CLINICAL PRACTICE

Assessment of Patients' Competence to Consent to Treatment

Paul S. Appelbaum, M.D.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author's clinical recommendations.

A 75-year-old woman with type 2 diabetes mellitus and peripheral vascular disease is admitted with a gangrenous ulcer of the plantar aspect of her left foot. A surgical consultation results in a recommendation for a below-the-knee amputation, but the patient declines the procedure on the grounds that she has lived long enough and wants to die with her body intact. Her internist, who has known her for 15 years, is concerned that she has been increasingly confused over the past year and now appears to be depressed. How should her physician determine whether her decision is a competent one?

THE CLINICAL PROBLEM

From the Division of Law, Ethics, and Psychiatry, Department of Psychiatry, College of Physicians and Surgeons, Columbia University and New York State Psychiatric Institute, New York. Address correspondence to Dr. Appelbaum at the New York State Psychiatric Institute, Unit 122, 1051 Riverside Dr., New York, NY 10032, or at psa21@columbia.edu.

N Engl J Med 2007;357:1834-40.

Physicians are required by law and medical ethics to obtain the informed consent of their patients before initiating treatment.[1] Valid informed consent is premised on the disclosure of appropriate information to a competent patient who is permitted to make a voluntary choice. When patients lack the competence to make a decision about treatment, substitute decision makers must be sought. Hence, the determination of whether patients are competent is critical in striking a proper balance between respecting the autonomy of patients who are capable of making informed decisions and protecting those with cognitive impairment.

Although incompetence denotes a legal status that in principle should be determined by a court, resorting to judicial review in every case of suspected impairment of capacity would probably bring both the medical and legal systems to a halt. (The terms "competence" and "capacity" are used interchangeably in this article, since the oft-cited distinctions between them — competence is said to refer to legal judgments, and capacity to clinical ones — are not consistently reflected in either legal or medical usage.) Thus, in most situations there is good reason to continue the traditional practice of having physicians determine patients' capacity and decide when to seek substituted consent.[2] Indeed, statutes regarding advance directives for medical treatment generally recognize a medical determination of incapacity as the trigger for activating these directives.[3] In addition, since consent obtained from an incompetent patient is invalid, physicians who do not obtain a substituted decision may be subject to claims of having treated the person without informed consent.[1] Physicians must therefore be aware that their patients may have impaired decision-making capacities, and they must be skilled at evaluating that possibility.

Patients whose competence is impaired are commonly found in medical and surgical inpatient units, and less frequently in outpatient clinics. Between 3 and 25% of requests for psychiatric consultation in hospital settings involve questions about patients' competence to make treatment-related decisions.[4,5] In many other cases, impaired decision making in hospitalized patients may go undetected,[6-9] even when