ABSTRACT. This paper concerns itself with the concept of diminished competence with particular regard to the problems and options that mentally compromised patients raise for medical management. It proceeds through three general stages: (1) a restatement of the sense and grounds of the new patients' rights ethos which the existence of such patients calls into question; (2) a consideration of what expanded responsibilities and tactics physicians should embrace to protect and enhance such patients' autonomy; and (3) the standards, criteria, and mechanisms by which paternalistic interventions might be justified in cases when the diminishment remains too substantial to merit acceptance of the patients' directives.

Key words: Competence, Autonomy, Paternalism, Diminished competence, Fiduciary responsibilities of physicians, Informed consent.

1. INTRODUCTION

This paper will seek to identify and address the ethical issues that mentally compromised patients raise within the typical physician-patient relationship. By 'mentally compromised', I mean to refer to what I suspect is a large population of problematic patients, ranging from those with either substantial neurotic problems and those whose mental status is acutely compromised by factors attendant to their illness, to more chronically afflicted patients who, as a result of the shift to community-based care for the mentally disabled, must now seek treatment directly from the private practitioner. More precisely, this paper will reflect on the ethical issues raised by patients of diminished competence. If one understands competence to involve substantial cognitive and volitional abilities, then one's concern should be heightened by the presence of factors in illness which might seriously undermine such abilities, e.g., fear, pain, stress, confusion, or the various debilitating effects of both diseases and treatments. Further, if such diminishment is widespread, then the new ethos of patients' rights, informed consent, refusal of treatment and anti-paternalism is called into serious question as it clearly must assume that such cognitive and volitional abilities remain essentially intact in most cases. That the new ethos has not paused for systematic reflection on the particular ethical issues raised by such 'grey area' patients highlights the need for the discussion that follows.

This discussion will proceed through the following stages: first, the wider context of this discussion must be arrayed, viz. the issues and values raised regarding the rights and needs of any patient. Here, particularly, the concern
will be to sketch out the anti-paternalistic stance of the patients' rights ethos and answer major objections to it. This initial discussion is foundational to the further inquiry as this new and clearly anti-paternalistic stance regarding competent patients will be retained in this paper. Second, the issues and options for managing patients of diminished competence will be canvassed. A basic tenet here will be that diminishment of competence exists over a broad spectrum of varying degrees, and thus that within the class of such patients, different tactics are appropriate, depending on the degree of diminishment. Finally, and throughout, this paper proceeds in agreement with the late Franz Ingelfinger in the belief that the only 'real protection' for patients is the conscientious and compassionate physician ([17], p. 466), and I will presume to suggest what such compassion and conscientiousness might amount to within the specifics of the physician-patient encounter.

2. AUTONOMY FOR COMPETENT PATIENTS: JUSTIFICATION AND OBJECTIONS

Lest the message of this paper be misunderstood, I should emphasize at the outset that I support the basic message of the recent patients' rights movement in health care. I still see no good reason why clearly competent people somehow should lose their right to maintain control over their lives simply because they become sick and come under a physician's care. Thus, my concern about the previously mentioned special class of compromised patients is at most an inquiry into possible exceptions to the general spirit and rule of patient rights and autonomy articulated over the past decade.

To my mind, however, this articulation has not been accomplished very satisfactorily. Couched mainly in terms of patients' rights and physicians' duties, it seems to have more of the spirit (and often tone) of legalisms meant to oversee what is perceived as essentially an adversary proceeding [1]. The patient has the rights, the physician the duties (and consequent legal jeopardy). However, such talk of rights and duties is hardly sufficient in a situation where most recognize that trust and beneficence are also crucial. At times the rhetoric supporting patient autonomy seems geared to the situation of strangers who have neither care nor concern for each other [5, 13]. Given the inherent power of physicians and the vulnerabilities of patients, it is folly to think that any such legalisms could be adequate.

We will be on firmer ground if we speak in terms of the goods and values that respect for patient autonomy would protect and enhance, rather than simply in terms of rights. Rights language, if still deemed necessary, would thus have the additional force and sense of principles which encapsulate particularly