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# Proxy Consent by a Physician When a Patient's Capacity Is Equivocal: Respecting a Patient's Autonomy by Overriding the Patient's Ostensible Treatment Preferences

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## ABSTRACT

Respect for patients' autonomy has taken a central place in the practice of medicine. Received wisdom holds that respect for autonomy allows overriding a patient's treatment preferences only if the patient has been found to lack capacity. This understanding of respect for autonomy requires a dichotomous approach to assessing capacity, whereby a patient must be found either to have full capacity to make some particular treatment decision or must be found to lack capacity to make that decision. However, clinical reality is more complicated, and, in borderline cases, different physicians may arrive at disparate judgments of capacity. In such cases, when

capacity-determination protocols fail to achieve consensus, physicians would benefit from guidance regarding the clinical decision-making process necessary to elucidate the most ethically sound course of action. This article considers one such case and argues that, in a limited number of cases, respect for autonomy may require overriding a patient's stated treatment preference when a capacity determination is equivocal, even though the patient has not clearly demonstrated a lack of capacity.

## INTRODUCTION

Respect for patients' autonomy requires honoring their healthcare preferences. Received wisdom holds that these preferences can be overridden only if patients have been found to lack capacity. We will argue, *contra* the received view, that in a limited range of cases physicians best respect patients' autonomy by overriding treatment preferences *even though* the patients have not definitively demonstrated a lack of capacity.

## BACKGROUND

*Principlism* holds that a physician's moral responsibilities are determined by the appropriate balance of four (potentially competing) moral principles: respect for autonomy, beneficence, nonmaleficence, and justice.<sup>1</sup> Although ortho-

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doxy holds that each of the principles carries equal weight,<sup>2</sup> respect for autonomy has become *de facto* “first among equals.”<sup>3</sup>

*Autonomy* requires that one be “free from both controlling interference by others and limitations that prevent meaningful choice. . . .”<sup>4</sup> Lack of decision-making capacity is one type of limitation that can “prevent meaningful choice.” Capacity “includes the ability to: 1. Receive information 2. Process and understand information 3. Deliberate [and] 4. Make, articulate, and defend choices.”<sup>5</sup>

*Capacity* is not an absolute property that applies across all decisions. Rather, an individual may have capacity to make some healthcare decisions but lack capacity to make others: “DMC [decision-making capacity] is a dynamic, task-specific, and changing talent . . . pertaining to the particular health care decisions at hand. Often, impairment is situational; the same patient may be competent for one decision and not another.”<sup>6</sup>

When a patient lacks capacity to make some healthcare decision, the decision should be made by an informed proxy.<sup>7</sup> Ideally, a patient’s family member or guardian will serve as proxy decision maker. However, if neither are available and the need for intervention is urgent, the treating physician may provide proxy consent using the *best interest standard*. The best interest standard justifies proxy consent when a medical intervention would be in a patient’s best interest and the patient lacks capacity to make her or his own autonomous healthcare decisions.<sup>8</sup>

It is generally thought that proxy consent is only permissible when a patient has been found to lack capacity. For this reason, it is important to accurately determine whether a patient has capacity to make a particular healthcare decision.<sup>9</sup> An attending physician generally makes this determination using a semistructured interview containing open-ended questions.<sup>10</sup> In equivocal cases, a psychiatry consult is warranted.<sup>11</sup> Neither the literature nor our local hospital protocols offer recommendations for how to proceed if a capacity determination remains equivocal after following these procedures.

We will argue that, in a limited number of cases in which the determination of capacity is equivocal, physicians may actually best respect a patient’s autonomy by overriding the patient’s stated treatment preferences. Our discussion focuses on the following anonymized case study,

drawn from an attending physician’s (CWA’s) experience at an urban tertiary care hospital.

### CASE STUDY

Frank, a man in his mid-40s, presented to the emergency department (ED) complaining of difficulty breathing. Although no healthcare records were available, Frank informed hospital staff that he had HIV/AIDS and was not currently receiving antiretroviral or antibiotic prophylactic treatment. His vital signs demonstrated profound hypoxia and he immediately required substantial supplemental oxygen (100 percent oxygen delivered by face mask). Chest radiography was consistent with pneumonia. It was judged likely that Frank’s low oxygen levels were caused by an infection that was potentially curable with antimicrobial medications. All of the physicians involved in his initial care recommended that Frank undergo urgent endotracheal intubation and mechanical ventilation to improve his chances of surviving long enough for antimicrobials to cure the infection. Frank did not decline supplemental oxygen or antimicrobial medications, but he refused intubation and mechanical ventilation. With some reservations, the initial the ED physicians judged that Frank had capacity to refuse intubation. The ED team therefore anticipated a course of limited care and sought admission to a general medicine floor rather than an intensive care unit (ICU) equipped to care for ventilated patients.

When interviewed by the general medicine admitting team, Frank intermittently removed his oxygen mask, causing his oxygen levels to drop into the seventies, a level that can cause confusion and can be imminently life threatening. While Frank was able to repeat the different therapeutic choices available to him, his refusal of intubation was at odds with his other stated preferences: despite refusing intubation and expressing an understanding that he would likely die if he was not intubated, Frank also expressed a desire to live and a desire to “see the sun again.” Perhaps unsurprisingly given his critical illness, Frank’s engagement with the general medicine team was intermittent.

Following the team’s evaluation, the general medicine attending judged, with some hesitation, that Frank lacked capacity to refuse intubation and mechanical ventilation. The general medicine team discussed this concern with the ED team. The two teams acknowledged that de-

termining capacity in this patient was challenging; given the different determinations reached by the two teams and the stakes of the intubation decision, the ED and the general medicine teams agreed to consult psychiatry to solicit a definitive opinion regarding Frank's capacity. However, when the psychiatry team arrived, Frank did not participate in their evaluation, and thus the psychiatry team stated that they could not draw any conclusion regarding whether he had capacity to refuse intubation or not. The general medicine team did not have the procedural skills to intubate Frank themselves, and the ED team, who were qualified to intubate, believed Frank had autonomously declined intubation, and thus refused to assist with intubation. Frank did not undergo intubation. He underwent admission to general medicine and died shortly thereafter.

Given the failure of the usual capacity assessment protocol to reach a clear judgment regarding Frank's capacity, and given the urgency and the high stakes of the case, the teams might have best honored their shared commitment to respect Frank's autonomy by overriding his expressed (but not clearly capacitated) refusal and intubating him. The remainder of this article will build a theoretical justification of this position that has broader implications for thinking about capacity.

### THE SLIDING SCALE AND EQUIVOCAL CAPACITY

Frank's final visit to the hospital gives rise to a range of ethical concerns. The central question is: Should Frank have undergone intubation? Although there was disagreement between the ED team and the general medicine team, the authors are of the opinion that the answer to this question is an unequivocal "Yes."

It is widely accepted that the standards for capacity vary depending on the implications of the decision being made.<sup>12</sup> For example, greater evidence of capacity should be required for a patient who expresses a wish to forego a life-saving treatment than for a patient who expresses a wish to not take analgesic ibuprofen. This view, that the standards for capacity vary dependent on the implications of a treatment decision, is known as *the sliding scale* account of capacity.

The sliding scale account of capacity is generally justified by a trade-off between the prin-

ciples of autonomy and beneficence.<sup>13</sup> As the potential harm of a treatment decision increases, the principle of beneficence becomes increasingly salient. As the principle of beneficence becomes increasingly salient, the principle of autonomy must similarly gain stature if it is to trump beneficence. Thus, the greater the potential harm of a treatment decision, the more demanding the standards for evidence of capacity.

The application of the sliding scale to Frank's case seems relatively straightforward. Frank's stated desire is to forego intubation. In the case at hand, not only is intubation likely to be short lived, but also, deciding not to undergo intubation is tantamount to deciding to die. Thus, in order to be capacitated to refuse intubation, a sliding scale demands significant evidence of Frank's capacity. Yet the available evidence is equivocal. It is thus plausible that Frank has failed to adequately demonstrate the level of capacity required to refuse lifesaving treatment. The application of the sliding scale to the case at hand appears to yield the result that Frank lacks capacity to refuse treatment and should thus have undergone intubation.

The authors are sympathetic with this analysis of Frank's case. Indeed, in attempting to convince the ED team to intubate Frank, the general medicine team highlighted the above considerations. The ED team remained unmoved.

At one level it is attractive to hold that Frank's death was the result of nothing more than an inaccurate judgment on the part of the ED team. The ED team wrongly judged that Frank was competent; had they made the correct assessment of Frank's capacity, he would still be alive. Yet ethics is fundamentally about reasons for action. If all that can be said is that the ED team made an inaccurate assessment of Frank's capacity, we are left without any additional tools for navigating similar cases in the future. We should thus demand that clinical ethics do more than answer the question: Should Frank have undergone intubation? An adequate clinical ethics should further provide guidance for careproviders who find themselves in cases relevantly similar to our case study.

There is voluminous literature on (1) how to determine if a patient has capacity and (2) appropriate clinical behavior when a patient lacks capacity. Shared throughout this literature is the implicit assumption that the totality of evidence will indicate that a patient either does or does not have capacity. The conversations

about Frank's capacity were constrained by this implicit assumption. The central question considered by the involved parties was: Does the evidence clearly indicate that Frank has the capacity to refuse intubation? However, there is a third option. The evidence may be equivocal. It may be that, even after taking the sliding scale into account, the evidence neither clearly indicates that Frank has capacity nor clearly indicates that Frank lacks capacity.

Cases in which the evidence for capacity is equivocal are unavoidable. Evidence for capacity falls on a spectrum, with clear evidence for capacity at one end and clear evidence for lack of capacity at the other end. In between these ends of the spectrum are cases in which there is some evidence for capacity and some evidence for lack of capacity. At the middle point of the spectrum the evidence is entirely indeterminate, giving one neither reason to believe that a patient has capacity nor reason to believe that a patient lacks capacity. The application of the sliding scale does not fundamentally change this analysis. By the lights of the sliding scale, the requirements for capacity change concomitant with the seriousness of the consequences of any given decision. The sliding scale will thus move where the bar for capacity falls on the spectrum. Yet wherever on the spectrum one sets the bar for capacity, evidence for capacity will still fall on a spectrum and, consequently, there will still be cases in which the totality of evidence remains equivocal.

While evidence for capacity may fall on a spectrum, intervention decisions are binary: either patients will undergo an intervention, or they will not. For pragmatic reasons, it may thus seem important to take a binary approach to assessing capacity. If Frank has capacity to refuse treatment, he should not be intubated and will, consequently, die. By contrast, if Frank lacks capacity to refuse treatment, he should be intubated, and will likely live. These are high-stakes decisions and there is no middle ground. Given that, medically, there is no intermediate position, it seems that our judgments about capacity must also admit of no degrees.

A *prima facie* clinical challenge is presented by the fact that evidence of capacity falls on a spectrum whereas intervention decisions are binary. This clinical challenge is resolved by holding that, in cases in which evidence regarding a patient's capacity is inconclusive, in deference to the patient's autonomy, the patient

should be presumed to possess capacity.<sup>14</sup> This presumption allows a binary approach to determining capacity. Cases in which capacity is equivocal are treated like cases in which a patient has clearly demonstrated capacity.

There are two distinct reasons to treat cases of equivocal capacity as instances in which a patient has capacity. First, decisions regarding interventions are binary; the patient either will or will not undergo the intervention. The received view provides a protocol for making binary decisions in instances when it is unclear whether a patient has capacity. Second, treating cases of equivocal capacity as instances in which a patient is clearly capacitated respects the patient's autonomy by shielding the patient from undue interference by physicians in the decision-making procedure.

Given that these distinct rationales support treating cases in which evidence for capacity is equivocal as instances in which a patient has capacity, under what conditions should we reconsider our approach to equivocal capacity? The binary demands of clinical decision making and the moral imperative to respect patients' autonomy are both nonnegotiable. It nonetheless remains unclear whether current practice regarding equivocal capacity best meets these two criteria. We should reconsider our approach to equivocal capacity if there is some other approach that (1) supports a binary approach to clinical decision making and (2) better respects patients' autonomy.

For the remainder of the article we will assume that clinical evaluations of Frank's capacity were equivocal. That is, we will assume that clinical evaluations of Frank's capacity give us no more reason to believe that Frank has capacity than they give us reason to believe that Frank lacks capacity. As noted in our discussion of the sliding scale of capacity, we do not believe that this assumption reflects the clinical reality. Nevertheless, there are good reasons for making this assumption. Although perhaps not theoretically accurate, in Frank's case this assumption fits the *de facto* clinical reality. The ED team was not responsive to the evidence that indicated Frank's lack of capacity. Although at the theoretical level it may be adequate to note that the ED team made a mistake and incorrectly judged that Frank had capacity, at the clinical level something actionable was required. The extensive literature on capacity nearly exclusively focuses on two issues: (1) how to determine whether a patient has

capacity and (2) the ethical implications of a determination of capacity or its absence. This leaves unaddressed cases in which evidence for capacity is equivocal. Consequently, when Frank's physicians could not achieve consensus regarding Frank's capacity, there were no further avenues for discussion. Had the bioethicists' approach to capacity facilitated discussions regarding how to approach cases of equivocal capacity, the general medicine team and the ED team could have had these conversations and, consequently, Frank might still be alive.

In cases of equivocal capacity, standard practice would have us treat patients as if they had capacity. We will consider another approach. Having assumed that the evidence regarding Frank's capacity was equivocal, we will ask two distinct questions. First we will ask, "What was the magnitude of threat to Frank's autonomy posed by each intervention decision?" Second we will ask, "What was the likelihood that each intervention decision would have infringed on Frank's autonomy?" Once we have answers to each of these questions, we will show that the answers to these two questions can inform binary clinical decision making. We will further argue that, rather than treating Frank as if he clearly had capacity, Frank's physicians would have best respected his autonomy had their decisions regarding his care been guided by the answers to these two questions.

#### **THE CASE FOR RESPECTING FRANK'S AUTONOMY BY OVERRIDING HIS TREATMENT PREFERENCE**

##### **The Magnitude of the Harm of Overriding Frank's Treatment Preference**

What were the implications of overriding Frank's expressed desire not to undergo mechanical ventilation? Assuming that Frank had the capacity to refuse treatment, overriding his stated treatment preference would have been a violation of Frank's autonomy. Nevertheless, while it is important not to understate this harm, it is also important not to overstate it. While some intubated patients may remain on life support indefinitely,<sup>15</sup> Frank's relative youth and the treatable nature of his acute illness made it very likely that he would have only remained on mechanical ventilation for a short period of time. Furthermore, even if his physicians had determined that it would have been in Frank's best

interest to remain on life support for a longer period of time, mechanical ventilation might have reversed Frank's low blood oxygen level, thus potentially restoring his full capacity and allowing him to decide for himself, clearly and without ambiguity, whether to continue life support. Consequently, although intubation risks infringed on Frank's autonomy, the magnitude of the threat was relatively small, as the intervention was likely to be short-lived and could have been reversed if Frank had clearly regained capacity.

##### **The Magnitude of the Harm of Respecting Frank's Treatment Preference**

Assuming Frank lacked capacity, a refusal to override his treatment preference would have constituted a violation of his autonomy. If patients lack capacity to make their own healthcare decisions, these decisions should be made by an informed proxy. Consequently, on the assumption that Frank lacked capacity to refuse treatment, failure to allow a proxy to make his healthcare decisions constituted a violation of established procedures for protecting a patient's autonomy and well-being.

More importantly, the failure to intubate Frank resulted in his death. In addition to preserving present autonomy, protection of future autonomy is an important consideration when making healthcare decisions.<sup>16</sup> Death deprives patients of the opportunity for any future decisions, preventing them from ever exercising their autonomy again. If Frank lacked capacity to refuse intubation, respecting his stated treatment preference was tantamount to denying Frank any future opportunity to make autonomous decisions. Refusing to intubate Frank threatened his immediate autonomy by denying him the opportunity to have his decision made by an informed proxy. More importantly, it further posed a significant and long-term threat to his autonomy by effectively preventing him from making any future decisions.

##### **Probability of Capacity**

In addition to considering the magnitude of potential harm to Frank's autonomy, we must further consider the likelihood of these harms occurring. If Frank made the informed and capacitated decision to refuse intubation, then we should not consider his subsequent death an

infringement on his autonomy. Similarly, if Frank lacked capacity to refuse intubation, then we should not consider forced intubation an infringement on his autonomy. Thus, in considering the likelihood of the above harms occurring, we must consider the likelihood that Frank had capacity.

Thus far, we have assumed that clinical evidence regarding Frank's capacity was perfectly equivocal, providing equally good support to the hypothesis that Frank had capacity and to the hypothesis that he lacked capacity. In the following discussion, we continue to accept this assumption. However, in instances when the totality of clinical evidence does not clearly indicate capacity or its absence, theoretical considerations may nonetheless slightly favor one hypothesis over the other. Such theoretical considerations do not constitute grounds for an all-things-considered judgment regarding Frank's capacity. An informed judgment regarding capacity must be made on the basis of clinical evidence. Theoretical considerations can, however, marginally shift the totality of the evidence. Thus, if the clinical evidence is perfectly equivocal, theoretical considerations may be able to shift the balance so that, if forced to give odds, we could, for example, give a 51 percent probability (after the application of the sliding scale) to the hypothesis that Frank lacked capacity and a 49 percent probability (after the application of the sliding scale) to the hypothesis that Frank possessed capacity. Such evidential shifts are, as a general rule, too minor to turn an instance of equivocal capacity into a clear instance of capacity (or its absence). These minor evidence shifts can, however, be relevant when asking the question: What is the likelihood that Frank had capacity?

When obtaining informed consent, physicians face a significant theoretical challenge. On one hand, it is essential that physicians provide information adequate for a patient to make an informed decision. On the other hand, pragmatic constraints prevent physicians from providing exhaustive information on every potential benefit and harm of every possible treatment. Thus, obtaining informed consent requires that physicians appropriately balance the informational needs of the patient and the pragmatic demands of practice.<sup>17</sup> Which information must physicians disclose? Informed consent requires that physicians provide all information that a "reasonable person" would want to know.<sup>18</sup>

The reasonable person standard allows physicians to make the (defeasible) assumption that patients are reasonable persons.<sup>19</sup> Given the limited duration of the intervention and the clear benefits of intubation, it seems clear that a reasonable person in Frank's situation would have chosen to undergo intubation and life support. By contrast, Frank refused intubation. This dissonance may mean one of two things: Frank had unarticulated reasons for refusing mechanical ventilation that the average reasonable person lacked or Frank was analogous to the average reasonable person, but, at that time, lacked capacity to make his own healthcare decisions. Frank's refusal of mechanical ventilation was not, by itself, evidence one way or another.<sup>20</sup> There was, however, an additional piece of evidence. Frank had hypoxia, a condition that can hamper decision making. Thus, against the background assumptions that (1) Frank was a reasonable person and (2) the reasonable person in Frank's situation would have chosen intubation, Frank's refusal of a lifesaving treatment, combined with his severe hypoxia, give us reason to suspect that Frank may have lacked capacity.

Given equivocal clinical evidence, no confident judgment regarding Frank's capacity could be made. Nonetheless, theoretical considerations like the above can marginally shift our assessment of the evidence. While the totality of evidence was not sufficient to secure agreement among the physicians involved in his case, theoretical considerations provide some (minor) evidence in favor of the hypothesis that Frank lacked capacity.

### **Respecting Frank's Autonomy**

The fact that the two teams evaluating Frank disagreed on his capacity to make decisions and the fact that the protocol to determine capacity failed to lead to a clear judgment indicates that despite the clinicians' best attempts to honor the theoretical ideal of respecting capacitated treatment decisions, sometimes clinical reality precludes clear determination of capacity. Rather than attempt to force Frank into one capacity category or the other, we have suggested that it may be more helpful for physicians to acknowledge that some cases are ambiguous. In so doing, physicians may more easily accept that there is uncertainty about which course of action Frank would autonomously choose, and thus proceed by considering which option had the

lowest attendant risk of compromising Frank's autonomy.

In considering which option had the lowest attendant risk of compromising Frank's autonomy, we must consider two factors: the magnitude of risk to Frank's autonomy and the probability that these risks might have been realized. First we will consider the question of probability. Although the totality of available evidence might not have permitted a confident judgment regarding capacity, the evidence might have nonetheless marginally favored one hypothesis over the other. In cases of equivocal capacity, we should first ask: Considering all things equally, did the evidence skew in the direction of capacity or lack of capacity?

Although the evidence regarding Frank's capacity to refuse treatment was equivocal, we believe it nonetheless leaned slightly in the direction of Frank's lacking capacity to refuse intubation. Consequently, if the implications for Frank's autonomy were equivalent for the decision to intubate and the decision not to intubate, we ought to have intubated. Under such conditions, the decision to intubate would have maximized the probability of respecting Frank's autonomy.

We must further consider the magnitude of the impact of potential clinical decisions on Frank's autonomy. In this instance, the decision to treat Frank risked a significant violation of Frank's autonomy; however, the magnitude of the harm was mitigated by the likelihood that, if intubated, Frank would shortly have been able to make a clearly capacitated judgment regarding the continuation of mechanical ventilation. By contrast, the decision not to treat Frank posed a dual threat to Frank's autonomy. First, on the assumption that Frank lacked capacity, following his stated preference would have infringed on his autonomy by not giving him the opportunity to have his treatment made by an appropriate proxy. More importantly, because Frank needed intubation to survive, the decision not to intubate led to his death and thereby prohibited Frank from making any future decisions. If Frank having capacity and Frank lacking capacity were both equally probable, his autonomy would have been best respected had he been intubated, as this was the decision with the least attendant risk to Frank's autonomy.

At the outset of this section we argued that the current practice regarding cases of equivocal capacity should be revised if there is some

other option that (1) allows for binary clinical decision making while (2) better respecting patients' autonomy. We have now suggested that, rather than treating cases in which the evidence for a patient's capacity is equivocal in the same way we treat cases in which there is clear evidence for capacity, in equivocal cases we should ask: What best respects the patient's autonomy? In answering this question, we should consider both the probability and magnitude of potential harms to the patient's autonomy. When this approach was applied to Frank's case, we found that both considerations indicated that Frank should have been intubated. Overriding his stated preference and proceeding with intubation would have best respected Frank's autonomy.

In arriving at this conclusion, we have simultaneously demonstrated that the proposed approach to cases in which evidence for capacity is equivocal meets both (1) and (2) above. First, it offers a binary method for clinical decision making. About any given intervention, we can ask: Does this best respect the patient's autonomy (when this is understood to be a question about the probabilities and magnitudes of harms to autonomy)? If the answer is "Yes, this intervention best respects the patient's autonomy," then we have reason to proceed with the intervention. If the answer is "No, this intervention does not best respect the patient's autonomy," then we have reason not to proceed with the intervention.

Second, as we argued in our analysis of Frank's case, this approach to cases of equivocal capacity may better respect patients' autonomy than current practice. If we accept the assumption that evidence for Frank's capacity was equivocal, current practice would have us treat him as if he were clearly capacitated. We have argued that his autonomy would have been better respected had physicians made the intervention decision based on consideration of the probabilities and magnitudes of potential harms to Frank's autonomy.

There is a real possibility that Frank genuinely wished to avoid intubation even at the expense of his life and that he had the capacity to make this decision. In advocating that Frank's stated treatment preferences should have been overridden, it is important to admit the genuine potential for real harm that was associated with intubation. There are, however, very real harms associated with all of the options that

were available. The best we can do is to consider all of the intervention options and form a considered judgment about how to proceed. That said, it merits emphasizing that while we can do no better than to act in line with our best judgments, it is also the case that sometimes our best judgments are wrong.

We have now argued that Frank's autonomy would have been best respected by overriding his stated wishes and proceeding with intubation. This conclusion contrasts with the received understanding of how careproviders ought to approach cases of equivocal capacity. With the aim of prioritizing patients' autonomy, current wisdom holds that patients must *clearly demonstrate a lack of capacity*, as opposed to merely failing to demonstrate capacity, in order for healthcare providers to override their healthcare decisions.<sup>21</sup> Cases like Frank's demonstrate that, in some instances when the evidence for capacity is equivocal, a patient's autonomy may be best respected by overriding the patient's stated treatment preference, even though the patient does not clearly demonstrate a lack of capacity.

### Beyond Frank

We have now argued that Frank's autonomy would have been best respected by intubating him despite his stated (but not clearly capacitated) desire to the contrary. This is an important result because it challenges the current assumption that a patient's autonomy is best respected by treating paradigm cases of capacity and cases of equivocal capacity similarly. Nonetheless, although Frank's case may challenge the received view regarding best practice in cases of equivocal capacity, significant theoretical and empirical work remains to be done to develop new clinical protocols to guide healthcare providers in cases of equivocal capacity.

The lessons of Frank's case are likely to apply to a variety of cases in which capacity is equivocal and some or all of the following conditions are met:

- The nonpreferred healthcare decision involves an acute intervention or can be easily reversed;
- The preferred healthcare decision would considerably and irreversibly restrict the patient's future autonomy;
- The patient's healthcare decision is contrary to what a reasonable person would choose;
- The patient has an acute condition that has

the potential to impair cognitive function, for example, hypoxia, septic shock, bacterial meningitis, severe hyponatremia, or hepatic encephalopathy;

- Healthcare providers do not have access to an advance directive or other evidence of the patient's treatment preference when the patient was capacitated.

Future work should (1) further develop and systematize a list of clinical considerations that are relevant to respecting patients' autonomy when evidence for the patient's capacity is equivocal, as well as (2) attempt to develop protocols for weighing the relevance of each of the above considerations when deciding what best respects a patient's autonomy.

### OPENING THE DOOR TO PARENTALISM?

Contemporary medical ethics is, rightly, characterized by a strong antiparentalist bent. Parentalism is a perennial concern any time there is discussion of healthcare providers overriding a patient's stated treatment preferences. Is the preceding discussion problematically parentalistic?

There are at least two ways in which our proposal could be problematically parentalistic. By failing to put appropriate emphasis on patients' autonomy, it could be problematically parentalistic at the theoretical level. Alternatively, the proposal could be theoretically unproblematic, but could be problematic because, at the level of application, it undermines safeguards against parentalism. We will consider each concern in turn.

We have argued that, in some cases when a lack of capacity has not been demonstrated, a patient's autonomy is best respected by overriding the patient's stated treatment preference. By making the autonomy of the patient the central value, our argument is, at least at the theoretical level, antiparentalist. There should thus be no concern that, at the theoretical level, our proposal is problematically parentalistic.

There is, however, room for concern that we are opening the door to parentalism at the practical level. Safeguarding the autonomy of patients while also valuing their well-being requires striking a careful balance between the authority of physicians and the power of patients to make their own decisions. One may be concerned that, in allowing healthcare providers to

override the preferences of a patient in the absence of a demonstrated lack of capacity, one shifts this balance too far in the direction of physicians' authority.

While this concern is well taken, it is unlikely to be relevant to the kinds of cases under consideration, that is, cases in which the evidence for a patient's autonomy is equivocal. To see why, reconsider the ED team's decision that Frank possessed capacity to refuse intubation. Note that there was effectively nothing, from an administrative or enforcement perspective, that would have prevented the ED team from making the opposite determination. A few words written in Frank's chart was all it would have taken for the ED team to justify the finding that Frank lacked capacity. In cases when a patient's capacity is equivocal, power already lies almost entirely with the physician. Consequently, there should be little concern that, at the level of application, our proposal is problematically parentalistic. In the relevant cases, at the practical level, physicians already possess all of the power. Consequently, once it has been judged that evidence regarding a patient's capacity is equivocal, implementation of our proposal would not further shift power in the direction of the physician.

There is, however, room for further concern regarding the parentalistic potential of our proposal. We have argued that, in some cases when a patient's autonomy is equivocal, a patient's interests are best respected by overriding her or his stated but not clearly capacitated treatment preferences. On the assumption that we can correctly identify cases in which the evidence for capacity is equivocal, there is no reason at either the theoretical or practical level to be concerned that our proposal is problematically parentalistic. We should not, however, take a blasé attitude toward the assumption that we can correctly identify cases in which the evidence for capacity is equivocal. If cases of clear capacity are treated as instances of equivocal capacity, implementation of our proposal could lead to deeply problematic parentalistic practices.

In order to guard against parentalism, some method is needed to determine when evidence for capacity is truly equivocal. Developing such a protocol falls well outside the bounds of this article. It is, however, an essential step in moving from consideration of Frank's case to providing generalized clinical recommendations. We thus endorse caution. If a protocol can be

developed that allows physicians to readily identify cases in which evidence for capacity is truly equivocal, respecting patients' autonomy likely requires a revision to current practice. If, however, no such protocol can be developed, it may be best to settle with the *status quo*.

## CONCLUSION

Failure to demonstrate a patient's decisional capacity is not generally thought to be sufficient to permissibly override a patient's healthcare preferences. Instead, the ethical justification for overriding a patient's refusal of an intervention relies on the patient clearly demonstrating a lack of capacity. Drawing on a case study, we have argued that this binary view fails to capture the complexity of determining a patient's capacity in challenging cases when the determination of a patient's capacity is equivocal. Furthermore, we have argued that by relying on an over-simplified binary view of capacity, it is possible to undermine a patient's autonomy by respecting the patient's preferences when the capacity underlying those preferences is equivocal. We suggest that in such equivocal cases, physicians can acknowledge the uncertainty of a patient's capacity and strive to implement the treatment option that poses the least overall risk to the patient's autonomy. In at least some cases, respecting patients' autonomy may require overriding their stated but not clearly capacitated healthcare preferences, even though the patients did not clearly demonstrate a lack of capacity.

## BLINDING OF THE CASE

Some elements of the case have been altered to protect the identity of the patient.

## NOTES

1. T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2012).

2. *Ibid.*

3. R. Gillon, "Ethics Needs Principles—Four Can Encompass the Rest—and Respect for Autonomy Should Be 'First among Equals,'" *Journal of Medical Ethics* 29, no. 5 (2003): 307-12.

4. Beauchamp and Childress, *Principles of Biomedical Ethics*, see note 1 above, p. 58.

5. G.L. Larkin, C.A. Marco, and J.T. Abbott, "Emergency Determination of Decision-Making Capacity: Balancing Autonomy and Beneficence in the Emergency Department," *Academic Emergency Medi-*

*cine* 8, no. 3 (2001): 282-4, 282.

6. *Ibid.*, 282; J.P. Demarco, "Competence and Paternalism," *Bioethics* 16, no. 3 (2002): 231-45; L. Ganzini et al., "Ten Myths about Decision-Making Capacity," *Journal of the American Medical Directors Association* 5, no. 4 (2004): 263-7.

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