not overall competence to perform all tasks as reflected in "perfect" competence. The concept of labeling, however, adds to the legal analysis by emphasizing that competence is in the eye of the evaluator. Legal decisionmakers must account for the fact that one's perception of an elderly person's competence, as measured by standard psychological tests or by direct observation, may have little relationship to his or her actual ability to perform specific tasks or to make particular health care decisions.

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*Maker*, 7 J. PROF. NURSING 328 (1991) (discussing nurse's role in assessing decisionmaking capacity); American Bar Association, Commission on Legal Problems of the Elderly, *supra* note 3.

59. Robert J. Sternberg, *Prototypes of Competence and Incompetence*, in COMPETENCE CONSIDERED 117-18, *supra* note 56 (emphasis in original). Frank Masterpasqua also has acknowledged the appraisal aspect of competence and the multidimensional nature of competence: "[C]ompetence can be defined as adaptive cognitive, emotional, behavioral, and social attributes, complemented by the person's implicit or explicit beliefs and expectations about his or her access to and ability to implement those attributes." Frank Masterpasqua, *A Competence Paradigm for Psychological Practice*, 44 AM. PSYCHOLOGIST 1366 (1989).

#### 4. *Competence as Perceived Control*

The notion of perceived or personal control is closely related to the motivational, contextual and labeling models of competence just reviewed. But whereas those formulations tend to treat competence more or less objectively, from the perspective of the outside observer, the concept of perceived control emphasizes the subjective experience of competence: the phenomenology of feeling effective in one's daily life and transactions with the environment.

A number of theorists and researchers have studied the importance of a sense of personal control for normal psychological functioning across the life-span.<sup>60</sup> Perhaps the most compelling of these analyses is Martin Seligman's work on learned helplessness, which vividly depicted the negative consequences of perceived lack of control in terms of experienced helplessness, depression, apathy and perhaps even premature mortality.<sup>61</sup> Because of the degenerative nature of aging, and hence its potential for reducing perceived control, there has been a great deal of research on the perception and exercise of personal control in late life, most of it indicating that strong benefits accrue to older persons from a sense of continued independence, mastery and control.<sup>62</sup>

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60. See, e.g., RICHARD DECHARMS, *PERSONAL CAUSATION* (1968) (presenting theoretical discussion of motivation and emphasizing importance of "personal causation"); EDWARD L. DECI, *THE PSYCHOLOGY OF SELF-DETERMINATION* (1980) (presenting motivational theory considering relationship among motivation, emotion, self-determination and well-being); MARTIN E. P. SELIGMAN, *HELPLESSNESS: ON DEPRESSION, DEVELOPMENT, AND DEATH* (1975) (discussing studies suggesting that loss of sense of personal control can result in sense of helplessness, depression and even death); Marjorie F. Lowenthal, *Toward a Sociopsychological Theory of Change in Adulthood and Old Age*, in *HANDBOOK OF THE PSYCHOLOGY OF AGING* 116 (James E. Birren & K. Warner Schaie eds., 1977) (discussing, in theoretical context, studies showing importance of sense of personal control for healthy development).

61. SELIGMAN, *supra* note 60.

62. See Greg Arling et al., *Institutionalization and Personal Control: A Panel Study of Impaired Older People*, 8 *RES. ON AGING* 38 (1986) (finding in study that institutionalization resulted in reduction in perceived control); Jerry Avorn & Ellen Langer, *Induced Disability in Nursing Home Patients: A Controlled Trial*, 30 *J. AM. GERIATRICS SOC'Y* 397 (1982) (finding in experiment that providing extensive assistance to nursing home residents resulted in poorer task performance, decreased self-confidence and increased perception of task difficulty); Ellen J. Langer & Judith Rodin, *The Effects of Choice and Enhanced Personal Responsibility for the Aged: A Field Experiment in an Institutional Setting*, 34 *J. PERSONALITY & SOC. PSYCH.* 191 (1976) (finding in experiment that nursing home residents told they had responsibility for themselves, given freedom to make choices, and given responsibility of caring for plant showed a significant improvement over comparison group on alertness, active participation, and general sense of well-being);

The perception and exercise of personal control are not, however, wholly intrapersonal; rather, they shape and are shaped by the physical and social environments. Thus, even the phenomenology of perceived control shares elements of the contextual and labeling models of competence offered earlier. From a contextual perspective, several insightful theoretical analyses suggest that institutional living itself may pose serious threats to one's sense of autonomy, control and even self.<sup>63</sup> Nursing home staff tend to perceive elderly residents as childlike, demanding and incompetent.<sup>64</sup> This tendency is reinforced not only by residents assuming the "sick role,"<sup>65</sup> but also by the hospital-like atmosphere and other cues in the nursing home environment.<sup>66</sup> Observations of staff-resident interactions have repeatedly shown that direct care personnel consistently reward resident helplessness

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Patricia A. Parmelee, *Social Contacts, Social Instrumentality, and Adjustment of Institutionalized Aged*, 4 RES. ON AGING 269 (1982) (finding in correlational study that control over social contacts was related to self-esteem, life satisfaction and perceived social control); Judith Rodin & Ellen J. Langer, *Long-Term Effects of a Control-Relevant Intervention With the Institutionalized Aged*, 35 J. PERSONALITY & SOC. PSYCH. 897 (1977) (finding in follow-up study that experimental treatment and/or processes that it set in motion had sustained beneficial effects over 18 months); Richard Schulz, *Effects of Control and Predictability on the Physical and Psychological Well-Being of the Institutionalized Aged*, 33 J. PERSONALITY & SOC. PSYCH. 563 (1976) (finding in field experiment that being able to control and predict social visits had powerful positive impact upon well-being of institutionalized aged); Michael Ziegler & David W. Reid, *Correlates of Changes in Desired Control Scores and in Life Satisfaction Scores Among Elderly Persons*, 16 INT'L J. AGING & HUM. DEV. 135 (1983) (finding in correlational study that extent to which elderly persons report control over desired outcomes was related to measure of life satisfaction and to staff ratings of control and vitality).

63. See IRVING GOFFMAN, *ASYLUMS* (1961) (presenting four essays providing sense of institutionalization experience from perspective of "inmate"); Ellen J. Langer & Jerry Avorn, *Impact of the Psychosocial Environment of the Elderly on Behavioral and Health Outcomes*, in CONGREGATE HOUSING FOR OLDER PEOPLE 15 (Robert D. Chellis et al. eds., 1982) (discussing ways in which institutional living may result in loss of perceived control and ways in which this problem may be overcome); Jeffrey Wack & Judith Rodin, *Nursing Homes for the Aged: The Human Consequences of Legislation-Shaped Environments*, 34 J. SOC. ISSUES 6 (1978) (discussing how nursing homes foster dependency and loss of personal control and possible solutions).

64. See H. Terri Brower, *Social Organization and Nurses' Attitudes Toward Older Persons*, 7 J. GERONTOLOGICAL NURSING 293 (1981) (providing general discussion of staff-resident interactions in long term care facilities).

65. TALCOTT PARSONS, *THE SOCIAL SYSTEM* (1951) (discussing how social forces create prescribed sick role in which patient must be helpless, technically incompetent and emotionally disturbed).

66. Alison I. Piper & Ellen J. Langer, *Aging and Mindful Control*, in *THE PSYCHOLOGY OF CONTROL AND AGING* 71 (Margret M. Baltes & Paul B. Baltes eds., 1986) (discussing how "physical and social environments of the elderly tend to encourage mindlessness").

and dependency, and ignore assertions of independence.<sup>67</sup> This situation, along with generalized ageism and older people's self-perceived decline,<sup>68</sup> may lead all involved to perceive and to label elderly nursing home residents as incompetent.

B. *Psychological Perspectives on Competency in Legal Forums:  
Combining the Competency and Informed Elements  
of Informed Consent*

Psychologists and psychiatrists who have worked on reformulating legal approaches to issues of competence emphasize the behavioral and labeling aspects of competence. Those involved in assessing the competence of an individual must make *judgments* about the individual's capacity to *function* within certain environmental and social constraints. Usually, these judgments focus on specific behavioral capacities.<sup>69</sup> Paul Appelbaum and Thomas Grisso, for example, suggest that assessments of competence to consent to treatment should focus on one or more of four behavioral capacities used in legal standards: communicating choices; understanding relevant information; appreciating the situation and its consequences; and manipulating information rationally.<sup>70</sup>

67. See Margret M. Baltes & Rainer Reisenzein, *The Social World in Long-Term Care Institutions: Psychosocial Control Toward Dependency?*, in *THE PSYCHOLOGY OF CONTROL AND AGING* 315, 320-36 (Margret M. Baltes & Paul B. Baltes eds., 1986) (reviewing research finding that dependent behavior of institutionalized elderly is rewarded).

68. See, e.g., J. A. Kuypers & V. L. Bengtson, *Social Breakdown and Competence*, 16 *HUM. DEV.* 181 (1973) (discussing how dependence on external social labeling may lead to internalized sense of incompetence in elderly persons).

69. See generally GRISSE, *supra*, note 51 (discussing methods for evaluating various legal competencies).

70. Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 *NEW ENG. J. MED.* 1635, 1635-36 (1988).

Communicating Choices

. . . [T]his concept requires the ability to maintain and communicate stable choices long enough for them to be implemented. . . .

Understanding Relevant Information

. . . The capacities at issue here include a memory for words, phrases, ideas, and sequences of information. But beyond the mere reception, storage, and retrieval of such information, patients must be able to comprehend the fundamental meaning of information about their treatment. . . .

Appreciating the Situation and Its Consequences

. . . .  
The attributes of the ability to appreciate situations include acknowledging illness when it is shown to be present, evaluating its effect

The ability to understand information is the behavioral capacity “referred to most often in legal cases and statutes” dealing with competence to make decisions.<sup>71</sup> Thus, the ability to understand information should be central to psychologists’ considerations of nursing home residents’ competence. The conception of competency as ability to understand information appears to implicitly include the first two elements of the legal informed consent doctrine—competent and informed. To consider competence without examining the ability of a person to understand, assimilate and manipulate the particular information relevant to the decision omits consideration of a vital part of the model. To evaluate a person’s ability to manipulate and assimilate information without considering how that information is presented also begs the question. Therefore, some psychologists have begun conceptually to merge the competence and informed elements in the legal model by viewing competence as a function of the manner in which information is presented to elderly people. They also have begun to facilitate competence by manipulating the manner in which information is presented.

Sherry Willis’ model of everyday competence for older adults provides a useful framework for considering both general competence in old age and the specific functional competencies that Appelbaum and Grisso highlight for legal decisionmaking purposes. Willis approaches these issues within a larger framework—the relationship between practical intelligence and psychometric approaches to measuring abilities:

Everyday competence represents the adult’s ability or potential to perform adequately those activities considered essential for living on one’s own. . . .

. . .[E]veryday competence represents the potential

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and the effect of the treatment options presented, and acknowledging that the general probabilities of risks and benefits apply to the situation. . . .

. . . .

#### Manipulating Information Rationally

Rational manipulation of information is the ability to use logical processes to compare the benefits and risks of various treatment options. . . .

Rational manipulation involves the ability to reach conclusions that are logically consistent with the starting premises. . . .

Assessing the relevant capacities requires examining the patient’s chain of reasoning.

*Id.* (footnotes omitted).

71. *Id.*

or capability of the individual to perform certain tasks, not the actual daily behaviors of the individual . . . .

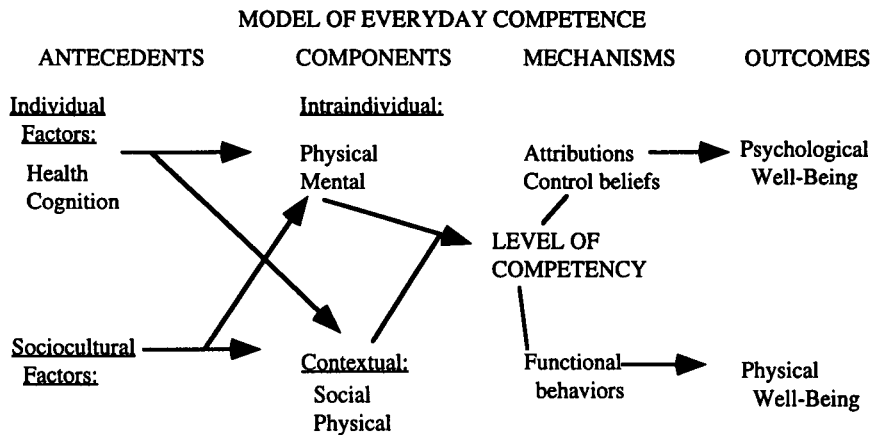
A second issue concerns the conceptualization of competence as involving multiple domains and multiple components. . . .

. . . [This] includ[es] both individual and contextual components. . . .

Finally, while everyday competencies may be judged to be universal when considered at the genotypic or latent construct level, at the phenotypic level they are culturally and contextually bound. . . .<sup>72</sup>

In applying her model of everyday competency to seven major domains of daily functioning,<sup>73</sup> Willis incorporates several noteworthy elements. First, the model embodies an interactive view, emphasizing both individual and contextual elements. Second, it acknowledges the variability in competence over time and across domains. Third, it avoids a dichotomy of competent/non-competent, while emphasizing the individual's level of competency within a particular domain. Moreover, Willis' work links the discussion of competence to the larger theoretical consideration

72. Sherry L. Willis, *Cognition in Everyday Competence*, in 11 ANN. REV. GERONTOLOGY & GERIATRICS 80-109 (1991).



Source: Willis, 1991:

Figure 1

73. *Id.* The seven major domains of daily functioning are medications, finances, shopping, meal preparation, transportation, telephone and housekeeping. *Id.* These are commonly known as the Instrumental Activities of Daily Living.



of the relationship between underlying abilities and their evidence in specific behaviors.

With regard to the legal informed consent doctrine, Willis' work emphasizes the importance of viewing the elements of informed consent as interrelated. Two recent studies illustrate the interface between the manner in which information is provided and the individual's consequent decisional capacity. Willis assessed the impact of different formats for presenting information upon decisional capacity among cognitively intact older adults. One study assessed older adults' ability to comprehend information from prescription labels.<sup>74</sup> Using a prototypical prescription label as a standard stimulus, Willis and Diehl assessed adults' ability to correctly identify the timing, dosage, duration and instructions from auxiliary labels. Using this single type of information (a prescription label), they found that the level of comprehension varied widely for different types of information on the label.<sup>75</sup>

A second study assessed the impact of different means of providing information (directions, charts, and forms) in different domains of everyday competence (e.g., food preparation, medica-

74. Sherry L. Willis & Manfred Diehl, *The Elderly's Comprehension of Information Regarding Commonly Prescribed Drugs*, (August 1989) (Paper presented as part of symposium entitled "Facilitating Medication Compliance in the Elderly," 97th Annual Convention of the American Psychological Association).

75. *Id.*

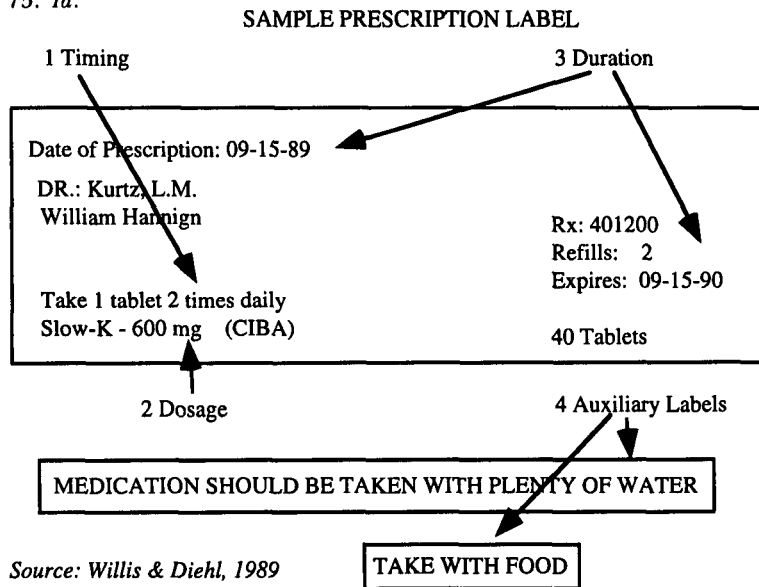
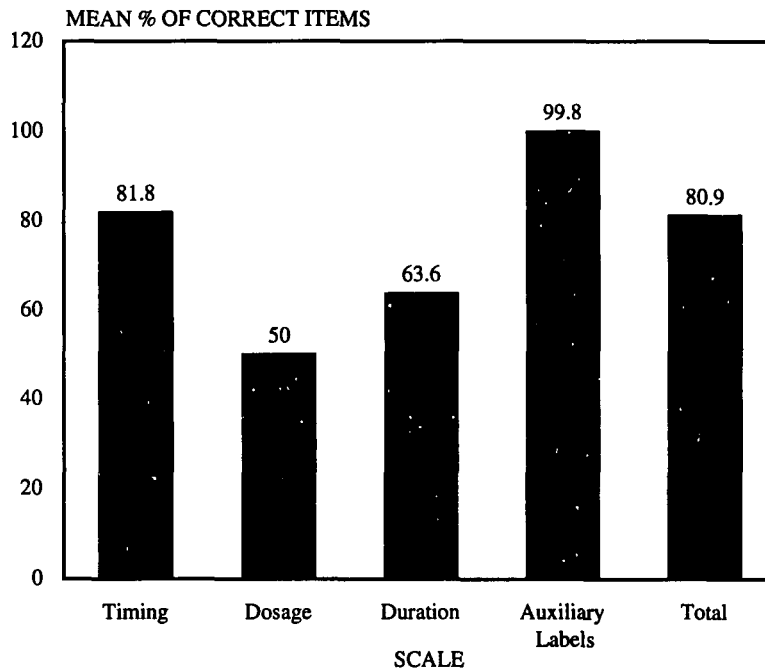


Figure 2

tion administration and telephone use).<sup>76</sup> Results indicated that community-dwelling older adults varied markedly in their performance within each domain, depending upon the means used to provide information.<sup>77</sup> In addition, there were differences across domains when the same format was used to provide

MEAN PERCENTAGE OF CORRECT ITEMS BY SCALE



Source: Willis & Diehl, 1989

Figure 3

76. Manfred Diehl, *Everyday Problem Solving in Older Adults: Performance-Based Assessment and Cognitive Correlates* (1991) (unpublished Ph.D. dissertation, Pennsylvania State University).

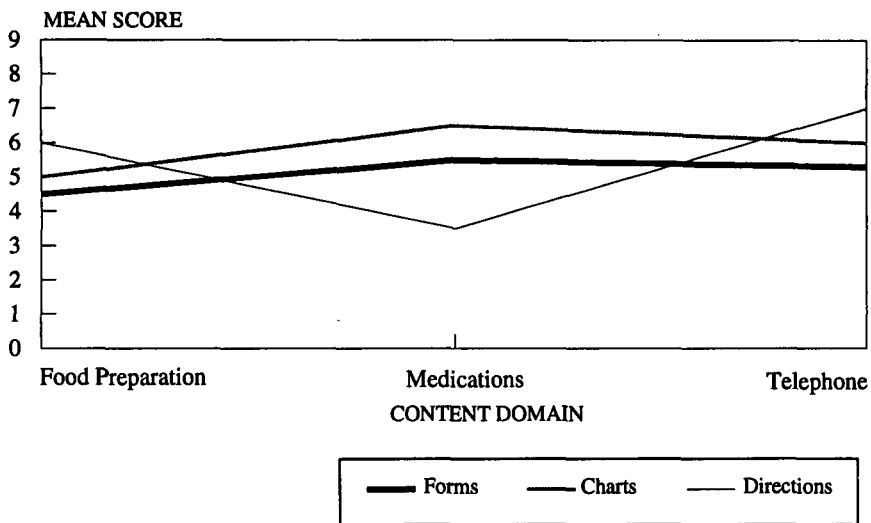
77. *Id.*

information.<sup>78</sup>

The implication of this research for the legal assessment of decisional capacity for legal purposes is clear. To the extent that information on medical care is presented in ways that enhance patient understanding, otherwise incapacitated patients can be made more competent through simple environmental interventions. Thus, legal rules and statutes could be modified to require that information be presented in ways consistent with Willis' framework to facilitate competent decisionmaking.<sup>79</sup>

78. *Id.*

MEAN PERFORMANCE SCORES ON OBSERVED TASKS OF LIVING  
BY CONTENT DOMAIN AND TASK FORMAT



Source: Diehl, 1991

Figure 4

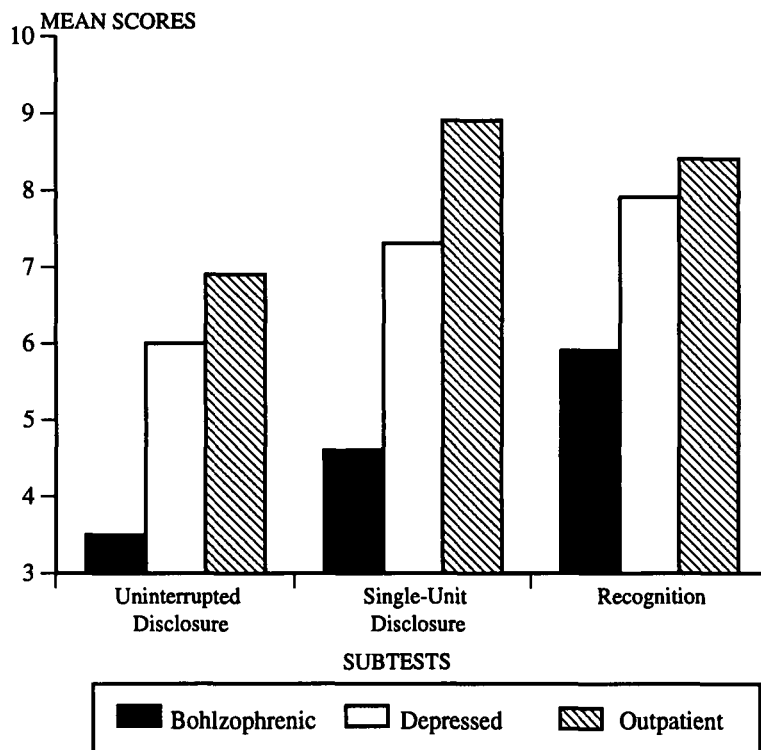
79. Another set of studies focuses on different approaches to conveying information to mentally ill individuals (regardless of age). Thomas Grisso and Paul Appelbaum, for example, have used standardized five-paragraph disclosure forms discussing four conditions: schizophrenia, depression, ischemic heart disease and deep venous thrombosis. Thomas Grisso & Paul S. Appelbaum, *Mentally Ill and Non-Mentally Ill Patients' Ability to Understand Informed Consent Disclosures for Medication: Preliminary Data*, 14 LAW & HUM. BEHAV. 667-79 (1991). They provided information in three different ways: uninterrupted disclosure; single-unit disclosure (breaking the description down by paragraph and asking questions immediately after each paragraph); and single-unit recognition (similar to single-unit disclosure, but asking for recognition of the correct information from a multiple choice format). *Id.* They presented the treatment information to four groups of patients: patients diagnosed with schizophrenia or schizoaffective disorder; patients diagnosed with major depression or bipolar disorder (depression); patients hospitalized with ischemic heart disease; and outpatients in a primary care clinic. *Id.*

Grisso and Appelbaum's preliminary results demonstrate, once again, the

Work by Alexander Tymchuk and his colleagues provides one example of the type of inquiry that can help legal decisionmakers and clinicians identify those aspects of the decision-making context that can be manipulated to enhance autonomy.<sup>80</sup> They developed two vignettes for high risk procedures and two vignettes for low risk procedures.<sup>81</sup> They used three presentation formats: a standard written description; a simplified format that used grammatically simpler structure and more familiar words; and a storybook format that accompanied the simplified verbiage

importance of both substance and format, as well as differences across patient groups (see Figure 5).

MEAN SCORES ON THREE UNDERSTANDING SUBTESTS,  
BY GROUP USING DEEP VEIN THROMBOSIS FORM



Source: Grisso & Appelbaum, 1991

Figure 5

80. Alexander J. Tymchuk et al., *Medical Decision-Making Among Elderly People in Long Term Care*, 28 GERONTOLOGIST 59 (Supp. June 1988).

81. *Id.* at 60. The high risk procedures were aortic valve replacement and carotid endarterectomy. *Id.* The low risk procedures were flu vaccination and sleeping pill use. *Id.*

with simple drawings.<sup>82</sup> Again, the differences in format and content produced significant differences in the effectiveness of decisionmaking as rated by expert judges.<sup>83</sup>

### C. *Voluntariness*

The third criterion of informed consent is that the decision must be made voluntarily. From a psychological perspective, this legal element may be paramount because it touches directly on cherished and psychologically central values of autonomy, self-determination and free will—that is, on individuals' perceived control. The psychological literature not only provides a focus for examining the voluntariness of informed consent, but also underscores the interrelatedness of all elements of the legal doctrine. The conception of competence as one's subjective sense of personal control is directly pertinent to the voluntariness of informed consent because voluntary action derives from and feeds back into one's sense of personal control. Older persons who feel "in control of their lives" may wish to be actively involved in making treatment decisions, and they may experience a feeling of helplessness or lack of control should they be excluded from decisionmaking. Yet the institutional environment may combine with older residents' general frailty to lead nursing home staff and elderly residents' family members to assume that older people are unable or uninterested in taking part in decisionmaking. Thus, decisions may be made without older persons' volition because they are simply never consulted about the issue.

Even when residents are consulted, their stated wishes may not be given full weight because of prevailing stereotypes about their competence to make reasoned decisions. In addition, the unwritten rules of proper resident conduct in nursing homes—rules that stress passivity, going with the flow and not making waves<sup>84</sup>—may lead older people to abdicate decisionmaking responsibility. In other cases, these unwritten rules may lead residents to acquiesce even when only very subtle pressure is placed on them by well-meaning family members or facility medical staff

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82. *Id.*

83. *Id.* at 62. The researchers found that "[t]here was less deterioration in decision-making after 1-week delay for the people who received information in the simplified or storybook formats than there was for the people who received information in the standard format." *Id.*

84. Robert L. Rubinstein & Patricia A. Parmelee, *Attachment to Place and the Representation of the Life Course by the Elderly*, in PLACE ATTACHMENT 139, 156-58 (Irwin Altman & Setha M. Low eds., 1992).

who feel that they know what is “best” for the elder patient. In short, the requirement that informed consent be voluntary may be overtly or subtly undercut by the prevailing power structure of long-term care institutions.

Research on “do not resuscitate” orders (popularly known as “DNR” or “no code” orders) illustrates the point well. A DNR order is a physician’s directive to withhold routine cardiopulmonary resuscitation (CPR) procedures from a given patient.<sup>85</sup> Just as they have the right to make other health care decisions, competent people presumably have a legal right to request or refuse that DNR orders be included in their medical records.<sup>86</sup> However, before OBRA 1990, formal policies regarding DNR orders were the exception rather than the rule in nursing homes.<sup>87</sup> Because the law cannot easily monitor such intimate exchanges, DNR decisions are rarely subject to legal review. Thus, responsibility for enforcement of the requirement that DNR decisions and other health care decisions be made voluntarily falls largely on health care providers and elderly residents’ families.

Existing data suggest that most competent older persons have definite—and generally unfavorable—attitudes toward receiving CPR or other life-sustaining measures.<sup>88</sup> However, although most older people say they would like to discuss such issues with their physicians, very few have actually done so,<sup>89</sup> and

85. See generally Stuart J. Youngner, *Do-Not-Resuscitate Orders: No Longer Secret, But Still a Problem*, 17 HASTINGS CENTER REP. 24 (1987) (discussing current practices regarding, and issues surrounding, decisionmaking about DNR orders).

86. For a general discussion of the legal status of do not resuscitate orders, see Dean M. Hashimoto, Note, *A Structural Analysis of the Physician-Patient Relationship in No-Code Decisionmaking*, 93 YALE L.J. 362 (1983).

87. See Steven H. Miles & Muriel B. Ryden, *Limited-Treatment Policies in Long-Term Care Facilities*, 33 J. AM. GERIATRICS SOC’Y 707, 708 (1985) (finding in 1985 that only 10.4% of long-term care facilities in Minnesota had administrative policies regarding DNR orders).

88. Bernard Lo et al., *Patient Attitudes to Discussing Life-Sustaining Treatment*, 146 ARCHIVES INTERNAL MED. 1613, 1614 (1986) (finding that majority of 152 patients studied “did not want life-sustaining treatment if demented”); Richard M. Snow & Karen Atwood, *Probable Death: Perspective of the Elderly*, 78 S. MED. J. 851, 852 (1985) (finding that only 5 of 70 patients in study (7%) “opted for all available measures to give every chance of survival”); Arnold Wagner, *Cardiopulmonary Resuscitation in the Aged*, 310 NEW ENG. J. MED. 1129, 1130 (1984) (finding in survey of elderly women that, in event of cardiac arrest in hospital, 11 wanted CPR, 77 did not want CPR and 64 wanted physician to choose).

89. Lo et al., *supra* note 88, at 1614 (finding in study of 152 patients that only 6% had discussed life-sustaining treatment with physician although 68% wanted such discussions).

only a minority make use of advance directives.<sup>90</sup> Additionally, physicians seem disinclined to involve patients or their families in the decision not to resuscitate.<sup>91</sup> As a result, not only are many DNR decisions not entirely voluntary, but the elderly patient may actually be excluded from the decisionmaking process. Physicians' and family members' assumptions about a patient's wishes are often erroneous,<sup>92</sup> and, in some cases, a patient's wishes may be directly and knowingly violated.<sup>93</sup> In short, a combination of

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90. Dallas M. High, *All in the Family: Extended Autonomy and Expectations in Surrogate Health Care Decision-Making*, 28 GERONTOLOGIST 46, 47 (Supp. June 1988) (finding in study of 40 elderly persons that only 6 (15%) had written directive regarding what they would want in medical care should they become terminally ill).

91. See Andrew L. Evans & Baruch A. Brody, *The Do-Not-Resuscitate Order in Teaching Hospitals*, 253 JAMA 2236 (1985). Evans and Brody found that out of 72 decisions to write DNR orders, only 20 (28%) had involved the patient. *Id.* at 2237. In 40 cases (56%), the decision to write a DNR order had been discussed with the family but not the patient; in 13 of these cases, the patient was deemed capable of decisionmaking. *Id.* In a survey of physicians of hospital patients who had actually undergone CPR, Susanna Bedell and Thomas Delbanco found that only 20 (13%) of the 154 patients and 21 (16%) of the 134 families had been consulted. Susanna E. Bedell & Thomas L. Delbanco, *Choices About Cardiopulmonary Resuscitation in the Hospital: When Do Physicians Talk with Patients?*, 310 NEW ENG. J. MED. 1089, 1090 (1984).

92. See Joseph G. Ouslander et al., *Health Care Decisions Among Elderly Long-Term Care Residents and Their Potential Proxies*, 149 ARCHIVES INTERNAL MED. 1367, 1370 (1989) (finding that in response to aortic valve replacement vignette, 47% of physicians and 39% of relatives thought elderly subject would make different decision than subject actually made; in response to carotid endarterectomy vignette, 62% of physicians and 31% of relatives thought elderly subject would make different decision than subject actually made); Allison B. Seckler et al., *Substituted Judgment: How Accurate are Proxy Predictions?*, 115 ANNALS OF INTERNAL MED. 92, 94 (1991) (finding that in response to current state of health scenario, only 88% of relatives and 72% of physicians accurately predicted CPR decisions of chronically ill elderly patients; in response to dementia scenario, only 68% of relatives and 59% of physicians accurately predicted CPR decisions of patients); Richard F. Uhlmann et al., *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. GERONTOLOGY: MED. SCI. M115, M117 (1988) (finding that for 5 out of 6 scenarios, percent agreement between patients' CPR or CPR plus ventilator decisions and physicians' predictions was not significantly better than that expected by chance alone, with percentage of incorrect predictions ranging from 27% to 48%; for 3 out of 6 scenarios, percent agreement between patients' CPR or CPR plus ventilator decisions and spouses' predictions was not significantly better than that expected by chance alone, with incorrect predictions ranging from 10% to 47%); see also Tymchuk et al., *supra* note 80, at 63 (noting that few elderly persons in study objected to presentation of "high risk" information in spite of staff and institutional review board concerns that elderly subjects would be uncomfortable receiving such information); Terrie Wetle et al., *Nursing Home Resident Participation in Medical Decisions: Perceptions and Preferences*, 28 GERONTOLOGIST 32, 36 (Supp. 1988) (finding that 64% of nurses believed nursing home residents had been given all information there was to know while only 28% of residents believed they had been given all information there was to know).

93. See Bedell and Delbanco, *supra* note 91, at 1090 (finding that in at least

misinformation, role relationships that emphasize patient incompetence and passivity, and perhaps well-meaning but nonetheless misguided paternalism interact to produce a climate in which the voluntariness of decisions for or against extraordinary treatments must be closely questioned.<sup>94</sup>

#### V. CONCLUSION: MERGING LEGAL AND PSYCHOLOGICAL PERSPECTIVES ON AUTONOMY AND INFORMED CONSENT

To summarize, the field of psychology offers some innovative ways to view legal questions of autonomy, decisional capacity and informed decisionmaking among elderly nursing home residents. Much of the preceding discussion has implicitly invoked the notion of transactionalism,<sup>95</sup> which views any psychological or functional phenomenon as an ongoing interplay of factors that can be fully understood only when viewed in relation to one another. From this perspective, autonomy is better viewed as a process rather than a state, and its fluidity across time and circumstances must be acknowledged and factored into any determination of decisional capacity.

Perhaps the most immediate application of the concept of transactionalism for the question of health care decisionmaking is its injunction to consider decisional capacity and informed consent standards contextually and as a whole. Thus, for example, the effects of cognitive deficits on decisionmaking capacity can only be assessed within and across the contexts in which decisions occur. More broadly, fulfillment of informed consent requirements depends not only upon what information is presented and in what format, but on the nature of the decision being made, the characteristics of the person making it, and the social and physical environments in which decisionmaking takes place. Informed consent presupposes decisional capacity, yet the manner in which information is presented shapes individuals' ability to compre-

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8% of 154 cases studied, CPR was performed even though physician believed that patient opposed procedure).

94. In addition, some commentators have speculated that care is foisted upon elderly people, without securing informed consent, because of reimbursement incentives. Marshall B. Kapp, *Enforcing Patient Preferences: Linking Payment for Medical Care to Informed Consent*, 261 JAMA 1935, 1936 (1989).

95. Transactionalism is "the study of the changing relations among psychological and environmental aspects of holistic unities. . . . The transactional whole . . . is a confluence of inseparable factors that depend on one another for their very definition and meaning." Irwin Altman & Barbara Rogoff, *World Views in Psychology: Trait, Interactional, Organismic and Transactional Perspectives*, in HANDBOOK OF ENVIRONMENTAL PSYCHOLOGY 7, 24 (Daniel Stokols & Irwin Altman eds., 1987).



hend and use it. Similarly, decisions about health care are truly voluntary only to the extent that the older person is involved directly in the informed consent process, either by receiving meaningful information about treatment options or by appointing in advance a surrogate decisionmaker.

One assumption underlying much of the preceding discussion is that facilitated autonomous decisionmaking is uniformly beneficial. Indeed, OBRA 1990 codifies the notion that nursing home residents should be involved in all facets of care, as long as they are "competent" to do so.<sup>96</sup> In fact, psychological perspectives on aging strongly suggest that it is not autonomy per se, but congruence between control options and personal capacity to exercise them that enhances well-being.<sup>97</sup> In addition, several psychological studies suggest that older persons vary considerably not only in their *competence* to make decisions, but also in their *desire* to exercise personal autonomy in health care and other kinds of decisionmaking.<sup>98</sup> Although there are several possible explanations for these individual differences, ranging from basic personality differences to the effects of normal aging or disease process, the bottom line is the same. For some persons, decisional autonomy is a valued right and its exercise is psychologically quite important; for others, it may be superfluous or even burdensome. For these two groups, health care decisionmaking may mean very different things and the exercise of autonomy in such decisionmaking may have diverse effects on the two groups.

More generally, psychological theory and research suggest that persons' "best interests" are inherently idiosyncratic and can

96. See *supra*, notes 3-13 and accompanying text.

97. For example, Powell Lawton maintains that functioning is optimized where environmental demands are congruent with individual functional capacity. M. Powell Lawton, *Competence, Environmental Press, and the Adaptation of Older People*, in *AGING AND THE ENVIRONMENT: THEORETICAL APPROACHES* 33 (M. Powell Lawton et al. eds., 1982); see also M. Powell Lawton & Lucille Nahemow, *Ecology and the Aging Process*, in *THE PSYCHOLOGY OF ADULT DEVELOPMENT AND AGING* 619, 657-66 (Carl Eisdorfer & M. Powell Lawton eds., 1973) (describing theoretical model in which congruence between individual abilities and environmental demands results in positive affect and adaptive behavior). From this perspective, more able elderly should benefit functionally and psychologically from an environment that demands that they use their abilities, including decisional competency, to the fullest. Overly supportive settings are presumed to produce boredom, depression and deterioration of existing abilities—i.e., docility. On the other hand, environmental demands that exceed the elderly person's ability will generate stress. Therefore, those who are disabled should be provided with supportive environments that are a good match for their abilities.

98. Wetle et al., *supra* note 92, at 37 (finding that some nursing home residents wanted to participate in treatment decisions whereas others wanted someone else to make health care decisions).

be identified and served only through careful examination of each individual and his or her circumstances. Implicitly or explicitly, this premise leads to a view of decisional capacity as a dialectic between the opposing forces of personal autonomy or self-determination versus the need for security through paternalistic intervention.<sup>99</sup> Both are necessary for psychological functioning and for older persons whose functional competence is compromised, limitations on autonomous action may be important to ensure physical and psychological security. To the extent that substituted judgment is properly implemented, it can enhance self-determination by removing from the elderly person a burden that he or she may be incapable or unwilling to assume. Thus, it has the potential to enhance the quality of life.

Autonomy is a complex concept both legally and psychologically. Intervention on behalf of the institutionalized aged is not intrinsically autonomy-curtailling; problems arise only when individuals are deprived of decisional authority improperly, because of failure to obtain informed consent. Thus, the central concerns are determining what in fact constitute proper circumstances for intervention and determining what factors should be considered in weighing such elements as voluntariness, decisionmaking capacity and the adequacy of disclosure among frail older people.

The probability of violation of informed consent standards in nursing home settings would be greatly reduced were the notion of transactionalism adopted more extensively by the courts and researchers alike. It is clear that the traditional legal orientation to fact—that is, to dichotomous determinations of decisionmaking capacity or other states—and the law's tendency to apply general decision rules to the "average" person are anachronistic because they are inconsistent with contemporary psychological perspectives on competence. Adherence to these legal traditions has led courts and legislatures in the past to fashion simplistic solutions to very complex problems, with only a minority of decisions reflecting sensitivity to individual differences among older people and their situations.

Psychology, for its part, too often fails to present its transac-

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99. See Altman & Parmelee, *supra* note 57, at 409-10 (discussing dialectic between autonomy and paternalism in context of medical and legal treatment of elderly persons); see also Patricia A. Parmelee & M. Powell Lawton, *The Design of Special Environments for the Aged*, in *HANDBOOK OF THE PSYCHOLOGY OF AGING* 464, 465-66 (James E. Birren & K. Warner Schaie eds., 1990) (discussing dialectic between need for autonomy and need for security in context of designing environments for elderly persons).

tional perspective in terms palatable to policymakers or the courts. Granted, the rise of transactional concepts, with corresponding contextual methodologies, has contributed to a much fuller depiction of the complexities of such phenomena as functional competence and personal control among institutionalized elderly. But investigators have only reluctantly examined these concepts in explicitly applied research. This is changing, as with Willis' groundbreaking work on functional competency, which is one of a very few attempts to plumb the implications of diagnostic measures for everyday functioning, and with the small but growing literature on informed consent. As these and similar issues continue to be explored, there is fertile ground for psychology to contribute to resolving current legal dilemmas of competency, informed consent and autonomous decisionmaking in long-term care settings.