Evaluating Medico-Legal Decisional Competency Criteria

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Abstract In this paper I get clearer on the considerations that ought to inform the evaluation and development of medico-legal competency criteria—where this is taken to be a question regarding the abilities that ought to be needed for a patient to be found competent in medico-legal contexts. In the ''Decisional Competency in Medico-Legal Contexts'' section I explore how the question regarding the abilities that ought to be needed for decisional competence is to be interpreted. I begin by considering an interpretation that takes the question to be asking about the abilities needed to satisfy an idealized view of competent decision-making, according to which decisional competency is a matter of possessing those abilities or attributes that are needed to engage in good or effective or, perhaps, substantially autonomous or rational decision-making. The view has some plausibility—it accords with the way decisional competency is understood in a number of everyday contexts—but fails as an interpretation of the question regarding the abilities that should be needed for decisional competence in medico-legal contexts. Nevertheless, consideration of why it is mistaken suggests a more accurate interpretation and points the way in which the question regarding the evaluation of medico-legal competency criteria is to be answered. Building on other scholarly work in the area, I outline in the "Primary and Secondary Requirements'' section several requirements that deci-sional competence criteria ought to satisfy. Then, in the ''Applying the Framework" section, I say something about the extent to which medico-legal competency cri-teria, as well as some models of decisional competency proposed in the academic literature, fulfil those requirements.

Keywords Decisional authority · Decisional competency · Idealized views of competency · Law · Medico-legal contexts · Mental Capacity Act 2005 · Proportionality · Necessity

Introduction

It is a fundamental ethical and legal tenet that the decision-making of competent adult patients with respect to their treatment and care is to be respected. This means that doctors and other appropriately qualified professionals must obtain the informed and voluntary consent of a patient before treating the patient or carrying out any sort of procedure. It means also that the refusals of competent adult patients to treatment must be respected.[1] One of the few circumstances in which it might not be necessary to respect an adult patient's decision-making—in either of the ways just outlined—is when a patient fails to be competent. In such a case it might be permissible for doctors and other appropriately qualified professionals to interfere with a patient's decision-making—for instance, by overriding a patient's refusal of treatment—if that is in the best interests of the patient as evaluated by the healthcare providers or a surrogate decision-maker.

In many liberal jurisdictions, including the UK, the US, and Canada, competence determinations by doctors and others are governed by law [4]. This is proper and sensible, given that, as we have seen, such determinations serve to distinguish between those who should and those who should not retain decisional authority [5, 20]. As one commentator puts it, ''there is no more profound infringement of the rights of citizens than the determination that they are incompetent'' [2], p 374, and, therefore, it is entirely appropriate that competence determinations are governed by strict legal principles. But this means there is a need to ensure that medico-legal decisional competency criteria—the standards by which competence determinations are judged and which usually make reference to certain decision-making abilities including those relating to understanding, deliberation and communication [4, 20]—are defensible; for if they are not the law will be allowing a degree of state interference that ought not be allowed and which would likely lead to unacceptable violations of people's sovereignty rights.

My concern in this paper is to get clearer on the considerations that ought to inform the evaluation of medico-legal criteria for decisional competence—where this is taken to be a question regarding the abilities or attributes that ought to be needed for somebody to be found competent in medico-legal contexts. In the "Decisional Competency in Medico-Legal Contexts'' section I explore how the question regarding the abilities that ought to be needed for competence is to be interpreted. I begin by considering an interpretation that takes the question to be asking about the abilities that are needed to satisfy an idealized view of competent decision-making, according to which decisional competency is a matter of possessing those abilities or attributes that are needed to engage in *good* or *effective* or, perhaps, *substantially autonomous* or *rational* decision-making. The view has some plausibility—it accords with the way decisional competency is understood in a number of everyday, including clinical, contexts—but fails as an interpretation of the question regarding the abilities that should be needed for

[1] The requirement to respect competent patients' decision-making is not normally taken to extend to patients' *requests* for treatment, however, because the degree to which requests should be respected will depend on such things as availability of resources and consideration of whether what is requested is clinically indicated (see [11], [35]).

decisional competency in medico-legal contexts. Nevertheless, consideration of why it is mistaken suggests a more accurate interpretation and points the way in which the question regarding the evaluation of medico-legal competence criteria is to be answered. Building on other scholarly work in the area, I outline in the ''Primary and Secondary Requirements'' section several requirements that decisional competency criteria ought to satisfy. Then, in the ''Applying the Framework'' section, I say something regarding the extent to which existing medico-legal criteria, as well as some models of competence proposed in the academic literature, fulfil those requirements.

What I have to say is aimed primarily at the evaluation of medico-legal competence criteria. However, my claims are just as relevant to the evaluation of competence criteria utilised in clinical instruments for assessing competence including the widely adopted MacArthur Competence Assessment Tool for Treatment (MacCATT-T).[2] This is for two reasons. First, these clinical instruments largely serve to aid clinicians and other relevant professionals to decide whether or not to allow a person retain decisional authority. Therefore, we would expect competence criteria utilised in those tools to satisfy the same requirements that medico-legal criteria need to satisfy. Second, competence criteria used in clinical instruments for assessing competence will need to reflect competency criteria adopted in law (and, therefore, satisfy the same requirements governing medico-legal criteria for competence), as otherwise clinicians and other relevant profes-sionals relying on those instruments will be at risk of behaving unlawfully, which would be unacceptable; a consideration that in large part must explain why the MacCATT-T is a tool that was designed anyway to help clinicians to measure abilities that *the legal system had already identified as relevant* to competence (see [20]).

Decisional Competency in Medico-Legal Contexts

Although there is some variation between different jurisdictions, many consider decisional competency to comprise decisional abilities such as understanding and appreciation, retention of information, and deliberation of risks and benefits [4, 20]. For instance, the Mental Capacity Act 2005 [26], which governs clinical practice in England and Wales (though not Scotland or Northern Ireland) outlines in S.3(1) four abilities that are required for competence (or 'capacity' as it is referred to in the Act), namely, the abilities to understand information relevant to the decision, to retain the information, to use or weigh the information as part of the process of making the decision, and to communicate the decision (whether orally or by other means). Note that, as is the case elsewhere, medico-legal competency criteria in England and Wales are task-specific; a person might possess the abilities in question with respect to one health-care decision but not with respect to another, and for that reason competency ought to be assessed for each health-care decision that has to be made. It is important to recognise as well that 'decisional competence' in medico-

[2] For a helpful review of different assessment instruments, see Dunn et al. [17].

legal contexts is what is commonly referred to as a *threshold concept*. Although people can possess varying degrees of decision-making capacity—some people might be better at making decisions than other people, for instance—decisional competency is not treated in law as a matter of degree; in medico-legal contexts a person either does or does not have the level of decisional capacity that is required to be considered competent and, thereby, qualified to retain decisional authority with respect to his or her treatment and care (see [5], pp. 26–29).

Now one way of interpreting the question of whether medico-legal competency criteria reflect appropriate standards for decisional competency is to take that question to be asking whether these criteria describe the decision-making abilities that are needed to satisfy some idealized view of competent decision-making. On this way of interpreting the question, we get clear on the abilities or attributes that are needed to engage in good or effective or, perhaps, substantially autonomous or rational decision-making, possibly by means of examining our intuitions regarding hypothetical or real-life cases where people appear to be displaying decision-making defects. For instance, after reflecting on particular cases, we might come to think that competent (that is to say, good or effective or substantially autonomous) decision-making involves choosing in a way that accords with one's 'underlying and enduring values' [5, 13], or having 'recognisable reasons' for the decisions one makes [8, 19], or possessing the ability to make a 'rational decision' [14]. And, then, we enquire into whether existing medico-legal competency criteria properly reflect those idealized views of competency or the capacities or attributes needed to satisfy such views.

For instance, Louis Charland [6] describes research conducted by Antonio Damasio [15], which suggests that people lacking certain emotional capacities are unable to engage in 'competent' or 'effective' decision-making. Charland observes that these patients ''turn out to be unable to plan effectively for the future, to show a marked absence of affect, to behave in self-destructive ways that violate their best interests, and to be unable to maintain healthy and steady social and personal relationships'' [6], p. 73), concluding that ''many existing tests and models for the determination of competence'' (including, we can suppose, clinical and legal tests of decisional competence) might need to be revised so to ensure that only those people who have the right emotional capacities are found competent [6], p. 78; see also [7].[3] In similar fashion, other commentators have argued that existing competency tests might make insufficient reference to people's *values*. For instance, Jacinta Tan and colleagues [34] explored whether the values of people with anorexia-nervosa—for instance, the value attached to being thin—might compromise capacity by virtue of being 'pathological' or 'inauthentic', or, in other words, resulting from an illness. If so, perhaps something like 'authentic values' needs to be a component of decisional competence criteria as well (see also [9, 37]).

Notice, then, that both Charland and Tan et al. seem to be suggesting that decisional competency in clinical and legal contexts ought to be a matter of whether

[3] For the view that competence criteria should include 'coherency of preferences' as a component, so to accommodate difficulties in decision-making that people with major depression experience, see Rudnick [32].

a person satisfies some sort of decision-making ideal, where for Charland it is a matter of whether a person can do such things as 'plan effectively for the future' and 'maintain healthy and steady social and personal relationships' and for Tan et al. a matter of whether a person is able to act or decide in ways that reflect an authentic set of values (and thereby, it might be held, be able to make decisions that count as properly autonomous decisions, ones that are expressive of that person's enduring values and commitments). Again, the idea seems to be that we begin with some account of good or effective or substantially autonomous decision-making—an account that might be informed by empirical data such as that described by Charland and Tan et al.—and then we use that account to evaluate existing legal and clinical competency criteria. To the extent to which it is discovered that competency criteria diverge sufficiently from the decision-making ideal, a strong case exists for amending the criteria in a way that reflects better the decision-making ideal in question.

The view that medico-legal decisional competence criteria should be evaluated according to whether those criteria satisfy an idealized version of competent decision-making can seem compelling. In many everyday contexts questions pertaining to decisional competence are questions pertaining to idealized views of competency. Such views seek to describe the sorts of decisional capacities that might be considered to be desirable or better or valuable for people to have—capacities that might be missing in the sorts of cases described by Charland and Tan et al., for instance—and are often employed because they provide us with decision-making ideals with which we might evaluate, and occasionally try to improve on, our own and other people's decision-making. This is true also in the clinical context where doctors might be concerned to help patients develop or restore their decision-making capacities. It might seem natural to suppose the same is true with respect to the way 'decisional competency' is to be understood in medico-legal contexts, that the medico-legal view of decisional competence is an idealized one. Moreover, it seems likely that many idealized views will include several, perhaps all, those capacities that find expression in medico-legal criteria for competence, such as understanding and retention of information. Again, this might lead us to suppose that decisional competence in medico-legal contexts is about those capacities needed to satisfy an idealized view of competent decision-making.

But the question regarding the abilities that ought to be needed for competence in the medico-legal context is not the question regarding the abilities needed to satisfy some kind of idealized view. As outlined at the beginning of the paper, in medico-legal contexts competence determinations principally function to distinguish between patients whose decision-making must be respected and patients whose decision-making it might be permissible not to respect. However, it is an entirely open question whether the abilities that are needed to satisfy an idealized view of competency—or, in other words, the abilities that might be needed to engage in good or effective or substantially autonomous decision-making—are the same abilities that ought to decide who does and does not retain decisional authority. Idealized views can serve an important role in many everyday contexts, but there is no a priori reason why we should suppose that such views ought to decide who

should and should not retain decisional authority.[4] And, in fact, it seems likely, as I argue at greater length in the ''Applying the Framework'' section, that conforming competence criteria to an idealized view will threaten to set the standard too high in terms of deciding who should and should not be allowed to have decisional authority.[5]

As way of illustration, consider those patients who refuse live-saving treatment because of an 'irrational fear' of the treatment in question. A number of commentators have claimed that such patients ought to be found incompetent even though it can be supposed they understand their situation and are able to deliberate regarding the risks and benefits of having the treatment, and for that reason are likely to satisfy existing medico-legal criteria for competence (see, for instance, [14, 36]). The patient has very good reason to accept the treatment (again we can suppose this is recognised by the patient) and would consent if not for the presence of an irrational fear. Now, we might allow that these patients would fail to satisfy many idealized views of competent decision-making, as their failure to consent does seem to count as a serious decision-making shortcoming of theirs. Nevertheless, it is not obvious that it would be right for the law to view such patients as incompetent for the purpose of something as serious as permitting (perhaps requiring) *removing from them their decisional authority*. Of particular importance here is a question regarding proportionality: would the value served by decisional competence criteria that would find these patients incompetent be proportionate to the harm that the presence of such criteria would likely cause (both to patients and people in society more generally)? And it might be observed that there are a number of areas parallel to the irrational fear case where the state is reluctant to interfere or legislate owing to worries regarding proportionality. For instance, even though it would be better for people not to participate in high-risk gambling activities (including, we might suppose, by many gamblers' own lights), the state is generally very reluctant to stop people from doing this—and it would seem reluctant precisely because it is aware of the need to ensure that in a liberal society people are given the freedom to enable them and society to flourish (including the freedom to make decisions that are unwise or not in their best interests, even as they might themselves acknowledge), even if, regrettably, that means some people come to serious harm as a result.

If this is correct, then the right way to interpret the question regarding the abilities or attributes that ought to be included in decisional competence criteria is not to be asking what abilities are needed to satisfy an idealized view of competent decision-making (as it is uncertain that such views ought to determine who should and should not retain decisional authority) but to be asking only (something like)

[4] To be clear, then, the claim is not that medico-legal decisional competency criteria fail to set standards against which decision-making can be assessed; for clearly they do. Rather the claim is that the standards that medico-legal decisional competency criteria set are those standards that a person's decision-making would need to achieve in order *for that person to be allowed to retain decisional authority*, and there is no a priori reason for supposing that those standards are or should be the same standards that need to be achieved in order for someone's decision-making to satisfy some kind or decision-making ideal.

[5] See also Appelbaum's rejoinder to Charland [6]: ''[B]efore expanding the traditional, cognitively oriented elements of standards of competence to include a component focused on emotional capacity, one ought to require compelling evidence that the change will produce more benefit than harm'' ([2], p.384).

what abilities or attributes (or set of abilities or attributes) the presence of which in a person should afford that person (legal) protection from state interference and the absence of which in a person should afford no such protection and might even require state interference with a person's decision-making. This way of interpreting the question tells us nothing about the nature of the considerations relevant to answering the question, although the need to satisfy a condition of proportionality is clearly one such consideration; I say more on this in the next section. But, it does throw into sharp relief that questions pertaining to appropriate standards for decisional competency are essentially questions pertaining to the acceptable limits of state intervention, and need to be answered with that thought very clearly in mind. And it serves to remind us as well that it cannot be supposed that the constructs that are employed in medico-legal contexts need have the same meaning than when used in some other every day, including clinical, contexts.

Primary and Secondary Requirements

I have sought to show, via discussion of the idea of utilising an idealized view of competent decision-making as a model for competence criteria in medico-legal contexts, that the evaluation of medico-legal competence criteria is an evaluation of the legal criteria governing which patients should and should not retain decisional authority with respect to their treatment and care—where consideration of the irrational fear case suggests that core to any such evaluation is the need for competence criteria to be proportionate. However, it is clear there are a number of requirements in addition to that relating to proportionality that medico-legal competence criteria ought to satisfy. In brief, medico-legal competence criteria need to be effective, proportionate, minimally-infringing, necessary, and equitable—where the rationale for these is that they seem to reflect accurately our considered view of what constitutes good law or policy, at least in liberal states. Moreover, instrumental to satisfying these (what we might call) *primary requirements* is the need for competence criteria to satisfy a number of *secondary requirements,* including the need to be clearly definable and for the abilities or attributes in question to be possible to assess or measure in a reliable way by clinicians and other relevant professionals (cp. [2], p. 385).

The primary requirements listed are familiar to other contexts (for instance, Childress et al. [10] outline several such requirements with respect to the evaluation of public health interventions). Moreover, some of these requirements find expression in other scholarly work on appropriate standards for decisional competence. For instance, Paul Appelbaum recognises a requirement of proportionality when he states that expanding competence criteria to include emotional capacity ''ought to require compelling evidence that the change will produce more benefit than harm'' ([2], p. 384). And Jessica Berg et al. [3], p. 377 are recognising a requirement of minimal infringement when they claim that although ''seriously impaired people should be protected, the right to make decisions for oneself should

not be burdened more than is absolutely necessary''.[6] Nevertheless, I am not aware of these requirements having anywhere been spelt out in a comprehensive and systematic way with respect to the evaluation of medico-legal competency criteria. In what follows, then, I build on existing scholarly work by explaining the requirements that competence criteria ought to satisfy in a more methodical and complete way than has been done to date—and by doing so provide something in the way of a useable framework with which decisional competency criteria can be evaluated.

To begin with, medico-legal competence criteria need to be *effective* in that their presence will succeed (or help to succeed) to achieve the fundamental goals that those criteria are designed to achieve, including the protection of people whose decision-making capacities have been compromised by injury or illness. If medico-legal competence criteria failed to be effective their presence would be unjustified because useless and potentially harmful for no benefit. Second, competence criteria need to be *proportionate* in that the achievement of the intended goal or goals is proportionate to the evils or harms that their presence is likely to cause. For instance, even if the presence of a criterion would succeed in helping to ensure some patients are protected from harm, such a criterion is unlikely to be justified if its presence is likely to lead to much greater harm (where that might take the form of serious distress to patients or the public at large, or the form of comprising a violation of people's rights to self-determination that would be considered unacceptable in a liberal society). Third, medico-legal competence criteria need to be *minimally-infringing* in that the criteria should lead to minimal interference with other important goods. For instance, decisional competence determinations should cause minimal interference with people's sovereignty interests, as well as minimal distress to patients and the public at large. Fourth, medico–legal decisional competence criteria need to be *necessary* in that the existence of such criteria is essential to protect the goods in question. Competence criteria will lack justification if there are alternative but more acceptable ways of achieving the intended goals. For instance, if it were possible to protect decisionally impaired patients without removing from them their decisional authority, then the presence of competence criteria would be very hard to justify. Fifth, competence criteria need to be *equitable* in that they do not discriminate unfairly, as might be the case, for instance, if those criteria would lead to the removal of decisional authority from patients on the basis of their age, colour or gender, or if those criteria risk bringing it about that patients with similar needs in very similar circumstances are treated very differently.

Moreover, instrumental to the satisfaction of the primary requirements just outlined, is the need for medico-legal decisional competence criteria to be clearly definable and for it to be possible for doctors and other relevant professionals to test the abilities or attributes in question (and thereby people's decisional competency) in a reliable manner (cp. [2], p. 379, [38]). If the constructs employed in medico-legal competence criteria are ill-defined or the capacities in question difficult to

[6] Other scholarly work containing relevant and insightful discussion, especially with regards to the need for the law to be proportionate in terms of the restrictions imposed on patients' autonomy or decision-making, include [25] (especially pp. 60–63), and [12] (especially pp. 524–534).

assess, then it is likely that people with similar levels of capacity will be treated differently with respect to whether they are allowed to retain decisional authority (hence, not satisfying a condition of equity), and that the interests of patients and members of the public more generally will not be protected adequately (hence, threatening not to meet conditions of effectiveness, proportionality, and minimal-infringement, for instance).

It is possible there are requirements other than those outlined that medico-legal competence criteria need to satisfy. For instance, no mention has been made of the need for competence criteria to comply with international and human rights obligations. This has been omitted because it might be argued that compliance with such obligations will demand only that decisional competence criteria satisfy the secondary and primary requirements outlined already: compare, for instance, a condition of equity and Article 14 of the European Convention of Human Rights prohibiting discrimination on such grounds as age and ethnicity. But, there might be reason to hold otherwise, that, in other words, compliance with international and human rights obligations should be a condition in addition to those outlined already. Also, each of the primary and secondary requirements outlined above might be expanded on. Regarding a condition of proportionality, for instance, it is likely there are considerations in addition to those outlined above that are relevant to assessing proportionality, including the likely effects that competence criteria might have on the public's perception of and trust in doctors and other health and social care professionals. Patients will seek medical advice and care only if they trust those responsible for treating and caring for them; therefore, any criterion that threatens to harm the relationship of trust between patients and relevant professionals will count strongly against that criterion. Moreover, it is important to emphasise as well that assessing whether decisional competency criteria satisfy a condition of proportionality will require assigning conflicting considerations their respective weightings and making an overall assessment of which considerations ought to preside. And although the issue needs more discussion than can be given here, I take it that conflicting considerations will need to be weighed in a way that reflects the core liberal values that underpin the law and which the law is designed to protect and promote. This is likely to mean, for instance, that the need to respect people's sovereignty interests is to be assigned a greater weighting than the need to protect people from their potentially harmful decision-making. In a liberal society people should normally be allowed to conduct their lives in the way that they choose or see fit (as long as they do not maim or injure others) even if, regrettably, that means some people suffer serious harm as a consequence of their decision-making.[7]

The claim that medico-legal competence criteria need to satisfy a condition of proportionality bears some resemblance to Buchanan and Brock's view regarding how a patient's decisional competence is to be evaluated [4, 5]. These authors draw

[7] The point applies to the evaluation of decisional competency criteria in societies that broadly share the liberal values of most North American and European states. These are the medico-legal criteria and legal contexts with which this paper is concerned. The question of how states that do not share such values are to evaluate decisional competency criteria (where these criteria exist) and weigh conflicting considerations is an extremely complex matter and a question that I am not able to answer at the present time.

on a principle of proportionality when they argue that the level of decisional capacity needed for competence should reflect an acceptable balance between respecting the patient's decision-making or autonomy on the one hand and ensuring risks to the patient are minimised on the other. This gives rise to the 'risk-related' (or 'sliding-scale') view of competence (see also [16, 20]). For Buchanan and Brock the higher the risk to an individual patient posed by a medical intervention, the higher the level of capacity required in order for the patient to be found competent and to be allowed to retain decisional authority. Conversely, the lower the risk posed to a patient, the lower the level of capacity required for competence. However, there are important differences between the Buchanan and Brock approach and the claims made in this paper. In particular, whereas Buchanan and Brock are saying that considerations of proportionality are relevant to assessing an individual patient's competence nothing of the sort is being assumed in the preceding discussion. In this paper competence is being treated as a legal determination solely and for that reason is a matter to be decided entirely on the basis of whether a person satisfies medico-legal criteria for competence. Consequently, if those criteria adopt a 'fixed' view of competence—that is a view according to which the abilities or level of capacity required for competence is the same (or remains fixed) for all patients and all treatment decisions—then satisfaction of those criteria will be sufficient to establish competence *irrespective* of the level of risk. In that case, risks to the patient will be relevant to determining competence only in so far as they are relevant to assessing whether a patient satisfies competence criteria, as might be the case, for instance, if a certain level of cognitive ability is required for the risks to be understood adequately (cp. [39], p. 97).[8] On the view defended in this paper a condition of proportionality is taken to govern not individual assessments of competence, but rather is taken to be relevant to evaluating the *medico-legal criteria* on which assessments of competence are to be based. And, of course, assessing whether medico-legal competence criteria satisfy a condition of proportionality will require weighing a far wider range of considerations than those relating to the interests of any one patient. Competence criteria potentially affect everyone and have wide-reaching consequences in terms of their effectiveness and harms they might cause—and these all need to be taken into account when evaluating whether or not decisional competence criteria are proportionate.

[8] Of course, it is consistent with a fixed view of competence that decisions carrying greater risk should require more rigorous evaluation of competence (see [20]; but for a sceptical note regarding the extent to which healthcare professionals *do* assess competence, even with regards to more serious treatment decisions, see [23], p. 109). Also, on a fixed view, risks are likely to be relevant to evaluating the *best interests* of a patient that is found to be incompetent. For instance, a treatment carrying a high risk of harmful side-effects is less likely to be in a patient's best interests than an equally effective treatment carrying little or no risk of harmful side-effects, especially where there is nothing to suggest that the higher risk option is more in keeping with the patient's beliefs or values and/or past wishes (see S.4 of the Mental Capacity Act 2005 [26]). It is an important question—but one that cannot be explored here—whether the law should adopt a risk-related or fixed view (but for relevant discussion see [39], [3], [20],[4]).

Applying the Framework

It is now possible to say something more regarding the extent to which existing and proposed competence criteria satisfy the requirements outlined in the preceding section. In what follows, I suggest that although there is reason to think that existing medico-legal criteria satisfy those requirements, there is much less reason for optimism regarding proposed alternatives that draw on more idealized views of competent decision-making.

To begin with, consider the Mental Capacity Act 2005 [26], which, as explained in the ''Decisional Competency in Medico-Legal Contexts'' section, outlines in S.3(1) four abilities needed for decisional competence, namely, the abilities to understand information relevant to the decision, retain the information, use or weigh the information as part of the process of making the decision, and to communicate the decision. Consideration of these criteria suggests that they might satisfy the requirements outlined above. For instance, the criteria seem to satisfy a condition of effectiveness, since they succeed in helping to ensure that many people whose decision-making has been impaired by injury or illness (including those who are very confused due to such things as stroke, dementia, brain-injury, and learning disability) are protected from the harmful consequences of their decision-making. There is reason also to think that medico-legal criteria satisfy a principle of proportionality, since on the face of it the criteria reflect standards for competence that achieve a satisfactory balance between on the one hand protecting people from the harmful consequences of their impaired decision-making and on the other hand helping to ensure that most people can for most of the time exercise significant personal sovereignty and in a way that is conducive to a flourishing society (and one in which trust in doctors and other professionals is maintained). Existing medico-legal competence criteria appear also to satisfy a condition of equity. For instance, the criteria do not discriminate on grounds such as age, ethnicity or gender (it is of particular note here that S.2(3) of the Act prohibits making capacity assessments on the basis of age, condition or appearance—where 'appearance' is interpreted widely to include such things as skin colour and the way people dress: see Chapter 4 of the Mental Capacity Act 2005 Code of Practice [27]), and those criteria ought to be possible to apply consistently, since the constructs they utilise are useable and not too difficult to define and the capacities to which those criteria refer can be assessed in a reliable manner[9] (cp. [37])—thereby satisfying the two secondary requirements described above. Fourth, there is reason to think that competence criteria are minimally-infringing. Of particular note here is the fact that competence criteria are task-specific. For instance, with respect to the understanding component, a person is to be found incompetent only if he or she fails to understand information relevant *to the decision at hand*. Consequently, a person might possess the abilities required with respect to *other* decisions to be made. This helps to ensure that people's autonomy interests are interfered with minimally. Finally, there is reason to think

[9] This is not to say that there might be some difficult cases such as when, for instance, a person refuses to discuss his or her reasons for consenting to or refusing treatment; thereby making it difficult to assess whether the person has weighed (or even understood) the information relevant to that decision.

medico-legal competence criteria satisfy a condition of necessity; for it is unclear how the law could protect people whose decisional capacities have been severely compromised by injury or illness unless the law contained competency criteria referring to the sorts of decisional abilities to which existing medico-legal criteria do refer.

Regarding the claim that medico-legal competence criteria should make reference to those abilities or attributes needed to satisfy some sort of idealized view of competent decision-making, there does seem to be reason to be sceptical. One initial worry is that there are a number of idealized views of competent decision-making, which gives rise to the difficult task of saying which idealized view of competency the law ought to adopt. A more substantial worry is that it seems likely that an idealized view of decisional competency will fail one or more of the conditions governing medico-legal competence criteria outlined above. And here it is instructive to note that many idealized views require the possession of decisional abilities that are not included in medico-legal competence criteria. Consider, for instance, the view that competency is the ability to make 'rational decisions' [14] or the view that competency requires a 'minimally consistent and stable set of values' or the ability to choose in accordance with such values [5]. But although S.3(1) of the Mental Capacity Act 2005 [26] holds that decisional competence requires the ability 'to use or weigh the information as part of the process of making the decision', it says nothing about *how* the information is to be used or weighed, as to whether, for instance, the information needs to be weighed or used in a way that might result in the making of a rational decision or a decision that is consistent with a person's underlying and enduring values. And it is reasonable to suppose that the law omits such abilities because it takes the view that those abilities would fail to satisfy the primary and secondary requirement outlined above. In part, this might be owing to concerns regarding definition and measurement (for instance, how are clinicians to define and reliably measure a person's 'enduring and underlying values', or a 'rational decision'?). But, it is likely also to be owing to a worry that even if such abilities or attributes can be defined and measured, including such abilities in medico-legal competence criteria will still fail to satisfy one or more of the primary requirements, including those relating to proportionality and necessity.

With respect to a condition of proportionality the worry is likely to be that if competence criteria were to refer to the sorts of abilities that might be needed to satisfy some more idealized view of competency, then this would set the standard too high, and would make permissible a degree of state interference that ought not be allowed.[10] As alluded in the''Decisional Competency in Medico-Legal Contexts"

[10] That considerations of proportionality have been accorded a high degree of importance by those responsible for shaping the law on decisional competence is supported by Coggon and Miola when they observe with respect to Lord Donaldson's judgement in the case of *Re T (adult: refusal of medical treatment)* [29] that it ''is reasonable to suppose that Lord Donaldson MR's celebrated statement that the law on decision-making should look to *capacity* rather than *rationality* is born of a concern to protect plural, incommensurable moral values that exist amongst the population, and to safeguard people from excessive interference in their decision-making'' ([12], p. 527; italics in original). Compare also Mr Justice Bodey's judgement in the case of *A Local Authority v A* [1] when considering whether the ability to understand information relevant to making a decision should include understanding the emotional and social consequences of refusing contraception—what Bodey J referred to as a 'social-consequences test'. Bodey J writes at para [61]: ''I am persuaded that this wider test would create a real risk of blurring the

section, it is a fundamental liberal value (and one conducive to a happy and flourishing society) that people are normally allowed to make decisions that might be unwise or not in their best interests, including where people's decision-making might not accord with their underlying and enduring values (even as they might themselves recognise). Second, regarding a condition of necessity, it might be suggested that there are alternative and more acceptable ways of managing some of the patients that proponents of more idealized views would like to be found incompetent. For instance, a number of commentators have argued that acceptance of more idealized models of decision-making may allow the compulsory treatment or detainment of patients with certain mental health conditions such as anorexia-nervosa or depression. For example, if Abraham Rudnick's 'coherency of preferences' is accepted as a component of competence, then this might justify compulsory treatment of people with severe depression, since according to Rudnick these patients fail to possess a coherent set of preferences [32]. Now, we might agree that conditions such as severe depression and anorexia-nervosa ought to warrant the law sometimes allowing removing from these patients' their decisional authority. But the question is what might be the most acceptable way of the law doing this? We have already seen that it would seem preferable for these patients not to be accommodated by broadening competence criteria (as this is likely to set the standard too high in terms of which patients should and should not be allowed to retain decisional authority, and is likely to mean that competence criteria will have to utilise constructs that are difficult to define and assess). So can these patients be accommodated some other way? Arguably the answer is 'yes' and this for two reasons. First, it is likely that many of these patients will be found to be incompetent on existing medico-legal competency criteria (on this point, see also [2], p. 385,[21]). For instance, many people suffering from severe depression might find it difficult to retain or weigh relevant information and be found to be incompetent for those reasons. But, moreover, many jurisdictions have designed separate legislation governing the compulsory treatment and detainment of patients with mental illness, where the issue is not whether the patient has capacity but rather whether the patient is a risk to him or herself (or others) as a result of having a mental disorder. Of course, the legal status quo might not be ideal. For instance, it is sometimes argued that mental health law is more discriminating and reinforcing of prejudice than mental capacity law (see, for instance, [33]). But even if this were true, the legal status quo might be *more acceptable* than a legal system that sought to permit the removal of decisional authority of people with mental illness by way of broadening medico-legal decisional competency criteria.

It is unclear whether the considerations just outlined show conclusively that medico-legal competency criteria should not comply with some more idealized view of competent decision-making; for I think it might still remain an open, albeit

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Footnote 10 continued
line between capacity and best interests. If part of the test were to involve whether the woman concerned understood enough about the practical realities of parenthood, then one would inevitably be in the realms of a degree of subjectivity, into which a paternalistic approach could easily creep.'' And he goes onto say at para [63]: ''To apply the wider test would be to 'set the bar too high' and would risk a move away from personal autonomy in the direction of social engineering''. For further discussion, see [24].

remote, possibility that after careful consideration it will be concluded that competency criteria should be revised in ways that better reflect some decision-making ideal. For the reasons I give that seems an unlikely conclusion, but I am not sure it can be ruled out definitively, at least yet. However, the considerations just outlined pose proponents of more idealized versions of decisional competency with a serious challenge. If such views are to find expression in medico-legal competency criteria then this will need to be demonstrated, which will require giving a convincing case for holding that legal adoption of the idealized view in question would, notwithstanding the considerations I have outlined, satisfy the secondary and primary requirements described in this paper. And I think that it is accurate to say that no such case has been made to date.

Concluding Remarks

I have argued that the evaluation of medico-legal competence criteria is an evaluation of the legal criteria governing which patients should and should not retain decisional authority with respect to their treatment and care As such the relevant question when assessing decisional competency criteria is whether those criteria are, amongst other things, proportionate, necessary and minimally-infringing, rather than whether they conform with some more idealized view of competent decision-making—one important implication being that it is possible, very likely even, that a system of law should tolerate and enshrine medico-legal criteria for decisional competency that might sometimes lead to regrettable outcomes because of patients making 'poor' decisions.

This paper has implications beyond the decisional competency case, of course. For instance, there seems to be no reason why the primary and secondary requirements outlined are not relevant also to the evaluation of areas of law aligned closely to the decisional competency case but where competence is not necessarily an issue. Consider whether and, if so, to what extent it is right for the state to intervene in the decision-making of mature-minors, people with mental illness and so-called 'vulnerable adults', for instance. The vulnerable adult case is worth mentioning briefly because in recent years the High Court of England and Wales has intervened to safeguard the interests of a number of adult persons deemed to be at risk of harm or exploitation (owing to inherent features such as age or disability and/or situational factors including social, cultural and economic circumstances: see [18], pp. 240–241), whether or not legal capacity is present: see, for instance, *Re G (An Adult)* [28], *Re SK (An Adult) (Forced Marriage: Appropriate Relief)* [30], *Re SA (Vulnerable Adult with Capacity: Marriage)* [31]. By way of exercising its inherent protective jurisdiction the court has considered situations in which judicial intervention might be initiated. Now, it is not possible to say here when, if at all, interventions with regards to vulnerable adults who have capacity can be justified. Nevertheless, it does seem to me that any legal provision in this area, including the possible creation of a statutory framework for protecting vulnerable adults, will need to satisfy the same requirements that medico-legal decisional competency criteria need to satisfy. It is worrying to note, then, that academic commentary on

the court's activity with respect to vulnerable adults has raised serious questions regarding whether such conditions are being met in fact (see [18, 22, 24].[11]

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[11] For instance, Dunn et al [18] raise concerns regarding proportionality when they state that ''justifying substitute decision-making on the basis of situational vulnerability could lead to interventions that are potentially infinite in scope and application'' (p. 241; see also [24]). They seem to raise also worries relating to equity when they remark that the courts' treatment of vulnerable adults seems to assume a 'status-approach' to defining vulnerability according to which a person is considered vulnerable (and thereby in need of court protection) simply by virtue of being disabled or of a particular age, for instance (p. 244). And elsewhere in their commentary, Dunn et al. seem to question whether current legal provision succeeds in being minimally-infringing, when they argue that statutory legislation if introduced would need to recognize that prior to any protective intervention being initiated "every attempt should be made to support adults with autonomous risk management" (p. 253).

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