

MENTAL COMPETENCY AND THE AUTONOMY OF PATIENTS

by

Barbara L. Secker

B.A., University of Toronto, 1991

**THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS (PHILOSOPHY)**

in the Department

of

Philosophy

© Barbara L. Secker 1993

SIMON FRASER UNIVERSITY

July 1993

**All rights reserved. This work may not be
reproduced in whole or in part, by photocopy
or other means, without permission of the author.**

APPROVAL

NAME: Barbara L. Secker

DEGREE: Master of Arts (Philosophy)

TITLE OF THESIS: Mental Competency and the Autonomy of Patients

EXAMINING COMMITTEE:

Chairperson: Dr. Martin Hahn

Dr. Susan Wendell
Senior Supervisor

Dr. Bjørn Ramberg

Dr. Earl Winkler
Department of Philosophy
University of British Columbia

DATE APPROVED:

28 July 1993

PARTIAL COPYRIGHT LICENSE

I hereby grant to Simon Fraser University the right to lend my thesis, project or extended essay (the title of which is shown below) to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the Library of any other university, or other educational institution, on its own behalf or for one of its users. I further agree that permission for multiple copying of this work for scholarly purposes may be granted by me or the Dean of Graduate Studies. It is understood that copying or publication of this work for financial gain shall not be allowed without my written permission.

Title of Thesis/Project/Extended Essay

MENTAL COMPETENCY AND THE AUTONOMY OF PATIENTS

Author: _

(signature)

BARBARA L. SECKER

(name)

9 August 1993

(date)

ABSTRACT

In *Mental Competency and the Autonomy of Patients*, I argue that competency is not simply a medical, biological or psychological concept that identifies some objectively determinable, fixed property of a patient. Rather, "competency" has a normative dimension shaped by society, based on certain moral and socio-political values and goals; in this and other ways, a patient's competence or incompetence is often socially constructed, that is, determined, at least partially, by social factors. I argue that contemporary theories of competency fail to realize their ethical and health policy aims due to both the nature of the dominant understanding of competency and the way competency issues have been construed. Further, preoccupation with establishing criteria and tests of competency masks the more profound issues: how traditional concepts of competency are brought about by certain prevailing societal values, and how these values - specifically those concerning individual autonomy - create, in many cases, the need for traditional construals of competency and incompetency. I then argue that, given the close relationship established in bioethics between concepts of competency and autonomy, developing a more realistic, relational account of patient autonomy would yield a practical notion of competency more adequate to the task of enhancing respect for autonomy and care of patients.

for William R.C. Harvey

ACKNOWLEDGEMENTS

I am indebted to Susan Wendell and Bjørn Ramberg for the invaluable assistance they have given me in the researching and writing of this thesis. I am very grateful to Susan Wendell for her ongoing encouragement, compassion and sense of humour, and for helping me to learn to enjoy my work.

I would like to thank Larissa Easson, Bill Harvey, Lorraine Landry, Mark Mercer and Dave Sturdee for their help and encouragement in this project.

I also wish to express deep gratitude to Julie Lefebvre, Bill Parsons, Jeff Secker, Lori Secker, Lois Todd, Larry Todd, and Susan Young for their moral support.

TABLE OF CONTENTS

Approval Page	ii
Abstract	iii
Dedication	iv
Acknowledgments	v
Table of Contents	vi
List of Tables	vii
Introduction	1
Chapter 1 - Mental Competency	6
1.1 Concepts of Mental Competency	6
1.2 A Philosophical Analysis of Selected Accounts of Mental Competency	16
1.3 Obstacles to Mental Competency	30
Chapter 2 - Individual Autonomy	35
2.1 Accounts of Individual Autonomy	35
2.2 A Philosophical Analysis of Selected Notions of Individual Autonomy	40
2.3 Obstacles to Individual Autonomy	58
Chapter 3 - Mental Competency and Individual Autonomy	60
3.1 The Relationship of the Meanings	62
3.2 The Relationship of the Criteria	64
3.3 The Relationship of the Applications	70
Chapter 4 - Alternative Conceptual Models	76
4.1 An Alternative Account of Autonomy	77
4.2 An Alternative Account of Competency	84
4.3 Alternative Conceptual Models and Standard Competency Issues	88
List of References	95

LIST OF TABLES

Table 1 -	The Dominant Model of Competency and the Kantian Model of Autonomy	67
Table 2 -	The Dominant Model of Competency and Dworkin's Model of Autonomy as Authenticity	68
Table 3 -	The Dominant Model of Competency and the Alternative Model of Competency	85

INTRODUCTION

In *Mental Competency and the Autonomy of Patients*, I argue that competency is not simply a medical, biological or psychological concept that identifies some objectively determinable, fixed property of a patient. Rather, "competency" has a normative dimension shaped by society, based on certain moral and socio-political values and goals; in this and other ways, a patient's competence or incompetence is often socially constructed, that is, determined, at least partially, by social factors. I argue that contemporary theories of competency fail to realize their ethical and health policy aims due to both the nature of the dominant understanding of competency and the way competency issues have been construed. Further, preoccupation with establishing criteria and tests of competency masks the more profound issue: how traditional concepts of competency are brought about by certain prevailing societal values, and how these values - specifically those concerning individual autonomy - create, in many cases, the need for traditional construals of competency and incompetency. I then argue that, given the close relationship established in bioethics between concepts of competency and autonomy, developing a more realistic, relational account of patient autonomy would yield a practical notion of competency more adequate to the task of enhancing respect for autonomy and care of patients.

In Chapter 1, after presenting a number of competing concepts of competency operating in the bioethics literature, I note that the bulk of this literature bypasses the question of the extent to which (in)competency can be socially constructed. I then assess a representative sample of the small subset of the literature that *does* bring to light a variety of factors which can enhance or undermine a patient's competence, and I discuss these and other factors as obstacles to competency.

In Chapter 2, I set out a number of accounts of individual autonomy found in the bioethics literature, and I examine critically two such concepts dominant in the health care setting. My critical analysis focuses on the applicability and adequacy of each concept of autonomy in the health care context. I then introduce some alternative ideas about autonomy that may lead to a more applicable, adequate notion of autonomy for bioethics. I conclude by showing that, as with competency, whether an individual is regarded as autonomous depends on social values and goals.

In Chapter 3, I explore some significant connections between dominant concepts of autonomy and concepts of competency in the health care setting, including the relationship between the meanings of the concepts, the relationship between the criteria of the concepts, and how the concepts are related in their applications. Based on the relationships established between these two concepts, I argue that if the dominant concept of autonomy were to change, it would be accompanied by corresponding change in the dominant concept of competency. Moreover, given my arguments in chapters 2 and 3, I conclude that the concept of autonomy is one of the key factors in the social construction of (in)competency.

In Chapter 4, I develop a preliminary sketch of an alternative relational model of autonomy for bioethics on which to base a corresponding alternative model of competency. I also consider whether these alternative models, which recognize the social construction of (in)competence, might resolve, redescribe, or create a different approach to the standard competency issues. The discussion I present in Chapter 4 is of an exploratory nature.

I have chosen to explore competency in relation to autonomy for a number of reasons. First, I am not aware of any feminist bioethical analyses of mental competency. Such analyses are needed because the concept of competency (like many other concepts

found in the health care system) embodies a power to oppress patients and mask other sources of oppression. Second, feminist analyses of autonomy need to be developed beyond critiques of nonfeminist accounts. An applicable - as opposed to an ideal - concept of autonomy is needed, one appropriate in formulating and meeting health policy goals. Third, in encountering feminist critiques of liberal, individualistic models of autonomy, and (generally sketchy) feminist proposals of alternative, relational models of autonomy, it struck me that competency issues would change quite radically given a relational model of autonomy. There are some interesting and important connections between concepts of competency and autonomy (as traditionally and as alternatively construed), which have yet to be explored in either the nonfeminist, or the feminist, bioethics literature. Fourth, in the health care setting and in the bioethics literature, patient autonomy generally operates as a fundamental, but relatively unanalyzed, notion. When what is meant by "autonomy" is given more careful attention, the picture of the autonomous person that emerges bears little resemblance to patients; thus, the adequacy and applicability of the currently dominant concepts of autonomy in the health care setting is questionable. By studying some of the issues associated with mental competency, I hope to expose some of the problems created in bioethics by unrealistic, inapplicable concepts of autonomy.

Although they are equal in importance to considerations of autonomy, I do not discuss in any depth theories of rationality or social justice, or relationships among rationality, autonomy, social justice and competency. The scope of this thesis is mental competency and individual autonomy in North America's present health care system (although I imagine that developing an alternative, relational theory of autonomy might have widespread, even global, implications).

This is a thesis in feminist health care ethics. Feminist bioethics and traditional bioethics are similar in that they focus on the importance of contextual details and actual persons in ethical problem-solving, they share an understanding of the moral significance of inequality within health care relationships, and they stress the values of caring and responsibility (Sherwin 1992: 76-84).

Feminist bioethics, however, is different from traditional bioethics in a number of important respects, which include, but are not limited to, the following. First, feminist ethics is characterized by its primary commitment to ending oppression: it "derives from the explicitly political perspective of feminism," wherein women's oppression (and oppression generally) is considered a principal moral and political concern, and it demands the elimination of all oppressive practices (Sherwin 1992: 49). In contrast, traditional bioethics has not characteristically included critical political analysis of the context of medical policy and practice and, thus, it is seen by some feminist ethicists as legitimizing the role medicine plays in maintaining society's oppressive and patriarchal structures (Sherwin 1992: 84-88). Second, the contextual nature of feminist ethics is both specific and general; that is, feminist ethics is interested in the details of a particular problem or case, and in how it is situated in and affected by not only the health care system, but also the larger historical, political, social and moral contexts in which health care operates. In contrast, traditional bioethics tends to view bioethical problems as created by individual cases and/or the health care system (Sherwin 1992: 88-92). Third, feminist ethics is committed to developing new models of interaction toward bringing about a system of health care that is "less hierarchically structured and less focused on matters of power and control than the current institutions" (Sherwin 1992: 92).¹

¹ For an excellent, detailed presentation of feminist health care ethics, see Sherwin (1992).

I intend this thesis as a contribution to the goals of feminist bioethics: to uncover ethical issues hidden from view in traditional assumptions regarding health care, to reconceive some crucial concepts and relationships in our health care system, and to realize a non-oppressive truly beneficial system of health care.

CHAPTER 1

MENTAL COMPETENCY

1.1 Concepts of Mental Competency

The practice of judging mental competency and incompetency in the health care context sparks conceptual and ethical questions, as well as practical concerns regarding social, legal and health care policy. A formal legal, or an informal medical, finding of incompetency may have a profound impact on a person's life, as it generally results in the loss of a particular right, or set of rights, accorded to competent persons.¹ For example, if an individual is deemed "incompetent," he/she may be formally or informally divested of his/her right to consent to or refuse medical treatment(s), choose a place of residence upon discharge from a health care institution, appoint a substitute decision-maker, access or disclose clinical records, manage financial affairs, and/or make or change a will.²

As widely expressed in the literature, competency determinations ideally are meant to promote self-determination where autonomy is present and to secure best interests where autonomy is absent. But, lack of agreement about what is entailed by the concept of mental competency, and how competency ought to be assessed, puts these ends in jeopardy. That is, persons who are competent may be found "incompetent" and, therefore,

¹ Although competency/incompetency determinations are, strictly speaking, legal (formal) determinations made by a judge, I am concerned mainly with medical (informal) determinations of competency/incompetency. Informal competency assessments (by psychiatrists and attending physicians) in the health care context occur much more frequently than do formal ones. Moreover, legal judgments of competency/incompetency typically rely heavily on medical diagnoses and expert psychiatric testimony.

² In the past, competency was conceived of as "general" or "global" (as opposed to task-specific), especially in the legal system. More recently, in the health care context, competency is usually viewed in task-specific terms. A person who is found incompetent to manage his/her estate may well be competent to make a decision about medical treatment alternatives. (See Silberfeld 1991 for a discussion of some of the advantages and disadvantages of conceiving of competency as task-specific rather than general.)

denied the right to make autonomous choices; and, persons who are incompetent may be found "competent" and, therefore, not afforded the necessary protection of their interests.

As Beauchamp (1991) points out, to say that there is no standard criterion, or set of criteria, of competence is not to say that there is no standard *definition* of "competence."

Underlying the various proposed criteria of competence is the core meaning of

"competence": "'X is competent to do Y' always means 'X has the ability to perform task Y.' 'Competence' thus *means* 'the ability to perform a task'" (Beauchamp 1991: 50).

Notice that Beauchamp conflates "ability" and "competence" in giving his standard definition. In doing so, he appears to depart from the ordinary use of "ability," which usually includes not only competence, but also means and opportunity. I assume that Beauchamp is equating competence and *intrinsic* ability, that is, ability independent of means and opportunity. For example, a patient may have the cognitive or psychological ability to make a decision about his/her health care (intrinsic ability), but he/she may not be given sufficient information to make a choice (means), or his/her practitioner may usurp his/her right to decide (opportunity).

The controversy surrounding the term stems not from disagreement about its basic, formal definition, but, rather, from disagreement over the acceptability of material criteria proposed to develop, or fill out, a concept or theory of competency with respect to a specific task (or kind of task). That is, the disagreement concerns which criteria yield a correct and applicable concept of competence (Beauchamp 1991: 50). Thus, the problem is: What does it mean to be competent/incompetent in situation S? More specifically: which abilities are relevant? To what degree must they be present (that is, at what point on the continuum is the threshold for competence to be set)? How do we test the level of these abilities?

In the health care setting, the general form these questions take is: what abilities, and what level of these abilities, does a person require in order to make a valid decision? And, of course, how do we test for a specified threshold level of such abilities? It is the various approaches and answers to these questions that occasion the dispute surrounding the concept of competency. In the remainder of this section, I will present a number of competing concepts of mental competency/incompetency (which represent the kinds of account or standard) operating in the bioethics literature.³ My purpose in so doing is to establish that one of the major competency issues is the lack of consensus about the notion of competency itself.

According to the Ontario Mental Health Act (R.S.O. 1980, s. 1(g)), "mentally competent" means "having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent."^{4 5}

³ I will be only *mentioning* these concepts of mental competency; I do not claim to do them justice.

⁴ I refer to Ontario's mental health legislation and, later, to the Ontario Ministry of Health's report on mental competency because, as an Ontario resident, I am not as familiar with other provinces' or countries' legislation and/or reports on the subject. In reading the literature from other parts of Canada and from the U.S., however, it is apparent that the major issues - the criteria of competency and the methods for its assessment - are the same.

⁵ Ontario's mental health legislation governing competency to make decisions regarding treatment, property and personal care has undergone recent changes. "An Act respecting Consent to Treatment" (O.M.H., 1992, Bill 109, s. 6(1)) provides the following revised definition of capacity (or competence):

A person who is capable with respect to a treatment [decision?] is able to understand the information that is relevant to making a decision concerning the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

"An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care" (O.M.H., 1992, Bill 108, s. 46) states that

A person is incapable of personal care if the person is not able understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

The (U.S.) President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behaviourial Research concludes that competency (or "decision-making capacity")⁶

requires, to a greater or lesser degree: (1) possession of a set of values and goals; (2) the ability to communicate and to understand information; and (3) the ability to reason and to deliberate about one's choices. (The President's Commission 1982: 57)

Culver and Gert suggest that "a patient is competent to decide whether to consent to or refuse treatment if she adequately understands and appreciates the information given to her during a properly conducted consent process" (Culver and Gert 1991: 621).

Elsewhere, they have defined ("tentatively") "incompetence" as follows:

[A] person is incompetent to do X if it is reasonably expected that any person in his position, or any normal adult human being, can do X, and this person cannot (and his inability to do X is not due to a physical disability). (Culver and Gert 1982: 54)

The Mental Incompetency Act (R.S.O. 1980, s. 1(e)) sets out the criteria for incompetence:

"mentally incompetent person" means a person,

Apart from substituting "capable" for "competent" and making more explicit what was previously implied (for example, with the addition of "relevant" and "reasonably foreseeable"), these definitions do not seem substantially different from the 1980 definition above.

I relegate the revised legislation to this footnote and keep the old legislation in the body of the chapter because I am concerned with the various notions of competency found in the bioethics literature, some of which adopts the old definition (see, for example, Roth 1977: 201) and which does not yet reflect the (minor) changes in the new legislation.

⁶ A relatively recent trend in bioethics is to use the term "decision-making capacity" to refer to informal assessments in the health care setting, and to reserve the term "competency" to refer to formal, legal assessments. This distinction reflects a move on the part of most bioethicists to view competence not as a general decision-making ability (the law has tended to view competency as a general or global feature of persons), but as a capacity to make an acceptable, informed choice with respect to a specific decision (or kind of decision). Most of the bioethical literature, however, uses the term "competency" to refer to both kinds of assessment. I will follow suit, except where the distinction is necessary for clarification purposes. (Note also that by "competency" I mean "mental competency.")

(i) in whom there is such a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury, or
(ii) who is suffering from such a disorder of the mind, that he requires care, supervision and control for his protection and the protection of his property;

Weisstub states that "competency" means

"the ability to process and understand information and to make well-circumscribed decisions based on that understanding....In a biomedical context, competency has become recognized as meaning the ability to understand information and to make rational decisions using such information" (Weisstub 1990: 26).

Weisstub refers to a specific (as opposed to general) competency to make a particular health care decision as "mental decision making capacity" which he defines as "the capacity to make an informed choice with respect to a specific decision ...[which requires] the subject to be able to understand the subject-matter of the decision and be able to appreciate the consequences of making or failing to make the decision" (Weisstub 1990: 32).

Beauchamp (1991) observes that, in surveying the bioethics literature, proposed criteria for competency can be grouped into seven general categories. A person is mentally competent to make a decision only if he/she is *able* to:

- 1) evidence a preference/choice regarding the decision at hand;
 - 2) understand his/her situation (or relevantly similar situations);
 - 3) understand disclosed information about the decision at hand;
 - 4) give a reason(s) in support of his/her choice;
 - 5) give a rational reason(s) in support of his/her choice;
 - 6) give risk/benefit-related reasons in support of his/her choice; and/or
 - 7) reach a rational/reasonable decision (judged, for example, in reference to a reasonable person standard)⁷
- (Beauchamp 1991: 65; for similar schemas, see Roth et al. 1977: 202 - 207; Caplan 1985: 179.)

⁷ Note that this range of abilities required by the various criteria for competence are ordered from the lowest level of required ability (criterion 1) to the highest (criterion 7).

Another common criterion for competency or incompetency is membership in a particular group/category. For example, young children and unconscious persons are typically presumed incompetent, and mentally disabled or elderly persons are often (mistakenly) presumed incompetent en masse.

Clearly, then, there is no consensus on what mental competency entails (and, consequently, no generally agreed upon threshold for competency or corresponding test).⁸ Even where it appears that some authors agree on a particular criterion of competency, their interpretations of that criterion may differ significantly. Disagreements about interpretation may arise because a particular criterion or concept of competency contains *other* concepts, the meanings or contents of which are disputed.

For example, consider Beauchamp's criterion 4 above: A person is mentally competent to make a decision only if he/she is able to give reasons in support of his/her choice. But, what is to count as a reason? A number of proposals have been made, such as a "reason" means: (a) a "rational reason"; (b) a "recognizable reason"; or, (c) a "relevant reason" (Weisstub 1990: 15).⁹ Suppose it is agreed that a "reason" means a "rational reason" (criterion 5). Such agreement would not necessarily lead to agreement about competency. There is considerable philosophical debate over how "rational" should be defined. This debate also affects the interpretation of "a rational or reasonable decision" in criterion 7. In the bioethical literature, it has been argued that "rationality" means: (a) behaving or choosing in a way consistent with a one's own values and goals; (b) behaving or choosing in accordance with how a 'reasonable' person in a similar situation would

⁸ I will not be discussing explicitly the various tests for competency/incompetency as such discussion is beyond the scope of this thesis.

⁹ It appears that criterion 4 does not preclude irrelevant or irrational reasons.

behave or choose; (c) choosing the best or most effective means of promoting one's chosen ends or goals (instrumental rationality); (d) choosing appropriate ends or goals (according to a particular theory of what is good for persons) (rationality of ends); and so on. (See, for example, Beauchamp 1991: 74, n. 5; Lo 1990: 196; Pepper-Smith and Harvey 1990: 3; Weisstub 1990: 15; Culver and Gert 1990: 629-632). For a more thorough discussion of some philosophical notions of rationality as they relate to concepts of competency, see Macklin 1983.) Similar controversy exists over the meanings of other key concepts, such as "understanding," "appreciation," "reasonableness," "risk" and "benefit."

Another discrepancy involves the fundamental concept of "ability." For example, if a patient wants to be discharged from the hospital to his/her home, and the health care professional believes that he/she should be discharged to an institution because the risks of living independently are too great, the patient's competency to choose his/her place of residence may be called into question. Testing the patient's ability to 'understand and appreciate' his/her situation may involve assessing his/her ability to function adequately in his/her home environment. That is, his/her functional ability may be taken as evidence of his/her cognitive or psychological ability to make a choice. By contrast, "ability to decide" can be understood apart from "ability to make one's decision effective in action." Some hold that a patient may have the ability to decide, but that he/she may make a poor decision, perhaps because he/she has not adequately taken into account his/her functional abilities, or his/her means and opportunities.

Of those who take functional ability as evidence of decisional ability, some argue that "ability" in this context means "actual ability," while others hold that it means "directive ability." That is, some insist that functioning adequately necessitates that one

function independently, whereas others maintain that a variety of formal and informal supports may allow one to function adequately by directing the actions of others (for example, if one can direct a trusted family member to take care of financial matters, or a live-in nurse to help with personal care). Thus, another form of disagreement about the notion of competency hinges on whether competency is viewed as simply an intrinsic, or as a relational, property of persons.

Another point of contention in the literature is whether criteria and assessment of competence should focus on the competence of the patient, or the competence of the decision or action.¹⁰ In other words, there is disagreement over whether it is the patient's ability to undertake the decision-making process, or the decisionmaking process, or the decision itself, that counts. A person may be competent, that is, have the *ability* to make a decision, but that person may fail, due to a variety of circumstances, to decide 'competently' in terms of process and/or outcome (see Pellegrino 1991: 31; Beauchamp 1991: 56-57). This tension is evident in Beauchamp's list of competency criteria above: criteria 1-6 appear to focus on the decisionmaking process, whereas criterion 7 focuses on the outcome. Those health care professionals who, despite the presumption of competence, question a patient's competency when he/she makes a certain kind of decision - for example, when he/she refuses treatment recommended by his/her health care professional - are focusing on the outcome of his/her decision, rather than the patient's ability to decide or decisionmaking process.

¹⁰ Note that a 'competent decision' does not make sense if competence is defined (as Beauchamp defines it above) as an ability. "Competent decision" or "competence of the decision" is ambiguous; it could mean: (1) a decision made by a competent person; or (2) a decision that is considered rational, given a particular standard of rationality, which judges (a) the means or the process of decisionmaking, and/or (b) the end or the content of the decision itself. I assume that, when "competent patient" and "competent decision" are contrasted, the latter refers to the rationality of the decision in sense (2).

In sum, the disagreement about the notion of competence is disagreement about acceptable criteria of competence and, further, about the interpretation and application of various criteria. Given the normative and conceptual complexity of the concept, the search for *the* criteria of competency (and *the* test of competency) "is a search for a Holy Grail" (Roth et al. 1977: 209).

I will use the following three case studies in this chapter and the remaining chapters in order to concretize my analyses of salient competency and autonomy issues.

Case 1:¹¹

Mrs. C. a 74 year old widow with congestive heart failure, angina pectoris, and mild dementia, has been admitted to the hospital for shortness of breath and chest pain. In the past three years she has suffered two heart attacks. During the past two months, her symptoms have worsened despite several medications.... Because there are no other medical treatments for her condition, her physician recommends angioplasty or bypass surgery in order to ameliorate her symptoms. Coronary angiography would be the first step, to see if angioplasty or surgery would be feasible.

Her dementia is mild. She has forgotten about several clinic appointments. She usually recognizes her primary care physician, but seldom knows the date or the name of the clinic. When she is hospitalized, her mental functioning gets worse. She has a nephew who lives in the same city and arranges for a woman to help her with shopping, cooking, and housecleaning. This woman seems to genuinely care for her. Mrs. C. can afford to pay for these services. She has no other relatives. She seems to enjoy watching television and sitting in the park. At clinic visits, she usually smiles when she sees her physician.

When asked about her wishes for further tests and treatment, Mrs. C. says that she wants to go home. After many discussions, the cardiology team convinces her to agree to an angiogram. But on the morning of the angiogram, she changes her mind, saying that she doesn't want anyone to put a tube into her heart. Before developing dementia, she has never expressed her preferences concerning life-sustaining treatment. Her nephew will do what she wants because she has always been independent and stubborn.

Mrs. C. is generally averse to medical interventions. Last year, she refused mammography for cancer screening, even though she is at high risk because of a family history of breast cancer. She has also refused drug treatment for a very elevated

¹¹ This case study is taken verbatim from Lo (1990: 193).

cholesterol level... after diet modification was unsuccessful, even though reducing her cholesterol might reduce her risk of further heart attacks.

Because some physicians and nurses are concerned that she is not competent to refuse tests or treatment, a psychiatrist is asked to see the patient. On a mental status examination, she does not know the date, the name of the hospital, or the name of her nurse. She recalls only one of three objects and cannot do serial subtractions from twenty. She cannot identify the President. She refuses to talk further with the psychiatrist, saying that she is not crazy.

Case 2:¹²

Mrs. G., an elderly widow who has lived on her own for a number of years, is hospitalized for treatment of a fractured hip resulting from a fall at home. In-hospital rehabilitation has restored some of her functional ability, but she shows some cognitive impairment. Moreover, an occupational therapy assessment has documented that she is unable to get to the toilet or cook without assistance. She cannot afford live-in help.

Out of concern that Mrs. G. may be at considerable risk at home, of falling while bathing, or of setting a fire while attempting to cook, the physician recommends that she consider placement in a nursing home. Mrs. G., however, is adamant: she denies that the O.T. assessment has demonstrated serious risk and demands to go home. In her opinion, the risks mentioned are not of overriding importance. Both the physician and the occupational therapist feel that Mrs. G.'s decision is irrational. She doesn't appear to understand or appreciate the risks she will face. On these grounds they question her competency to decide her place of residence. Mrs. G. is found incompetent to decide her place of residence and is discharged to a nursing home.

Case 3:¹³

Mr. W., 81 years old, was hospitalized as a result of a fall at home. The question arose of his competency to manage his finances and to live independently. Because Mr. W. had fallen on previous occasions, and had apparently acted 'appropriately,' concern was focused not so much on his ability to live independently, but on his ability to manage his estate. Mr. W. was apparently "confused and suspicious" about his finances; however, it was thought that the medications he was taking exacerbated his confusion and suspicion, in fact this state seemed to diminish when his medication was decreased.

A formal assessment of Mr. W.'s financial abilities yielded a low score on the Mini Mental State Examination (MMSE); however, Mr. W. had little formal education and it was felt that this factor should be taken into account in interpreting his score. Mr. W. couldn't remember specific information about the state of his finances, but he knew how and where to obtain such information. He couldn't write a cheque, but he could identify

¹² This case study is taken verbatim from Pepper-Smith and Harvey (1990: 3).

¹³ This is a hypothetical case study, although aspects of it are modelled after a real, but confidential, case study.

errors when someone else filled it out for him. His bank manager and his family helped him with his banking. Mr. W. was found competent to manage his estate.

1.2 A Philosophical Analysis of Selected Accounts of Mental Competency

The bulk of the standard bioethics literature on competency is concerned with identifying the appropriate criteria and effective procedures for the assessment of competence, primarily competence to make a health care decision (see, for example, Silberfeld 1990, 1991, 1992; Kline 1991, 1992; Pomerantz and Nesnera 1991; Mackay 1989; Draper and Dawson 1990; Culver and Gert 1990; Applebaum and Grisso 1988; Freedman 1981; Roth, Meisel and Lidz 1977). For the most part, this quest for (and debate over) the criteria and testing of competency bypasses the question of the extent to which (in)competence is an intrinsic attribute of a patient, and the extent to which (in)competence is determined by factors extrinsic to the patient.

For example, in considering the inconsistency in assessment outcomes resulting from a particular model of competency (the same patient is judged to be competent by one practitioner and incompetent by another), Culver and Gert state:

Thus, whether this patient is regarded as competent depends not on an attribute of the patient, but on a professional disagreement about the meaning of a set of signs and symptoms. Yet if "*competence*" is an *attribute of persons, which most believe to be the case*, then changes in competence should covary with changes *in the person*, not with theoretical disagreements between two physicians. (Culver and Gert 1990: 635-636; my emphasis)

These authors, like most in the field, do not consider how a patient's competence may be affected by other than internal changes or factors, how his/her (in)competence may be

largely socially constructed¹⁴; moreover, in failing to consider this, many accounts of competency appear to proceed on the unstated assumption that a patient is simply inherently competent or incompetent.¹⁵ As I will argue, this question is of fundamental importance and must be explored thoroughly before adequate criteria and tests of competency can be established.

There is, however, a small subset of the literature on competency which brings to light a variety of factors which can enhance or undermine a patient's competence. This subset can be divided further into two general groups. In the first group, discussion focuses on a narrow range of factors affecting competency, factors within the health care setting; in the second, a broader range of social, political and normative factors are identified. Both kinds of discussion raise, explicitly or implicitly, aspects of what I take to be the fundamental issue - the social construction of (in)competence.

In the remainder of this section, I will first describe briefly what I mean by "the social construction of (in)competence." I then will consider some of the insights and

¹⁴ It may be claimed that the mainstream authors concerned with identifying the appropriate criteria and effective procedures for the assessment of competence recognize that the absence of such criteria and procedures can (in a certain sense) 'create' incompetence. Clearly whether a patient is labelled 'competent' or 'incompetent' depends on at least (a) the competency criteria chosen, (b) how high the standard of competency is set, (c) the effectiveness of the test employed to assess competency, and (d) the skill of the practitioner in administering the test. (See Macklin 1983 for a discussion of how inaccurate findings of 'competence' and 'incompetence' may be due to the questionable expertise of psychiatrists, and the dubious accuracy or relevance of the test instrument(s) in detecting decisionmaking capacity; also see Silberfeld, Harvey, Dickens and Pepper-Smith (1988) for a discussion of how the absence of adequate criteria results in the "over-subscription" of incompetence and excessive institutionalization, and their proposed interdisciplinary approach to defining competency standards and making assessments; also see Weisstub 1990: 27-29; Morreim 1990: 105-108.) However, I am interested in other factors influencing (in)competence which may persist despite adequate criteria and effective test instruments. Moreover, clinical and social factors affecting (in)competence need to be taken into account *before* such criteria and tests can be created and their adequacy determined.

¹⁵ Sometimes the assumption is stated explicitly: "The law has tended to address competency as a fixed attribute of an individual, a characteristic in itself with an inherent stability" (Applebaum and Grisso 1981: 1466).

limitations of a number of discussions, taken from both groups identified above, regarding factors affecting competency.¹⁶ The goal of this section is to demonstrate that (in)competency is, in many cases, largely socially constructed, to provide a critical basis for discussion of the relationships between competency and autonomy in subsequent chapters, and to justify proceeding with a preliminary, alternative account of mental competency in chapter 4.

When I say that (in)competence is socially constructed, I mean that (in)competence is not simply an intrinsic property of a person, but, rather, is determined, at least partially, by social factors. Not only does society shape the notion of (in)competency, based on certain moral and socio-political values, beliefs and goals, but society also has the power to provide or withhold particular resources necessary to meet the standard(s) of competence it sets. Thus, the main reason for a patient's incompetence could be social, rather than individual. *To the extent that society can enhance or undermine a person's competence, (in)competence is socially constructed.*¹⁷ As the chapter progresses, I will

¹⁶ The authors I refer to in this section do not use the phrase "the social construction of (in)competency"; however, they recognize at least to some degree that patient competence often hinges on certain factors external to the patient.

¹⁷ This way of expressing the social construction of (in)competence can accommodate cases where a patient's incompetence is not socially constructed. For example, I do not tend to think of the mental incompetence of an irreversibly comatose or a severely mentally disabled patient as socially constructed. In such cases, there is no inherent ability which can be enhanced or undermined by social factors. (I suppose it could be argued that the incompetence of the comatose patient, for example, is socially constructed if her state, and thus her incompetence, was brought about by factors extrinsic to the patient, a gross error in drug prescription, for example. I am interested, however, in cases which fall into the 'grey area' where patients are not clearly competent or incompetent, where patients have at least some capacity for decisionmaking, and social factors will determine whether they meet the threshold requirement of a given standard of competence.)

make apparent some specific factors which contribute to the social construction of (in)competency.¹⁸

In "Clinical Issues in the Assessment of Competency," Applebaum and Roth (1981) express concern that, despite the influential role of psychiatrists in both legal and health care systems, little attention has been given to developing psychiatric skills for assessing patients' decision-making capacity. The authors state that, regardless of which test is chosen, the assessment of a patient's competency to consent to (or to refuse) treatment can be affected by various clinical factors. They identify five potentially influential factors that clinicians must consider when evaluating competency: 1) the "psychodynamic" elements of the patient's personality; 2) the accuracy of the historical information provided by the patient to the physician; 3) the accuracy and completeness of the information presented by the physician to the patient; 4) the stability of the patient's mental status over time; and, 5) the effect of the setting in which consent is sought. The authors stress consideration of each of these factors toward ruling out possible causes of "pseudo-incompetency," and toward arriving at a sound determination of either competency or incompetency.

To show how patient competence may be enhanced or undermined, I will look briefly at clinical factors #3 and #5.¹⁹ Regarding the third factor, when a patient has insufficient or distorted knowledge about the nature of his/her situation and proposed treatment, the locus of the patient's problem may not best be described as *in* the patient

¹⁸ For a related and more thorough discussion of how (dis)ability can be socially constructed, see Wendell (1989: especially 109-112).

¹⁹ It is neither practical nor necessary for me to explain how all the factors I mention in this article and throughout this section may affect patient competency. I will mention numerous such factors, but I will pick and choose only a handful of them to show how (in)competency can be created.

(that is, as resulting from deficiencies in his/her mental functioning), but as elsewhere in the health care setting. As Applebaum and Grisso point out, professionals caring for the patient (and generally many share this responsibility) may provide incomplete and/or confusing information to the patient; in addition, information might be given to the patient too far in advance such that it is forgotten by the patient at the time of the competency evaluation (Applebaum and Grisso 1981: 1464).

The authors suggest that, in order to eliminate any professional responsibility for a patient's confusion about, or lack of 'understanding and appreciation' of, the nature of his/her situation and his/her health care options, the physician's explanations to the patient should take place in the presence of a psychiatric consultant. While such a caution may legally protect the physician, it will not necessarily help the patient in his/her effort to demonstrate his/her competence. Applebaum and Roth make no reference to the standard of disclosure of information required. There are at least three from which to choose: the professional standard requires a level of disclosure which a 'reasonable' physician (or health care professional) would meet; the objective standard obligates the health care professional to disclose that information which a 'reasonable person' in a similar situation would need; and the subjective standard necessitates that the health care professional ensure that the patient in question, given his/her particular circumstances, has sufficient information to understand the nature of his/her situation. Clearly (unless the professional standard *becomes* the subjective standard), the subjective standard of disclosure will best promote a patient's 'understanding and appreciation' and, thus, on many accounts, his/her competency.

With respect to the fifth factor, the authors note that a patient's competence may be influenced by the setting in which the patient is to be evaluated and by the nature of

the evaluator. For example, a patient may need certain information in order to be able to 'understand and appreciate' his/her situation, but may be unable or unwilling to obtain the necessary information from a particular practitioner whom he/she dislikes, or in a hospital at which he/she is angry (Applebaum and Grisso 1981: 1465-66). Such patients, however, may be able or willing to hear the relevant information from another person in another setting. This is an important consideration, but the authors limit their discussion of the effect of setting to cases where "hostile" patients dislike the practitioners and/or the institutions.

In "Assessing Decision-Making Capacity," Lo (1990) devotes a section to outlining factors which may threaten a patient's competence and recommends ways that physicians can (and ought to) enhance the decision-making capacity of their patients. Lo considers additional factors (omitted by Applebaum and Grisso) related to setting. He points out that an unfamiliar hospital environment, and the loneliness and depression that often accompany it, may decrease capacity (even if only temporarily). Moreover, some patients may have difficulty trusting practitioners who are virtual strangers to them and, thus, these patients may be reluctant even to discuss treatment options with their practitioners. Since competence to make a health care decision cannot exist without knowledge of the decision to be made, Lo suggests that this problem might be overcome if continuity of care by hospital staff, and involvement in decision-making of the patient's primary care physician, family and friends, were arranged (Lo 1990: 196-197).

Other factors Lo considers which potentially affect the outcome of a competency assessment include: hearing impairments - many older patients have some impairment in hearing which may compromise understanding; communication difficulties - some patients are unable to speak or write (following a severe stroke, for example), but somehow must

express themselves if their competence is to be assessed; iatrogenesis - certain treatments (for example, drug therapies) often impair decisionmaking capacity; and, timing - not only do some patients need more time than others to make a decision, but competence may fluctuate as a function of a variety of possible factors. The strategies Lo presents for overcoming such difficulties demonstrate that the competence of some patients, who otherwise might be judged incompetent and excluded from decisionmaking, can be enhanced (Lo 1990: 196-197). Other clinical factors that should be considered include the potential impact of different languages, cultures and levels of education on the outcome of a competency assessment. In addition, making an important decision or being assessed for competency is very stressful for many patients; 'normal' reactions, such as fear, anxiety, ambivalence, vacillation, memory problems and misinterpretation of questions or requirements, should not be assumed to be symptoms of incompetence.²⁰

Although articles like those by Lo, and Applebaum and Roth are superior to the larger body of literature on competency which neglects to acknowledge factors affecting competency, these discussions are short-sighted. In addition to factors within the health care setting which practitioners must appreciate and respond to, there are other factors which originate in a larger social context that play important, and often unrecognized, roles in influencing (in)competency.

In her psychological essay, "The Illusion of Incompetence," Langer discusses her research findings and interpretations regarding "how and why people give up control" and the psychological consequences that ensue (Langer 1979: 301). According to Langer, people can relinquish control in two ways. First, they can infer a loss or lack of control

²⁰ For further discussion of problems surrounding informed consent see, for example, Meisel and Roth 1981; Cross and Churchill 1982; Lidz and Meisel 1983.

from the situation they are in. Second, people's actions can induce their giving up control. Langer's purpose is to demonstrate how all such instances of "relinquishing control...many lead to an illusion of incompetence and therefore, may indeed, be costly" (Langer 1979: 302). She argues, however, that the latter, action-induced lack of control, is both more pervasive and more debilitating.

Several of Langer's observations are valuable in considering why and how incompetency is created, and how it might be minimized or prevented. Langer states that situational inferences of incompetence may result from "learned helplessness," the presence of an apparently competent competitor, the absence of active-involvement, and a lack of familiarity with the task at hand. The latter three determinants appear especially relevant in considering what factors may bear on decision-making capacity and the outcome of a competency evaluation.

Langer states that many people, when put in a situation with an overtly confident individual, may deduce that they are incompetent at tasks that they can in fact perform quite effectively (Langer 1979: 304). Consider the physician-patient relationship. A physician or psychiatrist assessing a patient's competency certainly may appear to the patient as an "overtly confident individual" (and an overtly powerful individual) which, together with the patient's role as "the passive recipient of services" (Langer 1979: 304), indeed may cause the patient to feel and/or appear incompetent. Moreover, if a competency assessment takes place in an unfamiliar environment or involves an unfamiliar task, patients may feel incompetent and give up, or they may "attempt the task with more stress than is necessary or productive" (Langer 1979: 304). All of these factors, together with nervousness and anxiety about the implications of the outcome of the assessment,

may inhibit severely the capacity of a patient and bring about a finding of incompetence - a finding that will have a critical bearing on the patient's life.

According to Langer, inadvertent actions falling under the categories of "mindlessness," "self-induced dependence," and "premature cognitive commitment" can also lead to the appearance of incompetence. It is important to consider all three of these factors (with a revisioning of the second and third) and how they may have an impact on capacity and its assessment. First, when responses or tasks that were previously done unconsciously or automatically ('mindlessly') are consciously considered, poorer performance results, which may lead to an inference of incompetence. This phenomenon is particularly relevant to functional competency assessments where a patient's ability to perform the daily tasks of living is judged by an occupational therapist. Recall Mrs. G.'s case. The occupational therapist documented that Mrs. G. could not cook without assistance (she forgot to turn off the stove element, she stuck her fingers in the toaster, and so on). Perhaps some of the situational factors above, together with the fact that she was giving heightened attention to overlearned tasks, had something to do with the outcome.

Second, Langer states that elderly (especially institutionalized) persons are frequently led to an 'illusion' of incompetence because "they bear negative labels; they do not engage in previously engaged-in activities; and people are typically doing things for them" (Langer 1979: 308). While I disagree that this is best characterized as "self-induced

dependence,"²¹ it seems to me that it is important to consider seriously the impact of these factors on decision-making and competency evaluations.

Finally, Langer illustrates "premature cognitive commitment" with an example relevant to elderly persons' experiences of incompetence. Because old age has no "psychological reality" for many younger people, when exposed to information - that senility (characterized by forgetfulness) accompanies old age, for example - they may dismiss such information as irrelevant to themselves without examining its truth or why it may only appear to be the case.²² In originally assuming the irrelevance of the information to themselves, however, there is "an implicit assumption of relevance, validity, and consequence of this information for others" (Langer 1979: 310). When these people become old and experience themselves forgetting things or are called 'forgetful,' they may erroneously assume that they are becoming senile and incompetent.

While it appears that many of Langer's valuable observations and insights can be extended to thinking about mental competency in the health care context, her analysis is limited by her failure to consider 'the larger picture.' This shortcoming is reflected in her terminology - the language of her discipline.²³ Throughout the essay, she employs terms such as "giving up control," "learned helplessness," "self-induced dependence," and speaks

²¹ Our market society fails to integrate certain of its "unproductive" members, making them dependent and resenting them *because* they are dependent (c.f. "The only remaining social role for the elderly seems to be as the recipients of care" (Silberfeld 1991: 69)). For example, women have traditionally been herded away from roles in the recognized work force into devalued domestic roles, for which they receive little or no remuneration. Yet, the single, senior, impoverished woman is resented as a burden, as one who has failed to take responsibility for herself and her future. We can see how independence is upheld at the same time that it is undermined by the roles society constructs for many individuals.

²² "For example, since the elderly are often ignored for many reasons, they may not be given as many reminders as their younger counterparts; or they overlook the fact that young, nonsenile people also are not infrequently forgetful" (Langer 1979: 311).

²³ The nature of Langer's language was pointed out to me by Susan Wendell.

of elderly persons "allowing themselves to wear inferior labels [or negative] labels." This 'victim-blaming' language serves to mask important socio-political questions, namely, why these phenomena occur. For example, Langer does not consider how our culture's ageism labels elderly persons as inferior, how the social roles we construct for them create their dependence, how society causes them to "give up control."

Similarly, the use of the word "illusion" in the title of the essay (together with its contents) not only suggests that the illusion of incompetence is an individual, rather than a social, failing, but also that the individual's experience of incompetence is not real. (This is like referring to psychosomatic illnesses as "illusory" despite the presence of actual symptoms of illness.) The experience of incompetence in the cases described by Langer is not an illusion, but it can be seen as created (and perhaps reversible) rather than 'natural.'

Langer's article shows that incompetency or the appearance of incompetency can be created through the interplay of a variety of psychological, situational and behavioural factors. As I have suggested, it may be that the very nature of competency assessments and the assessment environment, together with certain aspects of human psychology, lead to findings of incompetence which do not accurately reflect a patient's abilities outside the evaluative context. Any adequate criteria and test of competency must take account of these kinds of factor.

In "Competency Assessments in Discharge Planning and the Question of Intergenerational Justice," Pepper-Smith and Harvey (1990) explore critically the seldom considered relationship between competency evaluations in discharge planning for the elderly, and the availability of social and health care resources. The authors argue that leading medico-legal interpretations of competency criteria, and the timing and setting of competency assessments in discharge planning, "may actually mask issues of resource

allocation" (Pepper-Smith and Harvey 1990: 3). In the language of ethics, competency determinations in this context raise issues of distributive justice.

Pepper-Smith's and Harvey's article is structured around a compelling case study (the second case study I set out above) which illustrates how poverty, alienation, and lack of both formal and informal supports for the elderly can bear on competency assessments. The patient in question is deemed incompetent to choose her place of residence because of "the risks inherent in her impoverished circumstances and because of a strong desire to return home" (Pepper-Smith and Harvey 1990: 4). Because the patient does not give overriding importance to the physical risks her physician is concerned with, she is perceived as failing to understand and appreciate her situation. As Pepper-Smith and Harvey state, "the significant fact is that this conflict [between physician and patient] is cast as a competency issue" (Pepper-Smith and Harvey 1990: 3).

These authors attempt to place the issue of competency in a larger moral and political context, and to understand how social distribution of resources can create 'incompetency.'²⁴ In addition, in considering the interpretation and application of competency criteria, the authors challenge traditional cognitive, instrumental conceptions of "rationality" and "appreciation." They state that these terms might be given a "more conative interpretation" such that "the pervasive, emotional aspects of the decision might be highlighted as eminently reasonable" (Pepper-Smith and Harvey 1990: 3). Furthermore, in discussing how competency ought to be evaluated, Pepper-Smith and

²⁴ Although it appears that Weisstub might give a moral and political analysis of competency, after describing competency as a construct - as "a value-laden concept serving socio-utilitarian ends" - in his first chapter, the remainder of the report and its recommendations do not follow up or reflect this insight (Weisstub 1990: 26).

Harvey emphasize the importance of the proper context for the assessment, given that "ability is habitually tied to setting and place" (Pepper-Smith and Harvey 1990: 4).

The authors' critical discussion regarding the importance of the interpretation given to competency standards, and the setting in which competency is assessed, demonstrates how the patient's decision to go home could be regarded as rational but for her lack of resources, which ultimately causes her "incompetence." The evaluation of the patient's competence is based on the concept of "anticipated risk" and, if she were able to afford assistance, the risks she is being asked to 'appreciate' would disappear: "What we have here is a rendezvous between a cognitive, instrumental interpretation of 'appreciation' and poverty" (Pepper-Smith and Harvey 1990: 4). Clearly, Pepper-Smith and Harvey view capacity as a relational, rather than simply an intrinsic, property of persons.

More generally, Pepper-Smith and Harvey note that, in Canada, over two-thirds of elderly people (many of whom are single women) live in poverty (see also Weisstub 1990: 16; Gee and Kimball 1987: 54).²⁵ They state that the lack of home-care services and other social support programs, together with the use of competency determinations, contribute to excessive institutionalization of the senior population. Those elderly persons who want to return home in spite of their poverty are effectively 'silenced.' We can see, then, the complex interplay between resource allocation and notions such as rationality and independence, and how this can lead to determinations of 'incompetency.'

²⁵ Again, it is interesting to note that Weisstub sets out facts regarding "geriatric poverty" but then states that "[t]he bleakness of the picture does not relate directly to capacity" (Weisstub 1990: 157). He appears to acknowledge that competency is tied to setting - he stresses the importance of "testing...the individual in the decisional context" (Weisstub 1990: 73) - but, unlike Pepper-Smith and Harvey, he does not consider how resources (or a lack thereof) may figure in the outcome of a competency assessment.

Toward furthering this already excellent discussion, I would suggest that we need to view the issue in an even larger moral and political context. To illustrate: The authors pose the question, "who sets the criteria of competency?" and their response is "[i]n a way, this does not matter. It is how the criteria are interpreted and applied in practice that makes all the difference" (Pepper-Smith and Harvey 1990: 3). While this may be true to a certain extent, it is, in fact, very important to know who sets the standards of competency, as such knowledge will provide insights into why and how such a concept is generated and sustained: How does the need for such a concept come about? Who has the power to institutionalize competency criteria and determinations, and to bring about the consequences that follow from them? Whose interests are served by such a concept, and who is oppressed by it? Similarly, although the authors hint throughout the article that resource allocation reflects societal values and power structures, they do not develop the connection between such values and systems, and why, how, and by whom, (in)competency is socially constructed.

In addition, as the authors state that competency is usually tied to setting, it would be helpful if they provided some clarification of what is meant by "setting." The notion of setting can be narrowly construed, for example, a patient's competence to care for herself may be tied to her home environment, in which she has developed certain coping mechanisms. Or, "setting" may be more broadly conceived to include not only particular environments, but also relationships (for example, friends, relatives, informal caregivers). It strikes me that developing competency criteria that account for the effects of setting in a broad sense, may alter, in time, dominant concepts of competency. If we could change the view of competency as an inherent, cognitive property of persons and understand it as a person's functional (perhaps even directive) ability in a relevant setting, then it might be a

small step from there to extend the concept of "setting" to "society" more generally. Perhaps then it could be acknowledged that someone's inability (incompetence) to "cope" or "measure up" is less a personal, than a societal, failure. Given a more relational view of competency, it would be difficult to imagine how society could justify not meeting certain fundamental needs of all of its members.

I would argue that Pepper-Smith's and Harvey's analysis does not address the issues identified in the last two paragraphs because it is limited by the standard bioethical methodology and assumptions (albeit less limited than is often the case). They venture to the far edge of this framework to consider macro-allocation issues, but do not proceed beyond because their concern is for fair distribution of resources between generations. They are citing availability of resources as an issue, but they are not asking why it is an issue. Why is our society even asking the question whether, in terms of justice, "we have any obligation to care for the elderly in the community through the provision of social-support programs, in order to assist those who wish to remain at home?" (Pepper-Smith and Harvey 1990: 4).

1.3 Obstacles to Mental Competency

In this section, I will use the cases set out earlier to illustrate more concretely some of the implications of choosing certain criteria and tests of competency, and how some of the factors mentioned above can construct 'incompetency.'

Consider Mrs. C.'s case. Depending on the criteria of competency adopted and the interpretation they are given, she may be regarded as competent or as incompetent. If the criterion of competency is evidencing a choice, Mrs. C. clearly has done so and, therefore, would be seen as competent. And, if the criterion is the ability to give a reason for her

choice, Mrs. C. has done this as well - simply, she does not want a tube put in her heart, and she wants to go home. However, if the chosen criterion of competency is that Mrs. C. give rational reasons for her choice, or that the outcome of her decision be rational, she likely will be found incompetent. Note that Mrs. C.'s competency to make a decision regarding medical treatment was called into question because she refused what was considered the medical good. Since many practitioners consider the outcome of the patient's decision to be evidence of (in)competence, had Mrs. C. consented, the question of her competency likely would not have arisen. If "rational reasons" is given a minimal subjectivist interpretation (rather than a more stringent objectivist one), such as "consistency with one's own values and goals," a case may be made for Mrs. C.'s competency given that she has a history of refusing medical intervention.²⁶ We are not given the outcome of Mrs. C.'s competency assessment, but clearly her case could go either way, and this fact illustrates how (in)competency can be constructed.

Assuming Mrs. C. is declared incompetent to refuse the recommended treatment, her incompetence may have been brought about by the effects of the several medications she is taking. Or, her apparently incompetent refusal could have resulted from a lack of understanding of her situation which, in turn, may have resulted from the health care team's inadequate disclosure of information. Perhaps the team appealed to the objective standard of disclosure, but Mrs. C. needed more time spent explaining things to her in ways that she could understand.

Moreover, it is noted that Mrs. C.'s mental functioning is worse in the hospital, yet it is there that she undergoes her mental status examination. Had it been conducted in another environment, perhaps Mrs. C. would have performed better. (And, as Macklin

²⁶ A very similar analysis could be given of Mrs. G.'s case.

(1983) and others have asked, what does the fact that Mrs. C. cannot name the hospital, her nurse, or the President have to do with her ability to make the decision at hand?) Similarly, if Mrs. G.'s assessment by the occupational therapist was conducted in the hospital, she may have performed poorly due to the foreign environment. Although it is recognized that the ideal setting for such assessment is the patient's own home, patients are often assessed in an institutional setting because to do so is less expensive. Here, then, is another way in which resource allocation can have an impact on the outcome of competency determinations.

As was illustrated above, what stands between Mrs. G. and her being judged competent to choose her place of residence is her poverty. If ours was a society that provided sufficient resources for its elderly and disabled members, then Mrs. G. likely would be deemed competent in this respect. Mrs. C.'s competence to decide her place of residence is not called into question because she can afford to pay for services that allow her to manage at home.

Whether Mr. W. is deemed competent to manage his estate depends on the assessor's understanding of competency: does the assessor require that Mr. W. be able to manage his estate independently (actual capacity), or merely that he be able to direct someone to manage it for him (directive capacity)? There is considerable disagreement over whether patients should be assessed in, or apart from, their day-to-day context, which may contain certain relationships and formal and informal supports that allow them to perform (or direct the performance of) the required tasks. Notice also that if Mr. W. did not have certain informal supports (for example, if he did not have a family or a bank manager willing to assist him), he likely would have been declared incompetent. Again, this shows that his competency, or incompetency, is not simply an inherent property, that

it depends on the operative account of competency and, in Mr. W.'s case, on whether there is anyone available to respond to his directives.

Furthermore, it was thought that Mr. W.'s low score on the mental status exam might be partly attributable to his lack of formal education. If social conditions lead to lack of basic educational opportunities, and a test of competency requires a certain level of education, then this is another social factor that may construct incompetence. If the factor of education was not identified and taken into account by the assessment team, Mr. W. may have been declared incompetent on the basis of the low test score.

We give the health care and legal professions the power to set the criteria of competence and to assess competence, based on concepts of health, disease, rationality, autonomy, ability, and so on, shaped largely by the health care profession. At a fundamental level, the concept of competence reflects the dominant social system of value; the substance and value we give to related concepts such as rationality and autonomy, for example, has a bearing on who is competent and who is incompetent. As Abernethy states,

[j]udgements about patient competence are embedded in the culture. A corollary is that the criteria used for evaluating competence adjust in order to produce outcomes that accord with the society's value system and current requirements for order and economy. (Abernethy 1991: 215)

Similarly, Kopelman observes that,

[t]he boundaries between capacity and incapacity, or between competence and incompetence,...can be drawn differently, based in part on what is valued, approved, needed, or understood. (Kopelman 1990: 317)

Competence, then, is not simply a medical, biological or psychological concept that identifies some objectively determinable, fixed property of a patient. The concept of competence has normative and socio-political dimensions, some of which have been illustrated in this chapter and some of which will be revealed in others. The remaining

chapters will be especially concerned with the concept of autonomy and the role it plays in the social construction of (in)competence.

CHAPTER 2

INDIVIDUAL AUTONOMY

2.1 Accounts of Individual Autonomy

In reaction to the traditional paternalism of the doctor-patient relationship, the past few decades have seen individual autonomy¹ emerge as a central concept in human research and health care settings. The doctrine of informed consent or refusal, and the principles of privacy, veracity and confidentiality reflect the relatively recent move to protect and enhance patients' autonomy in decisions about their health care. The bioethical principle of respect for autonomy entails the *prima facie* moral (and sometimes legal) duty to respect the autonomy of patients, which involves recognizing them as possessing the corresponding *prima facie* right to exercise their autonomy of choice and action.

Respect for autonomy has become a fundamental (and arguably the paramount) principle in bioethics; however, the nature and value of the basis of this principle - the concept of autonomy - are disputed. A number of different, incompatible accounts of autonomy can be found in the literature. It is more common, however, to find the term used rather intuitively; "autonomy" is rarely given deep analysis and, thus, frequently operates in bioethics as a vague, ambiguous and elusive concept.

As with the concept of competency, different accounts of autonomy appear to share an abstract conceptual core - the idea of self-government - suggested by the

¹ Hereinafter I will refer to individual (or personal or patient) autonomy as "autonomy." I will use qualifying adjectives to specify other kinds of autonomy, such as political, legal, moral, or economic autonomy.

etymology² of the term. Theorists are not divided on the concept of autonomy at this abstract level, but, instead, on the particular content the concept is to be given. Thus, in bioethics, the questions to entertain are: What does it mean for X to be self-governing in situation S? Which capacities and circumstances ought to be present, and to what degree?

What follows is a number of accounts of autonomy found in the bioethics literature which represent a variety of responses to these questions. The passages set out below should make it clear that autonomy is not a univocal notion and that, therefore, there is no single "principle of (respect for) autonomy" which can be straightforwardly referred to or "applied" in the discipline of bioethics.

In their introduction to *Biomedical Ethics*, Mappes and Zembaty write:

A Kantian position central in biomedical ethics describes autonomy in terms of self-control, self-direction, or self-governance. The individual capable of acting on the basis of effective deliberation, guided by reason, and neither driven by emotions or compulsions nor manipulated or coerced by others is, on the Kantian position, the model of autonomy. (Mappes and Zembaty 1986: 30)

According to Gerald Dworkin, autonomy

is authenticity plus procedural independence. A person is autonomous if he identifies [at a higher level] with his [lower-order] desires, goals, and values, and such identification is not itself influenced in ways which make the process of identification in some way alien to the individual. (Dworkin 1989: 61)³

In Agich's view,

² Greek, "autos" (self), "nomos" (rule or law).

³ This quotation is taken from a chapter originally published in 1981 and reprinted in 1989. In *The Theory and Practice of Autonomy*, Dworkin (1988) revises his view: "The idea of autonomy is not merely an evaluative or reflective notion, but includes as well some ability both to alter one's preferences and to make them effective in one's actions" (17). I include Dworkin's earlier account in the body of this chapter as it is this authenticity model that many bioethicists have adopted.

"Autonomy" literally means "self-rule," that is, behaviour that is spontaneous and self-initiated; such behaviour is regarded as action in the sense that it manifests intentionality. Human action, in turn, can be regarded as free if the individual agent can identify with the elements from which it flows; an action (or choice) is unfree or coerced if the agent cannot identify with or dissociates herself from the elements that generate or prompt the action. (Agich 1990: 13)

Beauchamp and Childress, the authors of numerous influential books and articles in bioethics, state that

the core idea of personal autonomy is an extension of political self-rule to self-governance by the individual: personal rule of the self while remaining free from both controlling interferences by others and personal limitations, such as inadequate understanding, that prevent meaningful choice. The autonomous person acts in accordance with a freely self-chosen and informed plan, just as a truly independent government acts to control its territories and policies. A person of diminished autonomy, by contrast, is in at least some respect controlled by others or incapable of deliberating or acting on the basis of his or her plans. (Beauchamp and Childress 1989: 68)⁴

More recently, Beauchamp summarizes the requisite components of a concept of autonomy as follows:

Whatever may in addition be packed into the concept, the autonomous person is one who is capable of independent, intentional, informed, and reasoned judgments and actions. Any viable theory of autonomous persons must accept something like these properties as necessary conditions of autonomy, because of their centrality to the concept. (Beauchamp 1991: 60)

⁴ A decade earlier, Beauchamp and Childress provided a somewhat more stringent account of autonomy, a view still prevalent in bioethics:

Autonomy is a form of personal liberty of action where the individual determines his or her own course of action in accordance with a plan chosen by himself or herself. The autonomous person is one who not only deliberates about and chooses such plans but who is capable of acting on the basis of such deliberations. ... A person's autonomy is his or her independence, self-reliance, and self-contained ability to decide. A person of diminished autonomy, by contrast, is highly dependent on others and in at least some respect incapable of deliberating or acting on the basis of such deliberations.... The most general idea of autonomy is that of being one's own person, without constraints either by another's action or by a psychological or physical limitation. (Beauchamp and Childress 1979: 56-7)

Young suggests that the term "autonomy" is best employed "when we wish to make a more global point about someone's life" (Young 1989: 78). According to Young, "the autonomous person orders his (or her) life according to a plan or conception which fully expresses his own will" (Young 1980: 571).

In his book *The Patient as Partner*, Veatch includes a chapter on the principle of autonomy and its foundational role in justifying the doctrine of informed consent.

Veatch's discussion of the concept of autonomy itself is limited to the following:

To be a person is to be an autonomous individual, the possessor of rights and of the freedom of self-determination. After all "autonomous" means "self-governing" (Veatch 1987: 41).

In *Philosophical Medical Ethics*, Gillon writes that autonomy is "the capacity to think, decide, and act (on the basis of such thought and decision) freely and independently" (Gillon 1985: 60).

As Beauchamp points out, the notion of autonomy has become so diverse that it can be used to refer to a duty, a right, a freedom, a disposition, or an action (Beauchamp 1991: 63). He identifies the following explications of the central meaning of "autonomy" in contemporary moral philosophy:

- 1) "authenticity";
- 2) "obedience to self-prescribed law";
- 3) "obedience to moral law";
- 4) "personal choice";
- 5) "the freedom to choose";
- 6) "having preferences about one's preferences";
- 7) "choosing and creating one's own moral position";
- 8) "mental health";
- 9) "conscientiousness";
- 10) "responsible action"; and,
- 11) "accepting responsibility for one's views and actions." (Beauchamp 1991: 63)

To supplement this list, Dworkin states that autonomy is often understood as a synonym for liberty (positive or negative), or for freedom of the will. Further, autonomy

is equated with dignity, integrity, individuality, independence, responsibility, and self-knowledge. It is identified with qualities of self-assertion, with critical reflection, with freedom from obligation, with absence of external causation, with knowledge of one's own interests. It is related to actions, to beliefs, to reasons for acting, to rules, to the will of other persons, to thoughts and to principles. (Dworkin 1989: 54)

Beauchamp's and Dworkin's comprehensive summaries present some of the very different ways theorists use the term, yet even the summaries taken together do not fully capture the complexity of the debate in bioethics surrounding the concept of autonomy. There is further disagreement about whether ethical concern should be focused on autonomous *persons* or autonomous *choices*,⁵ or both (see, for example, Beauchamp and Childress 1989: 68-69; Gunderson 1990: 254). Those who agree that it is the autonomy of persons that counts are often at odds about whether "autonomy" should refer to the (psychological) *capacity* for autonomy or the actual *condition* of autonomy (Feinberg 1989: 28-43; see also Katz 1984: 105-107). Related questions which inspire a variety of responses include: Can an individual be autonomous if he/she has the ability and freedom to make a decision, or must he/she also have the ability and freedom to implement such a decision him/herself? Can a person be autonomous if he/she delegates authority to another to decide and/or act for him/her, or must he/she decide and/or act for him/herself? (Collopy 1988). And, does socialization preclude autonomy? (see Meyers 1989; Young 1980, 1986).

⁵ This idea of an 'autonomous choice' does not appear to make sense on its own if the abstract conceptual core of "autonomy" is self-governance. What some thinkers no doubt mean by 'autonomous choice' is a choice made by an autonomous person. Others, however, who are concerned that an autonomous person may fail in a particular instance to make an autonomous decision (for example, his/her choice to refuse life-saving treatment is not properly informed), argue that an autonomous choice is one an individual makes intentionally, with understanding, and without controlling influences that determine the choice (Beauchamp and Childress 1989: 68-69).

Because autonomy is a notion that admits degrees, bioethicists disagree on the threshold required for autonomy. Some theories of autonomy set high standards for its achievement, whereas other accounts make less rigorous demands, or acknowledge substantial or partial autonomy (see Beauchamp and Childress 1989: 68-69).

Others debate whether autonomy is a global (or general) concept or a local (or specific) one (see Young 1986; Dworkin 1989: 60; Beauchamp and Childress 1989: 68-69; Collopy 1988: 15-16). For example, is autonomy more properly understood as a feature of a person in some aspects(s) of his/her life (for example, in particular preference formations or specific choices), or as a feature of a whole person and his/her whole life? (Christman 1989: 13).

Furthermore, ostensibly similar concepts of autonomy, in fact, may differ significantly due to the interpretations given other key terms contained therein. Clearly there are many divergent views on what is meant by "the self," "one's own will," "reason," "independence," "freedom," "ability," "action," and so on.

Given the importance of the concept of autonomy in bioethics, further analysis clearly is needed toward identifying an adequate, applicable concept of autonomy, and toward developing a corresponding theory which explains how "autonomy" is related to other important concepts and values, its justificatory role for normative claims, and so on (see Dworkin 1989: 55).

2.2 A Philosophical Analysis of Selected Notions of Individual Autonomy

In section 2.1 I demonstrated that the concept of autonomy in bioethics is subject to an extensive range of understandings. Two views, however, dominate the bioethics

literature: I will refer to the first as 'the Kantian concept of autonomy' and to the second as 'the authenticity model of autonomy' (developed by Dworkin).

In this section, I will outline these two influential accounts and offer a brief critical analysis, focusing on the applicability and adequacy of each concept in the health care context. I am more interested in the practical problems involved in applying these concepts than I am in the abstract conceptual flaws of each model; thus, I will be concerned with the latter flaws only to the extent that they affect or create the former. I then will present selected alternative understandings of autonomy which offer some insight into how "autonomy" in bioethics might be reconceptualized. The aim of this section is to probe some of the practical and conceptual problems in dominant concepts of autonomy in bioethics, to provide a foundation for further discussion of autonomy and competency issues, and to justify proceeding with a preliminary, alternative account of autonomy in chapter 4.

The Kantian view of autonomy⁶, as it operates in bioethics, is sketched above in the passage by Mappes and Zembaty (1986). This view, or at least important components thereof, also appears to underlie the concepts of autonomy of Beauchamp and Childress (1979, 1989), Beauchamp (1991), and Gillon (1985), as set out above. To recapitulate, on this account an autonomous person is a free, independent, fully rational, self-governing individual. He/she has the self-contained capacity to decide and to act on the basis of reasoned deliberation; his/her choices and actions are influenced by reason, not by emotion

⁶ I do not claim that what has come to be called the Kantian model of autonomy in bioethics is faithful to the philosophical ideas and interpretations of Kant. Some thinkers have argued that Kant's concept of autonomy has been misinterpreted in a variety of ways (see Hill 1989). Perhaps a different adjective should be used to distinguish this model; however, I continue to refer to this view of autonomy as 'Kantian' for lack of a better term, and so that it will be recognized by readers accustomed to this name.

or inclination; and, he/she is free from physical or psychological constraints, imposed by him/herself or by others, to choose and act.

My main criticisms of Kantian autonomy involve its impracticality given the realities of patients and the health care setting, its potential for abuse, and its oppressive normative assumptions about human nature. First, this abstract, idealistic concept is not applicable to the health care context. Patients on the whole bear little resemblance to the Kantian free, self-sufficient, fully rational agent. In the health care setting, patients standardly lack (or have reduced) cognitive and volitional capacities which render them nonautonomous on this view (O'Neill 1984: 176). In other words, patients generally are subject to certain internal or external controlling influences which impede capacity for reason and, therefore, Kantian autonomy.

For example, common internal constraints include pain, anxiety, fear, depression, effects of treatment, lack of information, inadequate understanding, false beliefs, and so on. Common external constraints include pressure from relatively powerful health care professionals, or from friends and family members (see Morreim 1991: 98-99; Wear 1991: 227; Pellegrino 1991: 34-38; O'Neill 1984). The institutional environment itself is often disorienting and restrictive, controlling patients in various ways via architecture, equipment, procedures and routines. Moreover, the highly rationalistic, individualistic Kantian account assumes that all one needs to qualify as autonomous, in addition to the requisite intrinsic capacities (no small feat), is negative freedom. Patients, however, are frequently in vulnerable positions, unable to act on their decisions, and require that positive measures be taken on their behalf. For example, non-interference will not benefit, or bring about the autonomy of, a patient who requires a professional's assistance to realize his/her choice of active euthanasia.

On the Kantian view, then, very few, if any, patients would be regarded as autonomous. Given the need in bioethics for an applicable concept of autonomy, the Kantian conception - based on an ideal view of the self as independent and fully rational - is inadequate; actual patients are likely to be dependent or interdependent, and their decisionmaking is not always based on reason. In the words of Katz,

Kant, in restricting his conception of autonomy to capacities to reason, without reference to human beings' emotional life and their dependence on the external world, projected a vision of human nature that estranged his principle from human beings and the world in which they must live (Katz 1984: 108) [and] it is therefore of little relevance to practical situations (Katz 1984: 110).⁷

This is not to say that the Kantian ideal of the autonomous agent has no place whatsoever; however, in bioethics, what is required is a model of autonomy that patients have some hope of approximating - if we are to build on that concept a principle of respect for autonomy to guard against unwarranted paternalism in health care contexts.

Second, due to the fact that this model is too general to be of practical assistance in responding to bioethical quandaries, there exists the potential for abuse both when professionals interpret the concept and when they attempt to apply it to specific cases.

Consider the following:

[The principle of respect for autonomy] does not apply to persons who are not in a position to act in a sufficiently autonomous manner - perhaps because they are immature, incapacitated, ignorant, coerced, or in a position in which they can be exploited by others.... The behaviour of nonautonomous persons may be validly controlled on grounds of

⁷ Katz goes on to argue that adherents of Kant who have attempted to bring his views to bioethics have neglected to examine critically his theory of human nature, and have collapsed his distinction between theoretical and living human beings: "Yet Kant contributed to this misunderstanding by projecting a view of human nature that endows human beings with greater capacities for living a life of reason than is in fact the case. Kant's view of *theoretical* man is hopelessly estranged from *real* man. He created the impression, perhaps unintended, that human beings can, and therefore must, employ solely their innate and developed capacities to reason in contemplating their choices" (Katz 1984: 109).

beneficence in order to protect them from harms that might result from their behaviour. (Beauchamp and Childress 1989: 73)

Because the Kantian concept is not well suited for application to actual patients in actual contexts, I am concerned that patients will be measured against its rigorous standards, that the majority will not 'measure up,' and that some health care professionals and institutions will attempt to justify unwarranted paternalism *because* patients are not considered autonomous. Those who are not perceived as autonomous may not be given a choice, or even consulted, about decisions concerning their care. An all-or-nothing conception of autonomy which the Kantian model appears to embrace has the potential to deny many, if not most, patients control over their health care, even when they have considerable capacity for agency.

Third, autonomy is highly prized by our western liberal society, and the high value given to autonomy as self-sufficiency is problematic in the health care setting. As Alastair Campbell explains, if autonomy is morally valuable, and if autonomy is equated with independence, then dependence is regarded as morally inadequate and, consequently, those who are dependent are devalued (Campbell 1991). In Campbell's words, the result is that

the chronically dependent become a special problem, an embarrassment to the dominant moral value. Fragility and vulnerability, rather than being seen as appropriate parts of life from the cradle to the grave, become obstacles to be overcome by the self-sufficient man or woman. The 'successful' patient is always the one who transcends the state of patienthood. (Campbell 1991: 106)

The nature of patienthood, however, is partially characterized by dependency of one kind or another; thus, the over-valuing of autonomy as independence is oppressive to patients who require and accept help, to those who are unable to 'transcend' patienthood. This attitude also may threaten the welfare of persons who require help but do not seek it or accept it when it is offered for fear of the stigma attached to being "nonautonomous."

Agich observes that this view of autonomy as independence has engendered certain 'defences' against dependency - "a denial of need, hostility toward helpers even in the face of disabilities that require assistance from others, contempt for the real or imagined weakness of others," and so on (Agich 1990: 12-13). Because the normative assumptions about human nature and capacity inherent in Kantian autonomy contribute to the devaluing of patients, this model clearly is inappropriate in the health care context.

In sum, the Kantian concept of autonomy does not provide adequate practical guidance for determining the kind and degree of autonomy present in patients (see also Agich 1990: 13). A more applicable account of autonomy is needed in the health care context, one which accommodates the realities of patients' situations, does not justify wholesale paternalism, and respects both dependence and independence.

The other influential view of autonomy under consideration here is Dworkin's model of autonomy as authenticity (encapsulated above in section 2.1) (Dworkin 1988; 1989).⁸ On Dworkin's view, an autonomous person is one who can identify at a higher level with his/her lower-order desire to act in particular ways. That is, to be autonomous one must have not only a lower-order desire to do X (for example, a desire to smoke), but also a higher-order desire to desire to do X (for example, a desire to desire to smoke). If one identifies with one's lower-order desires, then those desires are 'authentic' and, thus, one is autonomous in acting on such desires. This is the 'authenticity' component of Dworkin's account. There is, in addition, a 'procedural independence' component which

⁸ There appear to be at least two varieties of authenticity models of autonomy. One, of which Dworkin's is an example, understands authenticity as higher-order desires confirming lower-order desires. The other views authenticity as consistency of the desire in question with one's other desires, beliefs and values; this variety does not refer explicitly to higher- and lower-order desires or preferences. As some of my objections concern both models and others only the former, when it is necessary to distinguish these, I will refer to the former as the 'hierarchical authenticity model' and to the latter as the 'nonhierarchical authenticity model.'

specifies that the identification process - the higher-order process of reflecting critically on a lower-order desire and approving of it - must be free from manipulation or constraint (for example, identification brought about through hypnosis).⁹

At first sight, Dworkin's model - because it construes "autonomy" more broadly than does Kant's - seems like it might provide bioethics with a workable concept of autonomy. Autonomy as authenticity also appears to escape some of the criticisms of the Kantian account since the former does not demand free, fully rational self-sufficient agents, nor does it require that the process and outcome of decisionmaking be rational in a strict sense - it does not necessarily preclude choices and actions based on emotion and inclination, so long as they are consistent with higher-order desires. After closer examination, however, the authenticity approach to autonomy is no more adequate than the Kantian one. My major objections to this view concern its ability to justify paternalism in the name of autonomy, its failure to address the problem of socialization, and its apparent inability to tolerate change in a person or to allow certain decisionmaking styles.¹⁰

My first criticism is that Dworkin's model allows for treating patients against their objections in the name of restoring autonomy. Gunderson provides an example in which a

⁹ As noted earlier, Dworkin (1988) has revised his view (see footnote 3). In addition to the higher-order capacity to reflect critically on lower-order desires, autonomy requires "some ability to alter one's preferences and to *make them effective in action*" (Dworkin 1988; 108, my emphasis). This is a more stringent account of autonomy, particularly if it requires nonattachment and self-sufficiency ("substantive independence") for autonomous action. There is some debate about whether Dworkin's concept of autonomy requires substantive, in addition to procedural, independence. Dworkin (1988:21) maintains that substantive independence is neither required nor desired (see also Meyers 1989:85); whereas Kupfer (1990; 189, n. 38) argues that substantive independence is an essential component of Dworkin's model. I will not explore this tension here. If Dworkin's model *does* demand substantive independence, then it is subject to my objections to the Kantian premium on independence outlined above.

¹⁰ Christman provides a good discussion of some serious conceptual difficulties with Dworkin's model which I will not take up here, namely the problems of infinite regress, 'ab initio,' and incompleteness (see Christman 1989: 6-11; 1992; also see Meyers 1989: 25-41).

patient refuses a procedure out of fear, but in his 'contemplative' moments admits that it would be in his interest to consent to the procedure. As Gunderson points out, on Dworkin's authenticity model, the doctor could perform the procedure without the patient's informed consent, and without interfering with his autonomy, because the procedure is in line with his higher-order preferences (Gunderson 1990: 258). Gunderson goes on to say that patients rarely make decisions by reference to higher-order desires and, on this account, this failure would 'justify' widespread paternalistic interference with patient liberty.

Cassell's (1977) interpretation of the authenticity model gives credence to Gunderson's worries. Cassell, a physician, claims in "The Function of Medicine" that illness robs many patients of their autonomy and that the physician's obligation - "as restorer of autonomy" - may involve treating patients even against their objections:

I believe that the function of medicine is to preserve autonomy and that preservation of life is subservient to the primary goal. However, this issue is confused by several factors. First, it is obvious that the best way to preserve autonomy is to cure the patient of the disease that impairs autonomy and return him to his normal life. (Cassell 1977: 18)

In my view, patients' reactions to pain, fear, uncertainty and the like should not be dismissed as irrelevant to autonomous decision-making. As Morreim asserts, "although these factors can obstruct one's reasoning, they can also sometimes form a legitimate basis for thinking and decision-making.... [p]ain can be a good reason to avoid a particular course of treatment" (Morreim 1991: 99). Moreover, if the principle of respect for autonomy is meant to keep paternalism in check, grounding this principle in a hierarchical authenticity model of autonomy will not accomplish the goal.

My second major criticism is that the problem of socialization presents serious difficulties for Dworkin's model. Consider first that Dworkin admits, on his view, one

cannot argue against slavery by appealing to autonomy. His view does not preclude saying:

I want to be the kind of person who acts at the command of others. I define myself as a slave and endorse those attitudes and preferences. My autonomy consists in being a slave. (Dworkin 1986: 272)

The socialization problem is this: Given the socialization process, in what sense do higher-order preferences reflect the authentic self any more than do lower-order ones? The higher-order self - the 'true self' - and its preferences have been socially constructed, as have many lower-order desires. Consider a person who has been socialized to adopt as his/her 'true calling' a life of complete subservience. He/she wants to want this completely subservient life and acts accordingly. On the hierarchical authenticity model, he/she may be autonomous because his/her higher-order desires are consistent with his/her lower-order desires. He/she has, however, been socialized (perhaps even conditioned and manipulated) to have his/her higher-order desires, so, in a certain real sense, his/her desires, choices and values are not his/her own (Christman 1992: 6-7).

Perhaps it could be argued that this socialized person is not autonomous, despite the fact that he/she identifies (at a higher-level) with his/her desires, because the condition of procedural independence is not met in his/her case. It is not clear, however, whether his/her process of identification is manipulated or constrained, just because his/her higher-order desires may have been formed by manipulation or conditioning; he/she has no concept of him/herself other than his/her socialized self with which to identify, but his/her reflective and critical faculties may now be free from manipulation and constraint. The little that Dworkin says about procedural independence does not clarify whether socialization precludes satisfying this procedural condition, and, thus, autonomy (it is

worth noting, however, that in the example of the slave above, Dworkin confers the status of "autonomous" on the slave without raising the question of procedural independence):

Spelling out the conditions of procedural independence involves distinguishing those ways of influencing people's reflective and critical faculties which subvert them from those which promote and improve them. It involves distinguishing those influences such as hypnotic suggestion, manipulation, coercive persuasion, subliminal influence.... Philosophers interested in the relationships between education and indoctrination, advertising and consumer behaviour, and behaviour control have explored these matters in some detail, but with no finality. (Dworkin 1988: 18)

I am not arguing that the 'true self,' - the autonomous self - need be free from all socialization.¹¹ In fact, certain aspects of our socialization - language, for instance - promote autonomy. My point is that Dworkin's condition of procedural independence provides no way of distinguishing between autonomy-enhancing socialization and socialization at the higher-order level which seems, intuitively, to strip people of meaningful autonomy.

The problem of socialization contributes to the unattractiveness of using the hierarchical authenticity model in the health care context. The following passage is somewhat disconcerting, considering the relative power of professionals in the professional-patient relationship, and the generally deferential role of patients.

It is an implication of my view that there is no specific content to the decisions an autonomous person takes. Someone who wishes to be the kind of person who does whatever the doctor orders is as autonomous as the person who wants to evaluate those orders for himself. (Dworkin 1988: 108-109)

Patients (women especially), however, have been socialized to be deferential to health care professionals and many have been conditioned to believe that 'the doctor knows best.' Are such patients, then, 'autonomously' giving up control of their decisions?

¹¹ See Meyers (1989; also 1987a, 1987b) for an interesting, general treatment of the socialization problem in hierarchical authenticity models of autonomy.

Consider another example. Our society teaches us that old people are a burden. Imagine the elderly patient who wants to cease life-prolonging treatment because he/she does not want to be a burden, and *wants* to want to cease treatment for such reasons. I am not at all sure that we ought to call such a patient 'autonomous.'

My third major criticism is twofold: the authenticity component appears to be intolerant of both profound personal changes in attitudes, beliefs and values, and nonreflective styles of decisionmaking. My 'intolerance of change objection' concerns mainly the nonhierarchical view of authenticity as consistency with one's desires, beliefs, values and life plans, a view which may be an (erroneous?) interpretation or adaptation of Dworkin's theory. (I will also consider whether Dworkin's hierarchical authenticity model is subject to this objection.)

As Morreim states,

the authenticity requirement seriously misconstrues the nature of human autonomy by ignoring one of its crucial features: the capacity to change one's mind, to re-evaluate and sometimes to reject even long-held values and beliefs (Morreim 1991: 97).

In the health care environment, demanding that patients make choices consistent with their former attitudes, value systems and/or life-plans is both unrealistic and dangerous. Serious illness is often accompanied by a (sometimes drastic) change in perspective, which may cause a patient to identify with new desires and values. For example, a patient who once firmly believed that he/she would want to be allowed to die should he/she ever be left seriously disabled by an accident or a disease may find him/herself with a changed set of attitudes and values should such an event occur. Or, he/she may find, in examining his/her attitudes and values, that they are changing or unstable. Change, uncertainty, ambivalence and vacillation are quite normal in the health care setting; their presence does not necessarily mean a patient is nonautonomous. More generally, as Agich writes, "since

individuals are never fully formed, but are always dynamically in the process of development, 'who an individual is' is always an open question" (Agich 1990: 13). Thus, the requirement that a patient's decision be consistent with a supposedly fixed set of values and goals does not account for his/her evolving or changing identity.

Consider Collopy's richer notion of authenticity, which brings an important ambiguity to light.¹²

Authenticity can be built from a shifting history of decisions and choices, consents and refusals. It can involve alteration as well as constancy, wavering as well as decisiveness, tentative inchings and trials, and all manner of consonance between past and present. (Collopy 1988: 14)

I have not seen such an account developed, but it may be the case that a certain reading of authenticity does not preclude change. If authenticity is construed as consistency of a set of desires, beliefs and values at a particular point in time (transitivity), then it may allow for change; whereas, authenticity as the consistency of a set of desires, beliefs and values over time (transitivity plus continuity) seems to disallow change.¹³

Dworkin's view of autonomy as global does not appear to give authenticity the flexibility Collopy believes it possesses: "the question of autonomy [is] one that can only be assessed over extended portions of a person's life. It is a dimension of assessment that evaluates a whole way of living one's life" (Dworkin 1989: 60). Given this conception of autonomy as global, it is not clear to what extent one's higher-order desires can undergo change - that is, whether Dworkin requires continuity of higher-order desires; thus, it also is not clear whether Dworkin's view is subject to the intolerance of change objection.

Meyers, however, describes Dworkin's account as fatalistic and incomplete because,

¹² Christman's (1992: 13, n. 23) analysis made me aware of the ambiguity which I explore below.

¹³ The intolerance to change objection applies to hierarchical and nonhierarchical authenticity models alike, if they adopt this second interpretation of authenticity.

although it includes the necessary components of self-discovery and self-direction, it leaves out the component of self-definition, which she defines as the ability to conceive and make changes in one's 'true self' (Meyers 1989: 42-43).

Regarding the intolerance of Dworkin's hierarchical authenticity model of autonomy to nonreflective decisionmaking styles, two points should be made. One, it seems unrealistic to demand that patients make all their decisions in this highly reflective manner. According to Christman, requiring autonomous persons to have "internally consistent beliefs and transitive desires is in some ways too stringent... few of us have examined all our beliefs and preferences and tested them for this standard" (and he adds that "if we did, few if any of us would pass") (Christman 1991: 14). In addition, "making explicit choices or decisions... is not the central feature of our lives, most of which are spent acting in habitual, taken-for-granted ways that are not experienced as the result of express decisionmaking" (Agich 1990: 13).

Two, even if such reflective decisionmaking is possible for patients, why must it be the *preferred* method of decisionmaking? Some people may not want to deliberate carefully about their choices in order to ensure that lower-order desires are in accord with higher-order desires, values and goals. As Double notes, "[u]nreflectiveness seems to be part of the autonomy of some persons" (Double 1992: 73). I can see no reason why an autonomous person making a particular decision could not choose arbitrarily or on the basis of 'gut' feelings; to demand the authenticity of lower-order desires, and procedural independence, may threaten, rather than promote, his/her autonomy. Double would agree:

Perhaps the most crucial element of autonomy is self-rule, self-possession, the idea of 'being one's own man [sic].' But for many of us, one's own man [sic] is a fool. That is to say, we are chock-full of unwarranted and false beliefs, fairly easily detectable logical inconsistencies, as well as a plethora of defective and biased strategies for collecting, weighing, and using evidence in inferences. Thus, the self-possession theme in the

autonomy notion appears to leave room for folks who are terrible reasoners, yet are candidates for autonomy. An account of *autonomy* should capture this thread. If we produce an account only of highly successful rational autonomy - an admirable quality to be sure - we have not succeeded. (Double 1992: 75)

Double stresses, however, that not all 'terrible' reasoners are candidates for autonomy. He proposes that the choice of an autonomous person must conform to, and be causally produced by, his/her individual decisionmaking ("management") style (Double 1992: 69, 77). For example, imagine two Jehovah's Witness patients, both of whom refuse life-saving blood transfusions. The first patient is generally unconcerned about what his religion has to say about providing relief to disadvantaged persons, participating in war, and so on; he is not in the habit of making decisions based on the dictates of his religion, and he refuses the transfusion for no deep reason - this stricture of his religion just 'grabbed' him. By contrast, for the second patient, following the dictates of her religion *is* her individual decisionmaking style, and she refuses the transfusion because it is forbidden by her religion. According to Double, the first patient is nonautonomous in his refusal, whereas the second is autonomous (Double 1992: 76).

While Double's account of autonomy is appealing in its accommodation of nonreflective decisionmaking styles, it appears subject to the 'intolerance of change' objection in that he makes no provisions for those people who want to make *changes* in their individual decisionmaking style. That is, Double's model seems to preclude adopting a new strategy (one that does not conform to, or is not produced by, one's individual decisionmaking style) of decisionmaking for a particular decision. Double might reply that one's individual decisionmaking style may be such that one does not go about making decisions in any particular fashion; however, Double's examples do not include such a style, nor is it clear how we could determine whether the condition that the person's

decision be *causally produced* by his/her individual decisionmaking style has been met if 'individual decisionmaking style' is so broadly construed.

Both Double's and Dworkin's models (and other authenticity models) are content-neutral in the sense that one is not judged autonomous or nonautonomous based on the nature of one's decision itself.¹⁴ That is, on these views, there are no substantive constraints on what one can choose autonomously. On these accounts, the constraints on autonomy are *procedural*, rather than substantive. The problem with Dworkin's requirements regarding the process of decisionmaking is that they are too constraining and, therefore, exclude too many patients; Dworkin's understanding of autonomous decisionmaking is too narrow, which makes his model of autonomy as authenticity inappropriate in the health care setting. Double's account does not appear to be a viable alternative to Dworkin's, because the procedural requirement (that one's decision conform to, and be produced by, one's individual decisionmaking style) disallows changes in how a patient believes that he/she ought to go about making choices.

To conclude my critique of the dominant concepts of autonomy in bioethics, the realities of the health care setting necessitate a reconceptualization of "autonomy." The Kantian conception's emphasis on self-sufficiency, and both conceptions' premium on deliberative rationality, are undesirable in bioethics. Further, both conceptions fail to consider a larger moral and political picture in which it can be seen that autonomy is influenced by a variety of social factors. Thus, the Kantian and Dworkinian models are impractical and inadequate for use in the health care setting.

¹⁴ Note that Double (1992) characterizes Dworkin's account of autonomy as "content-specific." Double, however, does not use "content-specific" in the sense described in the above paragraph; what Double means is that, with regard to quantity and quality of critical reflection, Dworkin's account requires "that autonomous persons achieve a certain level of normatively ('logical') appropriate reflection about their motivations" (Double 1992: 66).

In the remainder of this section, I will introduce a number of alternative ideas about autonomy that may provide some insight into how bioethicists ought to reconceptualize "autonomy." These perspectives are characterized by a more relational, contextual understanding of autonomy - one in which autonomy is not equated with independence, deliberative rationality or negative liberty, and is recognized as being largely socially constructed.¹⁵ I will expand on these ideas and attempt to develop them further in chapter 4.

In a passage quoted above in section 2.1, Beauchamp (1991) claims that "the autonomous person is one who is capable of independent, intentional, informed, and reasoned judgments and actions... [and that] [a]ny viable theory of autonomous persons must accept something like these properties as necessary conditions of autonomy" (Beauchamp 1991: 60). There are, however, alternative views which do not regard such features as necessary conditions of autonomy, and the basic reason for this is that they hold a different view of the self:

In place of the isolated, independent, rational agent of traditional moral theory, feminist ethics appeals to a more realistic and politically accurate notion of a self as socially constructed and complex, defined in the context of relationships with others. (Sherwin 1992: 53)

Given a social picture of the self, autonomy must be understood as a relational, not simply as an inherent, property of persons.

In his article "Reassessing Autonomy in Long-Term Care," Agich (1990) explains how traditional construals of autonomy as independence fail to accommodate an ineliminable feature of long-term care - impaired (at least given the usual rigorous

¹⁵ Several mainstream ethicists mention some social factors affecting autonomy, but these discussions are far from thorough and have not yet given rise to a concept of autonomy defensible in bioethics (see, for example, Kupfer 1990; Benn 1982; Christman 1989; Feinberg 1989).

standards) decision-making capacity. He states that a concrete, as opposed to an abstract, notion of autonomy is required if it is to be of practical and analytical significance in long-term care (Agich 1990: 12-13). According to Agich, we need a fuller conception of autonomy,

one that acknowledges the essential social nature of human development and recognizes dependence as a nonaccidental feature of the human condition. Such a concept would systematically attend to the history and development of persons and take the experiences of daily living into account; it would view individuals concretely and see choice as a problem of positively providing options that are meaningful rather than as an issue of removing obstacles to choice or impediments to action. (Agich 1990: 12) A fuller account of the nature of autonomous moral agency would include a framework for interpreting what autonomy concretely means and for articulating the essential historical and social nature of persons by taking seriously the concrete developmental aspects of becoming and being a person, as well as the phenomenological reality of being an agent in the world of everyday life without embracing the notion that the ultimate source of value or authority is tradition or community. (Agich 1990: 13)

Two things are striking about Agich's relational, contextual understanding of autonomy. First, due to the recognition that actual people are enmeshed in concrete social situations, autonomy and dependence, or interdependence, are not understood as mutually exclusive. Second, a richer notion of freedom - negative *and* positive freedom - accompanies this view. Accordingly, an adequate account must appreciate "how individuals are interconnected and how persons develop in terms of historical and social circumstance" (Agich 1990: 15).

In interpreting 'independent living' (for those with disabilities and chronic illnesses), not as requiring independence and noninterference, but as "the ability to perform those normal functions of daily living that define the individual's own sense of self-worth and identity," Agich brings to light some important interrelationships among autonomy, dependence and interdependence.

Maintaining a sense of autonomous well-being is consistent with dependencies on medication or professional care *if* those dependencies help to maintain a sense of functional integrity in the areas of life that individuals value. (Agich 1990: 16)

Agich cites an example of a wheel-chair-using person who requires assistance from others in a number of activities of daily living. This assistance, however, enables her to work for a particular charitable organization with which she identifies strongly. Her dependency does not interfere with (in fact, it promotes) her participation in what has meaning to her, and her inability to undertake certain tasks alone - such as shopping or bathing - is less significant to her than her ability to work. Thus, certain dependencies and interdependencies in personal and professional relationships can be empowering - they can actually enhance meaningful autonomy.

In a similar vein, Burt observes that

[i]t is...paradoxical that handicapped people must depend on others' assistance in order to achieve their goal of independence from others. But... [they] resemble everyone who, in striving for independent autonomy, is nevertheless constrained by an inescapable economic and social network of interrelated dependencies... (Burt 1984: 455, in Weinberg 1988: 273-274)

Given a broader definition of autonomy in which autonomy and dependency are not necessarily incompatible, and dependencies and interdependencies are necessary for autonomy, the social construction of autonomy is apparent.

What needs to be stressed is how various resources, such as education, employment opportunities, medical services, and housing, are essential to the exercise and development of...[the capacity for autonomy]. And given that the distribution and production of these resources are within the purview of control of these political institutions, it follows that the *unequal* distribution of those resources essential to the development and maintenance of these capacities *violates* this basic regard for individual autonomy. (Christman 1989: 19)

2.3 Obstacles to Individual Autonomy

In this section, I will revisit the case studies outlined in chapter 1 to illustrate that whether an individual is regarded as autonomous depends on the conception of autonomy adopted and on the presence or absence of certain socio-political conditions.

Recall Mrs. C. The description of her scenario provides a good example of the authenticity model of autonomy in action - authenticity understood here as transitivity and continuity in her set of attitudes, beliefs and values. Although Mrs. C. experiences 'mild dementia' which may well render her nonautonomous on the Kantian view of autonomy, her refusal of an exploratory procedure may be seen as autonomous if autonomy is understood as consisting in authenticity. Mrs. C. does not want the procedure, and it might be said that, given her history, this desire to refuse treatment is consistent with her past preferences. It is noted in the case study that Mrs. C. "is generally averse to medical interventions" and her history of treatment refusal is highlighted. Given this model, then, Mrs. C. may be respected as an autonomous decision-maker despite the health care team's disapproval of the content of her decision.

Mrs. C., unlike Mrs. G., is able to afford financially the assistance she needs to live at home. Assuming she prefers living at home to living in an institution (and there is some evidence for this provided in the case study), Mrs. C. not only has the capacity to choose her place of residence (at least on an authenticity model), but she also has the resources to actualize her choice. Mrs. G., by contrast, is unable to finance the live-in help she needs in order to live at home in conditions acceptable to her health care professionals. The outcome of Mrs. G.'s case (the finding of incompetence and her discharge to a nursing home) suggests that her decisional autonomy - her capacity to decide without external coercion or restraint - is subordinated to her executorial

autonomy - her capacity to act on her decisional autonomy, which is thwarted by her poverty.¹⁶

Mrs. G.'s cognitive impairment, and her refusal to arrive at an objectively 'reasonable' decision based on an analysis of strictly physical risks and benefits, means that she would be relegated to the ranks of the nonautonomous on a Kantian account; however, like Mrs. C., because she has a history of fierce independence which may be taken as evidence that her desire to go home is in keeping with her character, Mrs. G. may be seen as autonomous given an authenticity model of autonomy.

Mr. W., who requires assistance in managing his estate, may be seen, on Collopy's distinction, to have "delegated," as opposed to "direct," autonomy. The latter capacity requires "unmediated, hands-on agency"; whereas, the former involves authorizing others to make decisions and/or to act on such decisions on one's behalf (Collopy 1988: 12). Mr. W. may also be seen to have decisional, but not executorial, autonomy. Thus, it is clear that whether Mr. W. is regarded as "autonomous" depends on the definition of autonomy adopted, and, further, on the presence of certain relationships and resources. For example, Mr. W. would likely not be regarded as possessing delegated autonomy if it were not for the presence of appropriate relationships with persons to whom he can delegate financial responsibilities.

¹⁶ The terms "decisional autonomy" and "executorial autonomy" are Collopy's (1988).

CHAPTER 3

MENTAL COMPETENCY AND INDIVIDUAL AUTONOMY

In this section, I will explore some significant connections between concepts of competency and concepts of autonomy in the health care setting. First, I will consider the relationship between the meanings of competency and autonomy; then, I will examine the relationship between the criteria of the two concepts; and, finally, I will discuss how these concepts are related in their applications in the health care context.

Given the lack of consensus in bioethics regarding the criteria of both concepts (as set out in chapters 1 and 2), it would be difficult (if not impossible) to discuss all the connections between competency and autonomy. It also would be of questionable value to attempt such a sweeping discussion, given the dominance of certain concepts of competency and autonomy in the health care setting. Thus, the relationships I will explore are those between the dominant notions of autonomy (outlined in chapter 2) and a widely held understanding of competency in bioethics (described below). What I hope to demonstrate in this and the final chapter is that the connections between these concepts are such that adopting a different model of autonomy would result in a different, corresponding model of competency. These chapters should make clear that the understanding of and value given to autonomy is a key factor in the social construction of (in)competency.

In bioethics, the leading concept of competency is closely related to, but not identical with, the dominant concepts of autonomy; however, due to the general lack of analytic rigour with respect to these concepts, "competency" and "autonomy" are frequently used as synonyms. That is, "competent patient" and "autonomous patient" are used interchangeably. Some more careful efforts to refine the concepts of competency and

autonomy also appear to conflate these terms. For example, according to Dworkin, "[p]atient autonomy is the ability of patients to decide on courses of treatment, to choose particular physicians, and so forth" (Dworkin 1988: 14). In this view, autonomy seems indistinguishable from competency - the ability to perform a task, where the relevant task is to make an informed health care decision.

Beauchamp's (1991) analysis of the connection between competency and autonomy provides a useful starting point for untangling these concepts and specifying the nature of their relationship. Beauchamp begins by describing roughly the dominant account of the criteria of the competent patient:

For many purposes, including consent to research and treatment, a *competent person* is widely regarded in our society as one who is able to understand and communicate relevant information, to weigh risks and benefits, and to make a decision about acceptance or participation in the light of such knowledge and in light of his or her relatively stable values. Such a person is able to behave purposively - that is, able to choose goals, able to choose appropriate means to goals, and able to act in accordance with the chosen goals and means. To be competent, the patient or subject need not actually perform these tasks, but their successful performance is one proof of competence. (Beauchamp 1991: 58-59)

Beauchamp notes that certain characteristics of this view of competency are shared by dominant notions of autonomy - characteristics such as judgement, communication, and stable valuing - and that this indicates close ties between the concepts, at least in our culture (Beauchamp 1991: 59). He then explores the hypothesis that the competent person is the autonomous person (that, for example, "a person is generally competent to authorize or refuse to authorize an intervention if and only if the person is autonomous") by considering both how the meanings, and how the criteria, of the terms are related (Beauchamp 1991: 59).

3.1 The Relationship of the Meanings

In his cursory comparison of the meanings of "competency" and "autonomy," Beauchamp restates that the former term means "the ability to perform a task" and the latter means "self-governance." He distinguishes the two meanings by pointing out that (a) a person may be competent to perform a task, but may not autonomously undertake its performance (if coerced or under hypnosis, for example), and (b) a person may undertake a task autonomously, but may be incompetent to perform it. The conclusion Beauchamp draws from this analysis is simply that the terms have quite distinct meanings, and that "competence is less closely related in meaning to autonomy than may at first seem apparent" (Beauchamp 1991: 59-60).

While I agree with Beauchamp that a person may be competent but nonautonomous with regard to a particular task, or autonomous but incompetent with regard to a particular task, and that the terms indeed are distinct, it seems to me that the core meanings of competency and autonomy are more closely related than Beauchamp's analysis indicates. To illustrate, consider the relationship between general and specific competency. A person may be generally competent to perform the tasks of daily living, but not competent to perform a specific task - or, in other words, he/she may possess general, but not specific, competence. Clearly, general competence and specific competence have distinct meanings, but they are very closely related. As Beauchamp states, a broad range of general abilities is required for general competence, and a particular set of specific abilities is required for specific competence, but "both are obviously ability-centered notions" (Beauchamp 1991: 56). Similarly, I will argue that autonomy, like competency, is an ability-centred notion.

To say that "autonomy" means "self-governance" seems to leave something important out of the definition. Implicit in the idea that a person is self-governing is that the person has the *ability* to be self-governing. The quality or state of being self-governing comes about only if one is *able* to be self-governing. Feinberg (1989) provides some support for my view in his discussion of two of the four closely related meanings he ascribes to autonomy: "autonomy as capacity" and "autonomy as (actual) condition."

It is possible in theory, I suppose, to possess both the capacity and the condition without the right of self-government. It is clearly possible to possess the right and the capacity while falling short of the condition. But *it does not seem possible* either to achieve the condition or to possess the right *while lacking (totally lacking) the capacity*. (Feinberg 1989: 28; emphasis mine.)

If the core meaning of autonomy were stated more accurately - "autonomy" means "the ability or actual condition of self-governance (where condition implies ability)" - then it would be more apparent that autonomy and competency are related in the sense that they are both ability-centred concepts.

Moreover, given that competency means "the ability to perform a task," autonomy as the ability or actual condition of self-governance appears to require particular kinds of competency. Autonomy requires a competency which may be broadly construed as the ability to be self-governing over one's whole life, or more narrowly conceived as the ability to be self-governing in certain instances. Feinberg writes of people who are "*competent to govern themselves*" (Feinberg 1989: 28; his emphasis). And Meyers links competency with autonomy by using the latter as an adjective to modify the former:

autonomy competency [is] the repertory of coordinated skills that makes self-discovery, self-definition, and self-direction possible.... To be autonomous... a person must possess and successfully use the skills of constituting autonomy competency. (Meyers 1989: 76)

Clearly, then, Beauchamp's failure to probe more deeply the meanings of the concepts in question results in an impoverished view of the nature of the relationship between the meanings of competency and autonomy.

3.2 The Relationship of the Criteria

Turning now to Beauchamp's discussion of the relationship between the criteria of competency and autonomy, his springboard is the hypothesis that, in our culture, being an autonomous person may be "*the* solely sufficient criterion"¹ for general (but not necessarily specific) competency (Beauchamp 1991: 60).² Beauchamp states that, although this appears a promising analysis, it is too crude a specification of the relationship between the two concepts "because both 'general competence' and 'the autonomous person' operate at an almost intolerably abstract level" (Beauchamp 1991: 60). Further, Beauchamp claims that the criteria of autonomy are "less broad, more determinate, and more stable" than the criteria of competency, and that "the reason the two notions come together so nicely *in our culture* is that we have *made* them come together by

¹ I will interpret this ambiguous phrase to mean "the necessary and sufficient criterion," given that, more often than not, Beauchamp (1991) expresses this relationship as "autonomy is the condition of general competence."

² "General competence" refers to a person's overall ability to perform the tasks of daily living, and "specific competence" refers to a person's ability to perform a particular task or kind of task. Note that "specific competence" can be used in at least two ways. Take the example of decisionmaking capacity (a specific competency); it can be understood quite broadly as the capacity to make decisions in general, or more narrowly as the capacity to make a particular decision given particular circumstances. A person may be a competent decisionmaker in general, but not in a particular instance. Beauchamp's analysis is confusing at times, because he appears to adopt the above understandings of general and specific competence, but then refers to the specific competence to decide in the broad sense as "general competence to consent [or refuse]"; and, sometimes he uses the term "general competence" in contexts where it is not clear whether he means a person's overall ability to perform the tasks of daily living, or a person's broad decisionmaking capacity. For the purposes of this section, I will assume that, when Beauchamp refers to a generally competent person, he has in mind what he calls the "received cultural view" of the competent person which I set out earlier in the chapter (see Beauchamp 1991: 60-61).

establishing autonomy as the condition...of general competence" (Beauchamp 1991: 60-61).³

Beauchamp then proceeds to explain why his hypothesis specifies that autonomy is the condition of *general* competence. In contexts where informed consent is sought, "general competence may be established solely through the criterion of the autonomous person, which at a minimum includes the possession of the ability to decide or choose autonomously" (Beauchamp 1991: 61). And, in the health care setting, general competence to decide is often taken to be the condition of the validity of a particular decision.⁴ However, if in soliciting informed consent we choose to look to specific competence to make a certain kind of decision (rather than to general competence to decide), then autonomy is not necessarily the sole criterion. This is because an autonomous, generally competent person may not be competent, or able to exercise his/her abilities, in a specific instance: "The *capacity to make* autonomous choices in general is distinct from the capacity to *make* such choices *in the circumstances*, and the presence of either capacity is no guarantee of its *exercise* in any single occasion" (Beauchamp 1991: 61; his emphasis).

³ While I agree with Beauchamp that the criteria of autonomy are more specific than those of general competency, I do not agree that "the properties that make up the autonomous person tend to be more stable and more independent of social evaluation than are the properties that constitute the competent person" (Beauchamp 1991: 60). As I stated in chapter 2, and hope to develop further in chapter 4, it is not clear to me that a viable theory of autonomy must hold that "the autonomous person is one who is capable of independent, intentional, informed, and reasoned judgments and actions" (Beauchamp 1991: 60). Moreover, I hope that this and the subsequent chapter make it clear that, like competency, autonomy is a social construct and, thus, is no more independent of social evaluation than is competency.

⁴ Note that the practical relationship between general competence (or autonomy) and the ability to make a particular health care decision is simply that the former may be taken as evidence of the latter, although general competence need not necessarily be considered in assessing specific competence.

While Beauchamp's observations are useful in thinking generally about the relationship between the criteria of competency and autonomy, he does not offer a refined version of his initial hypothesis, despite his expressed dissatisfaction with it. He concludes his analysis essentially as he began: "being autonomous is the criterion of being competent. When we search for the competence to consent, we look to the *criterion* of autonomy" (Beauchamp 1991: 61). A more detailed analysis of the relationship between the criteria of competency and autonomy is needed, and it should take account of the fact that there are at least two dominant concepts of autonomy in bioethics.

Consider the following tables which set out, above the horizontal line in each table, the criteria shared by dominant models of competency and autonomy.⁵

⁵ The set of criteria of competency in both tables is extracted from Beauchamp's (1991: 58-59) summary of the dominant view of competency in bioethics which I quoted directly earlier in this chapter. The set of criteria of Kantian autonomy in the first table is derived from the accounts of Mappes and Zembaty (1986), Beauchamp and Childress (1989, 1979), and Gillon (1985), as set out in chapter 2, section 2.1. The set of criteria of Dworkinian autonomy in the second table is taken from the account of Dworkin (1989), as set out in chapter 2, sections 2.1 and 2.2.

Table 1	
The Dominant Model of Competency	The Kantian Model of Autonomy
<ul style="list-style-type: none"> . ability to understand (and appreciate) relevant information } <ul style="list-style-type: none"> . ability to weigh risks and benefits } <ul style="list-style-type: none"> . ability to use such knowledge to make a decision } <ul style="list-style-type: none"> . ability to behave purposively (i.e., to choose goals, to choose appropriate means to those goals, and to act in accordance with chosen goals and means) 	<ul style="list-style-type: none"> . ability to decide on the basis of reasoned deliberation (this appears to be a shorthand way of expressing the bracketed criteria in the opposite column; clearly, reasoned deliberation requires understanding and appreciation of information, and risk/benefit analysis) . ability to behave purposively (i.e., to choose goals, to choose appropriate means to those goals, and to act in accordance with chosen goals and means)
<ul style="list-style-type: none"> . ability to communicate relevant information . ability to make a decision consistent with a relatively stable set of values and goals 	<ul style="list-style-type: none"> . ability to decide and act independently, free from internal and external constraints

Clearly from Table 1, the dominant model of competency and the Kantian concept of autonomy share the bulk of their criteria. Even the criteria that fall below the horizontal line in each case can be understood to be implicit in the other concept. For example, although accounts of the Kantian concept of autonomy do not generally state explicitly that a patient's decision must be consistent with that patient's values and goals, a decision that does not so conform is often taken as evidence that adequate reasoned deliberation has not taken place. Similarly, the above view of competency does not state explicitly that a patient must be able to decide free from internal and external controlling influences, but it is understood that decisionmaking abilities may be hampered by factors such as fear, pain, depression, professional and familial pressure, drug therapies, and so on.

Table 2	
The Dominant Model of Competency	Dworkin's Model of Autonomy as Authenticity
<ul style="list-style-type: none"> . ability to make a decision consistent with a relatively stable set of values and goals 	<ul style="list-style-type: none"> . ability to reflect critically, at a higher-level, on a lower-order desire . ability to approve, at a higher-level, of the lower-order desire . ability to undertake this identification process free from manipulation and constraint
<ul style="list-style-type: none"> . ability to communicate relevant information . ability to understand (and appreciate) relevant information . ability to weigh risks and benefits . ability to use such knowledge to make a decision . ability to behave purposively (i.e., to choose goals, to choose appropriate means to those goals, and to act in accordance with chosen goals and means) 	

Although the first criterion listed in Table 2 in the competency column does not appear to be in perfect correspondence with the first three criteria listed in the autonomy-as-authenticity column, its very general statement could be interpreted in the light of Dworkin's theory (recall the different interpretations of authenticity and consistency described in chapter 2). And, as in the first table, although the first three criteria of competency falling directly below the horizontal line do not seem to correspond to the

criteria of Dworkin's model, they may be implicit in Dworkin's concept of critical reflection. For example, for a patient to reflect critically on his/her lower-order desire to refuse potentially life-saving, but severely debilitating, treatment, he/she presumably would need to understand and appreciate relevant information and engage in risk/benefit analysis in order to discover whether the lower-order desire to refuse meets the approval of his/her higher-order desire to preserve life but not at the cost of 'quality of life.' (Note that Dworkin's (1988) revised view of autonomy (see chapter 2, note 3) now includes the criterion "the ability to behave purposively," although the criteria in the above table do not.)

The above tables and brief analyses demonstrate that the criteria of the leading concept of competency are closely related to the criteria of the dominant concepts of autonomy, especially to that of the Kantian model (which is *the* dominant model in bioethics).⁶ An explanation for the close relationship of the decisionmaking abilities specified by each concept will be given below. Beauchamp's hypothesis - that, in the health care setting, autonomy is taken to be the solely sufficient condition of general competence - is, practically speaking, correct. That is, autonomy is the condition that must be satisfied when general competence is evaluated. However, the *conceptual* relationship between competency and autonomy should be expressed as 'the criteria of general competency correspond roughly to the criteria of autonomy,' as opposed to 'autonomy is the criterion of general competence' (Beauchamp's preferred description), which describes

⁶ Note that the concepts of competency and autonomy are also related in that, as ability-centred notions, they are threshold concepts for the purpose of health care policy. That is, a person's ability can be represented on a continuum ranging from complete inability to marginal ability to full ability; in bioethics, a threshold is set for the abilities relevant to competent, autonomous decisionmaking, and patients falling below this arbitrarily set threshold are judged incompetent (nonautonomous) for decisionmaking purposes.

the way the two concepts are related in practice, but does not adequately describe their conceptual relationship.

The reason the criteria of competency correspond roughly to the criteria of autonomy, and the reason this correspondence means that (in practice) autonomy is the criterion of general competency (rather than competency is the criterion of autonomy) are that, in bioethics, *competency* is what is being evaluated, and the purpose of the competency evaluation is to promote autonomy. This brings me to the discussion of the relationship between competency and autonomy as the concepts are *applied* in the health care setting.

3.3 The Relationship of the Applications

If a patient is judged generally competent (autonomous), then he/she is accorded the right to exercise his/her autonomy. In other words, if one has the capacity for autonomy, one is given the right of autonomy, and the competency assessment is used to determine who has the capacity and, therefore, the right. For example, competent patients are taken through informed consent proceedings - a mechanism in place to promote the right of autonomy, and its successful exercise, though the conditions of disclosure, comprehension and voluntariness. A patient must be competent in order for his/her decision to be considered valid or authoritative. If he/she is deemed incompetent, the focus shifts from protecting autonomy to securing well-being.

[Competency and consent] are used to delineate the scope of a person's (right to) autonomy or self-determination as well as well-being (physical, mental, etc.). Persons who are incompetent lose the right to have their choices respected and become subject to the laws governing advocacy, guardianship and surrogate decisionmaking" (Harvey et al. 1992: 9).

In the bioethics literature, the goal of the competency evaluation is widely understood to be the promotion of patient autonomy, and the risk accompanying such evaluation is understood to be the loss of autonomy. As Morreim states, in the health care setting, "our moral interest in competence stems largely from the moral premium we place on respect for autonomy" (Morreim 1991: 93). The major issue discussed in the literature on competency is how to balance the patient's right to autonomy and the physician's responsibility to ensure the patient's well-being, which may involve making decisions for the patient without his/her authorization ("paternalism"). This moral dilemma is characterized as a conflict between the principle of respect for patient autonomy and the principle of beneficence (see Sherwin 1992: 137-157).

Lo's (1990) article, "Assessing Decision-Making Capacity," is an example of the standard construction of and approach to this ethical conflict. Lo is concerned primarily with the authoritative role physicians and psychiatrists play in the often difficult and controversial evaluation of patients' competence to make informed decisions about their health care. He explains that competency assessments are so significant because, if a person is deemed incompetent, his/her decision-making power may be taken away. In assessing decision-making capacity, he states, "physicians must balance protecting patients from harm with respecting their autonomy" (Lo 1990: 194). Lo argues that, given the tremendous power of physicians in this area, it is crucial that they understand the concept of decision-making capacity and establish clear standards for its evaluation; otherwise, such determinations may be inconsistent and unfair.⁷

⁷ Note that if control over decisionmaking becomes a contest between the patient and his/her physician, the physician can set a higher threshold level and use a more rigorous test of competency. Although, ideally, competency assessments are meant to promote the right to autonomy, in practice even the right to autonomy as negative freedom may be hampered, given the power of physicians to invoke more stringent criteria for competency. Similarly, if a physician adopts a low standard of

The fundamental dilemma regarding the criteria and assessment of competency is perceived, then, as the conflict between promoting patient autonomy and securing the patient's best interests - the principle of respect for patient autonomy weighed against the principle of beneficence. Moreover, it is generally held that the former principle is to be favoured over the latter both in choosing criteria of competency and in assessing individual cases (Weisstub 1990: 2). Lo's view accords with this: "The obligation of physicians to protect patients from harm conflicts with their obligation to respect the autonomy of persons to make decisions that others might regard as foolish, unwise, or harmful" (Lo 1990: 194).

Framing the issue in terms of a conflict between autonomy and beneficence, however, is problematic in that it threatens the goals of protecting patient autonomy and securing patient welfare. These goals are put in jeopardy in part because the dominant models of autonomy underlying the principle of respect for autonomy are inadequate (see chapter 2), and in part because the autonomy-beneficence dichotomy supports an all-or-nothing approach to decision-making. The aim of the competency evaluation is to identify those who are competent to make important decisions about their lives and those who are not. A competency assessment requires that a threshold level for competence be set; current health care policy demands that patients who meet the threshold requirement be categorized as "competent," and those who fail to meet it as "incompetent."

The standard approach to mental competency determinations may be successful for those who are clearly competent or incompetent: generally, in such cases, it is desirable to promote autonomy (the patient makes the decision) or secure best interests (a substitute

competency (simple evidencing of a choice, for example) which protects the right to autonomy above all else, this may work against the actual exercise of autonomy, because often beneficence or positive measures taken on behalf of the patient are needed in order to promote autonomy.

makes the decision for the patient), respectively. But, the competence and autonomy of patients exist along a continuum - patients are seldom fully competent or incompetent, but, rather, are generally marginally or partially competent and to different degrees. The vast majority of competency assessments involve patients in this "grey" area - those of limited competence.

In such cases, to promote either individual autonomy or beneficence, to preserve decision-making power or take it away, may neither adequately respect, nor adequately care for, the patient. When

[t]he key question is: which should be the dominant principle - the patient's freedom to choose what he thinks is good for him, or the doctor's freedom to intervene when, in his opinion, the patient has made a harmful or dangerous choice? (Pellegrino 1991: 48)

the focus is not concern for patient well-being, which ought to reflect the knowledge that autonomy and beneficence are not necessarily incompatible, and that the consideration of one may be needed to promote the other. Due to the present need to assign patients to either the category of "competent" or "incompetent," some patients who could at least participate in decision-making may be denied that opportunity, and others who require assistance may not receive it. Thus, (in)competence is created. Further, as Sherwin points out, being granted full decisionmaking authority as the only option to paternalism may be less than desirable:

patients often are at a disadvantage in medical contexts: when they are ill, they are likely to be frightened of abandonment, and they may not be confident about their own judgement; hence, they may not be eager to insist on their rights to independent judgment. Individual authority is not necessarily their preferred alternative [to paternalism] under such circumstances. (Sherwin 1992: 140)

Sherwin goes on to say that "the structure of the debate [autonomy versus beneficence] in the traditional bioethics literature seems to offer no satisfactory option" and she calls for

the development of an alternative nondichotomous decisionmaking model that "neither replace[s] patient authority with technical expertise nor abandon[s] patients to their 'rights'" (Sherwin 1992: 140).

To conclude, then, the dominant concepts of competency and autonomy are closely linked in meaning, criteria and application. I have described these relationships between the two concepts in order to make the following claim: if the dominant concept of autonomy were to change (that is, if its criteria were altered), we would expect a corresponding change in the dominant concept of competency. This is not to say that, if the criteria of autonomy were changed, then it follows *logically* that the criteria of competency would change similarly. As I noted earlier, there is no necessary connection between the criteria of the two concepts. Thus, the close relationship between the criteria of the prevailing concepts of competency and autonomy in the health care context does not itself account for the expectation that, if the criteria of autonomy were to change, then the criteria of competency would change.

What *does* account for this expectation is the relationship between the applications of the concepts. The rough correspondence of the criteria of competency and autonomy is established in our society's health care context because autonomy is highly valued, and we aim to respect it. More specifically, to be respected as autonomous, one must have the capacity for autonomy. The purpose of creating the criteria and tests of competency is to determine whether the capacity for autonomy is present and, therefore, ought to be respected. To be respected as autonomous, then, one must be competent. And, in practice, the necessary and sufficient condition of competency is autonomy. Therefore, given current values and practices in health care, it stands to reason that, if our understanding of what it means to be autonomous were to change, then our criteria of

competency - which are established and tested for toward respecting autonomous decisionmaking capacity - would adjust accordingly. As long as it is patient autonomy that we seek to promote through competency assessments, the criteria of competent decisionmaking will be the criteria of autonomous decisionmaking, however we conceive the latter.

It should be apparent, then, that the concept of autonomy contributes to the social construction of (in)competence in two ways: If it were not for the 'moral premium' our society places on autonomy, then it is likely that we would be less concerned with competency and its evaluation. And, because the concept of competency is informed by the concept of autonomy, the model of autonomy we choose may determine whether a person is considered (in)competent. In chapter 4, I will discuss how certain changes in prevailing autonomy ideals would improve competency determinations and respect for patient autonomy. I will explore the possibility of a more interactive approach to decisionmaking in the health care setting, which would work to empower patients by enhancing their ability, rather than to exclude them by labelling them "incompetent" if they 'fail' to measure up.

CHAPTER 4

ALTERNATIVE CONCEPTUAL MODELS

It seems to me that there are at least two ways to arrive at an alternative, more adequate notion of competence for the health care setting. One, we could divorce the prevailing concepts of competency and autonomy (so that autonomy is no longer the criterion of general competence), leave the dominant model(s) of autonomy intact, and develop new criteria for competency that would better respect the partial nature of patient autonomy.¹ Or, two, we could develop an alternative model of autonomy on which to base a corresponding alternative model of competency. I choose the second option because its undertaking seems more interesting and valuable, given that certain persons and groups of persons are oppressed by unrealistic models of autonomy in other than health care contexts.²

In this final chapter, I will provide a preliminary sketch of an acceptable, practical model of autonomy for bioethics. That is, I will outline what considerations a good, applicable notion of autonomy in the health care context ought to take into account that the dominant models do not. I will also provide a tentative set of criteria of this alternative concept of autonomy so that it can be compared more easily with the criteria of the dominant models, detailed in chapter 3. Then, in the light of the relationships between

¹ As Beauchamp points out, the two concepts are closely tied in our culture, so much so that autonomy is usually taken to be the sole criterion of general competency, but there is no *necessary* connection between dominant notions of autonomy and competency. For example, it would possible to develop a concept of competency that does not require the ability to make *independent* judgments (Beauchamp 1991: 60-64).

² For example, it can be argued that regarding autonomy as independence oppresses people with physical and/or mental disabilities, people who care for dependent persons, people who are dependent on caregivers, people who are impoverished or financially dependent, and so on.

autonomy and competency described in chapter 3, I will describe the criteria of the corresponding alternative account of competency, comparing it with the leading concept of competency. Finally, I will compare briefly responses based on the dominant and alternative models of competency to some of the standard competency issues.

4.1 An Alternative Account of Autonomy

An alternative account of autonomy, adequate and applicable in the health care context, would need to be built on a conception of the self which is significantly different from the rational individualist view of the self underlying the Kantian concept of autonomy. As Sherwin states (and as I argued in relation to patients, in chapter 2), "actual people are not independent, and their decision-making does not always meet the norms that define rationality"³ (Sherwin 1992; 137). What is needed is an account of the self as at once separate and connected (see also Sherwin 1992: 53, 137-157; Hoagland 1988: 144-146; Weinberg 1988; Agich 1990). In constructing her account of moral agency and choice, Hoagland invokes "a self who is both elemental and related, who has a sense of herself making choices within a context created by community" (Hoagland 1988: 145). For Hoagland, the self is not essentially *defined* in terms of others, but it does emerge through interactions with them. Hoagland's term for this separate yet connected self is "autokoenoeny" (o to ken o ne) which means "the self in community":⁴

An autokoenoenyous being is one who is aware of her self as one among others within a community that forms her ground of be-ing, one who makes her decisions in consideration of her limitations as well as in

³ Given the context of this passage, it seems clear that Sherwin is referring to traditional philosophical notions of rationality - instrumental rationality and rationality of ends.

⁴ Greek, "auto" (self), "koinonia" (community, or any group whose members have something in common) (Hoagland 1988: 145).

consideration of the agendas and perceptions of others. She does not merge with others, nor does she estrange herself; she *interacts* with others in situations. (Hoagland 1988: 145; her emphasis)

Hoagland's description of the autokoenoous person is very useful in articulating some of the features of the view of the self - as neither wholly socially constituted, nor completely independent - which would give rise to a better, practical model of autonomy for bioethics. In addition, however, a more developed account of the nature of the self in community is needed both to 'fill out' and to justify such an alternative model. Central questions include: In what ways, and to what extent, is self-identity constituted or defined by community? In what ways, and to what extent, is it chosen? How do social experience and personal choice interact? What, if any, moral consequences follow from responses to these questions? (Pursuing any one of these questions leads one into issues of great complexity, well beyond the scope of the present work.)

An alternative model of autonomy built on the relational, contextual view of the self in community must account for the self's capacity for agency, its relationships to others, and its social context. Sherwin describes what Hoagland's "autokoenoony" might mean in the health care context:

autokoenoony suggests an understanding of patients existing in a social world, where their ends and activities are defined in conjunction with others they trust. This view offers a more realistic perspective of patients choosing in the company of others who help shape their lives; when patients are confronted with difficult decisions, physicians and patients might include in the decision-making process those others who are trusted by the patient. (Sherwin 1992: 156)⁵

⁵ Since not all patients have people who care about them, that they can trust and rely on, it is important that Sherwin adds: "Patients who are isolated, that is, who have no others they can trust, could be helped to form relationships that would foster their decision-making in an interactive way. Self-help groups of patients with a common condition, for instance, usually provide patients with the opportunity to explore the complexities of their decisions in a nonhierarchical environment" (Sherwin 1992: 156).

The alternative bioethical model, then, would treat autonomy as a relational, not simply as an intrinsic, property of patients. On this model, dependence and interdependence do not necessarily preclude autonomous decisionmaking; in fact, certain relationships so characterized may be necessary for such decisionmaking.

Hoagland's distinction between "depending on someone" and "being dependent on someone" may be important here. According to Hoagland, a person is a moral agent - the subject of her choices - if, when someone she is depending on is unable to keep his commitment, she is still able to 'carry on,' which may involve replanning what she wanted to do, finding another person to help her, giving up the particular project and moving on to another, or some other strategy. A person is not a moral agent - not the subject of her choices, but the "object of events" - if she is dependent on a person, and if that person cannot keep his commitment, she falls apart, she cannot carry on (Hoagland 1988: 145-146). Although this distinction is useful for thinking about autonomy in relationships, it seems to me that Hoagland should specify whether it is to apply to people globally or specifically. For example, Mr. W., who is dependent on a trusted other to help him with his banking, may 'fall apart' if his assistant moves to another city and, thus, may lack agency with regard to this area of his life; however, it may not be appropriate to say that Mr. W. is not a moral agent if he is able to 'carry on' with other aspects of his life.

This alternative account of autonomy would be superior to the now dominant models largely because it is based on a conception of the self which seems more directly applicable to actual patients. Given the understanding of autonomy as relational, patients, as a group, would not be dismissed as nonautonomous (as they potentially could be on some readings of the Kantian or Dworkinian concepts); neither would the class of patients be devalued for their 'failure' to exhibit highly prized independence (especially if the

alternative relational model were not restricted to the health care context, but adopted by society at large).

An adequate bioethical model of autonomy would characterize autonomous decisionmaking as cooperative, rather than antagonistic. This would help to undermine the present struggle for control over decisionmaking; that is, the main issue would no longer be whether the patient should make the decision (autonomy) or the decision is best given to the physician (paternalism), but, rather, how to empower patients to make their decisions, how to foster decisionmaking capacity.⁶ Due to the relational, contextual nature of an alternative model of autonomy based on a more realistic view of the self, the focus would be on the enhancement of the patient's ability to make a particular decision (or set of decisions), given his/her particular relationships and circumstances. Ideally, but not necessarily, specific decisions made by the patient and those he/she trusts would promote the patient's overall, or long-term, autonomy and interests. This model of decisionmaking would be interactive, where the purpose of interaction is to enhance the patient's capacity for autonomous decisionmaking, not to create opportunities for paternalism, or manipulation of the patient by relevant others. The main concern, then, would not be whether the patient is autonomous or nonautonomous - whether he/she is to be allowed to participate or not in decisions about his/her health care - but, rather, whether all that could be done to enhance decisionmaking capacity has been done, and whether the patient can use these resources to make a decision. Note that it does not follow that the patient who

⁶ This is not to say that reconceiving autonomy along these alternative lines would itself *eliminate* the conflict between patients and physicians over decisionmaking power. An alternative model of autonomy which assigns less theoretical weight to such conflict may contribute to diffusing this 'power struggle,' but, clearly, before the focus in health care moves from awarding decisional authority to enhancing decisionmaking capacity, certain compatible political, economic and educational structures would need to be in place.

is unable to make a decision even after every effort has been made to foster his/her decisionmaking capacity should be excluded altogether from the decisionmaking *process*. Patients should be encouraged to participate in decisions about their health care to the fullest extent that they are able.

The emphasis on enhancing the autonomous decisionmaking of patients would bring a positive dimension to the concept of autonomy. That is, if our interest is in fostering autonomous decisionmaking capacity and its realization, then, in many (if not most) cases, more is required than the concept's negative dimension of noninterference. This idea is captured in Agich's call (from chapter 2) for a richer concept of autonomy which would view "choice as a problem of providing options that are meaningful rather than as an issue of removing obstacles to choice or impediments to action" (Agich 1990: 12). An adequate alternative approach to autonomy in the health care setting would demand the provision of resources needed for the exercise of patient autonomy. This would involve looking beyond the artificial boundaries of the health care context to the larger moral and socio-political context. (I will illustrate this point later when I revisit the case studies.)

A better, practical account of autonomy would not require that patients have freedom of action - that is, the ability to make their decisions effective in action. It would separate the question of whether a person is capable of autonomous decisionmaking from the question of whether he/she is able to effectuate his/her decision, and it would focus on the former. As Hoagland argues, that we are unable to control certain factors which affect us, and which may determine whether we can carry out our decisions, does not mean that we are unable to make choices. A useful concept of autonomy must focus on our ability to affect our situations, not to control them:

choice is at the very core of the concept of 'moral agency.' *It is not because we are free and moral agents that we are able to make moral choices. Rather, it is because we make choices, choose from among alternatives, act in the face of limits, that we declare ourselves to be moral beings.* That is what it means to be a moral being....[M]aking choices within limited situations is a matter of affirming moral agency, not undermining it. (Hoagland 1988: 230-231; her emphasis)

Such a model of autonomy would force us to look at why certain autonomous patients cannot execute their choices; the social factors affecting the exercise of autonomy would become more apparent. On this model, patients like Mrs. G. would not be declared nonautonomous or incompetent to choose to return to their homes just because they are unable to cope due to inadequate resources; instead, it would be clear that the reason Mrs. G. cannot exercise her autonomous decision to return home is that she is poor. Furthermore, if society truly values autonomy, then it has an obligation to promote its flourishing, which, in Mrs. G.'s case, might mean that she be provided with the resources she needs to return home.

A more adequate account of autonomy would not imply self-control or self-domination, that "the one who is autonomous is the one who can rise above her nature and exercise self-control though will power" (Hoagland 1988: 144). We need a nonhierarchical model which does not hold that patients must 'rule' themselves to be autonomous (and that if they cannot rule themselves, others can legitimately rule them). As Hoagland points out, we are not in full control of ourselves, we are subject to the control of others and to the constraints of circumstances. In addition, the alternative model would not specify that deliberative rationality should prevail over emotion in autonomous

decisionmaking, nor that lower-order desires should conform to higher-order ones, given all the drawbacks that those specifications were shown to have in chapter 2.⁷

Like Dworkin's (1988, 1989) account, the alternative model of autonomy would be content-neutral in the sense that it would not be the *content* or outcome of a patient's decision (refusal of treatment, for example) that would determine whether he/she were considered autonomous; instead, the status of a patient's autonomy would be determined by the nature of his/her decisionmaking *process*. The procedural requirements of such a model, however, would be less constraining than Dworkin's or Kant's, reflecting a broader conception of autonomous decisionmaking. For example, it would not be necessary that the patient's decision be consistent with his/her 'higher-order,' or past, values and goals, but it would be necessary that the patient be able to understand his/her alternatives and that his/her decision not be coerced.

Predictably, there are some problems and obstacles - both conceptual and practical - to be overcome before this alternative realistic, relational concept of autonomy could function adequately in the health care context. Clearly, what I have provided above is only a preliminary sketch of the kinds of things that a better, applicable model of autonomy would need to take into account; further conceptual development is needed. Problems to consider include: how to enhance the decisionmaking capacity of patients who are unable to form relationships of trust; how to discern which relationships are worthy of trust; how to resolve conflicts that arise in cooperative decisionmaking efforts; and how to guard against manipulation and unwarranted paternalism. And, as Sherwin points out, a

⁷ Given that the core meaning of autonomy is "self-rule" or "self-governance," perhaps a new term should be chosen for this alternative model of agency if it is to reject the idea of self-domination. One option would be to adopt Hoagland's term "autokoemony," the core meaning of which is "the self in community."

model of autonomy that focuses on empowering patients - on strengthening their agency - to make decisions that benefit them will "require radical rethinking of the patient-physician relationship and development of improved patterns of communication and mutual respect" (Sherwin 1992: 156).

The criteria of autonomy based on the alternative model characterized above might be expressed as follows:

A patient who is autonomous to make a decision is able to:

1. recognize the nature of the decision to be made (i.e., that there are options and what those options are), with or without the assistance of others;
2. respond to the need to make a decision by undertaking to make such decision, alone or with the assistance of others;
3. communicate and interact with others, if necessary, toward making the decision;
4. understand information relevant to the decision to be made and use this understanding to consider the likely pro's and con's of available options, with or without the assistance of others; and
5. arrive at a decision, with or without the assistance of others.

4.2 An Alternative Model of Competency

Based on the nature of the relationship established in the health care context between the concepts of competency and autonomy (as described in chapter 3), the alternative model of autonomous decisionmaking described above would give rise to a set of competency criteria that corresponds to the set of autonomy criteria just listed. In Table 3 below, the sets of competency criteria of the dominant and alternative models have been organized for the purpose of comparison such that (a) an empty space in one column opposite a criterion in the other column indicates the lack of shared or related criteria, and (b) a criterion in one column opposite a criterion in the other column indicates related (albeit often substantially different) criteria.

Table 3

The Dominant Model of Competency	The Alternative Model of Competency
<ul style="list-style-type: none"> . ability to communicate relevant information . ability to understand (and appreciate) relevant information . ability to weigh risks and benefits . ability to use such knowledge to make a decision . ability to make a decision consistent with a relatively stable set of values and goals . ability to behave purposively (i.e., to choose goals, to choose appropriate means to those goals, and to act in accordance with chosen goals and means) 	<ul style="list-style-type: none"> . ability to recognize the nature of the decision to be made, with or without the assistance of others . ability to respond to the need to make a decision by undertaking to make such decision alone or with the assistance of others . ability to communicate and interact with others, if necessary, toward making the decision . ability to understand information relevant to the decision to be made and, to use this understanding to consider the likely pro's and con's of available options, with or without the assistance of others . ability to arrive at a decision, with or without the assistance of others

Although the two accounts of competency outlined in Table 3 are roughly similar in that the competent patient must be able to communicate, understand, weigh risks and benefits, and decide, there are five main differences between the alternative model and the dominant one. First, all of the specified abilities of the competent patient on the alternative model may be possessed independently, or may rely, to a greater or lesser degree, on the

assistance of others; a patient who is dependent or interdependent in certain respects may be competent. This stands in contrast to the dominant understanding of competence, where it appears that the competent patient must possess these abilities independently and make his/her decision(s) alone; thus, in the dominant model, even well-meaning health care professionals, families and friends are seen as 'intruding,' and all such "incursions on voluntariness constrict the ...[patient] who requires the least possible interference with his or her freedom to make a decision" (Kline 1991: 71).

Second, unlike the dominant model, the alternative model of competency does not demand that the patient base his/her decision on his/her 'understanding and appreciation' of relevant information; that is, as long as the patient is able to understand and consider information relevant to the decision at hand, he/she may base his/her decision on this understanding and consideration, or on other considerations, such as emotion, inclination, moral or other values, religious beliefs, and/or the opinions of others involved in the decisionmaking process. This feature of the alternative model helps guard against labelling 'incompetent' a patient whose decision (to refuse treatment, for example) is taken as *proof* that the patient is *not* able to 'understand and appreciate,' or whose decisionmaking process is seen as irrational because his/her choice of means does not appear to others appropriate to his/her goal or ends (for example, given her desire to live, Mrs. G.'s decision to return to her home was considered irrational by those professionals concerned solely with the physical risks involved in her doing so).⁸

⁸ This is not to say that there may not be any cause for concern if a patient is making a decision which, for example, does not seem to take into account relevant information, or does not seem to be consistent with the patient's past goals and values. If such a patient does not provide explanations for, or does not appear to recognize, changes in decisionmaking style or values, closer examination of his/her competency may well be warranted (but such decisions in themselves do not warrant a conclusion that the patient is incompetent) (see also Morreim 1991: 121-122, n 4.).

Third, in not requiring that a competent patient's decision be consistent with his/her relatively stable set of beliefs, values and goals, the alternative model of competency allows for fundamental changes in the patient's outlook. The alternative model requires consistency only in the senses that the patient's decision must be free from central contradiction (for example, the patient's final decision cannot be to accept treatment and to not accept treatment), and that the patient must not make any blatant and unresolvable means-ends errors in reasoning (for example, a patient who very much wants to live, and requires a life-saving blood transfusion to do so, is not competent if he/she refuses the transfusion and cannot be made to understand that its purpose is to save his/her life and not part of a plot to kill him/her).

Fourth, if the dominant model of competency requires that the patient be able to *act* in accordance with chosen goals and means (see the last criterion in Table 3 above)⁹, the alternative model differs from it in that the latter is concerned with psychological, not executional, capacity. That is, on the alternative model, a patient does not have to be able to execute or act on his/her decision in order to be considered competent. Accordingly, this feature of the alternative model may bring to light certain factors external to the patient that prevent him/her from exercising what may be his/her competently made decision.

⁹ It is not clear to me what is meant by being "able to act in accordance with chosen goals and means." Although Beauchamp states that the competent patient need not necessarily perform the tasks related to this ability to behave purposively (Beauchamp 1991: 58-59; see my chapter 3), others may interpret this criterion as requiring executional ability. My point is that the alternative model requires neither that the competent patient *actually* act on his/her decision, nor that he/she be able to act on his/her decision.

Fifth, the alternative model makes explicit that which presumably is implicit in the dominant account, that is, the patient must be able to apprehend that a decision regarding particular options is required, and intend to make such a decision.

In sum, in contrast to the dominant model of competency, the proposed alternative account makes provisions for trusted others to assist the patient in his/her decisionmaking, for different decisionmaking styles, for changes in the patient's beliefs, values and goals; and by focusing on psychological, rather than executional capacity, it highlights factors originating outside the competent patient which may affect his/her ability to exercise his/her decisionmaking capacity or to execute his/her decision.

4.3 Alternative Conceptual Models and Standard Competency Issues

In this final section I will describe briefly the general approach of both the dominant and the alternative models of competency - built on their corresponding models of autonomy - to some of the standard competency questions set out below. Note that the major competency question - that is, *What are the criteria of competency?* - has been dealt with in the previous section.

. When ought competency to be called into question?

On the dominant model of competency, in practice if not in theory, a patient's competence is often called into question when he/she refuses what his/her physician considers the 'medical good'; that is, certain decisional outcomes that are considered irrational often give rise to questioning patient competency. Similarly, patients who do not reason as it is predicted a 'reasonable person' would, or who make decisions at odds with their past value system, may be suspected of incompetence. For example, despite the

presumption of competence that allegedly operates in the health care context, Mrs. G.'s decision to return to her home despite the accompanying physical risks was considered irrational and, on these grounds, the question of her competency to choose her place of residence was raised.

On the alternative model of competency, given the 'lower' or more realistic standard of competency based on a more accurate view of the self, the presumption of patient competence should be taken more seriously. From what we know of Mrs. G., the question of her competency likely would not have arisen given the alternative understanding of competency; she has made a decision based on considerations different from those of the health care team, but considerations she takes to be of overriding importance. On the alternative model, Mrs. G.'s competency as psychological decisionmaking capacity appears intact. That her poverty would hamper, in certain respects, the 'quality' of her life at home is important, but it does not affect her competency to *decide* to live at home. The alternative model of competency separates the issue of poverty from that of competency; a patient's poverty alone would not give rise to the question of competency.

Patients who appear to be functioning well - that is, who appear to possess the decisionmaking abilities described in the right-hand column of Table 3 - should be encouraged and helped when necessary to make decisions that affect them. In contrast, patients who (despite all efforts to help them in ways which take into account their special needs) make decisions which are blatantly contradictory, for example, or who cannot explain decisions which reflect radical departures from past values, may be candidates for a competency assessment. The question of competency is less pressing given the

alternative model, however, because the focus is on enhancing patient decisionmaking capacity in a cooperative way, rather than on awarding decisionmaking power.

. How ought we to test for competency?

This question is perhaps the most difficult on both accounts of competency. As Harvey et al. state, the frameworks used in the evaluation of competency (and yet to be coordinated in the bioethics literature) include psychiatric, cognitive, functional and decisionmaking frameworks, each of which has particular merits and shortcomings (Harvey et al. 1992: 10). Given the vast number of proposed methods of assessment in each framework (see, for example Weisstub 1990: 163-231) and the potential to devise countless new tests of the alternative competency criteria, I will attempt to describe only the general nature of competency evaluations.

It is unlikely that the alternative approach to competency determinations would make use of the commonly employed 'mental status' tests. As Macklin points out, the mental status tests were devised originally for purposes other than assessing patients' decisionmaking capacity (for example, one test was created to detect the presence and location of brain lesions or other organic brain defects), and the tests are of questionable relevance to patients' abilities to make decisions (Macklin 1983: 208-209). For example, the popular Mini Mental State Examination (MMSE) was used to evaluate Mr. W.'s competence. It is not clear, however, how the abilities evaluated by the MMSE - for example, the ability to copy a geometric figure, to count backward from 100 by seven's, or to repeat the phrase "No ifs, ands or buts" - relate to Mr. W.'s ability to manage his finances. Also, recall that, in interpreting Mr. W.'s score, those who administered the MMSE had to take into account that he had little formal education. Not only is the

relevance of this test questionable, but factors such as level of education, language and culture have been shown to influence 'competency' scores.

The tests of competency on the alternative model should evaluate relevant, practical decisionmaking abilities; further, the skills of the patient should be evaluated in his/her decisional context, not in the abstract, and the patient's formal and informal supports should be taken into account. For example, since competency does not require self-sufficiency on the alternative model, any adequate test of Mr. W.'s competence to manage his finances must register that, although Mr. W. may not be able to remember the details of the nature and extent of his assets, liabilities, income and expenses, he can access this information through his bank manager and family members. He cannot make decisions and act on his own with respect to his estate, but he can decide with assistance and direct the actions of trusted others.

The alternative model shares, at least for the time being, a problem with the dominant approach to competency - how to test 'understanding.' In practice, a patient's ability to understand relevant information is usually tested by having the patient register the information and then asking him/her to recall it - the patient must repeat the information in his/her own words. That the patient can repeat information, however, is no guarantee that the patient has *understood* the information. Not only must we find a relatively reliable way to infer understanding, but we also must decide how sophisticated understanding must be, and what to do in cases where a patient appears to understand the risks, but not the benefits, or *vice versa* (Roth, Meisel, Lidz 1977: 206).

. What happens when a patient is incompetent to decide for him/herself?

If a patient is deemed incompetent using the dominant approach to competency, he/she loses his/her right to make his/her own decisions; instead, a surrogate decisionmaker is appointed (ideally by the patient) to make decisions on behalf of and in the best interest of the patient. In contrast to the competent patients whose right it is to have their wishes heeded, Freedman writes: "For the incompetent - the voiceless - we are forced to look elsewhere than at their desires, in giving expression to their rights" (Freedman 1981: 53).

On the alternative model, it does not follow from the fact that a patient is deemed incompetent that his/her wishes will not be heeded or that he/she will not participate in decisions affecting him/her. All patients who can be involved in decisions affecting them should be involved to the fullest extent possible, even if, ultimately, the surrogate decisionmaker and the rest of those involved in the decisionmaking process feel that the patient's preference, at odds with how they perceive his/her best interests, cannot be allowed to override his/her best interests. Surrogate decisionmakers - ideally those in a special relationship of trust with the patient - should make decisions on behalf of patients who are clearly incompetent, such as infants, severely mentally disabled persons, or persons irreversibly comatose.

. How can we improve/enhance the decisionmaking capacity of patients?

As I discussed in chapter 1, this question is not given sufficient attention in the standard literature on competency. Most of the authors who do concern themselves with the question focus on a narrow range of clinical factors affecting patient competency, and call for physicians to strive to remove barriers to patients' effective decisionmaking.

The alternative approach to competency is geared toward enhancing the decisionmaking capacity of patients in at least two ways. First, it suggests that decisionmaking in the health care setting be regarded as it is in many other areas of life - as an interactive, cooperative process undertaken by the patient and those persons he/she trusts. Second, because the alternative model is concerned with actual patients making actual decisions in actual contexts, and because it focuses on psychological rather than executional ability, this model is better able to point to factors external to patients which may affect their decisionmaking capacity and/or their ability to realize their decisions. Accompanying this model is the awareness that '(in)competence' can be socially constructed, that it can be influenced by factors such as dominant concepts, values, goals and resources; and this knowledge can be used to demonstrate the arbitrary and normative nature of competence, to question relevant values and goals that are oppressive to many groups, and, appealing to the value society attaches to autonomy and competency, to call for the provision of resources necessary to enhance the capacity for autonomy and to allow competent persons to exercise their autonomous choices.

Enhancing decisionmaking capacity on this alternative model of competency, which is based on a relational, contextual understanding of autonomy, involves looking beyond the bioethics framework and the health care setting, to a larger moral and socio-political context. For example, Mrs. G.'s poverty, which, on the dominant model, constructs her 'incompetence,' is not a problem that originates within the health care system, but in our chosen economic system; it is up to society to create fair distributive schemes which ensure that programs of social support and services are in place to enable people to exercise the autonomy we value.

I have provided and argued for an alternative, practical notion of competency - based on an alternative, relational model of autonomy - for bioethics. Although what I have presented here requires substantial development and refinement, I believe that it holds considerable potential for positive changes in the nature of decisionmaking and patient care in the health care setting.

LIST OF REFERENCES

- Abernathy, Virginia. 1991. "Judgments about Patient Competence: Cultural and Economic Antecedents." In *Competency: A Study of Informal Competency Determinations in Primary Care*. Mary Ann Gardell Cutter and Earl E. Shelp, eds. Dordrecht: Kluwer Academic Publishers.
- Agich, George J. 1990. "Reassessing Autonomy in Long-Term Care." *Hastings Center Report* (November/December): 12-17.
- Applebaum, Paul S. and Loren H. Roth. 1981. "Clinical Issues in the Assessment of Competency." *American Journal of Psychiatry* 138(11): 1461-1466.
- Beauchamp, Tom L. 1991. "Competence." In *Competency: A Study of Informal Competency Determinations in Primary Care*. Mary Ann Gardell Cutter and Earl E. Shelp, eds. Dordrecht: Kluwer Academic Publishers.
- Beauchamp, Tom and J. Childress. 1979. *Principles of Biomedical Ethics*. New York: Oxford University Press.
- _____. 1989. *Principles of Biomedical Ethics* 3rd ed. New York: Oxford University Press.
- Benn, S.I. 1982. "Individuality, Community and Autonomy." In *Community*. E. Kamenka, ed. London: E. Arnold Publishers.
- Campbell, Alastair. 1991. "Dependency Revisited: The Limits of Autonomy in Medical Ethics." In *Protecting the Vulnerable: Autonomy and Consent in Health Care*. Margaret Brazier and Mary Lobjoit, eds. London and New York: Routledge: 101-112.
- Caplan, Arthur. 1985. "Cries and Whispers: Ethical and Policy Issues Raised by Impaired or Diminished Competency in Elderly Patients." in *The Challenge of Time* Volume V of the *Canadian Gerontological Collection*. E. McGee and G. Gutman, eds. Winnipeg: Canadian Association on Gerontology.
- Cassell, Eric J. 1977. "The Function of Medicine." *Hastings Center Report* (December): 16-19.
- Childress, James F. 1990. "The Place of Autonomy in Bioethics." *Hastings Center Report* 20(1) (January/February): 12-17.
- Christman, John, ed. 1989. *The Inner Citadel: Essays on Individual Autonomy*. Oxford: Oxford University Press.
- _____. 1991. "Autonomy and Personal History." *Canadian Journal of Philosophy* 21(1): 1-24.

- Collopy, Bart J. 1988. "Autonomy in Long Term Care: Some Crucial Distinctions." *The Gerontologist* 28 (Suppl.): 10-17.
- Cross, Alan W. and Larry R. Churchill. 1982. "Ethical and Cultural Dimensions of Informed Consent: A Case Study and Analysis." *Annals of Internal Medicine* 96(1): 110-113.
- Culver, C.M. and B. Gert. 1990. "The Inadequacy of Incompetence." *Milbank Quarterly* 68(4): 619.
- Cutter, Mary Ann Gardell and Earl E. Shelp, eds. 1991. *Competency: A Study of Informal Competency Determinations in Primary Care*. Dordrecht: Kluwer Academic Publishers.
- Double, Richard. 1992. "Two Types of Autonomy Accounts." *Canadian Journal of Philosophy* 22(1)(March): 65-80.
- Draper, Ronald J. and David Dawson. 1990. "Competence to Consent to Treatment: A Guide for the Psychiatrist." *Canadian Journal of Psychiatry* 35(4): 285-289.
- Dworkin, Gerald. 1982. "Autonomy and Informed Consent." In *Making Health Care Decisions 3*. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research.
- _____. 1986. "Paternalism: Some Second Thoughts." In *Philosophy of Law* 3rd ed. Joel Feinberg and Hyman Gross, eds. Belmont, California: Wadsworth Publishing Company: 268-272.
- _____. 1988. *The Theory and Practice of Autonomy*. Cambridge: Cambridge University Press.
- _____. 1989. "The Concept of Autonomy." In *The Inner Citadel*. John Christman, ed. New York: Oxford University Press: 54-62
- Feinberg, Joel. 1989. "Autonomy." In *The Inner Citadel*. John Christman, ed. New York: Oxford University Press: 27-53.
- Freedman, Benjamin. 1981. "Competence, Marginal and Otherwise: Concepts and Ethics." *International Journal of Law and Psychiatry* Vol. 4.: 53-72.
- Friedman, Marilyn. 1986. "Autonomy and the Split-Level Self." *Southern Journal of Philosophy* 24(1): 19-35.
- Gee, Ellen M. and Meredith M. Kimball. 1987. *Women and Aging*. Toronto and Vancouver: Butterworths.
- Gillon, Raanon. 1985. *Philosophical Medical Ethics*. London: Wiley.
- Gunderson, Martin. 1990. "Justifying a Principle of Informed Consent: A Case Study in Autonomy-Based Ethics." *Public Affairs Quarterly* 4(3): 249-265.

- Hill, Thomas E. 1989. "The Kantian Conception of Autonomy." In *The Inner Citadel*. John Christman, ed. New York: Oxford University Press: 91-105.
- Hoagland, Sarah. 1988. *Lesbian Ethics: Toward New Values*. Palo Alto, California: Institute of Lesbian Studies.
- Katz, Jay. 1984. *The Silent World of Doctor and Patient*. New York: The Free Press.
- Kline, Stephen A. 1991. "Mental Competency to Make Medical Decisions." *Health Law in Canada* 11(3): 70-78.
- _____. 1992. "Mental Competence to Manage One's Finances." *Health Law in Canada* 12(4): 101-103.
- Kopelman, Loretta M. 1990. "On the Evaluative Nature of Competency and Capacity Judgments." *International Journal of Law and Psychiatry* 13: 309-329.
- Kupfer, Joseph. 1990. *Autonomy and Social Interaction*. Albany: State of University of New York Press.
- Langer, Ellen J. 1979. "The Illusion of Incompetence." In *Choice and Perceived Control*. Lawrence C. Perlmutter and Richard A. Monty, eds. Hillsdale: Lawrence Erlbaum & Associates.
- Lidz, Charles W. et. al. 1983. "Barriers to Informed Consent." *Annals of Internal Medicine* 9(4): 539-543.
- Lo, Bernard. 1990. "Assessing Decision-Making Capacity." *Law, Medicine & Health Care* 18(3): 193-201.
- Macklin, Ruth. 1983. "Philosophical Conceptions of Rationality and Psychiatric Notions of Competency." *Synthese* 57: 205-224.
- Mappes, T.A. and J.S. Zembaty, eds. 1986. *Biomedical Ethics* 2nd ed. New York: McGraw-Hill.
- Meisel, Alan and Loren H. Roth. 1981. "What We Do and Do Not Know About Informed Consent." *Journal of the American Medical Association* 246(21): 2473-2477.
- Meyers, Diana T. 1987a. "Personal Autonomy and the Paradox of Feminine Socialization." *Journal of Philosophy* 84(1): 619-628.
- _____. 1987b. "The Socialized Individual and Individual Autonomy: An Intersection Between Philosophy and Psychology." In *Women and Moral Theory*. E. Feder Kittay and D. Meyers, eds. Totowa, N.J.: Rowman and Littlefield: 129-138.
- _____. 1989. *Self, Society, and Personal Choice*. New York: Columbia University Press.

★ Morreim, E. Haavi. 1991. "Competence: At the Intersection of Law, Medicine, and Philosophy." In *Competency: A Study of Informal Competency Determinations in Primary Care*. Mary Ann Gardell Cutter and Earl E. Shelp, eds. Dordrecht: Kluwer Academic Publishers.

O'Neill, Onora. 1984. "Paternalism and Partial Autonomy." *Journal of Medical Ethics* 10: 175-80.

Ontario Government. 1980a. *The Mental Health Act*. Toronto: Queen's Printer for Ontario.

Ontario Government. 1980b. *The Mental Incompetency Act*. Toronto: Queen's Printer for Ontario.

Ontario Government. 1992a. *Bill 109: An Act respecting Consent to Treatment*. Toronto: Queen's Printer for Ontario.

Ontario Government. 1992b. *Bill 108: An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care*. Toronto: Queen's Printer for Ontario.

★ Pellegrino, Edmund D. 1991. "Informal Judgments of Competence and Incompetence." In *Competency: A Study of Informal Competency Determinations in Primary Care*. Mary Ann Gardell Cutter and Earl E. Shelp, eds. Dordrecht: Kluwer Academic Publishers.

Pepper-Smith, Robert and William R.C. Harvey. 1990. "Competency Assessments in Discharge Planning and the Question of Intergenerational Justice." *Westminster Affairs* 3(2): 3-5.

Pomerantz, A.S. and A. Denesnera. 1991. "Informed Consent, Competency, and the Illusion of Rationality." *General Hospital Psychiatry* 13(2): 138-142.

○ ★ Roth, Loren H., Alan Meisel and Charles W. Lidz. 1977. "Tests of Competency to Consent to Treatment." *The American Journal of Psychiatry* 134: 279-284.

Sherwin, Susan. 1992. *No Longer Patient: Feminist Ethics and Health Care*. Philadelphia: Temple University Press.

★ Silberfeld, Michel, William R.C. Harvey, Bernard M. Dickens and Robert J. Pepper-Smith. 1988. "A Competency Clinic For the Elderly at Baycrest Centre." *The Advocates' Quarterly* 10(1) November: 23-28.

★ Silberfeld, Michel. 1990. "The Mentally Incompetent Patient: A Perspective from the Competency Clinic." *Health Law in Canada* 11(2): 33-37.

★ _____ . 1991. "The Value of Clinical Judgment in Competency Assessments." *Health Law in Canada* 11(3): 68-9, 83.

_____ . 1992. "New Directions in Assessing Mental Competence." *Canadian Family Physician* 38: 2365-2369.

Veatch, Robert. 1987. *The Patient as Partner*. Bloomington and Indianapolis: Indiana University Press.

✧ Wear, Stephen. 1991. "Patient Freedom and Competence in Health Care." In *Competency: A Study of Informal Competency Determinations in Primary Care*. Mary Ann Gardell Cutter and Earl E. Shelp, eds. Dordrecht: Kluwer Academic Publishers.

Weinberg, Joanna K. 1988. "Autonomy as a Different Voice: Women, Disabilities and Decisions." In *Women and Disabilities: Essays in Psychology, Culture, and Politics*. Michelle Fine and Adrienne Asch, eds. Philadelphia: Temple University Press.

✧ Weisstub, David N., Chair. 1990. *Enquiry on Mental Competency: Final Report*. Toronto: Queen's Printer for Ontario.

Wendell, Susan. 1989. "Toward a Feminist Theory of Disability." *Hypatia* 4(2): 104-124.

Young, Robert. 1980. "Autonomy and Socialization." *Mind* 89: 565-576.

_____. 1986. *Personal Autonomy: Beyond Negative and Positive Liberty*. New York: St. Martin's Press.

_____. 1989. "Autonomy and the Inner Self." In *The Inner Citadel*. John Christman, ed. New York: Oxford University Press: 77-90.