COMPETENCE AND PATERNALISM

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ABSTRACT

Some bioethicists have argued in favor of a sliding scale notion of competence, paternalistically requiring greater competence in relation to more significant risk. I argue against a sliding scale notion, taking issue with the positions of Allen E. Buchanan and Dan W. Brock, Ian Wilkes, and Joel Feinberg. Rejecting arguments that a sliding scale is supported by legal cases, by ordinary usage, and by fallible judgments about competence, I argue in favor of greater evidence of competence when risk is greater. Two clinical cases are examined, both involving amputation, to show that my fixed concept of competence, with a requirement of clearer evidence of competence when risk is high, better accounts for good moral decisions in bioethics.

A competent, informed, non-coerced patient is widely thought to have the right to refuse treatment. Assuming information and non-coercion, competence overrides well being. While this primacy of autonomy over beneficence strikes some as extreme, it is a fact of life in bioethics, the law, and at least in official medical treatment in many countries. However, a proposal by Allen E. Buchanan and Dan W. Brock, in their work, Deciding for Others: The Ethics of Surrogate Decision Making, weakens this priority by incorporating paternalism into the definition of ‘competence’. Paternalism is most appealing in those cases in which a patient’s decision puts her or him at high risk. If ‘competence’ is defined

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in a way that is functionally related to risk, then well being may be protected while apparently allowing autonomy full sway.\footnote{2}

I will argue that including risk in the definition of ‘competence’, or even raising the standard of competence due to risk, is a fundamental mistake that obscures proper decision making in bioethics. I examine Buchanan and Brock’s proposal and its best support – that it accords with court decisions, that it takes account of ordinary judgments about competence, that it deals best with fallibilist concerns – and show why all of these fail to convince. Nevertheless, I show that risk and uncertainty may require raising the evidence of competence. While the discussion on the definitional relation between competence and risk has tended to proceed on an abstract basis, I conclude by exemplifying my position with an examination of two actual medical cases, decided by courts, involving amputation. My attempt is to use abstract examination of a difficult issue to help make a concrete and applicable proposal, one that points to the need for further clinical investigation.

**SLIDING SCALE AND THE LAW**

Brock and Buchanan oppose their notion of competence to one requiring fixed minimal capacity. According to a fixed scale notion, whether a person is competent only relates to decision-making capacities, and not to the nature of the decision.\footnote{3} By contrast, Brock and Buchanan maintain that competence is ‘a relational property determined by a variable standard. Whether a person is competent to make a given decision depends not only upon that person’s own capacities but also upon certain features of the decision itself including risk and information requirements’.\footnote{4}

This notion of competence is related to the common sense claim that competence is determined in relation to a particular task.\footnote{5} A person may be competent to multiply and divide but not

\footnote{2} Buchanan and Brock’s position, conflating competence and risk, lacks initial intuitive appeal; its main attraction is that it protects well being. But their case is strengthened by Ian Wilks’s argument, appearing in *Bioethics*, that inclusion of risk fits well with an ordinary notion of competence. They are aided, too, by providing an alternative to Joel Feinberg’s argument that in risky decisions fallibilism dictates a higher standard of competence.

\footnote{3} Ibid., p. 59.

\footnote{4} Ibid., p. 60.

\footnote{5} Ibid., p. 18.
to judge a mathematical proof. Likewise a person may not be competent to understand complex issues involving risk related to medical treatment, but may be competent to judge easier cases. Complexity of medical treatment in relation to risk is not the issue under consideration. Brock and Buchanan also demand a higher standard of competence for decisions involving greater risk, even if risk factors are not difficult to understand.6

They claim that perhaps the most important defense of their risk related conception is that it coheres well with the law.7 Courts in the United States do not permit paternalistic interference with a voluntary choice made by a competent patient.8 So by adding risk as part of the definition of ‘competence’, Buchanan and Brock want, so to speak, to have their cake and eat it too. Raising the standard when risks are high tends to paternalistically protect patients, yet since this is built into the definition, they claim that it adheres to legal abhorrence of paternalistically interfering with competent decisions.9

Despite their claims, by incorporating paternalism their definition loses what they claim is its best support – that it coheres with the law’s rejection of paternalism. They seem to believe that by building paternalism into the concept, they can, in effect, subvert the law’s intention, and thus bring in a protection by a technicality that they believe is much needed.

In a law journal review of U.S. court decisions on competence10 by Jessica Wilen Berg, Thomas Grisso and Paul S. Applebaum, no mention is made of court decisions using risk as part of the standard. Furthermore, these authors mainly support a single standard, because such a standard is easier to apply consistently, and does not as easily permit manipulation by construing a case as high risk.11

The legal right of competent persons to make harmful decisions is well recognized. That decision is about accepting risk and stands separate from the risk accepted. Building risk into the concept tends to take away that ability to accept or judge potential harm. The law rejects paternalism, so the level of risk, a paternalistic consideration, should not be part of the issue about

6 Ibid., p. 60.
7 Ibid., p. 61.
8 Ibid., pp. 60–61.
9 Ibid., p. 62.
11 Ibid., p. 378.
whether a person is competent. So, at least based on the law, what seems to be required is a concept of competence that is risk independent.

Even if their definition coheres well with court decisions, that would not necessarily make it a fit concept. On the other hand, if their appeal to the law does not support their inclusion of risk in the definition of ‘competence’, as I have argued, Brock and Buchanan may still be correct that risk should be a legitimate part of the definition. That is a separate issue, to which we now turn.

ASYMMETRICAL COMPETENCE

A more formidable defense of Buchanan and Brock’s position is that risk is not an independent variable and that it is a simple mistake to separate the two. This may be demonstrated by analogy to other circumstances in which risk is part of the defining feature of competence. Such an argument for incorporating risk is offered by Ian Wilks. He believes that when negative consequences are more likely, an increased importance is typically placed on minimizing the likelihood that those consequences will materialize. Under such circumstances, ‘the more important it is . . . for the task to be performed by someone with a higher level of reliability at the task (in other words, a lower level of errancy)’. In short, being unreliable is reason to think that a person is incompetent.

The question is mainly about physical risk. So Wilks squarely faces this with a contrived example designed to hone in on the relationship between risk and competence.

Consider the difference between performing a high wire act with safety net in place below, and performing the same high wire act with net removed—and yet without the fact of this removal being communicated to the one who walks the rope. It is clear that the physical level of dexterity required for someone to traverse the wire successfully is the same in either case. . . .

13 Ibid., p. 156.
Wilks asks us to consider two walkers, one of whom, let’s call her Alice, is quite gifted and so not affected by the presence or absence of the net. Alice is equally competent to walk in both circumstances. The other, call him Bob, is less skilled. Bob is competent to walk with a net but not without one. Note here that apparently the determination of competency is based on the risk involved, and not on the walker’s lack of skill, which is the same whether or not the net is in place.

This is a case of asymmetrical competence. With the same skill level, an acrobat can be competent to perform in an easier situation but not in a more difficult one. Wilks concludes that it is ‘entirely in accordance with correct usage to describe this as a case where the acrobat is competent to walk the line in the second instance [with the net] but not in the first’.¹⁵ Competence, he argues, depends on risk.

Gita S. Cale¹⁶ rejects his view, claiming that Wilks incorporates value standards. Wilks responds that value judgments are unavoidable, that standards of performance are typically normative, and that standards tend to involve evaluation of outcomes.¹⁷ But Wilks’s reply masks the use of values in his example. Standards are used in two ways: one is that we judge Bob to be a relatively poor acrobat. To be sure, this involves values: he falls too much, is not graceful, and so on. These are normative. And note that incompetence in relation to these values is assumed in the example. Another value is introduced, one that is used to judge Bob’s established level of competence as an acrobat. This standard has to do with safety. Bob’s already established competence is judged too low to allow him to walk without a net. He is not competent enough to perform safely. This judgment is about the fact that he might be seriously harmed if he walks. That is an added paternalistic value that demands a higher level of competence; it is not part of the determination of the level of Bob’s tightrope walking competence.

The example is as persuasive as it is because many people would readily assent to such paternalistic interference with poor Bob who, after all, does not know in Wilks’s example that there will be no net. Furthermore, safety standards are used as reasons to prevent people from doing many things when they are not

¹⁵ Wilks, op. cit. note 12, p. 156.
fully competent or even regardless of competence levels. \footnote{In Assessing Competence to Consent to Treatment: A guide for Physicians and Other Health Professionals (1998. Oxford. Oxford University Press: 13) Thomas Grisso and Paul S. Appelbaum point out that in many cases with a high risk of harm, social policy is employed to override competent individual decision making, such as in mandated use of seat belts. But they quickly add that this is not the case in heath care.}

Socially, we often accept such paternalistic interference. Many people would judge that Bob’s desire to walk the tightrope, even if he were to accept the risk autonomously, is not worth it. If this is the case, then many people believe that this form of paternalism is a justified interference with Bob’s autonomy.

In the case of informed consent to medical treatment, the social judgment seems to be that paternalistic interference, for well-known reasons, is unacceptable. In terms of medical treatment, a competent person is permitted to judge whether risk is acceptable and a paternalistic imposition on that judgment is not legally permitted.

To be persuasively analogous to informed consent in medical cases, the tightrope walking case would have to be about Bob’s determination of whether he should accept the risk. To make a good judgment, he must be competent to decide and would need to know that he isn’t good at tightrope walking. In an appropriately liberal society, it might be up to him to make that determination. But then the question would not be about how he does at rope walking, but about whether he is competent to judge and accept the substantial risk that exists partly because of his incompetent tightrope walking. In this case, paternalism is not built into the notion of competence to make a decision about tight rope walking and gives no support to Buchanan and Brock’s sliding scale that insists on requiring that a patient show a higher level of competence when risk is greater.

THE FALLIBILIST ARGUMENT

While competence and risk are conceptually distinct, it may be that there are good reasons to raise the required level of competence when risks are greater. Joel Feinberg argues that this is so because competence may be difficult to determine, and incorrectly allowing an incompetent person to accept great risk could have disastrous consequences.

Competence is not easy to determine. Its determination involves an examination of communication, understanding, appreciation
(of the fact that circumstances are relevant to oneself), reasoning skills, and a stable value system. These standards are not clear and all involve value judgments. The grandest attempt to operationalize ‘competence’, the MacArthur Treatment of Competence Study, applies relatively arbitrary numbers to each ingredient based on answers to questions, and then suggests that these numbers be given further study.\textsuperscript{19} They are not recommended as ways to override clinical judgment.\textsuperscript{20}

Given that competence is only fallibly determined, some philosophers have claimed that we should compensate by making a standard of competence more rigorous to avoid mistakes that potentially harm patients. Refusing an incompetent person such a choice increases beneficence, avoids harm, and does not violate autonomy. And suppose a person who is incompetent is judged competent, and makes a choice involving great harm, perhaps death. Much is lost. That person, because incompetent, could not decide autonomously, and the choice may have a high probability of leading to serious harm.

It might seem that those who reject Buchanan and Brock’s inclusion of paternalistic concerns in the definition of ‘competence’, can avoid the problem of mistaken determinations of competence by themselves requiring a more rigorous standard of competence when the risk is greater.

The argument is epistemological, not paternalistic, or so Feinberg claims.\textsuperscript{21} Because voluntariness is in many cases difficult to determine, he argues that we should cautiously deal with cases involving great risk. Feinberg insists that this must not be done for paternalistic reasons, but only because of doubts about whether a person has chosen in a truly voluntary fashion.\textsuperscript{22} This argument is similar to the one that claims we can raise the standard when the issues to be decided are more complex. These are claims about competence or about whether competence can be adequately determined, and supposedly not about paternalism.

Buchanan and Brock insist that Feinberg’s epistemological approach fails. They argue that the paternalism which they favor,


\textsuperscript{22} Ibid., p. 119.
not mistaken judgments, is the proper reason behind Feinberg’s claims. Feinberg, they think, misses an important symmetry. Any raising of the standard of competence would reduce ‘a false positive determination of voluntariness, it at the same time would increase the risk of a false negative...’ Based on this symmetry, Buchanan and Brock argue that Feinberg’s appeal cannot be to self-determination alone. That is, without considerations of well being, Feinberg would have no reason to override a decision involving significant harm because doing so would equally risk false negatives (falsely judging that a person is not competent) and false positives (falsely judging that a person is competent), without reason to prefer one to the other. Feinberg worries more about false positives because that would subject such a person to involuntarily accepted risks. Paternalism, Buchanan and Brock claim, is the only acceptable reason for Feinberg’s greater emphasis on false positives.

But Buchanan and Brock avoid a clear statement of the main point. The question is about balancing self-determination with the avoidance of harm. The best way to make the argument against Feinberg is as follows: If we mistakenly apply a given standard of competence, then harm can befall a person. This, of course, is bad. So the level of required competence may be raised to avoid such mistakes. But by raising the level, we symmetrically increase the chance that a voluntary choice is overridden. Since autonomy overrides beneficence, this mistake is more serious, morally speaking. Thus the epistemological point fails.

This way of stating the argument makes it clear that for people who give autonomy priority the consequences of falsely judging a person incompetent should be more serious, morally speaking, than the consequences of a false positive. A false positive judgment that a person is competent may mean terrible harm, but a false negative means a morally reprehensible breach of autonomy. The point that Feinberg is making is that it is more important to avoid serious harm, under such circumstances, than to respect autonomy. Yet this seems to be contrary to his rejection of paternalism.

The question is, can an ethicist who gives autonomy greater weight than nonharm or beneficence judge that a violation of autonomy (given a false negative) is less serious under uncertainty than a false positive? A positive answer must show why the symmetry argument, that by raising the standard of competence false negatives and false positives are likely at a roughly equal rate, does not mean that the standard should not be raised.

23 Buchanan and Brock, p. 45.
The symmetry problem can be effectively addressed. Buchanan and Brock, as well as Feinberg and most bioethicists, including those who give priority to autonomy, agree that nonharm and human welfare are morally important. Assuming this, suppose the level of competence is raised under risky circumstances as Feinberg suggests. Suppose also that false negatives are thereby increased. If the two cases (false positive and false negatives) are genuinely symmetric, and if autonomy takes priority, then Buchanan and Brock would be correct in rejecting Feinberg. But they are not symmetric.

In the final section we shall examine two cases involving decisions about competence and risk, but for now let’s simply imagine a case involving great risk, one where a false positive involves the expectation of serious harm. This is bad. And a false positive means that autonomy is not protected. An incompetent person is not autonomous. So a false positive contributes nothing to autonomy and involves the expectation of great harm. A false negative, on the other hand, avoids harm, and this is good, but it also violates genuine autonomy, which is bad. And the violation of autonomy, according to those, such as Feinberg, who give it priority, more than offsets the harm avoided. Assuming that avoiding harm does have value, as paternalists insist and most of those who support autonomy recognize, that value placed on nonharm partially offsets the violation of autonomy.

This, then, is the asymmetry: A false positive involves no value on the autonomy side (because no autonomous decision was made) but might involve a significant loss of value on the side of well being. A false negative involves significant loss of autonomy, but perhaps a significant gain in well being. Under these circumstances, a false negative may be acceptable to those who give priority to autonomy.

Here is a numerical example offered for the sake of illustration. A false positive is given a zero weight on the autonomy side, because autonomy is neither enhanced nor violated. But a serious harm occurs. This is given a significant negative value, arbitrarily represented by $-10$. A false negative involves a significant and morally more significant negative value due to the violation of autonomy. Since the moral 'harm' involved is great, a number significantly lower is assigned to the violation of autonomy, here $-12$. But the false negative avoids harm; this gets a high positive value, 10. In this example, as the table below indicates, a false positive produces a value of $-10$, while a false negative produces a value of $-2$. 

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False Positive | Autonomy | Harm
---|---|---
0 | | −10
False Negative | −12 | 10

Thus the symmetry argument fails.

These numbers are meant to represent an attempt to weigh moral claims with priority placed on autonomy. In case there is no doubt, autonomy would produce the greater value. But where there is significant doubt, greater expected value might be achieved (depending on circumstances), even by those giving priority to autonomy, by risking a false negative.

As mentioned, this analysis only works for those who assign nonharm a morally significant role in relation to autonomy. But a further proviso is required. One clear advantage to respecting autonomy is that people tend to know best their own value structure, for example, what they are willing to endure, and generally have a good sense of the basis of their own well being. In this way autonomy and nonharm are correlated. So the violation of autonomy may result in significant harm even though well intentioned health care professionals or court officials believe that a given autonomous decision will lead to harm. Of course, if a patient is incompetent, then that correlation of harm and well being is broken. But if the correlation is extremely close or invariable between autonomous choice and harm or well being, then the above analysis fails and symmetry holds. That is, under the assumption of a very close link, virtually every case in which a competent person is judged incompetent will be a case of harm as well as a case of a violation of autonomy, against what was argued above. This would reintroduce the symmetry.

But if the link is less close, so that there is a significant chance that autonomous choice leads to loss of well being, then the symmetry argument fails. The analysis is important because it is reasonable to believe that autonomous people are often mistaken about their own well being, especially when a choice made now leads to enduring loss of function or persistent pain. Keep in mind that the cases we are exploring involve the risk of serious harm and typically the judgment that a patient is making a harmful choice, even in terms of his or her own future well being. But though this is the case, the correlation between autonomous choice and well being appears strong enough to influence the analysis by making it more complex than the above numerical...
example suggests. In making clinical judgments, respect for autonomy involves the recognition that competent patients tend to know best about what harms need to be avoided and those that are acceptable. Since the link does not appear to be invariable, when autonomy is in doubt such issues require careful clinical investigation. While abstract analysis can help to pose problems and suggest solutions (such as the one soon to be offered), unless it is coupled with careful clinical investigation, mistakes are likely.

The argument against symmetry is not intended to permit raising the standard of competence. The reason focuses on the claim that when we know a person is competent, greater moral value is realized by allowing choice. Suppose we allow, in general, the standard of competence to be raised because we want to avoid false positives in risky circumstances. Also suppose we know, or are virtually sure, that in a particular case a person has achieved an adequate level of competence, yet fails to achieve a raised level of competence. Under this circumstance we produce a false negative and achieve lower moral value (at least for those who give priority to autonomy). Raising the standard of competence to avoid mistakes entails violating known competence.

An answer – one that should be acceptable to those favoring autonomy – is to recognize that in very risky circumstances we may legitimately require greater evidence of autonomy. This is indicated by the above table. Given doubts about competence, we may be faced with asymmetric loss of moral value. But as the evidence for competence increases, and doubt decreases, then expected moral cost from false judgments declines. Some level of evidence, given a priority on autonomy, will lead to an acceptable, because low, risk of a false positive. Thus, assuming serious risk, a more rigorous examination may be required in cases involving uncertainty about competence.

TWO CLINICAL CASES

The proposal requiring more evidence in cases involving more serious risk is complex. It involves rejection of paternalism and acceptance of the priority of autonomy. It also supports the requirement of increased evidence when substantial doubt exists about whether a person is competent. But this is dependent on the claim that need for increased evidence depends on the level of expected harm.

This analysis better mirrors actual complexity of judgments about competence than the positions of either Buchanan and Brock or of Feinberg. As such it can provide better guidance for
clinical decision making. This can be shown by two cases involving judgments about competency, both similar in that they involve gangrene and the apparent need for amputation.

In Lane v. Candura \(^{25}\) the Court determined that Mrs. Candura was competent to refuse amputation of her leg due to gangrene in her foot, part of which had been previously removed also due to gangrene. On two separate occasions Mrs. Candura consented to the surgery and later withdrew consent. She did not wish to be an invalid and did not believe that the operation would cure her. Furthermore, she did not fear death. Her train of thought tended to wander, and her sense of time was distorted. Her refusal of consent vacillated and she showed signs of mild mental impairment. So we might find reason to believe that she was not competent. But on the other side, she was well aware of her circumstances and perceptively answered questions. She appreciated the dangers she faced due to her refusal of consent. The Court concluded,

> We find no indication in any of the testimony that that is not a choice with full appreciation of the consequences. The most that is shown is that the decision involves strong emotional factors, that she does not choose to discuss the decision with certain persons, and that occasionally her resolve against giving consent weakens.

In determining competency, the Court found the evidence in favor of competence to be clear. So the probability of a false positive is, in effect, considered low. Even though the risk involved is substantial, overriding autonomy is not acceptable to the Court. In terms of our analysis, the evidence appears clear, though not without question, that Mrs. Candura is competent, and therefore the expected moral gain (for those who place a priority on autonomy) due to the possibility of a false positive is slight.

We turn to a second, much different case, offered by William J. Winslade. \(^{26}\) He was appointed counsel to a Los Angeles court to help determine the competency of Mr. T, who denied that he had gangrene and that his doctors told him that his foot needed to be amputated. Mr. T. believed he had a sore toe, that it was getting better, and that God would take care of him. Also, he concurred with the view that people with gangrene may require

\(^{25}\) 376 N.E.2d 1232.

\(^{26}\) W.J. Winslade. Humanistic Problem Solving: the Case of Mr. T. *The Journal of Clinical Ethics* 1997; 8: 389–397.
amputation in order to live, but he steadfastly rejected the claim that he had gangrene.\textsuperscript{27} In this way, he indicated an absence of appreciation of his medical circumstance, a fact that reduces the chances that he is acting autonomously. Three physicians examined Mr. T. Two thought that he was competent but irrational or depressed. One thought that he was incompetent or demented.\textsuperscript{28}

Mr. T seems to fit well into our table. There is some reason to believe he is competent. He may, for example, be in denial in order to deal better with his own competent rejection of amputation. But he may genuinely lack understanding of his circumstances. Even if there is an equal chance of a false positive and a false negative, opting for amputation produces the expectation of greater moral value on the assumption that the expectation of death is a harm nearly as morally serious as the violation of autonomy.\textsuperscript{29}

The court decided that Mr. T. was not competent, and his foot was amputated. After the amputation, Mr. T. required physical therapy in order to end his confinement to a wheelchair. He refused that therapy.\textsuperscript{30} Assuming that such therapy can be forced, should his refusal be overridden?

Refusal of physical therapy does not involve the same risk as the refusal of amputation. So now the table changes, with a decreased level of harm involved with a false positive. The evidence required in this case may be placed at a low level, perhaps at communication of his refusal to consent. So even if he again showed a 50/50 chance of being incompetent, the decision to respect his possible autonomy may be morally sound.

But this brings to mind the second proviso discussed above. It might be the case that Mr. T. was competent. Under the assumption that the link between competence and well being is not overwhelmingly strong, we may determine that requiring greater evidence of competence is morally satisfactory. But given that there is a link, we may believe that the standard of evidence used was too high. The problem is to determine whether a

\begin{itemize}
\item \textsuperscript{27} Ibid., p. 392.
\item \textsuperscript{28} Ibid., p. 393.
\item \textsuperscript{29} Of course, the more one believes that the violation of autonomy deserves greater consideration, the more one would need to be skeptical or in doubt about Mr. T.’s autonomy. This can be seen by inserting a much higher negative number representing moral harm in our table when a competent person is judged to be incompetent. Our analysis only works when expected harm is given very serious moral consideration.
\item \textsuperscript{30} Ibid., p. 394.
\end{itemize}
mistake about his competence would lead to decreased well being, as is suggested by those who claim a very strong link between autonomy and harm. Providing an answer is difficult because we don’t know whether he was competent. Assuming that in many cases autonomy is violated, the way to explore the issue is by examining several similar cases. In the case of Mr. T. it seems to many that well being was improved and harm avoided by the amputation. So if in similar cases the verdict is similar, then the link would appear less strong and greater evidence of autonomy may be morally acceptable.

Examining cases requires dialogue among clinical investigators about harm done and avoided, well being, and competence. This is especially true when a patient’s expressed wishes are overridden. It is not completely clear, for example, that Mr. T’s well being was improved. If careful investigators conclude that in such cases well being was not improved, then lowering the standard of evidence of competence in similar cases may be morally required.

The discussion of these two cases indicates the concerns and variables that need to be taken into account in making a decision to override the expressed rejection of treatment. (1) The rough probability of competence based on evidence in favor or against it. (2) The extent to which autonomy is given moral weight in relation to beneficence or nonharm. (3) The risk involved. And (4) the strength of the link between competent judgment and well being.

CONCLUSION

There are no compelling reasons to conflate paternalism and competence. Doing so, instead, is hostile to established legal rights, to clear moral thinking, and to common sense notions of each. It may be permissible to require greater skill in complex cases; it also may be permissible to require more evidence of competence in risky cases. These need not involve placing beneficence above autonomy. If the courts and standard analysis have gone too far in affirming autonomy, this is too important an issue to be decided by definitional fiat. Rather it needs careful and thorough moral and empirical scrutiny. This is especially true given a link between autonomy and well being. Autonomy is too important, and paternalism is too controversial, to be buried in a ‘concept’ of competence. Nevertheless, much about competence and autonomy is unclear. We do not have adequate notions of either. Developing adequate concepts and
determining how informed consent should relate to paternalism require more work, including careful examination of clinical studies. Such attempts are not helped by conflating issues that are best kept separate.

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