Competence to Consent to Treatment As a Psycholegal Construct

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The issue of whether civilly committed patients should be extended the right to accept or refuse treatment has generated much controversy and litigation during the past 15 years. In general, the current rule is that in nonemergency situations, individuals who are competent to give informed consent to treatment should be extended the right to refuse it. Obviously, the manner in which this rule is implemented partly depends on how competence to consent to treatment is defined and measured. Most researchers have implicitly assumed that an understanding of treatment information is the sole criterion of competence. It is argued that such a definition may be incomplete and is in need of reexamination. Following a review and analysis of the relevant legal and psychological literature, a comprehensive construct of competency to consent to treatment is proposed and future directions for research are discussed.

INTRODUCTION

The issue of whether civilly committed patients should be extended the right to accept or refuse treatment has generated much litigation and controversy during the last 15 years (Appelbaum & Gutheil, 1979; Dowben, 1979; Plotkin, 1977; Gutheil, 1980; Brooks, 1980). In the past, a number of judicial decisions have addressed the involuntary use of such intrusive or experimental procedures as psychosurgery (Kaimovitz v. Michigan Department of Mental Health, 1973), aversive behavior conditioning (Knecht v. Gillman, 1973), and electroconvulsive therapy (N.Y.C. Health & Hospitals v. Stein, 1972; Gundy v. Pauley, 1981). Recently, the question has been raised with more commonly accepted procedures such as psychotropic medication (Rennie v. Klein, 1982; Rogers v. Okin, 1982). The general rule which has developed is that in nonemergency situations, indi-

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individuals who are deemed competent to give consent to treatment should be extended the right to refuse it (Shah, 1981; Solomon, 1979).

The question of whether civilly committed patients are competent to give informed consent has become the focus of a small but growing number of research studies (for review, see Meisel & Roth, 1981; Roth, et al., 1982). The emergence of such studies represents an important step forward in that they form the foundation of a new field of empirical inquiry regarding the functional abilities of civilly committed patients. Unfortunately, however, many of the studies done to date are of little "utility in answering the questions raised in the debate about informed consent, as a result of conceptual and methodological flaws" (Meisel & Roth, 1981, p. 2473).

Most of the current studies are subject to at least one of three methodological criticisms. Several studies can be criticized for their use of exceedingly small samples or select types of patients (e.g., schizophrenics), thereby raising the question of whether the results are representative of all civilly committed patients (e.g., Pryce, 1978; Soskis, 1978; Stanley, et al., 1981). A second problem is that several studies failed to control or standardize the means by which treatment information was disclosed to the patients or the means by which the patients' understanding of this information was measured (e.g., Pryce, 1978; Soskis, 1978). Thus, these studies are subject to the criticism that patients may have received inadequate communications or were evaluated on the basis of unreliable criteria. A third problem with some of the studies is that their failure to include control groups makes it difficult to determine whether the findings are representative of mentally ill patients, physically ill patients, or people in general (e.g., Grossman & Summers, 1980; Pryce, 1978; Roth et al., 1982).

One of the primary conceptual flaws which underlies many of the current studies concerns the definition of competence to consent to treatment. Most researchers have implicitly assumed that an individual who understands treatment information is competent to give informed consent to treatment (e.g., Grossman & Summers, 1980; Pryce, 1978; Roth et al., 1982; Soskis, 1978). A difficulty with this definition is that although understanding is, undoubtedly, a necessary element of competence to consent to treatment, it may not be the sole criterion. For example, the process by which an individual synthesizes this information also may be relevant to the issue of competence. Thus, prior to conducting further research in this area, the question of how competence is to be defined needs to be reexamined. The primary purpose of this article is to begin this type or reexamination.

FROM A LEGAL PERSPECTIVE

Any attempt to outline a comprehensive definition of competence to consent to treatment should be based upon and seek to incorporate relevant legal principles. It will be helpful to view this concept within the broader legal doctrine of informed consent.