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› Patients' Decision-Making Competence: Discontents with a Risk-Relative Conception

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1 Introduction

Informed consent requirements are a cornerstone of modern biomedical ethics and medical law. "Gate-keeping"[1] for the whole procedure of soliciting a patient's personal consent to medical interventions is his or her mental *competence.* Taking competence as coming in degrees, some ethicists have proposed a "sliding-scale" conception of those mental capacities (making up for competence) that are deemed necessary for a patient's valid consent. In a nutshell, the suggestion requires the higher a degree of decisional abilities, the higher the (potential) harm of the medical decision at stake. Although ethicist James Drane[2] is often regarded as the originator of this idea, others made similar suggestions even before him, not the least the legendary President's Commission in 1982.[3] Since then, this suggestion of a sliding-scale or, as I prefer to call it in line with probably dominant terminology, a *risk-related*[4] conception of competence (RRCC) has been adopted by many clinicians, psychologists, and bioethicists. They welcome it as a reconstruction of common clinical practice and as allowing a "balance between the competing values of self-determination and wellbeing that are to be served by a determination of competence"[5]. Others, however, have criticized the risk-related conception for various conceptual and normative reasons, thus arguing for the alternative, i. e. a *fixed* concept of patients' decision-making competence. Notably, although a controversial and high-level exchange of

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[1] To my best knowledge the by now common *gatekeeping* metaphor has been coined by Faden/Beauchamp, 1986, pp.287.

[2] Drane/ 1985.

[3] Roth/Meisel/Lidz, 1977; President's Commission, 1982, Vol 1, pp.60. Similarly: Gaylin, 1982. I owe the first reference to Culver/Gert, 1990 p.632 and the following ones to Beauchamp, 1991, p.70.

[4] There are several important ambiguities in the term 'risk', well-known from other fields of decision-making analysis: (1) risks can be understood and quantified either as the mere likelihood that *some* negative effect might realize, or else as a *joint* parameter (in standard decision theory: the mathematical product) of the probability and quality of possible negative effects. Moreover, risks can be taken (2) as gross or net, (3) subjective or objective, as well as (4) expected *ex ante* or realized *ex post.* For the *principled* purpose of this paper it seems acceptable to understand 'risk' as some non-negligible probability of some non-negligibly *net*-harmful consequences assessed from an intersubjective *ex ante* perspective – and to leave all the detail questions open.

[5] Buchanan/Brock, 1989, p.64.

arguments between some bioethicists has taken place around the 1990s,[6] something like an expert consensus or *explicitly* adopted majority view on this practically important issue has not yet been issued.

In this paper I attempt to provide a systematic analysis of relevant arguments, critically reconsidering older ones and elaborating on what I consider some new concerns. As a result, I will join the camp of RRCC-opponents, holding that only a *fixed* concept of decisional competency fits the very reasons why we (should) value autonomy – despite some initial plausibility to the contrary. More specifically, I will argue that not only hidden paternalism in matters of risk-taking, but also a dangerously inflationary attribution of autonomy (e. g. in cases of severe mental disturbance) with a number of problematic implications are lingering in RRCC's background. In any case, I want to show that the RRCC issue still or anew deserves bioethical attention.

2 Decision-Making Competence: Preliminary Aspects

2.1 A Precondition for Valid Authorization

In medico-legal and bioethical contexts 'competence' is a common shortcut for patients' *decisional* competence[7] and as such I will use it, too. The main medical area in which this concept plays a role is the context of informed consent, where patients are asked to make personalized decisions for or against suggested medical interventions in either clinical or research contexts.[8] For the sake of brevity I will in the following only speak of decision-making on medical 'treatment' options.

Following dominant understanding, the main impetus of the informed consent doctrine is to grant competent patients decisional *authority* with regard to their medical treatment – i. e. choosing between professionally appropriate interventions or refusing any of them.[9] Ethically, this "autonomous authorization model of informed consent"[10] has been pioneered and notably fleshed out more than 30 years ago by US-bioethicists Beauchamp, Childress, and Faden[11] and has since become the reigning model. According to common legal, ethical, and practical standards,[12] a patient's consent should be authoritative or binding, if it fulfils the requirements of originating from a patient who (i) is competent, (ii) actually understands what he is consenting

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[6] Macklin, 1987; Buchanan/Brock, 1989; Culver/Gert, 1990; (Beauchamp, 1991; Wicclair, 1991 and 1997; Wilks, 1997 and 1999; Cale, 1999; Checkland, 2001; DeMarco, 2002.

[7] Some authors insist that competency is a purely legal term: e. g. (Ganzini et al. 2004, p.264, but common usage proves to the opposite.

[8] I use the term 'intervention' in a loose way, covering therapeutic, diagnostic, and preventive procedures, hospitalizations etc. Other patient decisions requiring competence may regard specific, often controversial interventions *primarily* asked for by patients such as elective abortions, assistance in suicide, or enhancement.

[9] Thus, in terms of *absolute* authority, patients' decisional power is that of a veto power. Whenever there are several reasonable options patients are, moreover, authorized to choose among them. Granting respect for patients' autonomy in this standard sense is clearly distinct from *wish-fulfilling medicine* – in contrast to some common suspicions.

[10] "Autonomous authorization" has already by been identified as the function of informed consent Faden/Beauchamp, 1986. As a label is has been coined by Miller/Wertheimer, 2015. I cannot here discuss their (and other authors') recent objections to the AA-model for consent to biomedical research.

[11] Beauchamp/Childress 11979; Faden/Beauchamp, 1986.

[12] In the following my focus will be on ethical considerations and literature. However, I certainly acknowledge that relevant debates are taking place in the legal(-ethical) literature, e. g. Alexander, 1996; Amelung,1992.

to, and (iii) decides voluntarily. These triple core requirements mirror the leading understanding of valid consent as *autonomous* authorization (AA) given that they correspond to the three standard criteria of autonomous action in general.

Thus, attribution of competence in the context of medical decision-making functions as an entrance ticket that entitles a patient to make *authoritative* self-regarding treatment decisions and to assume responsibility for part of this choice. An important other part of responsibility stays, of course, with care-takers who must properly recommend and explain treatment options and refrain from interfering with voluntary decision-making. But the final authorization rests with the patient. This is not the place for analyzing the underlying reasons various stakeholders have to welcome or deplore this partial shift of responsibility. One can admit of informed consent policies sometimes being motivated by caretakers' fear of legal liability or their wish to personally reduce some of their own responsibility, to shorten patient contact etc.[13] However, such secondary motivations do not rule out a serious ethical concern with respecting patients' personal *autonomy*. Despite the enormous variety of different concepts of personal autonomy in ethics that I cannot even start to discuss in this paper, the core idea of patient autonomy in bioethics is the notion of (optional) authority in personalizing one's medical treatment with an eye also on one's non-medical values and preferences. It is this specific task that must dictate patient competence. As we shall see, it thereby renders RRCC a questionable idea.

Since the early attempts to flesh out ethically sound criteria for valid informed consent, scholars have had, however, to differentiate between ideal and non-ideal approaches, where the latter take into consideration that 'ordinary' people often make decisions under less than optimal conditions (inner and outer ones) and that 'ordinary' medical personnel most often have to judge their patients' decision-making within limited time and with restricted expertise. Clearly, such real life obstacles to the ideal of fully autonomous consent (whatever that is, exactly) should be remedied to the extent possible. But in addition, informed consent *policies* should, according to the standard view, already accept substantially autonomous decisions as valid. Moreover, policies must make a set of reasonable presumptions and set certain standards of evidence for the validity of consent.[14] One such element is the presumption of competence in the case of most conscious adult patients. In the words of bioethicist Govern den Hartogh's:

> We assume in the case of most patients, and of most persons generally, that they are competent in all their decisions until a reason for doubt arises, we do not investigate their competence in the case of each and every decision. That would be impossible in practice, but there is more fundamental reason for the presumption as well: we can only take each other seriously and treat each other as moral equals on this basis.[15]

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[13] Cf. O'Neill, 2007.

[14] According to my understanding, the difference between a given consent's *real* qualities and its assessment by legal and institutional policies corresponds to the difference between what Faden/Beauchamp (1986 p.277f.) have called informed consent (sense1) and (sense2). In any case, the gap between hypothetical ethical requirements for any single case of decision-making and actual policy requirements can account for some puzzling questions. They regard, e.g., issues of self-induced non-understanding, robust false beliefs, or imprudent decision-making by competent patients. In all such cases that I cannot here pursue any further, ethically legitimate policy might accept resulting decisions *as if* sufficiently autonomous and 'informed' although they do not fulfill the standard criteria.

[15] Hartogh, 2015, p.72. Likewise: (Buchanan/Brock,1989, pp.57).

As Hartogh goes on to explain, the most prominent "reason for doubt" regarding patients' competence is that their decisions deviate from their physicians' treatment recommendations. Given that these recommendations are commonly based on professional comparative risk/benefit assessments of available treatment options, a deviation is likely to appear puzzling, unreasonable, or irrational. Thus, this might justify and trigger a process of competence assessment because one of several possible explanations for a judgmental deviance between a physician and her patient is the latter's lack of competence to properly make the judgment and decision at stake. Hence, according to mainstream assumptions, a decision's irrationality is to be taken as an indicator for *potential* incompetence, not as the latter's proof – although the conceptual relation between incompetence and irrationality proves somewhat tricky and controversial (see next paragraph).

2.2 A Set of Abilities

Obviously, competence does not consist in one single element but rather in a set of mental capacities. One minimalist account asks for (i) a capacity to understand and communicate[16] and (ii) a capacity to appreciate various treatment alternatives. On closer look, this "understand-and-appreciate account of competence"[17] can only serve as a rough shortcut as which I will deliberately use it in the following. However, for the purpose of conceptual, ethical, psychological, or clinical analyses both, additions and further fine-graining would be necessary.

A patient's appreciation, for instance, presupposes the capability to deliberate, i. e. to process information in a basically consistent way and to be potentially responsive to new aspects and arguments. But it also needs the capability to assess available treatment options in the light of one's personal values and preferences, thus making subjective *comparative* evaluations. Again, a background condition of such evaluations must be what is usually called "the possession of a (stable) set of personal values".[18] This last item cannot properly be called a capability in the strict sense. Rather, as already common-sense psychology has it, such value set is the result of a person's biographical experiences over time, not the least formed by personal relations, social determinants, and a more or less conscious reflection of who one wants to be. In debates on how to conceptualize autonomy, this "evaluative self-image"[19] is playing a key role in at least two aspects. One aspect concerns the logical and substantial links between the focal autonomy of a patient's treatment decision and her personal autonomy on a more global scale. The other aspect concerns the ways in which the acquisition of one's value-set can be disturbed in autonomy-violating ways (e. g. by repression, traumatization, or brain-washing). Both aspects can be disregarded in the context of the sliding scales dispute that mainly focuses on patients' *cognitive* sophistication or deficits.

Cognitive competence, too, is an issue of on-going interdisciplinary discussion among legal and philosophical scholars as well as among cognitive scientists. Debates concern its composite

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[16] Communication of choice is sometimes listed as a necessary element of competence. Strictly speaking, this is not required for decision-making as such, but rather for its operationalization (think of a locked-in patient who might well come to a decision but might under unfortunate circumstances not be able to communicate it). However, in *practically* oriented lists communication is a standard item. Moreover, communication usually has an important role in the process of patient understanding.

[17] Culver/Gert 1990, p.639; likewise Checkland, 2001, p.36.

[18] Hence, various authors add "the possession of a set of values and goals" as a third minimalist requirement. Compare (Wicclair, 1991, p.91; Buchanan/Brock, 1989, p.23).

[19] Quante, 2011 pp.174.

nature, its interdependence with emotional or volitional capacities, and its practical assessment in bedside situations.[20] All of this will again be ignored in the following – in favour of a somewhat sketchy understand-and-appreciate concept of competence. Whatever its more precise nature, its realization surely is a gradual, not a binary phenomenon. People can memorize, understand, deliberate, appraise, or make a choice with gradual goodness.[21] Against this background it is commonly and reasonably agreed, that an authoritative patient decision only needs a sufficient amount of each of the capabilities that are constitutive of competence, thus resulting in a *sufficient* degree of competence itself. It is this sufficiency threshold that proponents of risk-relativity in the determination of competence want to handle flexibly whereas their opponents advocate a fixed, i. e. risk-independent threshold.

2.3 Competence and Rationality

Impaired decision-making capacities can lead to irrational choices. The latter can, according to the AA-model of legitimate consent, possibly be overridden in order to protect patients from harm due to incompetence. To characterize a decision as 'irrational' can, however, be understood in three distinct ways – inviting for normative misunderstanding and controversy that can only gain from more conceptual differentiation.

In its most narrow understanding decisional irrationality results from a deficit in the capacity to perform *procedurally* correct deliberations (drawing logically correct conclusions etc.). Here, irrationality does indeed correspond to a subset of incompetence. Quite a number of authors take this way, e. g. lawyer-ethicist Larry Alexander:

> If one's choice […] is to count as valid consent, one must presumably be of a certain *age*, lack serious *mental disease, irrationality*, or *intoxication*, and have a certain degree of *self-control*.[22]

Irrational decisions in this dipositional-procedural sense lack a necessary condition for authority. Thus, if they prove immune against consultation and are prone to appreciably harm the patient they can be disregarded.

A very different concept of irrationality, however, refers *only* to the decision's content. In particular, well-minded physicians have long tended to regard as irrational those patient-decisions that seem incompatible with widely shared values, e. g. decisions to refuse life-saving treatment under certain conditions. According to the depicted standard AA-view, irrationality in this sense of *substantive* deviation from what others consider objectively good or *reasonable* can never serve as a justification to override a patient's decision. Otherwise, broadly accepted rights to personalized value-judgements and to their authority would be violated. This danger of undermining patient autonomy by overstretching the concepts of irrationality and competence has

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[20] To quote Louis Charland, bioethicist and philosopher of cognitive sciences: "The combined theoretical and practical nature of decisional capacity in the area of consent is probably one of the things that makes it so intellectually compelling to philosophers who write about it. But this is still largely uncultivated philosophical territory. One reason is the highly interdisciplinary and rapidly changing nature of the field. Clinical methods and tests to assess capacity are proliferating. The law is also increasingly being called upon to respond to these clinical developments. All of this makes for a very eclectic and challenging field of inquiry." (Charland, 2011, sec. 1).

[21] Ibid, sect. 3. I do not here take issue with questions of the exact nature – gradual or binary, actual or dispositional – of each capability at stake.

[22] Alexander, 1996, pp.166.

long been recognized. It has caused various authors to insist on a strictly *procedural* – in contrast to an *outcome* oriented – understanding at least of competence, if not also of rationality.[23] Yet another conceptual strategy to block an outcome-based understanding of competence is to describe competence assessment in the practice of informed consent procedures as "gatekeeper".[24] This already introduced metaphor reflects the view, that competence is in principle *independent* of particular decisions' outcome: Whenever a patient is determined incompetent to make a pending decision, the informed-consent 'game' is over and some surrogate's decision must be sought. To be sure, in many cases, it will still be important and necessary to inform the patient about her condition and treatment alternatives, to assess her preferences, and to deliberate together (see below 5.3.). But the goal of seeking and relying on *her* treatment authorization must be dispensed with, whenever the patient is 'kept off the gate'.

Between the two depicted options of understanding competence/rationality as dispositional-procedural or else as outcome-oriented in an objective sense, there is, however, a third option that does not fit into the standard binary model of process/outcome views. Probably, it touches the most contested issue in this context, namely the authority of patients' decisions whose content turns out *subjectively* unreasonable, i. e. incompatible with the decision-maker's *own* values. Whether or not you call such decisions irrational,[25] doesn't – as Jason Hanna has recently unfolded and argued for – their "imprudence" resulting from a somewhat "impaired" decision-making undermine their validity as much as is admitted in cases of decisions under obvious pain or emotional distress?[26] Answers to this problem require a deeper analysis of the normative differences between a dispositional and an actual-use understanding of competence/rationality – a task that I must leave to another occasion.

2.4 Task-Specificity

Yet another agreed-upon assumption of the standard view on patients' competence is its task-specificity. In the words of Culver and Gert:

> To discuss competence with precision one should focus on a person's competence to do a particular kind of action or make a particular kind of decision, rather than trying to characterize the person as a whole. [...] However, even this is too wide a classification, for a person may be competent to make one kind of medical decision and not another kind.[27]

Assuming *some* task-specificity for patients' decision-making competence is indeed highly plausible for at least two reasons that I will soon discuss. Nevertheless, fine-graining the context-de-

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[23] So, for instance, Buchanan and Brock: "An adequate standard of competence will focus primarily not on the conent of the patient's decision but on the *process* of the reasoning that leads up to that decision" Buchanan/Brock, 1989, p.50. Feinberg has insisted on differentiating between a decision's "rationality" in the procedural sense and its "reasonableness", obviously without having been followed. (Feinberg, 1989, pp.106).

[24] Beauchamp and Childress 2013, pp.114

[25] Thus e. g. Culver/Gert write: "If one requires a patient to *make use* of his competence when making a decision, the one is no longer judging the competence of the person to decide, but the rationality of the decision made." (Culver/Gert, 1990, p.622; emphasis added).

[26] Compare for instance Hanna, 2011. A plausible answer might refer to some surplus value of a policy that insists on the normative difference between impairment and imprudence, even if it cannot be justified in single cases.

[27] Culver/Gert 1990, p.620.

pendence of competence requirements should only go as far as can reasonably be justified. In particular, the task-specificity 'doctrine' and its prima facie plausibility should not be taken as carte blanche for RRCC by simply claiming a medical decision's degree of riskiness to be one of its relevant task-specific aspects.

These are the two arguments in favour of task-specificity: First, is a *general* feature of the very concept of competence. Depending on the task in question, criteria of competence gain strictly different content. Competences to (i) artistically walk on a tightrope[28] or (ii) to consent to one's medical treatment exemplify huge involved differences. Obviously, the first task requires athletic skills, a good sense of balance, and freedom of giddiness whereas the second task requires understanding and evaluating alternative medical risks and benefits for one's own future life within the framework of one's value set.

A second impulse for requiring task-specificity when it comes to patients' medical decision-making results from certain paradigm clinical experiences. Thus, as often discussed, a patient suffering from severe psychotic delusions might prove competent to play chess on a highly competitive level or to make sophisticated financial transactions. But the same patient might be incompetent to evaluate anti-psychotic medication, just because she does not realize the pathological nature and provenance of her delusional episodes. Experiences of this type have given rise to medico-legal maxims and regulations not to judge a psychiatric patient *per se* as lacking decisional competency, but to determine her competence with an eye on the specific decisional task she is facing.[29]

In addition, care-takers are aware that patients' competence may fluctuate according to their emotional conditions: decreasing when they are in a state of pain, anxiety, or excitement and increasing when they feel relaxed and taken care of. Therefore, physicians are commonly advised to regard competency as a context-sensitive phenomenon and to strive as much as possible for optimal conditions when seeking a patient's informed consent. Unquestionably, awareness regarding the context-dependent fragility of patient competence is important. But it goes without argument that context-regarding and task-regarding relativity can in principle be kept and handled apart.[30] Thus, context-dependent fragility of cognitive capabilities is a different issue than their task-specificity, though they might look adjacent on first sight. Moreover, to acknowledge that the capabilities making up for someone's competency are decisively task-specific (high wire competence differing from decisional competence) does not solve the problem of how finely these tasks should be *individuated.* This will turn out to be an important point for the risk-relativity issue of decisional competence.

2.5 The Idea of a Risk-Related Concept of Competence

Take the following example from a recent clinical paper, meant to inform and educate physicians about the understanding and assessment of patients' decision-making capacities:

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[28] Tightrope walking as a comparative example for understanding competence has been introduced into the RRCC debate by Wilks (Wilks, 1997, pp.419). As others have consequently done, I will stick to it.

[29] Ganzini et al., 2004

[30] Beauchamp seems to overlook this point when he equates "the specific competence to make a certain kind of decision – e.g., whether to cease a certain drug therapy" with "the capacity to *make* such choices in the circumstances (Beauchamp, 1991, p.61).

> [A] mildly demented patient might be able to decide that she wants antibiotic treatment for a urinary tract infection because the treatment allows her to pursue important goals such as feeling well or staying out of the hospital, and its burdens and risks are low. On the other hand, the same patient might be unable to weigh the multiple risks and benefits of a complex neurosurgical procedure with uncertain trade-offs between quality and quantity of life.[31]

Obviously, the example is meant to illustrate the view that a patient's competence (here: her being "able") to decide on medical treatments ought to be assessed relative to the "burdens and risks" involved in the decision at stake. The example suggests that a given cognitively impaired patient might be competent to authorize a low-risk antibiotic treatment while not being competent to authorize neurosurgery. Note, however, that the example remains somewhat ambiguous on two points that will later come up for discussion: First, it does not say whether the patient should also be considered competent to *refuse* the antibiotic treatment (most probably not), whereas her asserted decisional incompetence regarding neurosurgery seems to refer to both consent and refusing. Second, the depicted scenario remains unclear as to whether the patient is deemed incompetent to decide about neurosurgery because of the *complexity* of the involved harms and risks of the procedure or rather because of the *degree of its riskiness* (probably the latter).

In any case, accepting a risk-relative conception of competence (RRCC) seems to correspond well with widely shared intuitions and to reflect common clinical practice. Moreover, RRCC has to the best of my impressions become an accepted view in bioethics and a – if not *the* – standard model in clinical care.[32] Before starting to critically analyze various arguments for and against this view, some attention must be paid to the general understanding and function of competence judgments in the particular context of patient care. As it will turn out, already this understanding is by no means uncontroversial, although crucial for the RCCT debate.

In his seminal paper of 1985, James Drane suggested three differently demanding standards of patient competence that should be applied in accordance with the quality and probability of harmful consequences of the decisions to be authorized.[33] Thus, he argued for:

a) A low standard of competence vis-à-vis decisions involving small risks and high benefit. This low standard, he suggested, would already be met whenever a patient is conscious and in possession of any ability to express consent, if only implicitly.

b) A middle standard of decisional abilities for choosing treatments with high risks of harm if they are a patient's only chance to get better or to survive. This standard could be met by patients who can understand their medical situation and the proposed treatment but who are unable to critically reflect and evaluate options in light of their values and beliefs.

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[31] Ganzini et al., 2004, p.264.

[32] This view is share e.g. by Checkland, 2001, p.36. Most notably and influentially since Drane's pioneering article, Dan Brock and Allen Buchanan have in length defended RRCC (Buchanan and Brock, *Deciding for Others*, Chapter One). In contrast, Tom Beauchamp and Jim Childress have in their common monograph *Principles of Biomedical Ethics* support a fixed threshold from the first edition (1979) to the latest one (2013). Remarkably though, Beauchamp has, in his singly authored essay "Competence" (1992) defended RRCC. For a recent RRCC-approval in research consent see Bromwich/Rid, 2015. For a recent example from the German-speaking literature see Hermann/Trachsel/Biller-Andorno, 2016.

[33] Drane, 1985.

Drane suggests that mildly cognitively impaired or borderline patients be among the candidates here.

c) A high standard of decisional abilities for refusing interventions of low risk and high benefit. Here Drane thinks that candidates must be reflective and self-critical and well as in possession of "mature coping devices".[34]

For matters of illustration and simplicity let us fill the categories of treatment in Drane's three standards with the treatment options involved in the example from section 1 above: antibiotic treatment for a urinary tract infection as a small risk/high benefit option and complex neurosurgery as a high risk/unclear benefit decision. Thus Drane would have us, for instance, accept a severely demented patient authorizing the antibiotic treatment, but not refusing it. Basically, Drane adduced two arguments, though not in much detail: the moral duty to properly balance respect for autonomy with patient benefit and common clinical practice. The last point is easy to imagine but hard to evidence, and it is certainly not a convincing argument for anybody who considers such practice faulty. The moral argument will be discussed below.

3 Arguments from Conceptual Grammar

Some authors[35] have tried to draw conceptual conclusions regarding RRCC from what they see as the *general* concept of competence. The underlying assumption is that there is a core concept with a general structure that is prior and transferrable to its contextualized subtypes. In particular, this is playing a role in arguments on normativity, externalism, symmetry, and risk-relativity. As I will try to argue, the idea of a deeper conceptual logic that might answer the controversy on RRCC is implausible. Rather, questions have to be answered within the context of decision-making competences.[36]

3.1 Externalism and Normativity

Some authors have disputed whether referring to competence's generally *externalist* rather than *internalist* concept can defend RRCC. In the words of Ian Wilks:

> Competence is not an absolute, not a feature solely native and *internal* to a person; competence to render a decision likewise is determined only partly by the qualities of mind that figure in the act. The nature of the options, with their benefits and risks, is also relevant; and this is very much the insight now supplied by those who justify a risk-related standard.[37]

Although some opponents of RRCC agree to this diagnosis[38] the point seems to be ill made: could anybody seriously deny that capabilities can be purely *internally* realized and at the same time be individualized by an *external* task?[39] Actually, this seems to be the standard case – as can be exemplified by the capability to distinguish between various shades of grey, to perform

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[34] Ibid, p.19.

[35] Prominently: Beauchamp 1991, pp.50.

[36] Likewise: Checkland 2001, p.51.

[37] Wilks 1997, p.426.

[38] E. g. Culver/Gert 1990, p.635.

[39] Likewise: Wicclair 1999, p.151.

tightrope dance over a distance of 100 meters, or to make a decision about medical treatment. Hence, the distinction between internalism and externalism in this sense seems of little help. What is ultimately needed to justify or reject RRCC will be a specification of the external task in question.

In the literature on decisional competence in medical contexts, it is often and rightly emphasized that this concept – like many other competences: even the one in high wire artistry – is *normatively* impregnated. This is by no means a general conceptual feature. Rather, certain circumscribed competences, e. g. the one to correctly memorize 100 digits in a row, are purely descriptive. Normativity comes into play whenever the task in question gets more abstract, allowing for gradual competence or for leeway in choosing and weighing relevant sub-competencies. In such constellations, competence is used as an evaluative résumé of someone's abilities or skills to perform a certain task. It involves three steps, namely (1) the *identification* of the relevant capabilities, (2) a determination of the *degree* to which these abilities are required, and (3) a personalized assessment of someone's possession of these requirements. The first two steps are prone to controversies resulting from dissenting views on the task in question. Thus, there seems to be some latitude, e. g. in deciding whether a (sufficiently) competent high wire artist needs jumping competence or whether the fact that he might be unable to perform for longer than ten minutes is of relevance. Whereas athletic competences involve aesthetic values, decisional competence in the context of informed consent involves ethical norms considered relevant for making authoritative decisions. Only the ascriptive third step, certifying the absence or presence of what has been fixed by the first two steps, is by itself non-normative: a given patient is described as meeting or not meeting agreed-upon standards. But, again, *their* nature and degree are set with an eye to their normative function. In Tom Beauchamp's words:

> […] Any concept that serves this function is inherently normative in the way it is used to *establish the abilities and level of abilities* – a normative choice of entry criteria – and to certify a person who possesses such abilities. […] Thus, it is a mistake to infer that empirical judgments of psychological competence are free of prior evaluative commitments. The reverse is true: they are inescapably value-laden.[40]

Setting due thresholds for patients' decision-making competence is reigned by two ethical norms: preventing patients from taking decisional responsibility without being 'fit' to do so on one side, and preventing 'fit' patients from getting infringed in their rights to authorize treatment as they like, on the other side.

Having said this, one crucial problem seems to evolve: Is there a clear distinction to be made between competence assessment *motivated* from those two norms as described by the last sentences, and competence assessment *incorporating* a balance of those two norms as RRCC proponents have it? I will come back to this point in sections 4 and 5. But here is already a short anticipatory answer: The *incorporating* (RRCC-) approach is bent on giving more weight to beneficence than liberals want to and it does so in an intransparent, uninformative mode. In contrast, the *motivated* (fixed threshold) approach is bent to explain what grounds legitimate claims to authority. Although a motivated approach can also be applied in a way that violates authority claims, these can only be overridden by blatantly and giving priority to beneficence-concerns.

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[40] Beauchamp, 1991, p.53.

Understanding patient competence as a normative concept is part of the more complex story of what it means to understand authorizing autonomy (AA), the overarching concept, as normative, too. If someone qualifies as an agent of sufficient (task-specific) AA, third parties have good *pro tanto* reasons not to interfere with his self-regarding decision-making. Thus, autonomy and its 'ingredients' are normative in this first sense of reigning third party behaviour. At the same time, they are conceptually and empirically constrained by *why*, depending on rival moral theories, AA is viewed as a claim right to be respected or as a value to be promoted in people's life, at least in our culture. The straightest and most simple answer points to AA's instrumental value in shaping one's life according to personal values and preferences as well as to a widespread preference for being in control as such. Both aspects would preclude, e. g., respect for 'authorizations' resulting from drunkenness, error, or manipulation. In this second sense, competence and AA are normative in that they inherit constraints by the very idea of what turns AA into an ingredient of a good life.

3.2 Asymmetrical risk-related Competences?

Drane's suggestion openly invites a remarkable asymmetry in the authoritative power granted to a given patient: lacking the proposed high standard (see above), she might be considered competent to consent to a certain intervention but incompetent to refuse it, or vice-versa. This asymmetrical competence has been repeatedly rebutted as paradoxical by some,[41] but also explicitly been defended by others. [42] As I will try to argue in this and the following section, only the former view is convincing.

It was ethicist Ian Wilks[43] who introduced the example of two tightrope walkers into the debate on RRCC in order to defend the latter despite its implication of asymmetrical competence. He makes us imagine two persons facing the challenges of tightrope walking. In Wilks scenario, one of them does a marvelous artistic job and can thus be called competent to walk on a high line with or without safety net. In contrast, the second candidate happens to still be a rather lousy high wire performer, thus facing a substantial risk that he might fall off the line. According to Wilks, it conforms to correctly using the concept of competence if one describes this second guy as incompetent to perform the high-wire act *without* safety net, but as competent to perform with the net in place. As Wilks asks and then concludes,

> What is the *basis* for the fallible walker's being competent to walk the wire with the net in place, but not without? It is certainly not something intrinsic to the person, not a matter of the person's abilities – since by the terms of the example, there is an equal chance that the fallible walker will complete the task successfully whether the net is in present or not […]. The difference lies entirely in something extrinsic to the person, in the level of risk the situation involves; and what emerges here is that the level of competence is affected not only by degree of ability but *also* by degree of risk.[44]

Profiting from various authors' critical answers to Wilks proposal[45], it seems obvious that in his case four different tasks-specific competences can helpfully get distinguished, i. e. the compe-

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[41] Cale, 1999; Demarco, 2002, p.234; Hartogh, 2015; Wicclair, 1991 and 1999.

[42] Buchanan/Brock, 1990; Wilks, 1999.

[43] Wilks, 1997 and 1999.

[44] Wilks 1997, p.420.

[45] Thus I owe insights from Cale, 1999; DeMarco, 2002; Checkland, 2001and Wicclair, 1999.

tence to (i) tightrope walking in general; (ii) walk a particular high line without a substantial risk of falling off; (iii) manage the same high line with a safety net in place (unknown to him), possibly interrupted by a drop-off; (iv) take responsibility for walking the high line without a safety net. Wilks' imagined lousy artist lacks (i) and (ii), but possess (iii); and we are left ignorant about (iv). What then does this case prove?

Competence (i) is a resumé evaluation depending on an artistic candidate's courage together with sophisticated acrobatic skills such as strength, body control, and balance management. Normally, possession of (i) is *indicated* by a comparatively low risk of falling off the line and thus of risking injury when performing *without* safety net, i. e. competence (ii).[46] In contrast, if someone has only mediocre acrobatic skills, he will surely lack (i) and (ii) in a package, but might nevertheless possess competence (iii), as in Wilks' example: he might possibly drop off the line but still get credit for mediocre performance. Contrary to Wilk's own description, what makes the mediocre guy competent enough for (iii), but incompetent for (ii) is his relative deficit in genuine ('internal') *abilities* when compared to the other, more brilliant high wire candidate. Competence (ii) for the risky task presupposes high artistic skills (i), while competence (iii) for the comparatively low-risk task does not. Hence, the lesson seems to be that competence-ascriptions might indeed depend on the whether the task in question involves running or avoiding certain risks; in such cases differences in competence can then be reduced to differences in relevant abilities. As with regard to other competences, their ascription depends on the exact nature of the task in question. This might simply become invisible if one attests the mediocre guy substantial tightrope competence when it comes to perform *with* a net and insufficient tightrope competence when the net is taken off.

Moreover, Wilks' analogy would, as others[47] have already argued, be a more appropriate test case for RRCC in medical decision-making if it turned on an acrobatic candidate's *decision* to perform without the safety in question. Obviously, this decisional competence would depend not primarily on acrobatic skills but mainly on the self-critical appraisal of one's acrobatic potential, as well as on understanding and evaluating the harmful consequences of falling including permanent injury or death. In the context of decision-making the central question is whether Wilks is justified in claiming that:

> […] cases do indeed exist where one can be competent to say yes but not no, or vice versa; and that it is thus not an anomaly in the risk-related standard [i. e. RRCC] that it entails the existence of such cases.[48]

Let us then take closer looks at this particular context.

3.3 Asymmetrical Decisional Competences?

On first sight, making an informed choice for or against a medical treatment T seems to be an essentially comparative task within a set of options.[49] In the simplest case, the choice is only between T and non-T. In this scenario, understanding and evaluation of risks and benefits *must*

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[46] Wicclair, 1999.

[47] E. g. Checkland, 2001, pp.49.; Wicclair, 1991, pp.97, and 1999, pp.151.

[48] Wilks, 1997, p.413.

[49] Epistemically this seems true even in light of a common asymmetry in consent versus refusal *practice*, where the former is taken to require substantial understanding of the relevant facts and prognoses whereas the latter goes without much ado.

count on both sides, because chances of benefit from T correspond to risks of non-benefit/harm from non-T. But also in more complex cases e. g. with options T1, T2, or no treatment, evaluation in any reasonable sense involves comparison, i. e. appraisal of each option in the light of its available alternatives.

However, as plausible as a symmetry requirement seems to be in the specific case of patients' informed decision-making for or against treatment options, this might not be true for decision-making competences in other contexts. What can be made of such arguments resulting from examples of the following kind? Take a European politician who is asked to take over major responsibility in nuclear energy politics right after the Fukushima catastrophe. Given her second-order knowledge that she lacks the relevant knowledge and expertise (and maybe even the competence to ever grasp the complex relevant facts) she decides against the offer.[50] Uncontestedly, she is competent to do so; but had she also been competent to decide the other way? Given the politician's lack of expertise on nuclear dangers, presupposed in the example, one might be tempted to deny this.

On closer sight, this conclusion in favour of an asymmetrical decision competence seems flawed, nonetheless. First of all, the decision on taking over responsibility for nuclear politics is clearly a different one than any decision on how to make use of this responsibility. Second, whatever the outcome of the decision *on* assuming responsibility, it must be based on the *competence* to roughly understand and appraise its necessary preconditions and its possible consequences in both, magnitude and quality. He must, in other words be competent to compare an affirmative and a negative answer and decide in light of this comparison. Therefore, someone who is competent to answer in the affirmative must also be competent to answer no – although her ignorance might be asymmetrical.

Following these arguments, RRCC so far turns implausible only in one of two possible readings. Thus, it does seem implausible that a patient might – as Drane or Brock/Buchanan see it – at the same time be competent to consent to treatment T, but incompetent to refuse T. Here the allleged asymmetry is *choice*-dependant. However, according to a second possible reading of RRCC the granted asymmetry is *choice-set*-dependant.[51] Under this version, a patient might be competent to authorize or refuse treatments whenever *all* options involve but low risk and low hazard, e. g. taking or not taking nose drops to alleviate symptoms fro a simple cold. At the same time she might be incompetent to decide for or against *any* available treatment options for a severe neurological damage. Let us look at this *choice-set*-dependant reading of RRCC in the next section.

4 Arguments from the Task at Stake

Taking stock of the analysis so far, patients' medical decision-making competence is to be determined by the task in question. Thus, understanding and individuating the latter gets of decisive importance. Hence, what exactly is the leading idea of granting patients authority over their medical treatment?

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[50] Compare Checkland, 2001, pp.41. on the complex role of second-order abilities in matters of competence.

[51] To my knowledge, in the RRCC literature this distinction has not been systematically pursued.

4.1 Making Treatment Preferences Decisive

Granting authority rights to patients is a special case of granting *rights* to persons. Rights in turn get justified in various ways – much dependent on various legal/ethical theories. Circumventing much of the involved controversies, there seems to be common ground for assuming that patients' authority-rights function (be it primarily or not) as instruments that protect their *interests* in choosing treatment options within the available choice set. The availability in question being determined by factual accessibility and professional standards, patients have to agree or refuse according to their values and preferences.

The importance attributed to *personal* decision-making can be analysed as a threefold one: (i) some medical aspects of an intervention (especially, but not only: pain) can be experienced in personally different ways and degrees, therefore demanding an individual assessment; (ii) generally wanted as well as generally unwanted medical aspects of a given treatment (especially, but not only: end-of-life issues) can have inter-individually different impact on patients' general preferences and thus need individual assessment. I will call this the *life-shaping*[52] or *holistic* aspects that some medical decisions might have; (iii) being treated as an authorizer over one's medical treatment has in our culture become *as such* an aspect of being respectfully treated as a person.

Trivially true but easily forgotten, the tasks in question are very different from physicians' tasks to come up with treatment recommendations in the first place: with regard to medical chances and risks, the patient's part is usually and inevitably that of a lay-user who has to rely on expert opinion, thus making various and again often implicit judgments on the expert's trustworthiness, on the information she considers pertinent, and on the treatment's potential impact on her life. Where this might be a simple task at the dentist who recommends refilling a back tooth, it might becomes complex in other contexts. Here, medical decision-making can, as already emphasized, gain the importance of *life-shaping* – in light of a patient's personal fears, hopes, values, or preferences that might well turn her into a 'non-standard' patient.

Hence, decisions about medical options might gain what I have called a holistic dimension. This is particularly likely, if such decisions might have substantial effects on one's quality or length of life – as in matters of reproduction, body shape or mental states, research settings for the treatment of major ailments, or end-of-life scenarios. Even here, life shaping is, of course, partial, given the many natural and social determinants of a human life. Moreover, life shaping neither needs to be ambitious, nor explicit, nor even positively wanted. But it is always an option to some extent, even if made up by negative decisions. Last not least, life shaping in the explained sense is an option not supported by all *cultures*.[53]

Given this trivial reminder, it should become clear that self-regarding medical decision-making might get *a* holistic, and value-laden dimension going far beyond the professional expertise of physicians. To perform this task, patients need to understand such core concepts as life, disease, death, and risk. They must have 'ordinary' computational skills, a decent memory, and the ability to deliberate. And they must have some evaluative framework relative to which they can appreciate and comparatively evaluate treatment different burdens, benefits, and life perspectives.

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[52] This – somewhat self-imposing – expression is owed to Silver (2002, pp.462).

[53] cf. Beauchamp, 1991, pp.59.

Obviously, these deliberations add nothing *really* new to the standard view of patient competence as a set of mental abilities (see Section 2). It might only make clearer that patient competency has to *differ* from other decisional competences – e. g. from physicians' competence for identifying best treatment options or from people's competence for risk assessment in various other private or professional realms contexts – mainly by its *personal evaluative holism*. This might also explain some of the ongoing controversies in bioethics about the proper conceptual place of personal values and personal value-conformity ('authenticity') in informed consent, because this place is often not sufficiently elaborated in the standard view.[54]

4.2 The Ordinary-Person Standard

Holistic decision-makers about medical treatments, I have suggested, do need a set of values and sufficient understanding of such key concepts as disease and death, risk and probability, uncertainties, of expertise and credibility. They need the ability to understand something about risk framing and to appreciate the potential occurrence of specific harms and benefits for their lives. But none of these requirements exceeds the competences of an ordinary person. This thesis does not follow from any empirical data showing that ordinary persons happen to have the competencies in question. Rather, it follows from the normative premise that competence requirements standards *should* be reigned by an ordinary person standard. After all, it is normal people that are viewed as giving shape and meaning to their lives, not some extraordinarily gifted sub-class of them.[55]

So far, nothing in this section has explicitly touched the main issue of RRCC, namely whether risky choice-sets (e. g., decisions for or against neurosurgery) do not, after all, require some deeper competence in grasping these decisions' potential life-shaping meaning than do low-risk choice sets (e. g., regular decisions at the dentist). But now, this suggestion can clearly be dismissed: What is needed in either scenario is a somewhat realistic assessment of the decisions' degree of riskiness and of riskiness as such: In order to meet AA requirements, a patient at the dentist must be competent to understand the relative *absence* of risk (and the latter's meaning). Likewise, the patient to whom neurosurgery has been recommended must be competent to understand the relative *presence* of risk and what this means for life and health and maybe for his life-plans etc. Hence, to assess some treatments as trivial and others as non-trivial for one's life-shaping project presupposes the very same basic competences.

On the other hand, there are many decision-makers who do not qualify for evaluative holism and thus do not count as competent decision-makers, even if the issues at stake are completely trivial. Of course, a severely demented patient might and should be respected in as many of their self-regarding choices on trivial matters or harmless issues as possible. But this should not blur important distinctions in justifying *why* someone's decisions should be respected (see section 5.4 below).

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[54] See section 2.2. above. Sometimes reference to values is made within the bundle of mental capacities, e. g. requiring "the ability […] to evaluate [treatment] consequences in view of one's own values" (Hartogh, 2015, p.71) – presupposing the possession of such values. Sometimes authenticity is introduced as an additional requirement outside (narrowly understood) competency, see (Quante, 2011). Value conformity should not get misunderstood as nailing patients down to their past values: As has often been emphasized, it should also entail leeway for new, may be 'courageous' evaluations.

[55] This view, I take it, belongs to the framing theses of the AA-model of informed consent. Compare Beauchamp/ Childress, 2013, pp.102.

4.3 Complex *versus* Risky Decisions

A controversially answered question in the RRCC debate concerns the role of certain medical issues' *complexity*. This complexity, it is sometimes argued, might in certain cases require beyond-ordinary cognitive skills, but should be kept apart from riskiness. In Beauchamp/Childress' words:

> It is correct to say that the level of a person's capacity to decide will rise as the *complexity* or *difficulty* of a task increases (deciding about spinal fusion, say, as contrasted with deciding whether to take a minor tranquilizer), but the level of competence to decide does not rise as the *risk* of an outcome increases. It is confusing to blend a decision's complexity or difficulty with the risk at stake.[56]

Convincing as this seems on first sight and in principle, I tend to think that a *complexity*-relative concept of competence will rarely, if ever be relevant and that the opposite view might rests on a misunderstanding: to make holistic evaluations, patients do *not* have to understand why and by which mechanisms s a spinal fusion or rather a tranquilizer might or might not be effective. Rather, they have to understand a procedure's chances of cure, uncertainties or its non-stand mode. Ordinary persons, I take it, can grasp such aspects if they are communicated understandably. Physicians' communication about complex treatment and about its expected consequences plays a major role in empowering patients to become autonomous authorizers. The task of translating science talk into messages that ordinary patients can understand remains a challenge. The same proves true for risk communication, which has been shown to lead to innumerable false beliefs on the part of patients. But ultimately this seems a matter of deficit understanding and incompetent communication on the side of physicians rather than a lack of capabilities on the part of patients.[57]

5 Arguments from Protection

5.1 Fallibilism: Raising Standards of Evidence or of Substance?

Paying particular attention a patient's competence whenever she wants to choose *against* recommended treatments has already been identified (see section 2.1.) as a prudent strategy in the service of detecting incompetence at low moral cost. The same is true for paying closer attention to a patient's competence whenever the choice-set involves considerable risks of harm in absolute terms – *regardless* of physicians' recommendations. In both cases not competence itself but *evidence* of competence is subject to stricter requirements in case of risk-taking decisions. Many have thus recommended this 'ethically innocent' precautionary policy.[58]

Obviously, raising the standards of *evidence* of competence for risky choices principally differs from then raising the *substantive* standards of competence's, i. e. in *degree or quality*. However, Joel Feinberg, pioneering forfeiter of respecting personal autonomy in both law and ethics, has tried to *link* the two in defending RRCC on what he sees as purely fallibilistic or epistemic ground:

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[56] Beauchamp/Childress 2013, p.120.

[57] See Gigerenzer et al., 2007

[58] E. g. Beauchamp/Childress, 2013, p.120); Wicclair, 1999, p.153.

> *The more risky the conduct the greater the degree of voluntariness required if the conduct is to be permitted.* […] [This] entails that the voluntariness required for permissible self-endangering actions should be determined by standards whose stringency varies directly with the gravity of the risked harm and with the probability of the risked harm occurring."[59]

Bioethicists Brock and Buchanan who accuse Feinberg of hidden, though unwanted paternalism, have famously criticized his argument.[60] In a nutshell they argue that any RRCC-policy will have two simultaneous effects: it will (i) protect some patients from the harm of risky, though incompetent decisions (the wanted effect), but it will also and (ii) violate the autonomy of some other patients who falsely get assessed as incompetent (the unwanted, but accepted side effect). Accepting (ii) as the moral price for (i), so Brock and Buchanan's argument, can only be justified from a position that ultimately ranks the reduction of harm by effect (i) morally higher than the violation of autonomy by effect (ii) – a (paternalist) position that they themselves favor anyhow and explicitly.

On closer analysis,[61] Feinberg's suggestion cannot get as easily dismissed as Brock/Buchanan have it, but it seems unconvincing, nevertheless. A Feinberg-style strategy can indeed – and against Brock/Buchanan – be reconstructed as compatible with giving first priority to the protection of autonomy over harm. Hence, a with an eye on policy-making the strategy might be justified in contexts with genuine *uncertainty* about the nature of the required competence and with a sufficiently high probability that severe harm from incompetent decision-making can indeed be prevented by effect (ii). From an *ex ante* view of uncertainty, a high likelihood of non-autonomously chosen harm can then outweigh a smaller likelihood of violating autonomy although respect for autonomy gets clear lexical priority over the prevention of autonomously self-afflicted harm.[62] *Ex post*, an analogous balance would fall true for collectives of persons so treated: many cases of prevented non-autonomously chosen harm might outweigh rare cases of violated autonomy. Given that the latter cannot be identified in advance, even proponents of inviolable autonomy rights might swallow this.[63] In such contexts, a policy of raising standards (and tests) might be justified on clearly autonomy-oriented grounds. These grounds, that is, do *not* require neglecting the prevention of harm, especially if unauthorized, in the moral calculus, only to rank it second place.[64]

But again, granting this presupposes circumstances of genuine conceptual uncertainty and appropriate proportionality. Both conditions seem *lack* in the context of medical decision-making. Here we *know* that ordinary person's competence is sufficient and that requiring *more*

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[59] (Feinberg 1989, pp.118/119). "Voluntariness" in Feinberg's understanding is synonymous to 'autonomous' in our understanding. The idea of variable standards of voluntariness (ibid. p,p.115) clearly pertains to competence as well as to autonomy's other gradual criteria. Feinberg's argumentation not does, by the way, specifically refer to medical decisions-making,

[60] Brock/Buchanan 1989, pp.45.

[61] I find myself in some agreement with and owe much to ethicist Joseph Demarco (DeMarco 2002) who has first drawn my attention to this particular debate.

[62] Compare Demarco, 2002, pp.236.

[63] Systematically, Feinberg's position falls under what Fateh-Moghadan and Gutmann have labeled the "endangerment"-variety of soft paternalism. They, too, rightly stress the importance of "proportionality" in justifying such policies and their inherent danger of hidden hard paternalism (Fateh-Moghadam/Gutmann, 2014, pp.392)

[64] This is what Buchanan/Brock seem, however, to require from a non-paternalist position: compare Buchanan/Brock, 1989, pp.41.

than this will thus *always* result in violation of autonomous authorization and often in the prevention of 'harm' that, given the choice-set available to them, patients themselves assess as minor evils. Therefore, RRCC does *not* seem justifiable an fallibilistic grounds.

5.2 Over-Exclusiveness: Hidden Paternalism

From a critical perspective, favoring RRCC can have both over-*exclusive* and over-*inclusive* motivations and consequences. Thus, it aims at (i) protecting patients, even if they might be competent according to the ordinary-person standard, against self-regarding decisions that from outside are deemed gravely harmful. And it is ready to (ii) grant decision-making authority to patients far *below* that standard as long as their decisions involve low-risk issues. Whether someone's pro-RRCC intuitions are more in line with (i) or with (ii), the two sides of the coin might well coincide as *two* mutually supportive lines of argument. I will briefly discuss the first one in this section and the second one thereafter.

Anti-paternalism holds that a competent patient's voluntary and informed decision should never be overridden so as to protect him from harm. In this paper there is no room to discuss paternalism and anti-paternalism in their own right. However, as several critics have warned, introducing RRCC turns

> […] the statement that a competent patient's decision may not be overridden for paternalistic reasons [into] a tautology rather than an expression of an important liberal-democratic principle.[65]

This conclusion is correct because RRCC is *masking* whether a patient's decision has been overridden due to 'real' incompetence or rather with an eye on impeding self-afflicted harm. This is especially true since RRCC-proponents do not (and probably cannot) give full particulars about what exactly they require for sufficient competence in cases of (seemingly) hazardous decisions. Rather, it seems conceivable that patients are *never* viewed sufficiently competent to make certain decisions (e. g. suicide).

Paternalists, of course, would not much mind and have explicitly suggested giving up the traditional distinction between the criteria of competence and harm.[66] But I can only confirm DeMarco's testimony:

> Autonomy is too important and paternalism is too controversial to be buried in a concept of competence.[67]

5.3 Over-Inclusiveness: Devaluating Authorization

Coming to the other end of the competence scale including incompetent patients into the sphere of personal *respect* seems to be a major motivation behind RRCC. Many of the underlying concerns can be understood: judging a patient incompetent can hurt or stigmatize her. As emphasized for instance by VandeVeer,[68] it might even function as a 'self-fulfilling prophecy'. Moreover, caretakers might easily forget that the incompetent should be respected as choosers

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[65] Wicclair, 1999, p.150.

[66] E. g. Hartogh, 2015.

[67] DeMarco 2002, p.244.

[68] VandeVeer 1986, p.415.

whenever possible, thus enhancing their preference satisfaction and their self-esteem. It is a sad and completely unnecessary story that the attribution of incompetence should lead caregivers to forget their duties of benefiting patients by following their self-regarding choices whenever possible without afflicting major harm.

This might be all the more true, as *over-inclusion* via RRCC would be limited to those decisions that are deemed low-risk/high-benefit in the first place. Hence, only *as-if-authority* or *illusory* autonomy is granted to those patients. For any harmful decision physicians would jump in and take over.

But even then, three serious objections have to be made against the attribution of illusory (or *pseudo-*) autonomy. First, it confounds reasonable concept of competence, authority, and autonomy, possibly inviting caretakers to lose respect for 'real' autonomy. Secondly, by circumventing the need for transparent surrogate decision-making procedures, RRCC re-opens a back door to paternalism in medicine. And thirdly, respectful over-inclusion might fuel the belief - wrong in my eyes - that severely demented patients can validly revoke their former advance directives. This is a contested issue that cannot be explicated here. Suffice it to hint at the logical connection between RRCC and the 'past-directive-versus-present-interest conflict' in severely demented patients.[69]

Thus, granting pseudo-competence to an incompetent patient might *look* respectful. Explicitly following her wishes in matters that involve but low risk and low harm as well as following her whenever she agrees to a recommended low-risk option surely is the right thing to do. However, doing this under the label of AA, means to obscure the locus of responsibility and ultimate decision-making.[70]

6 Conclusions

In this paper, I have argued in favor of a *fixed* concept of decisional competence for patients in the context of giving their informed consent to medical treatments. Although its alternative, a risk-relative conception of competence (RRCC), might well have become the reigning conception among clinicians and clinical ethicists it runs into fundamental problems. As ethicist DeMarco has put it about fifteen years ago:

> [...] including risk in the definition of 'competence', or even raising the standard of competence due to risk, is a fundamental mistake that obscures proper decision making in bioethics.[71]

I have tried to reaffirm this view by reviewing well-known RRCC-objections from symmetry problems and the dangers of *hidden* paternalism towards patients with uncompromised competence. Moreover, I have argued that RRCC misconceives the specific task behind patient competence, i. e. optionally making medical decisions with an eye on one's shape of life within the boundaries of being *ordinary* women and men. Finally, by attributing illusory autonomy to clearly incompetent patients, RRCC not only obscures the need for surrogate decision making, but it also implies conceptual de-differentiations that turn out highly problematic in other areas of bioethical dispute, e. g. about honoring advance directives against severely demented patients' expressed behavior.

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[69] Compare Dworkin, 1996; Dresser, 1997; Jox et al., 2012; Schoene-Seifert et al, 2015.

[70] Likewise Wicclair, 1991, p.101.

[71] (DeMarco 2002, p.232)

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