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At the Bedside

Beyond Determining Decision-Making Capacity

Edmund G. Howe

ABSTRACT

One of the most important and difficult tasks in medicine is to determine when patients have the capacity to make decisions for themselves. This determination may determine a patient's life or death. This article presents criteria and approaches now used to make this assessment and discusses how these approaches are presently applied in five common disorders that can serve as paradigms for approaches in other disorders. I propose that since there are new diagnoses and treatments, reconsidering our current practices is warranted. The possibilities that clinicians can nudge patients to make better choices for themselves and, above all, that clinicians can maintain and maximize positive patient/careprovider relationships during and after these assessments, are emphasized.

In this issue of *The Journal of Clinical Ethics* (*JCE*), Juliana Kan Yin Li, in "Rethinking the Assessment of Decision-Making Capacity and

Edmund G. Howe, MD, JD, is Professor of Psychiatry and Director of Programs in Medical Ethics at the Uniformed Services University of the Health Sciences in Bethesda, Maryland; and Editor in Chief of *The Journal of Clinical Ethics*. The opinions or assertions contained herein are the private views of the author and are not necessarily those of the AFRRRI, USUHS, or the Department of Defense. The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript. Conflicts of interest: none.

Making Treatment-Related Decisions," discusses one of the most important yet difficult tasks in medicine—determining patients' capacity.¹ This task is most important because the stakes are often so high. This is exemplified in the case of a ballet dancer who needed both feet amputated if she was to survive, previously presented in *JCE*.² The dancer refused the amputations, and her capacity to make that decision was questioned. She chose finally to have the amputations and live.

Determining capacity is difficult for several reasons. First, it may be a very close call. Second, even though the criteria for these determinations have been established for decades, and reliable screening measures exist, conclusions regarding a patient's capacity to make decisions are left up to clinicians. This is as it should be, because the nuances of a patient's circumstances may rightly alter a clinician's determination. How the criteria are interpreted and applied may differ from clinician to clinician. As Kan states, when patients have "an indeterminate level of cognitive impairment or coexisting psychiatric disease . . . there are disagreements amongst various healthcare professionals . . ."

A determination of a patient's capacity may be extraordinarily far reaching, affecting life and death decisions. Due to the exceptional importance of determining patients' capacity and its difficulty, I will discuss it in this introduction,

building on Kan's article. First, I will review the present criteria commonly used and the problems commonly encountered when these criteria are applied. Second, I will discuss the problems encountered in five different disorders, that can serve as paradigms representing many other disorders. Third, I will discuss additional ways clinicians may use to determine patients' capacity. Our current approach may be the best in most cases, but we might wish to define "best."³ It is possible that we may be able to do even better, as we have diagnoses and treatments that we didn't have in the past. For patients with new diagnoses and/or treatments, past approaches may be suboptimal. We may need new criteria to determine their capacity to make decisions.

There are other ways that we may help patients more than we usually do. For example, with patients' permission, we may explore with them whether they are making the best decisions for themselves. In some cases, when patients change their decisions, a determination of capacity may no longer be necessary. This is because a determination of capacity is less likely to be sought when a patient's choice seems clearly to be best for the patient.⁴ In rare cases, with clinicians' unconditional support, patients may regain decisional capacity.

Our greatest present challenge may be, however, one we have always had: to preserve relationships with patients that are marked by profound, mutual caring as we assess their capacity to make decisions. Regardless of the outcome of an assessment, the goal is for patients, families, and clinicians to feel like allies as they seek to maximize patients' interests.

To fully appreciate the importance of relationships, consider the ballet dancer mentioned above. She may have known that if she was found to lack capacity, she might lose both of her feet, the exact opposite of what she wanted. If her clinicians determined that she lacked capacity and amputated her feet over her objections, the possibility of future collaboration in making treatment decisions for her might not exist. We must strive to help patients to make the best possible decisions for themselves.

HOW DO WE ASSESS CAPACITY NOW?

Presently, when we assess patients' capacity, we use four principal criteria.⁵ We assess their understanding of the information we give them, their ability to appreciate and apply this

understanding to themselves, their ability to reason, and their ability to communicate what they want. Let us consider each in more detail, in turn.

The Need to Understand

The first requirement, understanding, is easily tested. We ask patients to repeat to us what we have just said to them. We ask them to paraphrase it and repeat it in their own words. The main difficulty with this criterion is how to determine whether patients truly understand in a deep enough sense. That is, patients may show a *literal* understanding and be able to cite accurate information, but, due to many causes that range from profound grief to severe depression, they may not be able to appreciate the importance of the information in a deeper sense.

Such assessments are unavoidably subjective. Thus, this is one reason—one among many—that different clinicians' conclusions regarding a patient's capacity may differ. Clinicians who make these determinations may use a so-called sliding scale. This scale allows clinicians to alter the threshold that a patient must meet to be considered to have capacity, so that clinicians can better meet each a patient's individual needs. For example, as Kan says, individuals may be held to a higher standard of decision-making capacity for decisions that carry higher risk.⁶ When clinicians use a sliding scale, their determinations may be more subjective, and this can be another source of differing determinations.

The possibility that clinicians' determinations of a patient's capacity may differ raises the question of whether a clinician should ever appeal a decision regarding capacity, especially, for instance, when the clinician is the sole dissenter among a group that has been tasked with assessing a patient's capacity. (Such a group could be comprised of ward staff or the staff and one or more psychiatric consultants.) A sole dissenting clinician might appeal the group's decision by requesting another expert opinion by an additional psychiatrist or other mental health specialist, or by bringing the case to an ethics committee, or even to a court.⁷

The best way to determine whether patients are able to appreciate the importance of the information given to them in a deeper sense may, paradoxically, not be by asking them direct questions. A lack of depth of understanding may be better inferred from how patients explain their underlying reasoning in making a medical

decision (a topic to be discussed in more depth below). It is possible that a patient's "deeper understanding" may be judged to be insufficiently deep. A patient's idiosyncratic religious views that go against his or her own best interests may be an example of this.

The Need to Appreciate

To test patients' appreciation of the information they receive, we can ask them how they would apply the information we give them to themselves. I will use a case example provided in an article by Paul Appelbaum and colleagues.⁸ Appelbaum was one of the first to put forth the criteria we use today to determine capacity. Appelbaum and colleagues discuss the case of a patient who had schizophrenia and needed treatment, but who denied that he had any disorder. The question that arose was whether his denial alone should be sufficient grounds for his clinicians to deem him to lack capacity. In their discussion of this case, Appelbaum and colleagues note the "philosophical and practical difficulties" that this question presents.⁹ Suppose, they ask, that clinicians could determine that a patient lacks capacity solely because the patient denies his or her illness. "Such a standard," they note, "hovers perilously close to the 'Catch-22' situation in which a patient's denial of the need for treatment is taken as evidence of that very need. . . ." ¹⁰ "Carried to an extreme," they continue, "such a standard would enable society to define a variety of nonconforming behaviors as illnesses and then to relieve the individual of the right to decide whether these conditions should be 'treated.'" ¹¹

These authors conclude that when patients show denial, clinicians should determine whether they have adequate capacity on an "individualized" basis.¹² But clinicians must not determine, however, that every time patients deny their illness, they lack capacity. The authors add that "safeguards would clearly have to be built into a system for evaluating competency" to prevent or at least reduce this risk of abuse.¹³ Such individualizing of the significance of denial increases the risk that clinicians' judgments regarding a patient's capacity may differ.

That risk is outweighed, Appelbaum and colleagues contend, by the need to avoid the false and circular reasoning that this would otherwise allow. They raise an additional, important concern: "Although evidence exists suggesting that

involuntary treatment of patients who manifest denial can be successful over the short run, we do not know what the long-term fate of patients who deny their illness would be if large numbers were subjected to treatment against their will."¹⁴

This attention to patients' long-term interests echoes the importance I placed earlier on maintaining caring relationships with patients, even when our immediate goal is to determine their decision-making capacity. One way to maintain caring relationships is to acknowledge with patients the uncertainty we share as we try to accurately discern their short- and long-term interests. Our relationships may become even more important later, as relationships may profoundly affect patients' long-term outcomes.¹⁵ At the end of this article I will discuss strategies to maintain caring relationships with patients. We can tell patients that, no matter what, we will work to get our relationship right.

Before going further, we should note two final considerations regarding denial. The discussion above outlined the importance of not using patients' denial of their illness to show incapacity. Two additional considerations may further enhance clinical care. First, denial is a psychological defense, and, like all defenses, it is adaptive. It is common in us all. We may benefit patients by sharing that denial is adaptive and universal when they show denial. Sharing these points may help patients overcome any shame they feel at having denial. Stating that denial is a defense we all share may help to convey to patients that we see them as equals. This may be particularly helpful because patients often experience vulnerability and dependency as a result of a serious illness.

Second, if we are able to see that, in this way, patients are like us, it may help us to not see patients as "other" when we treat them. This is particularly important when patients have psychoses, because we may be prone, even unwittingly, to see these patients as, in some way, fundamentally different than we are.¹⁶ Patients with schizophrenia may be especially perceptive, and "scan" clinicians more than other patients do, in part perhaps due to their illness, to see if there are any signs that their clinicians feel negatively toward them.

The Need for Reasoning

Clinicians observe patients to see whether they can reason. At this point, clinicians need

to assess patients' reasoning process, not the content of their reasoning. One approach is for clinicians to describe a circumstance to patients that they might possibly encounter, and ask them how they would respond, and why. Then clinicians can change aspects of the circumstance, each time of increasing its unlikeliness, and each time asking patients how they would respond, and why. As some point, patients may change how they say they would respond. Or they may not. Either way, patients and clinicians may gain important new awarenesses from this process. Where patients will "draw the line," or why they won't, may reveal deeper values that patients hold, but they may not have known were present. This new awareness may move patients to make new and different choices, and the result might be that they do not need to have their capacity assessed.

Patients may be judged to have capacity even when their reasoning is inconsistent. A patient I saw, for example, had had a leg amputated due to diabetes. But she needed to have the other leg amputated if she was to live, for the same reason. She said she had already had one leg amputated and didn't want her other leg amputated, under any condition. She said that she took Geritol, an alcohol-based iron and vitamin B tonic that was popular at the time, and that she believed it would keep her well. She spoke with conviction. We might ask, as we consider her conviction, how patients' strong feelings may affect our own feelings and our assessments of patients' capacity. We might, for example, side too much with what patients want, or perhaps to avoid doing that, we might lean too much the other way. My patient was determined by a court to have capacity. She refused the amputation and died nine months later as a result.¹⁷

Jodi Halpern, a psychiatrist and philosopher, describes a case in which she saw a patient who already had both her legs amputated.¹⁸ The patient was choosing to die because she saw no reason to live. Senior doctors saw the patient as having capacity, and they urged Halpern, who was then less senior than these doctors, to follow suit. Halpern did, and the patient died. Halpern says that she now regrets what she did—or rather what she failed to do. She believes that she should have asked the patient more about any ambivalence she might have felt. That might have enabled the patient, Halpern believes, to get newly in touch with a reason to live. I regret my not doing more with the patient I saw who was

taking Geritol. She laughed with others on the ward where I saw her and she seemed to love her time with them. In response to my greater questioning, she might have seen closeness with other patients as a reason to live.

I mention the regret that Halpern and I felt to emphasize that when we determine a patient's capacity, we can opt to do more than we would usually. For example, rather than primarily seek to arrive at a "yes" or "no" answer to the capacity question, we could invite patients to discuss with us whether what they are choosing is really what they most want. We could ask, to a greater extent, about any ambivalence they may be experiencing. It might have a significant effect. At the end of this article, I will relate a real case in which it did, with what I regard as a result that was close to miraculous.

The Need to Communicate

Patients' abilities to communicate may be less open to subjective appraisal, and thus be subject to less disagreement. But determinations of capacity in patients who have difficulty communicating may still be open to wholly different views. The ability to communicate may be lost in many ways. Patients may, for example, have difficulty speaking or putting their thoughts into words after a stroke. Patients who are in a locked-in state may be able to communicate only by blinking or by moving their eyes, when looking up could be agreed to mean "yes," and looking down could be agreed to mean "no." With such strategies, these patients may be able to communicate complex thoughts. They can choose letters, one by one, to make words using an alphabet chart.¹⁹

Even patients in a minimally conscious state may be able to communicate. Clinicians may be able to discern what they want by asking them to imagine themselves in different settings, such as actively playing tennis, or more quietly sitting, watching television. In this system, "tennis" can mean "yes," and "television," "no," and, using brain imaging, clinicians can detect patients' answers from their responses. Clinicians can test patients' responses for consistency, asking them the same kind of question in different ways, for example, "Is your name Joe?" when it is, and later, "Is your name Fred?" when it isn't.

Presently, a question that is still controversial is whether these patients should be considered to have sufficient capacity to choose to live or die, by having lifesaving measures withdrawn

at their request.²⁰ Testing may do more still: clinicians can ask them questions to discern whether they can reason abstractly. At what point should their capacity be considered sufficient to allow them to decide what happens to them?

Then, too, these patients might be regarded as existing in a new diagnostic category; they were thought to be in an irreversible, persistent vegetative state (PVS). This is the first paradigmatic question I will raise: Should our present criteria, based on past research and experience, continue to suffice when there are new research findings? A final question in this section is, How can we maximize our relationship with every patient whose capacity we assess? We can imagine how patients in a minimally conscious state, who do not want to continue to live, might respond when, during an assessment, they realize that the testing may determine whether they can die as they want.

Consistency

Another criterion sometimes considered in assessing capacity is whether patients can communicate consistently. If patients vacillate in saying what it is that they want, it may be grounds for deciding that they do not have the capacity to make medical decisions.²¹ A threshold ethical question is whether patients should be free to change their mind, even at the last minute. Patients might, for example, beg that a respirator be restarted, even though they have said previously and consistently that they want it turned off.²² We might consider again how patients' urgent wants may affect clinicians' feelings, and how they may affect clinicians' assessments regarding capacity. If clinicians determine that a patient does not have capacity, could they later regret this determination? Halpern and I have. Both of us regret not asking more questions prior to concluding as we did. Emotionally charged memories tend to remain with all of us. They haunt us, and fester. Should this possible harm to clinicians warrant assignment of some moral weight?

LIMITATIONS WHEN PATIENTS HAVE DIFFERENT DIAGNOSES

The limitations that clinicians face when they determine the capacity of patients may vary, depending on the patients' disorder. I will discuss five disorders, as paradigms for the many other disorders patients have.

Acute Stress Disorder

In this issue of *JCE*, Kan presents the case of a 25-year-old man who was speeding as he drove in a car with several friends. He lost control of the car, it crashed, and all those with him died. The crash left him with quadriplegia and not able to breathe on his own. He survived on a respirator. His situation poses the following question: Our present criteria for determining decision-making capacity is wholly cognitive; it doesn't take into account, at least directly, patients' emotions; is this suboptimal? Reason and emotion are highly interrelated. Should we seek a way to give emotions greater moral weight? Kan states, "Currently, assessments are largely based on patients' cognitive ability and do not sufficiently take into account other factors that influence patients' judgment." Appelbaum notes that the impact of affect and emotions influence patients' judgment.²³ This patient, as Kan observes, is likely to be feeling deep grief and guilt, and the emotions may skew his cognitive abilities. This may occur outside his and his assessors' awareness. Such skewing may be subtle; an example of this subtle skewing is when patients are depressed.²⁴ Depression may distort their cognition in three ways: they may misperceive; they may attribute their misperception to wrong and arbitrary causes; and they may overgeneralize from this wrong view and believe they are, as a whole, simply "no good."

Specifically, suppose a depressed person is giving a lecture. She may misperceive and see one person in the audience who is asleep or not paying attention. She may infer from the one person that the lecture she is presenting is boring. But the person in the audience may simply not have slept well the previous night. The lecturer may conclude that since she is a poor lecturer, she is worthless, when this is not the case.

Cognitive therapy is one evidence-based therapy for depression. Its aim is to help depressed patients recognize their misperceptions, should they occur. With such recognition, depressed patients can dispute their misperceptions. Misperceptions are not delusions; they are not fixed beliefs that conflict with reality. As discussed later in this article, even when patients have delusions, the patients may still be regarded as having capacity. When clinicians assess patients for capacity, they may not detect such skewed perceptions and thoughts, and, even when they do, they may judge patients to have capacity.

Returning to the case of the 25-year-old patient on a respirator. He may feel grief and guilt that would be hard for most of us to imagine. Suppose he wants to disconnect his respirator so he can die. A practical question is whether his clinician should try to persuade him to wait—to defer the decision, so that he has more time to consider it. He could, for instance, discuss this decision with loved ones and perhaps meet and talk with others who have similarly acquired quadriplegia and who have found enough meaning in living to want to continue to live. He might later go to a rehabilitation center and change his mind. This patient may have the legal right to have his respirator shut off and thus die. If he is a lawyer or has a lawyer by his side, this may be more likely. In any case, the ethical question still exists: Should his clinician try to persuade him to wait to make a decision? Ethically, his clinician could be seen to be exploiting his vulnerability by using the clinician's relatively greater power wrongly, by trying to persuade him. Alternatively, an attempt to persuade the patient to wait may be seen as a justified endeavor, over the longer run, to increase his autonomy. This issue of *JCE* includes articles on clinicians' nudging patients, and the article by Kalle Grill, "Shove and Nudge: A Comment on Iserson," especially strongly makes this case.²⁵ In any event, to attempt to persuade the patient to wait would not be remaining neutral.

Another question is whether the patient's clinician should, to enhance his autonomy, provide him information that may support a decision to not wait. For example, if the patient waits until later and turns his respirator off at that time, he may have become able to breathe on his own because his brain may have recovered that much. But if, at that time, the patient still wishes to die, he could only accomplish this by refusing food and water. Should his clinician inform him of this while trying to persuade him to wait? Informing him might, paradoxically, support a decision to wait, because how we "work" is often not logical. That is, his clinician's disclosure of this information may move him to trust the clinician more. He might believe that if his clinician is willing to tell him this in spite of what the clinician is trying to persuade him to do, this must be someone he really can trust.

Bipolar Illness

Patients with bipolar disorder are a specific example of the dilemma regarding emotions that

can occur in determinations of capacity. These patients may have highly altered emotions that may greatly skew their thinking.²⁶ Even when they are thinking clearly, their strong emotions may *drive* them to do whatever they do, possibly without their even knowing it. This may occur when patients are experiencing mania. Due to mania they may, for example, be more likely to take risks, and this may make it more difficult for them or their clinicians to discern. Further, even if their clinicians do discern this, they may not see the patients' drivenness as sufficient ground to conclude that they lack capacity. Such drivenness is best illustrated by a patient's description: "When becoming unwell, treatment at home is not suitable for me. I need to be admitted to the hospital under compulsory treatment, even if I seem to still have some control—otherwise I am likely to get overconfident and start getting involved with people and activities that disrupt my life."²⁷ He continues, "You're just unwell at the time. I mean, I know the difference between being well and being unwell, but when you're under [mania] you don't know the difference . . . because everything seems so real you think that you are well and that everybody else is making a wrong diagnosis."²⁸ Here, practically, clinicians may try to tell these patients that they are more likely to make risky choices due to their mania. To benefit from this information, patients would have to accept that they have mania. This would not be unlike the case presented by Appelbaum and colleagues, described above, regarding a patient who was in denial regarding his schizophrenia.

But even if patients don't accept that they have mania, they may trust their clinicians enough to be able to accept that diagnosis, solely on the basis that their clinicians say they have it, and they trust their clinicians. Trust may be maintained even when clinicians go against what patients want. An example is when clinicians have patients restrained. How clinicians respond to patients as they restrain them may wholly determine how patients later feel toward the clinicians.²⁹ This illustrates why the patient/clinician relationship may be all important. Clinicians may use these instances as another opportunity to convey indirectly to patients that they view the patients as equals. Clinicians may say that they, themselves, sometimes are driven and might not be aware of it at the time. For example, we can consider: Who among us has not acted out of anger or out of hurt in a way

that harmed a loved one, that is, in retrospect, the exact opposite of what we wanted to do? Such explicit self-admission may help patients reduce the shame that they may be feeling. It may also help them feel safer. That may, in turn, help them feel less stressed, and then they may be more able to change their mind. In rare cases, they may regain the capacity to make medical decisions.

Schizophrenia

We considered, above, an example of a patient with schizophrenia who showed denial. From this one example, it may seem that clinicians would not be able reach patients with cognitive difficulties when the cognitive difficulties are more severe. Clinicians may be able to reach these patients, as they often retain the capacity to make decisions.³⁰ An example is that of psychiatrist David Mee-Lee, who is skilled in reaching these patients. He works with patients who deny their illness and refuse the antipsychotic medications he believes they need. He does this by agreeing with them that it is possible that they *could* go without meds, and asks them if they would be willing to try the meds should they become psychotic off the meds. With this approach, he often succeeds. Why? I believe this approach succeeds because, in agreeing with patients, Mee-Lee implicitly acknowledges a path they can follow. Clinicians may set forth a similar path when they assess patients' capacity to make decisions.³¹

Dementia

The predominant problem some patients face is a lack of memory,³² and this deficit may continue to increase over time. As this is the case, there may be greater limits on what clinicians can offer them in terms of making their own medical decisions. But patients may continue to know what they want and continue to be able to communicate it, even when they cannot remember their past. Perhaps we might assess the capacity of these patients in a different way than has been done in the past. Might we help them more by seeing their memory as less essential to decision making?

Patients whose memory is greatly impaired may want to form new relationships, and they may no longer recognize those to whom they have been married for half a century. To assess the capacity of these patients, we could use, to a greater extent than we currently do, a sliding

scale. Or we could carve out an exception to our usual criteria and establish new criteria that place less weight on cognitive ability and more weight on what patients say they want. This is similar to what we already do now: We honor patients' present wants even when their advance directive, which was completed a while ago, states something different.

There is a second way in which we might consider using a different standard: We may in rare circumstances opt to lie. While this seems counterintuitive, we may choose to do this for the same reason we may advise patients' loved ones to lie. We may do this to spare patients from unimaginable and repeated suffering. For example, some patients repeatedly forget the death of their lifelong partner, and when a loved one tells them the truth, —that their partner is dead— patients may receive the news as if they are hearing it for the first time. Their grief may be profound. Worse still, after suffering this agonizing experience, they may soon forget and ask their loved ones the same question again. Better than repeatedly inflicting this pain, their loved ones might say, "He's out at the store. He'll be back soon." The patients may then respond "Okay," and not feel grief. They have not been told the worst possible news.

In the same way, clinicians' lying about patients' increasing memory deficits may spare patients and their loved ones. A remarkable, just-published clinical update reports that there is no empirical evidence that screening to detect cognitive impairment earlier, when patients have dementia, helps or harms them or their caregivers.³³ This finding goes against the common assumption that clinicians should diagnose dementia as soon as possible. Instead, we might refrain from making an early diagnosis because doing so may place a dark cloud over patients, from when they are first diagnosed through the rest of their life. Thus, when the need to assess patients' capacity is equivocal—when it is clear that they still are making the best choices for themselves—we might avoid even inadvertently placing a dark cloud over their future, until a diagnosis becomes necessary.

Traumatic Brain Injury

Members of the military in the Mid-East may drive over an improvised explosive device (IED) that explodes and shatters their legs and damages their brain.³⁴ These bombs may cause a different kind of traumatic brain injury (TBI) than the

blunt trauma caused, for example, by a car accident.³⁵ An IED blast may damage small blood vessels throughout the brain, and these injuries may cause different kinds of psychological deficits.³⁶ Patients with a blast injury may retain literal understanding, but lose deeper understanding, as discussed above. Extensive psychological testing may show these deeper deficits. This testing may suggest that the patients can't integrate past wants and experiences as they would have before the blast injury.³⁷ Some patients have leg injuries that can't heal, and like the patients we considered above, refuse a lifesaving amputation. Should they be judged to have the capacity to refuse amputation, knowing that, if they do, they will die? This question is another example of when we might ask whether our present, gold standard criteria should be revised for a specific group of patients.

This question can become still more complex. Like patients with minimal consciousness, which we considered above, the brain of patients with TBI may heal. If their brain may heal, it may be more important to keep them alive, because in a short time their decision-making capacity may be better and they may want treatment. Further, service members' occupation may warrant being taken into account, as they knowingly take on additional risks for the greater society. We might adopt a stricter standard than is usually followed to help service members who are injured by an IED. This exception to the standard could be grounded on the moral principle of compensatory justice, to reward or compensate them for the greater risks that they take.³⁸

If we establish new criteria that limits, to a greater extent, service members' autonomy to choose to die under these conditions, we should inform them of this in advance. On the other hand, perhaps this need to inform should apply to all patients. That is, to fully respect them, we should inform them of the criteria we would use in determining their capacity to make decisions. Informing patients of this in advance may be ethically analogous to telling the patient who was in a car accident, discussed above, what might happen if he waited to see whether he wanted to discontinue his respirator.

ADDITIONAL APPROACHES

As noted above, we can use a sliding scale to alter how capacity is assessed based on a patient's disorder, to best meet each patient's in-

dividual needs. We may go beyond this and help patients to see additional options, and perhaps they may decide that what they really most want now is different from what they thought they wanted previously. We can ask them additional questions—for example, ask them about any ambivalence they have. Other interventions we will now consider include structuring our future encounters with patients, dislodging patients' past blocks, and "shoving" or "nudging" patients to consider new options, if we believe they should and can. Structuring in advance how we will intervene may help patients know that we will strive, above all else, to be their ally, regardless of what occurs. Sharing our insights regarding past blocks—that is, patients' past experiences that may narrow their widest possible choice of options—may help bring this about. Shoving or nudging is especially complex and controversial, but may increase the range of what patients can choose.

Structuring Present and Later Encounters

As in any encounter between individuals, our first minutes together with our patients may determine what will follow. These first moments can create trust or block it thereafter. We should consider what to say to a patient from the first moment we imagine that the patient's decision-making capacity may need to be assessed. (In general, considering what to say may be efficacious and respectful at the beginning of every encounter.) We might begin the discussion by saying what has occurred to us, that is, that we or another clinician may need to assess the patient's capacity, and why. We might explicitly say that we are sharing this with the patient at the very first moment that we can. Giving a patient this information and doing it as early on as possible may be all that we can do to merit the patient's trust.

We can spell out how things might go from there, underlining that regardless of what occurs, we will be with the patient in spirit—and in practice—in pursuing whatever it is the patient feels she or he wants, to the degree that we can. This core truth makes it clear from the outset that the patient will not be alone. Every effort must be made to be inclusive, to inform the patient of what comes next, what's expected or in contention, and why it serves mutually shared goals. Once this conversation of shared decision making is begun, it may become a way to proceed—together.

When clinicians first say all this, it may seem to some patients to be just words, especially since we have given them news that may fill them with feelings of distrust. Still, even so, saying this could help soften the pain that stems from what they have heard. Patients may then know that we will face the future in the clinical arena with them, even if they have no one else. Not being alone, even having only one other person, their clinician, may help patients cope with what may occur more than anything else.

Usually, there are two possible outcomes from an assessment of capacity. One is that patients are found to have capacity and can choose what they want to happen. The second outcome is that they are found to lack capacity, and a substitute decision maker will make decisions for them. But there may be a third possibility: patients may change their mind, like the ballet dancer who initially refused the lifesaving amputation of both of her feet. When patients change their mind about a treatment, clinicians may see this new choice as sufficiently reasonable, and decide that capacity assessment is no longer needed. Since this may be the best possible outcome, especially from the patients' perspective, it might be ideal for us to discuss the pros and cons of all of the options with patients, in whatever time we have to do so.

We can explain that refusing treatment might result in an assessment of their decision-making capacity, and this might lead to having a surrogate make the treatment decision—and that what a surrogate will choose can't be known ahead of time. Such a discussion might prompt patients to change their initial decision, and thus sharing this information with them may be somewhat coercive. Yet this information is accurate, and it may be more important for patients to be informed than to not feel coerced.

An optimal place to begin in these situations might be to explore any ambivalence that patients feel. We can point out, regularly if needed, that we will continue to support patients in every way we can, and that our being with and for them is not contingent on their willingness to discuss other options, or even their reasons for wanting what they are choosing. This may seem nonsensical and paradoxical. Our efforts to explore their ambivalence may, in some cases, overwhelm patients. We must try to sense when this is happening. When we do, we should stop, ask if we can revisit the conversation, and listen to the answer. Otherwise our efforts may be

seen as coercive. This attempt to not be coercive will mirror what we have already said. It might be the key to nudging patients to choose to do something that may be better for them.

We can tell patients they can choose whether or not we are among those who will assess their capacity. (If patients don't want us to be part of an assessment, we should tell colleagues ahead of time that we will excuse ourselves, and why.) This is similar to what David Mee-Lee does. He tells his colleagues beforehand that he will encourage his patients who have schizophrenia to go without medication if they believe they could, so that they will be more likely to take medication if they need it, and so they may perhaps be willing to continue to work with him.

We can indicate to patients that, by excluding ourselves from those who will assess their capacity—if they are assessed—we may be better able to advocate for their views, since we will not feel any pressure to agree with a group decision. If patients can see this, it could be that their adequate capacity has already been demonstrated. The ultimate goal is to help insure that patients do not see us as having a mixed and thus somewhat compromised allegiance. We should say, for the same reason, that we will do this regardless of our own personal views. The critical gain for patients, when we are allied with whatever it is they most want, is that regardless of what they want, they can *feel*—rightly—that at least this one member of the hospital staff will take their side, and will take it whether or not we agree with them. Patients can no longer, easily at least, see the staff as being wholly against them, and this may make a profound difference in how they view the medical system in future years. We can add that if the staff decides that an assessment is needed, we can—if the patient wants this—pursue an appeal with the patient, to the degree that this is possible. We can indicate that we are willing to be physically present, and, if the patient wants this, even take the lead in an appeal. Should the patient want this, his or her request might end up in a court. We can finally say, although it may be obvious, that what ultimately occurs may well be out of our and our patient's hands. We can guarantee only that we will stay with the patient so that together we will do the best that we can.

Dislodging Past Blocks

In this issue of *JCE*, Robert M. Guerin, in his article, "On Transference in Clinical Ethics Con-

sultation: Recognizing and Working through the Past in Surrogate Decision Making,” describes how he sought to help a surrogate make the best decisions for her mother, an elderly, incapacitated, terminally ill woman.³⁹ This approach should also work for patients who are making difficult decisions. Guerin reports that he began with an open-ended question in a family meeting with the surrogate and her brother and sister. He said, “ ‘Tell me a little about the circumstances that led to the signing of the advance directive.’ ” This approach is safe, optimally respectful, and commonly taught as the best way to begin. The only approach that may be softer may be to ask first if it is okay to ask this question. Otherwise, from the imperative form of this statement, some patients may hear this as a way that a clinician is telling them what to do. Patients who feel threatened may misconstrue the intent behind these words, and may more easily say “no” to whatever clinicians seem to be telling them, rather than asking them. Patients may appreciate clinicians’ asking rather than telling, and, with this greater appreciation, be more willing to share important information.

In this case, Stephanie, the patient’s surrogate, says, speaking of her mother, “ ‘Her brother Jim had recently passed,’ ” and adds, “ ‘She was devastated. The care he received toward the end really affected her.’ ” Guerin responds, “ ‘I can tell that you did what you did because you cared deeply for your uncle.’ ” Here, his response optimally indicates his respect for Stephanie and for how she is. Because Guerin expresses his appreciation for her character and emotional strengths, Stephanie may be, for a good reason, more open to what he says next. What Guerin says to Stephanie is not pat or covertly manipulative; it recognizes her strengths. (Such strengths are almost always present in patients and family members, and should be acknowledged.) Guerin continues, “ ‘It seems to me there are many similarities between your uncle’s last admission and your mother’s current admission.’ ” All clinicians can recognize such similarities and share them when they think they see them. We can ask whether patients think that their experience in the past could be influencing their views in the present.

Guerin provides a compelling rationale for us to do this, especially when we suspect that patients may be at an impasse. Guerin quotes Brian Bird, a psychiatrist, in his analysis of the case: “ ‘In view of anxiety’s [and all emotions’]

direct link with the past, it is always wise, in the case of any obscure anxiety, to suspect that the patient’s present reaction is being influenced by something that happened long ago, or that the patient is reacting as he is now because he is repeating the way he reacted then.”⁴⁰ In the family meeting, Susan, the surrogate’s older sister, sees such a similarity, and says, “ ‘Mom was devastated by Uncle Jim’s experience. And I’m sure if she could speak to us now, she would tell us the same thing about her experience. If the doctors could tell her that she should focus on comfort, I think Mom would be relieved.’ ” Guerin explains how the children’s past may be influencing their views in the present: “ ‘I don’t believe in ghosts. But sometimes it can feel like ghosts from our past are haunting us because important relationships from our past can affect us in the present. You cared for your uncle, and it’s because you care for your mother that the old feelings are returning: the stress, the anxiety, the anger toward loss.’ ”

Guerin then says, “ ‘I know it feels like we are putting our foot down once again. And that’s because we are. We are deciding that your mother needs comfort care at this time in her life. But this time it’s slightly different. I think I know what your mother’s wishes are. And I think we have an obligation to respect those wishes.’ ”

I quote the article at such length because I want to address Guerin’s last comment in context. I fear that this was a risky way for him to proceed. That is, when he says, “ ‘I know it feels like we are putting our foot down once again. And that’s because we are,’ ” I fear that some patients, after hearing something like this, might conclude that Guerin’s prior insightful and compassionate intervention was intended to move them to become more receptive to the staff’s doing what it has already decided it will do.

Guerin reports this wasn’t the case. Stephanie and her siblings are able to understand that their anger toward the medical team and their defensiveness are reminiscent of their anger in their uncle’s case. They “ ‘admitted that their mother was determined to avoid purposeless suffering when she completed her advance directive. They also admitted that their present predicament was similar to their uncle’s.’ ” Guerin thinks he sees appreciation in their eyes, and he sees that Stephanie starts to cry.

What might we do differently if we see the risk of possible coercion in advance? When

staff has already decided what they will do, we should tell patients or their surrogate the moment it becomes clear. This removes any possible ambiguity. But there may be a price for doing so: once we let patients or surrogates know this, we may no longer be able to help them as Guerin does. We might be able to pursue this kind of breakthrough before a definitive outcome has been determined, as Guerin does. We may still ask ourselves, though, which value should prevail: Is it preferable to respect the autonomy of patients or their surrogate by telling them as early as possible what staff has already decided? Or is there more benefit to patients or their surrogate to not disclose that a decision has been made until they have worked through what they believe is best, without the influence of the staff's decision?

Myself, I would disclose what had already been decided, so patients or their surrogate would know that I want them to have all of the information available. When a decision has been made, we should not ask patients or their surrogate what they think should be done; rather, we should acknowledge that since what will occur has already been decided, we can imagine they may, having been "overruled," have little or nothing they want to say to us at all.

Shoving Or Nudging

In this issue of *JCE*, Kenneth V. Iserson writes, in his article, "Do You Believe in Magic? Shove, Don't Nudge: Advising Patients at the Bedside," that "Clinicians have a professional duty to shove, rather than nudge, patients toward [certain] goals."⁴¹

Some Pros and Cons of Shoving or Nudging

Iserson's view is controversial. It goes against the views that many hold: that beyond giving patients information, clinicians should remain as morally neutral as possible. Daniel M. Hausman comments on Iserson's article in "The Paradoxes of Respectful Guidance: A Comment on Kenneth V. Iserson, 'Do You Believe in Magic? Shove, Don't Nudge, Advising Patients at the Bedside,'" "Some might object to this presupposition and maintain that the way out of the difficulties and responsibility of providing guidance is to leave treatment decisions entirely to patients."⁴² Thus, when patients ask clinicians questions such as what they would do if they were in the patient's situation, clinicians may say something like, "I'm not *you*. Therefore, it wouldn't make sense

for me to tell you what I would do," as nicely as they can.

This commitment to neutrality may have come about in part as a needed correction to clinicians' being overly and unjustifiably paternalistic in the past. Perhaps the strongest present argument in favor of such neutrality is that it protects clinicians from wittingly or unwittingly imposing their view on patients when patients don't want it, and could be harmed by it. If clinicians say what they would do and patients follow suit, and it ends badly, patients may feel worse and blame themselves. On the other hand, if patients go against what their clinician says and it ends badly, patients may blame themselves bitterly for not having "listened."

Every aspect of our encounters with patients may be unavoidably colored by our values, which may be expressed in no more than our body language—we may never explicitly state what we believe. Thus, I suggest that when patients ask us what we would do, we should ask patients whether we can discuss the pros and cons first. This approach may end up favoring patients who are assertive enough to ask us what we would do—patients who would like to ask us what we would do but are insufficiently assertive, would be left out. If we take the initiative to ask all patients, "Would you like to know what I think?" some may find it hard to say no. A way around this difficulty might be to ask all patients, and say that if they want to know, we would like to discuss the pros and cons of doing so, first.

There are good reasons to share more with patients as Iserson and, to a degree, Hausman suggest. Hausman states, for example, that rational arguments are "almost always permissible." He uses as an example patients who refuse a colostomy because of its "horror." It may be, he points out, that patients refuse because they have erroneous beliefs regarding what it is like to live with a colostomy.

Finally, there may be the worst result when patients ask us what we would do, and we respond that we won't say. Then patients may feel offended and even abandoned, although this is irrational, in that a decision to remain neutral would be for their benefit.

Practical Aspects

Iserson cites his "demeanor" during his initial interactions with patients in the emergency room, among a few other core factors, as the

reason he gains sufficient trust in this setting to shove or nudge. How might Iserson or others best do this? In their commentary on Iserson in this issue of *JCE*, Ian Hargraves, Victor M. Montori, and Jon C. Tilburt, in “*Curare Aude*—Caring for Patients, with Them,” give us some clues.⁴³ “Grab a chair,” they say. In this vein, I recently attended a presentation by D.W. Alexander, a pediatrician who said he carries a small chair with him on the ward so that when he sits, his eye level is *below* that of the children he sees, so that they can feel more confident when speaking to him.⁴⁴ “Be curious,” Hargraves and colleagues continue. In this spirit, we might keep in mind that all patients have unique depths; as Alexander relates, children say the “darndest,” unpredictable things, for example, this exchange he overheard: parent: “Are you hungry? What would you like?” child: “A wasp sandwich, perhaps. . . .”⁴⁵

At times our feelings of compassion may run thin. For example, emergency rooms are often flooded with patients who are in serious distress, and we may feel anger or even contempt for patients who come in for concerns that seem trivial, like an ingrown toenail that “can’t wait.” We can seek ceaselessly to replace these feelings with compassion, which may, in and of itself, move patients to feel cared about, and even move them to share critical medical information that otherwise they wouldn’t have disclosed.

Is it possible to renew feelings of compassion? There are different ways. One is to remind ourselves that, to patients, their malady was concern enough to move them to come all this way at this time.⁴⁶ Another (my favorite) is to think of the very worst moment in my life. It still surprises me, in ways I can’t imagine beforehand, how this strategy can move me to convey, with passion and rich imagination, the support and caring I wish to convey to patients: sharing, for example, that it is possible to love an imperfect spouse as one can love a three-legged dog. A religious clinician I know takes a deep breath and closes his eyes a split second before every new patient he sees. When first opening them again, he seeks to see Jesus within that patient. He also advocates that every time we see a patient, we imagine that we are seeing that person for the first time.⁴⁷

When we are in the emergency room, it may be necessary to interrupt patients. If a patient is having a heart attack three feet away, it may take 30 seconds to excuse ourselves to a patient who

has less emergent needs by saying, “I’m sorry.”

But such considerations of the “how” leave two core questions unanswered. The first is, When—if ever—should clinicians “shove”? My answer is when patients will suffer otherwise. A man told me, for example, that he had put his head down over the heart of his severely ill mother the very moment she died. He believed he had killed her. I shoved against his concern with vengeance. He said that he had wanted his mother to die “in peace,” and I explained with as much authority as I could muster that she *had* died this way—that people often, it seems, need “permission to die,” and by placing his head over her heart, he had given her permission.

The second unanswered question is, When should we not even nudge? This is not clear, in the same way that it is not clear when to self-disclose to patients. For example, I once told a patient who was hurting how I had similarly hurt, hoping it might help her to feel less alone, but fearing that it might reduce her belief (true or false) that I had something to offer her. All of us are frail. Should we never not share this?

I mentioned at the beginning of this article that I would report a case from my experience in which a patient responded miraculously after a clinician asked him about any ambivalence he might feel. Here it is. Mr. C. was a military veteran in his 60s. He had a 20-year history of heroin use. He had, through all that time, refused to be detoxified, much less enter a rehabilitation program. During his most recent hospitalization, he had again refused to accept any rehabilitative interventions. Just prior to his discharge, though, his primary clinician asked him whether he felt any ambivalence. Suddenly, for the first time, Mr. C. burst into tears. He expressed the pain he had felt for 20 years at having disappointed his daughter due to his addiction. He agreed for the first time to begin rehabilitation.⁴⁸

CONCLUSION

We have explored how we can assess patients’ capacity to make medical decisions, and asked how we might do better. We have discussed expanding how to use a sliding scale, and that we may wish to consider establishing some new exceptions to our standard practices. We have considered examples of when these may be most needed, and we have considered ways to do this, that range from trying to see, sharing similarities, and shoving—for better or worse. The

key point is that we should consider going beyond assessing patients' capacity, to cementing our relationships with them. This may, in some cases, lead patients to change what it is they choose.⁴⁹ Still more important is what patients may feel over the longer run. Notwithstanding the outcome, patients who know that we have listened, emotionally engaged, self-reflected, and remained present, so that they can continue to see us as their ally, is our challenge and goal, that surpasses any other.

CONFIDENTIALITY

The names and details of cases have been altered to protect the identity and privacy of patients and family members.

EXPRESSION OF APPRECIATION

I would like to thank Norman Quist for pointing out numerous critical points that added nuance and balance to this article.

NOTES

1. J. Kan Yin Li, "Rethinking the Assessment of Decision-Making Capacity and Making Treatment-Related Decisions," in this issue of *The Journal of Clinical Ethics* 31, no. 1 (Spring 2020). The words "capacity" and "competency" refer to clinical capacity and legal competency. I will use only "capacity" in this article for clarity.

2. S. Napier, "When Should We Not Respect Patients' Wishes," *The Journal of Clinical Ethics* 25, no. 3 (Fall 2014): 196-206.

3. See P.S. Appelbaum and T. Grisso, "Assessing Patients' Capacities to Consent to Treatment," *New England Journal of Medicine* 319 (1988): 1635-8.

4. "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." P.S. Appelbaum, "Assessment of Patients' Competence to Consent to Treatment," *New England Journal of Medicine* 357, no. 18 (1 November 2007): 1834-40, 1835.

5. For a concise list of the four main criteria and questions clinicians commonly ask to assess them, see Appelbaum, *ibid.*, 1836.

6. "Although some commentators object to this 'sliding scale' approach, it makes sense from a policy perspective." *Ibid.*, 1836. See also J.F. Drane, "The Many Faces of Competency," *Hastings Center Report* 15, no. 2 (1985): 17-21.

7. Clinicians have no means to verify objectively that patients lack capacity. S.Y. Kim et al., "Variability of Judgments of Capacity: Experience of Capacity Evaluators in a Study of Research Consent Capacity," *Psychosomatics* 52, no. 4 (2011): 346-53. Screening

measures can help. The MacCAT-T has been validated in a variety of populations, has demonstrated high reliability and construct validity in a number of contexts, and appears to be the most widely used measure in studies of healthcare decision-making capacity. B.W. Palmer and A.L. Harmelle, "Assessment of Healthcare Decision-Making Capacity," *Archives of Clinical Neuropsychology* 31, no. 6 (September 2016): 530-40. See also T. Grisso, P.S. Appelbaum, and C. Hill-Fotouhi, "The MacCAT-T: A Clinical Tool to Assess Patients' Capacities to Make Treatment Decisions," *Psychiatric Services* 48, no. 11 (1997): 1415-1419. This test takes approximately 20 minutes to administer. Appelbaum, "Assessment of Patients' Competence to Consent to Treatment," see note 5 above, 1837.

8. L.H. Roth et al., "The Dilemma of Denial in the Assessment of Competency to Refuse Treatment," *American Journal of Psychiatry* 139, no. 7 (July 1982): 910-3. (Appelbaum is the second author listed.)

9. *Ibid.*, 912.

10. *Ibid.*

11. *Ibid.*

12. *Ibid.*, 912.

13., *Ibid.*, 913.

14. *Ibid.*, 912.

15. When clinicians assess capacity, we are pursuing the best for patients. These patients may experience us as their adversaries, as when we examine patients for forensic purposes. When we examine patients for forensic purposes, we should warn them that we are working for the state, not for them.

16. "I am still me in psychosis. . . . I can't divide myself into the ableist Sick Me and Healthy Me, or Sick Me and Real Me." S. Antonetta, "Even When I'm Psychotic, I'm Still Me," *New York Times* (21 February 2020). I'd like to thank Norman Quist for this reference.

17. This case is reported in *In re Harris*, 477 A 2d 724 (DC 1984). For a discussion of this case, see V. Cohn, "DC Expands the Right to Refuse Treatment," *Washington Post*, 22 August 1989.

18. J. Halpern, *From Detached Concern to Empathy* (New York: Oxford University Press), 2001, 111, discussed in E.G. Howe, "The Edge-of-the-Field of Clinical Ethics Now, After 30 Years: Does Research Ethics Show Us the Way?" *The Journal of Clinical Ethics* 30, no. 1 (Spring 2019): 3-16, 5-6.

19. V.J. Iyer, D.G. Finch, and C.O. Kalu, "Unlocking the Locked-In Syndrome: Capacity Evaluation and a Multidisciplinary Approach to Care," *Psychiatric Annals* 48, no. 9 (September 2018): 448-51.

20. ". . . using neurophysiological and functional neuroimaging approaches, clinicians are able to record residual brain network connectivity that is sustaining a covert awareness." R.S. Calabrò et al., "The Right to Die in Chronic Disorders of Consciousness: Can We Avoid the Slippery Slope Argument?" *Innovations in Clinical Neuroscience* 13, no. 11-12 (November-December 2016): 12-24.

21. See Palmer and Harmelle, "Assessment of

Healthcare Decision-Making Capacity,” see note 7 above.

22. The question of when we should respect patients’ prior request, rather than their most recent request, is at the core of so-called Ulysses contracts, in which patients indicate in advance that they want us to do what they said they wanted earlier on, even if they have changed their mind. See, e.g., R. Spellecy, “Reviving Ulysses Contracts,” *Kennedy Institute of Ethics Journal* 13, no. 4 (December 2003):373-92.

23. P.S. Appelbaum, “Ought We to Require Emotional Capacity as Part of Decisional Competence?” *Kennedy Institute of Ethics Journal* 8, no. 4 (December 1998): 377-387.

24. P.S. Appelbaum, et al., “Competence of Depressed Patients for Consent to Research,” *American Journal of Psychiatry* 156, no. 9 (1999): 1380-4.

25. K. Grill, “Shove and Nudge: A Comment on Iserson,” in this issue of *The Journal of Clinical Ethics* 31, no. 1 (Spring 2020).

26. G.S. Owen, W. Martin, and T. Gergel, “Misevaluating the Future: Affective Disorder and Decision-Making Capacity for Treatment—A Temporal Understanding,” *Psychopathy* 51, no. 6 (2018): 371-9.

27. T. Gergel and G.S. Owen, “Fluctuating Capacity and Advance Decision-Making in Bipolar Affective Disorder—Self-Binding Directives and Self-Determination,” *International Journal of Law and Psychiatry* 40 (2015): 92-101, 92.

28. *Ibid.*, 94.

29. A. Khalib, M. Ibrahim, and D. Roe, “Re-building Trust after Physical Restraint During Involuntary Psychiatric Hospitalization,” *Archives of Psychiatric Nursing* 32, no. 3 (June 2018): 457-61.

30. S. Hostiuic, M.C. Rusu, I. Negoii, and E. Drima, “Testing Decision-Making Competency of Schizophrenia Participants in Clinical Trials: A Meta-Analysis and Meta-Regression,” *BioMed Central Psychiatry* 18, no. 1 (5 January 2018): 2. See also B.W. Palmer et al., “Decisional Capacity to Consent to Research among Patients with Bipolar Disorder: Comparison with Schizophrenia Patients and Healthy Subjects,” *Journal of Clinical Psychiatry* 68, no. 5 (2007): 689-96.

31. Mee-Lee presented this approach at an American Psychiatric Association annual meeting some time ago. His talks, “tips,” and other writings are available at https://dhss.delaware.gov/dsamh/files/si2013_tipsforsustainingchange.pdf.

32. R.J. Gurrera et al., “Cognitive Performance Predicts Treatment Decisional Abilities in Mild to Moderate Dementia,” *Neurology* 66, no. 9 (2006): 1367-72.

33. C.D. Patrode et al., “Screening for Cognitive Impairment in Older Adults: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force,” *Journal of the American Medical Association* 323, no. 8 (February 2020): 764-785. Clinicians may, though, by being maximally supportive, help patients gain greater capacity. Y. Zhang, G. Zhang, and B. Liu, “Investigation of the Influence of Emotions on Working Memory Capacity Using ERP and ERSP,”

Neuroscience 357 (15 August 2017): 338-348.

34. Between 2001 and 2006, of 546 service members with combat-related amputations, 127 had a traumatic brain injury (TBI). A.J. Rauh et al., “Effect of Traumatic Brain Injury among U.S. Service Members with Amputation,” *Journal of Rehabilitation Research and Development* 50, no. 2 (2013): 161-72.

35. A.L. Clark et al., “Blast-Exposed Veterans with Mild Traumatic Brain Injury Show Greater Frontal and Poorer Executive Functioning,” *Frontiers in Neurology* 9 (November 2018): 873.

36. R. Abutarbush et al., “Exposure to Blast Overpressure Impairs Cerebral Microvascular Responses and Alters Vascular and Astrocytic Structure,” *Journal of Neurotrauma* 36, no. 22 (2019): 3138-57.

37. G.A. Elder, “Update on TBI and Cognitive Impairment in Military Veterans,” *Current Neurology and Neuroscience Reports* 15, no. 10 (2015): 68.

38. The choices offered to patients should, to the degree possible, be individualized. For a paradigmatic example of this, see L. Resnik, S. Klinger, A. Gill, and S.E. Biester, “Feminine Identity and Functional Benefits Are Key Factors in Women’s Decision Making about Upper Limb Prostheses: A Case Series,” *Disability and Rehabilitation: Assistive Technology* 14, no. 2 (February 2019): 194-208.

39. R.M. Guerin, “On Transference in Ethics Facilitation: Recognizing and Working through the Past in Surrogate Decision Making,” in this issue of *The Journal of Clinical Ethics* 31, no. 1 (Spring 2020).

40. B. Bird, *Talking with Patients*, 2nd ed. (Philadelphia, Pa.: J.B. Lippincott, 1973), 20.

41. K.V. Iserson, “Do You Believe in Magic? Shove, Don’t Nudge: Advising Patients at the Bedside,” in this issue of *The Journal of Clinical Ethics* 31, no. 1 (Spring 2020).

42. D.M. Hausman, “The Paradoxes of Respectful Guidance: A Comment on Kenneth V. Iserson, ‘Do You Believe in Magic? Shove, Don’t Nudge, Advising Patients at the Bedside,’” in this issue of *The Journal of Clinical Ethics* 31, no. 1 (Spring 2020).

43. I. Hargraves, V.M. Montori, and J.C. Tilburt, “*Curare Aude*—Caring for Patients, with Them,” in this issue of *The Journal of Clinical Ethics* 31, no. 1 (Spring 2020).

44. D.W. Alexander, “Moral Injury and the Ethics of Care,” lecture at the Uniformed Services University of the Health Sciences, Bethesda, Md., 20 February 2020.

45. *Ibid.*

46. C.I. Wade, personal communication with the author, 25 February 2020.

47. Alexander, “Moral Injury and the Ethics of Care,” see note 42 above.

48. S.F. Hague and A. D’Souza, “Motivational Interviewing: The RULES, PACE, and OARS,” *Current Psychiatry* 18, no. 1 (January 2019): 27-8, 28.

49. A.L. Stewart, J.A. Bourgeois, and K.A. Sheehan, “Understanding the Breadth and Depth of C-L Psychiatry: Decisional Capacity Assessments,” *Psychiatric News* 55, no. 3 (7 February 2020): 15, 20.