

Perspectives

Beyond Capacity: Identifying Ethical Dilemmas Underlying Capacity Evaluation Requests

Nicholas Kontos, M.D., Oliver Freudenreich, M.D., John Querques, M.D.

Background: *Psychiatric consultations involving the evaluation of patients' medical decision-making capacity often seem to have little to do with truly compromised patient autonomy.* **Objective:** *The authors seek to examine hidden ethical dilemmas that lead to capacity evaluation requests.* **Method:** *The authors utilize the "principlism" approach to biomedical ethics to illustrate some common moral issues in patient care that are poorly captured by the "autonomy-versus-paternalism" paradigm.* **Results:** *Patient autonomy sometimes comes into conflict with ethical imperatives to do "good," to*

avoid harm, and to deliver care fairly, as well as with the autonomy of others. Consultation psychiatrists are well positioned to unearth these dilemmas and begin to address them. **Discussion:** *Effective engagement of everyday ethics in clinical medicine is hindered by reflexive resort to capacity evaluations when moral problems arise. Greater attention to matters of values, aggressive urges, and obligations to others can enhance the negotiation of routine ethical dilemmas.*

(Psychosomatics 2013; 54:103–110)

The execution of capacity evaluations in clinical medicine has changed little in recent decades. Notwithstanding attempts to standardize these assessments^{1,2} and wrangling over issues such as risk relativity,^{3–5} methods promulgated over 20 years ago⁶ remain in place today.⁷ Yet, capacity evaluations are performed on a growing proportion of hospitalized patients and constitute an increasing percentage of psychiatric consultation requests.⁸ The latter occurs despite continued articulation, if not general awareness, that these assessments are not the exclusive province of psychiatry.²

The burgeoning of capacity evaluations might simply reflect greater awareness of clinical and social imperatives to safeguard the interests of persons whose self-governance may be medically compromised. However, nearly 40% of such requests are determined by consultants to be "not about capacity" at all,⁹ and a third of patients seen in this context may have intact decisional capacity.¹⁰ In many of these cases, it is suspected that the capacity evaluation request is really a "euphemism for physicians' frustration in managing some patients who are unable to progress smoothly."¹⁰

This frustration and its linkage to questions of decisional capacity might stem from the heavy emphasis on patient autonomy in contemporary medical ethics. The rise of patient autonomy to its current status as the trump card of medical ethics is well-documented,^{11–14} as is its relationship to a decline in society's trust of authority in general and medical authority in particular.^{15–17} "Autonomy vs. paternalism" may be what medical academia implies to be the totality of medical ethics. Unfortunately, not all frustration in medicine can be resolved by this "circumscribed, binary moral system."¹⁸

We propose that the effort to make ethical square pegs fit the round hole of autonomy vs. paternalism might ac-

Received March 12, 2012; revised June 4, 2012; accepted June 6, 2012. From the Department of Psychiatry, Massachusetts General Hospital, Boston, MA (NK, OF, JQ); Harvard Medical School, Boston, MA (NK, OF, JQ). Send correspondence and reprint requests to Nicholas Kontos, M.D., Psychiatry Consultation Service, Massachusetts General Hospital, 55 Fruit Street, Warren 605, Boston, MA 02114; e-mail: nkontos@partners.org

© 2013 The Academy of Psychosomatic Medicine. Published by Elsevier Inc. All rights reserved.

count for many unwarranted capacity evaluations. By “unwarranted,” we refer to evaluations initiated in the absence of a clearly articulated suspicion as to whether and why the patient might lack capacity. This is not to say that psychiatric consultation itself in these cases is necessarily unwarranted (though it may be), but rather that the capacity evaluation label is misapplied.

The use of capacity evaluations to address unrelated moral dilemmas may be compelling to doctors because of their dual medical and legal nature. Medically, because these evaluations often fall to psychiatrists, “psychosocial” and ethical problems can be effectively outsourced. Further, psychiatric consultation invokes mental illness and a disease model that is congenial to physicians but can be unproductive or even harmful.^{19,20} Legally, consultee and consultant both may hope that any moral quandary that is transformed into a capacity issue will ultimately be resolved by a judge and the “alluring rationality of legal thought.”²¹

In this paper, we offer four prototypical scenarios illustrating ethical dilemmas that often trigger unwarranted capacity evaluations. We organize these dilemmas using Beauchamp and Childress²² four principles, or common moral norms, of biomedical ethics—autonomy, beneficence, nonmaleficence, and justice. While recognizing that so-called “principlism” has its detractors and is far from the only valid approach to medical ethics,^{23–25} we utilize it for two reasons. First, because it is today’s dominant bioethical framework and, thus, the one most likely to be familiar to clinicians; second, because it caters well to the posing of ethical dilemmas as clashes between two premises. Ultimately, our format is less important than its use as a stimulus to encourage clinicians about to request or conduct capacity evaluations to identify and address other relevant moral issues. Values, aggressive urges, and obligations are among the issues hiding within many unwarranted capacity evaluations and which therefore inform our examples.

In our four sample ethical dilemmas, the autonomy side of each one should be presumed to mean intact autonomy. Unwarranted capacity evaluations seek to dispel, rather than resolve, moral quandaries by removing one variable from the equation (i.e., when patients are deemed to lack capacity, their autonomy [superficially] can no longer collide with physician paternalism). In contrast, the problems identified below require consideration of two valid premises for ethical conduct in conflict with each other. Lastly, our categories are not mutually exclusive and, in reality, are rarely pure. Simplification is used here in the interests of illustration and starting a discussion.

AUTONOMY VS. BENEFICENCE

Mrs. A, an 80-year-old woman with uncontrolled diabetes mellitus complicated by recurrent cellulitis and chronic ulcerations of the legs, lives alone and is felt to be medically “unsafe” to return home. Psychiatry is consulted to assess her capacity to refuse a “safe discharge” plan that includes placement in a nursing home.

Conflict between patient autonomy and physician beneficence might initially seem an unnecessary topic for a paper about underlying issues in capacity assessments. Such an assumption would be based on an equating of beneficence with paternalism, of which the latter is not a contemporary bioethical principle and is usually invoked with disapproving tones. Muddling these two concepts impedes the negotiation of a physician’s authority when it butts up against a patient’s preferences.

Paternalism exists when a physician believes he or she “has better insight into the best interests of the patient than does the patient”²⁶ and, thus, “makes the medical good of the patient the only good and subverts other goods to that good.”²⁷ As justifications for clinical action go, paternalism alone cannot supervene intact patient autonomy.

Beneficence addresses the physician’s obligation to pursue the good of the patient; it is the positive counterpart of “do no harm.” However, it ought not explicitly equate the good of the patient with medical good.^{22,26} Health is merely the domain where the physician has the greatest sanction and skills to promote the good of the patient directly. Beneficence requires an appreciation of a patient’s best interests in order for a physician to consider how and whether that patient might be served by medical actions. The physician does not hold that appreciation passively, though, and is obliged to offer respectful counsel to patients. Not merely information brokerage, such counsel is especially important when it might challenge patients. Unlike strict paternalism, beneficence can validly stake out territory when its practice is impeded by another valid principle (e.g., autonomy).

To a degree, these simplified descriptions are self-serving, setting up paternalism as a straw man to be torn down by beneficence. Nonetheless, for our purposes, they briefly capture two modes of medical decision-making that can be easily conflated.

Errors of authoritative commission by physicians who care for “uncooperative” patients can occur when the importance of patients’ value systems is paternalistically under-recognized. In the case above, the consultant learned

that the patient valued minimization of medical risk less than she did privacy and the subjective dignity of living in her own home. When health is the end-all and be-all of “best interests,” any treatment refusal seems irrational. Many off-target capacity questions stem from these presumptions; confusion can ensue when a consultant then finds such a patient to be decisionally capable.

Errors of authoritative omission can occur when physicians are so conditioned against being paternalistic that they do not counsel or challenge patients who act contrary to their own stated interests.²⁸ While Mrs. A eventually articulated a clear value system, a physician could still discuss with her whether dignity and risk reduction need to be mutually exclusive. If a values-based discussion reveals and refines an incompletely thought-through decision by a patient, any lingering preoccupation with capacity dissipates, the doctor–patient relationship is enhanced, and the patient is better served.²⁹ In the course of performing the consultation, the psychiatrist will likely initiate this kind of dialogue. Accompanying an assessment that reframes the ethical landscape of the case, the consultant’s recommendations can point the consultee toward a more thoroughgoing extension of the conversation.

More than simply accepting the patient’s surface values, these discussions require that one respectfully challenge them (e.g., in terms of their consistency with the patient’s decisions and actions). A superficial or overly enthusiastic idealization of patient-centered concepts may sometimes inhibit physicians from providing counsel counter to their patients’ stated wishes.³⁰ However, when excessive, such inhibition—especially when buttressed by the fallback option of a capacity evaluation—may really constitute “moral abandonment.”²⁷

AUTONOMY VS. NONMALEFICENCE

Mr. B, a 42-year-old man with active polysubstance dependence presents to the emergency department (ED) intoxicated and requesting detoxification. Admitted to medicine and placed on an effective detoxification regimen, he becomes hostile and abusive to staff the next morning. He denies physical distress, demands discharge, and throws a chair when attempts are made to persuade him to stay. Psychiatry is consulted to assess his “capacity to leave against medical advice.”

The principle of nonmaleficence formalizes the traditional injunction that doctors “above all, do no harm.” Discussions of nonmaleficence typically focus on euthanasia and withdrawal of life-sustaining care—actions ar-

guably entailing harm, but without hostility. However, physicians may more frequently be confronted by temptations—both conscious and unconscious, personal and social³¹—to gratify unsavory urges stemming from bias, prejudice, having a bad day, and retaliatory fantasies inspired by “hateful” patients.³² The foregoing case exemplifies the latter in that the team probably wanted to eject the patient; allowing vs. effecting that ejection is a distinction without a difference. Either would gratify their hatred toward him, creating the perception of a harmful act even if discharge is the “right” outcome. The request for a capacity evaluation in a situation like this might actually be an attempt by clinicians to guard against their inappropriately acting on (or out) negative countertransference.

While medical ethics skews toward addressing a narrow range of nonmaleficence, advice on physicians’ responses to difficult patients typically comes from psychiatrists admonishing physicians against acting on negative countertransference³³ and from generalists’ advice on negotiation and relationship-building.³⁴ Left with few options for dealing with recalcitrant patients,³⁵ physicians may feel that any gratifying actions taken with them must be “bad.” Hence, in cases like the one above, where there really is no question about Mr. B’s capacity, and where there might not even be any medical advice against which he seeks discharge, the pleasure of being rid of the patient nonetheless feels wrong.

A capacity evaluation provides an out from this situation but actually distracts from the real matter at hand. When skillful and good-faith attempts at engaging difficult patients fail, providers are unavoidably angered. Capacity evaluation requests under these conditions often involve an against-medical-advice discharge demand or a *staying-against-medical-advice* scenario with a patient who is prolonging or otherwise impeding proper care. In the former situation, the consultant’s finding of intact decisional capacity provides cover for the combined relief of a cleared bed and a clean conscience. In the latter situation, the same finding might elicit anger directed toward the psychiatrist who did not provide the desired medicolegal cover for that relief.

Either way, very little is accomplished by keeping these consultations within a capacity-related ethical frame. Instead, psychiatrists’ familiarity with managing countertransference can be directed toward acknowledging (without psychodynamic jargon) their own and others’ valid emotional responses to the patient and avoiding reflexive responses to them. Consultants and consultees alike must be willing to “think dirty” about patients.³⁶ This means

Dilemmas Underlying Capacity Evaluation Requests

accepting that some patients work against providers' efforts and their own declared interests. Otherwise, unnecessary capacity evaluations may be the least of several potential evils that include overt hostility, therapeutic excess, and paradoxical indulgence. However, actions that gratify the negative feelings evoked by such patients, while often impermissible, cannot be categorically taken off the table.

That discharging or challenging hateful patients might feel good means neither that these actions are forbidden nor that capacity evaluations are necessary or appropriate means of obtaining permission for them. Instead, challenging some patients' maladaptive approaches to health and medicine may be an underappreciated ethical imperative^{37,38} that the limited lens of autonomy vs. paternalism renders easy to miss.³⁹

AUTONOMY VS. JUSTICE

Mr. C, a 68-year-old man with chronic obstructive pulmonary disease presents to the ED with shortness of breath for the fourth time in as many weeks. Mr. C continues to smoke two packs of cigarettes per day and to refuse offers of smoking cessation consultations and therapies. Mr. C has repeatedly left the hospital prior to completion of courses of steroids and antibiotics. His smoking precludes home oxygen, and he is inconsistently adherent with medications. With Mr. C now demanding admission to "fix my breathing," psychiatry is consulted because "he keeps coming back . . . he can't take care of himself."

Some patients exercise their intact autonomy in an adolescent manner whereby they "behave freely but are repeatedly medically rescued when predictable adverse consequences ensue."³⁷ Cumulatively, these patients can exact tremendous costs from the health-care system in terms of both resources and morale. Capacity evaluations are sometimes requested when physicians grow weary of caring for seemingly intractable over-utilizers of the health-care system. Some physicians may feel pushed to consider the impact on various levels of society (e.g., hospital, country) of autonomy exercised in an "adolescent" fashion.

Justice is a difficult principle to fix firmly in terms of definition and status. Centered on the idea of fairness,⁴⁰ the invocation of justice still begs questions about what is fair.²² For physicians, considerations of justice generate friction, involving as they do intersections between individual patients and the social structures of which they are

parts.⁴¹ For our purposes, we apply a noncommittal idea of fairness that simply acknowledges that no doctor or patient is an island, that our rights are harnessed to obligations to one another, and that today's clinical medicine can no longer afford to divorce itself from public-health and systems-level views of distributive justice.^{18,42,43}

Problems in the care of so-called "bounce-back" patients, whose serial presentations run in parallel with ineluctable non-adherence, ironically relate to some of the nobler aspects of medicine—namely, nonabandonment and impartiality. While it is naïve to think that true impartiality and unerring steadfastness exist in patient care, expectations of and among doctors are that these are at least ideals of practice.

Physicians have little leverage with patients whose choices and behaviors seem to consume medical resources unfairly by legitimate exercise of their civil rights (e.g., the Emergency Medical Treatment and Active Labor Act of 1986) and reliance on doctors' moral obligations. In the case above, the Mr. C's frequent hospital presentations are framed as putative evidence of an inability to care for himself. However, Mr. C is caring for himself, after a fashion, in a system that does not obligate him to follow medical advice in order to receive medical care. While a capacity evaluation may provide a temporary distraction from this awkward truth, it will not provide relief to any of the involved parties. Further, those involved parties include not only doctor and patient but also other patients waiting for ED or hospital beds, as well as a citizenry coping with escalating taxes and insurance premiums.

These unpleasant realities go largely unaddressed by the autonomy-centered ethics and patient-centered medicine themes that dominate contemporary medical education. Even when a rights–duties disparity in the doctor–patient relationship is acknowledged, the responsible physician is left with the complex question, "how do we distinguish between [a patient's] assumed risk and imposed risk?"⁴⁴ After all, any given "bounce-back" patient could be socially disenfranchised in a way that precludes his following good medical advice.^{45,46} Still, fairness in a relationship within a broader social network ought to prohibit the patient from not disclosing those hindrances to his providers while continuing to ask for their help.⁴⁷

Reciprocally, physicians should try to bring those barriers to light. If good-faith attempts to identify and rectify such problems fail, the patient's right to care would not be forfeited. But intact autonomy does not automatically trump justice-based allowance (if not moral obligation) for the physician to discuss frankly with a patient the impact of his

behavior in the broader scheme of things, or to consider not offering treatment options that have repeatedly proven futile. As with the other dilemmas discussed here, the psychiatrist's work may position him to be the first to notice the indication, and have the opportunity to conduct a justice-oriented discussion with the patient (and consultee). Further, as an "outsider," a psychiatric consultant is well situated to introduce this topic and assess the patient's cognitive and affective responses to it. The perceived threat of a doctor subordinating one's needs to the greater good is diluted by the consultant's advisor, rather than decider, role.

Multidisciplinary and/or ethics committees, rather than individual clinicians, sometimes ensure fair deliberation of particularly high-stakes decisions informed by justice considerations,¹⁶ as with listing decisions for organ transplantation candidates. The complexity of sorting through this kind of dilemma explains and illustrates the inadequacy of transmuted it into a capacity issue.

AUTONOMY VS. AUTONOMY

Mrs. D, a 72-year-old woman, has essential hypertension, which, because of longstanding medication non-adherence, is uncontrolled and complicated by kidney disease. She is hospitalized after a third fall in as many months and is found to be posturally unstable. She refuses inpatient rehabilitation and her family does not want her to return to their home, even though she owns it. She was recently diagnosed with mild cognitive impairment, but family reports that she is demonstrating her usual "stubbornness."

That autonomy can ethically collide with autonomy may seem a facetious proposition. We argue that this appearance speaks to the problematically narrow view of autonomy vs. paternalism that this paper addresses—in this case, demonstrating the ease with which the autonomy of persons other than the patient is forgotten. Physicians are disallowed from accepting patient choices made under conditions of coercion, but what is a physician's proper response when a patient's decision creates unreasonable restrictions on others' autonomy?

The concept and preeminence of patient autonomy has been criticized for its almost exclusive "atomistic" orientation where decisions are seen as necessarily deriving purely from the individual. "Relational" autonomy places decisions in a broader context where social influences are important in value formation, decision-making, and consideration of the impact of one's decisions on others.¹⁴

Paying attention to certain word choices and presumptions associated with the idea of autonomy assists in un-

derstanding how this term is usually employed. Buchanan and Brock⁴⁸ identify the primacy of "respect for *individual self-determination*" in patient care. Beauchamp and Childress²² state that autonomy entails, "at a minimum, self-rule that is free from . . . *controlling interference* by others." Thus "a person of diminished autonomy . . . is in some respect *controlled* by others" (emphasis added). It is a far reach to fully isolate the "individual" from his important relationships or to lump "controlling interference" together with ordinary (even desirable) interpersonal influence, but, as Schneider⁴⁹ notes, "blunter versions are in some ways the more consequential formulations of the autonomy paradigm."

The same might be said of "patient-centered medicine," which, when coupled in its "blunter" form with atomistic autonomy, can obscure the rights and plights of other stakeholders in a given patient's medical decision-making. Relevant parties include health-care providers and patients' family and friends, especially those in caretaking roles. If one allows some room for the idea that "autonomy entails the capacity to live in an interactive community of moral agents,"⁵⁰ the lives and feelings of others matter, though how much is a touchy subject.⁵¹

Draper and Sorell³⁵ highlight the plight of "captive physicians" who feel constrained by the behaviors of patients who persistently seek help while rejecting medical advice. Patients' loved ones often find themselves similarly trapped, but with fewer options for liberation and fewer degrees of freedom than have physicians. In the case above, the patient is making decisions entirely in keeping with a lifetime of low valuation of health. Now, however, these decisions all but guarantee serious morbidity. One could argue that Mrs. D is demonstrating the epitome of adult, atomistic autonomy, fully accepting the personal consequences of her decisions. On the other hand, and possibly at the root of the capacity evaluation request is the unasked question of whether Mrs. D has the right to impose those consequences on others. By forcing her family to either bear witness to her incurring degrading injuries unto death, or sever their relationship with her, is she restricting their liberties in an impermissible way?

Is Mrs. D just imposing a hard decision for her family members' exercise of their own autonomy? Or, do the exigencies of emotion⁵²⁻⁵⁴ and attachment⁵⁵ create a situation where the family's choices are so unreasonable and so unrealistic that one questions whether Mrs. D's intact autonomy can be truly "respected"? These can be taboo questions in an individual-oriented society where medicine is increasingly expected to accommodate personal

Dilemmas Underlying Capacity Evaluation Requests

preferences.^{56,57} Relative to the other dilemmas discussed above, a clash of autonomies, shunted into the premises and mechanisms of capacity questions, seems more often to lead to findings that patients are “incapable.” One wonders if doctors and judges are bending the letter of the law to accommodate what Appelbaum, in a different context, calls a “common sense model.”⁵⁸

We argue that prematurely taking this path perpetuates “blunt” thinking about patient autonomy, allows buck-passing to already-overtaxed courts, and is dishonest to all involved. The psychiatrist happening upon this sort of dilemma should acknowledge it, hold the capacity question at bay, and encourage more forthright transactions among providers, patients, and families, who all may respond favorably to clarification and challenging of the value systems at play. Adult autonomy, in contrast to the adolescent variety, not only permits, but demands, this kind of honesty.

CONCLUSION

Observing an increase in capacity-evaluation requests in the general hospital and suggesting that misidentified ethical dilemmas underlie many of them, we utilized “principlism” as a way around reflexive use of the “autonomy vs. paternalism” template. Our sample dilemmas indulge autonomy-centric medical ethics to an extent by always placing patient autonomy at one pole. Of course, physicians face many moral issues not involving patient autonomy, but these sorts of problems generally do not lead to capacity-evaluation requests.

It has been suggested that psychiatrists should not try to be “amateur ethicists,”⁵⁹ and that they approach capacity assessments with an overly legalistic stance.⁶⁰ We see

these two points as valid, but also as somewhat confusing and contradictory, especially in view of the unresolved nature of ethical expertise.^{61–63} The recognition and—when routine—resolution of ethical dilemmas are essential skills for any physician. Consultation psychiatrists should not claim unearned expertise in this area but can offer the benefit of experience-based knowledge in situations associated with capacity-evaluation requests. We have attempted to stay within these bounds in this paper.

Staying within these bounds in practice can be difficult. Consultation psychiatrists walk a fine line between demonstrating reasonable credibility in the ethical realm and not embracing the role of “resident ethicist . . . [or] unit holistic humanist.”⁶⁴ An “unwarranted capacity-evaluation request” may not be an unwarranted psychiatric consultation, since other psychiatric issues can be at play or clarification of the problem itself is reason enough for consultation. However, the newly revealed ethical dilemma itself is a distinctly non-psychiatric concern for all involved in the patient’s care.

Thus, we see the psychiatrist’s role as elucidating the “real” issue, relaying that finding to the consultee, and being one (albeit often the first) among many to broach it with the patient. Involving, as they often do, strongly held values, interpersonal aversion, or obligations to others, these discussions are difficult. Recognizing tensions between patient autonomy and other ethical principles is the first step in handling these high-stakes, high-affect interactions responsibly and honestly.

Disclosure: The authors disclosed no proprietary or commercial interest in any product mentioned or concept discussed in this article.

References

1. Grisso T, Appelbaum PS. *Assessing Competence to Consent to Treatment: A Clinician’s Guide*. New York, NY: Oxford University Press, 1998
2. Sessums LL, Zembruska H, Jackson JL: Does this patient have medical decision-making capacity? *JAMA* 2011; 306: 420–427
3. Wicclair MR: The continuing debate over risk-related standards of competence. *Bioethics* 1999; 13:149–153
4. Wilks I: Asymmetrical competence. *Bioethics* 1999; 13:154–159
5. Buller T: Competence and risk-relativity. *Bioethics* 2001; 15:93–109
6. Appelbaum PS, Grisso T: Assessing patients’ capacities to consent to treatment. *N Engl J Med* 1988; 319:1635–1638
7. Appelbaum PS: Clinical practice: assessment of patients’ competence to consent to treatment. *N Engl J Med* 2007; 357:1834–1840
8. Knowles FE III, Liberto J, Baker FM, Ruskin PE, Raskin A: Competency evaluations in a VA Hospital: a 10-year perspective. *Gen Hosp Psychiatry* 1994; 16:119–124
9. Kornfeld DS, Muskin PR, Tahil FA: Psychiatric evaluation of mental capacity in the general hospital: a significant teaching opportunity. *Psychosomatics* 2009; 50:468–473
10. Umopathy C, Ramchandani D, Lamdan RM, Kishel, LA, Schindler, BA: Competency evaluations on the consultation-liaison service: some overt and covert aspects. *Psychosomatics* 1999; 40:28–33
11. Stirrat GM, Gill R: Autonomy in medical ethics after O’Neill. *J Med Ethics* 2005; 31:127–130
12. Wolpe PR: The rise of autonomy in American bioethics: a sociological view. *Bioethics and Society: Constructing the Ethical Enterprise*. Devries R, Subedi J, Eds. Upper Saddle River, NJ: Prentice Hall, 1998, pp 38–59

13. Callahan D: Can the moral commons survive autonomy? *Hastings Center Rep* 1996; 26:41–42
14. Tauber AI: Sick autonomy. *Perspect Biol Med* 2003; 46:484–495
15. O'Neill O. *Autonomy and Trust in Bioethics*. New York, NY: Cambridge University Press, 2002
16. Rothman DJ. *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*. USA: Basic Books: 1991
17. Imber JB. *Trusting Doctors: The Decline of Moral Authority in American Medicine*. Princeton, NJ: Princeton University Press, 2008
18. Kontos N, Querques J, Freudenreich, O. Two's company, three hundred million's a crowd: balancing clinical integrity and population consciousness in medical education. *Acad Med* 2011; 86:1341
19. Perl M, Shelp EE: Psychiatric consultation masking moral dilemmas in medicine. *N Engl J Med* 1982; 307:618–621
20. Kontos N, Freudenreich O, Querques J: Ownership, responsibility, and hospital care: lessons for the consultation psychiatrist. *Gen Hosp Psychiatry* 2008; 30:257–262
21. Appelbaum PS, Roth LH: Clinical issues in the assessment of competency. *Am J Psychiatry* 1981; 138:1462–1467
22. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 6th ed. New York, NY: Oxford University Press, 2009
23. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 7th ed. New York, NY: McGraw-Hill Medical, 2010
24. Walker T: What principlism misses. *J Med Ethics* 2008;35:229–231
25. Gert B, Culver CM, CKD *Bioethics: A Systematic Approach*, 2nd ed. New York, NY: Oxford University Press, 2006
26. Pellegrino ED, Thomasma DC. *For the Patient's Good: The Restoration of Beneficence in Health Care*. New York, NY: Oxford University Press, 1988, pp 7
27. Pellegrino ED: Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship. *J Contemp Health Law Policy* 1994; 10:47–68
28. Brock DW, Wartman SA: When competent patients make irrational choices. *N Engl J Med* 1990; 322:1595–1599
29. Fulford KWM: Facts/values: 10 principles of values-based medicine. *The Philosophy of Psychiatry: a Companion*. Radden J, Ed. New York, NY: Oxford University Press, 2004
30. Chew-Graham CA, May CR, Roland MO: The harmful consequences of elevating the doctor-patient relationship to be a primary goal of the general practice consultation. *Fam Pract* 2004; 21:229–231
31. Messner E, Groves JE, Schwartz JH. *Autognosis: How Psychiatrists Analyze Themselves*. Chicago, IL: Year Book Medical Publishers, Inc., 1989
32. Groves JE: Taking care of the hateful patient. *N Engl J Med* 1978; 298:883–887
33. Strous RD, Ulman AM, Kotler M: The hateful patient revisited: relevance for 21st century medicine. *Eur J Intern Med* 2006; 17:387–393
34. Quill TE: Recognizing and adjusting to barriers in doctor-patient communication. *Ann Intern Med* 1989; 111:51–57
35. Draper H, Sorell T: Patients' responsibilities in medical ethics. *Bioethics* 2002; 16:335–352
36. Freudenreich O, Kontos N, Querques J: The muddles of medicine: a practical, clinical addendum to the biopsychosocial model. *Psychosomatics* 2010; 51:365–369
37. Kontos N, Querques J, Freudenreich O: Fighting the good fight: responsibility and rationale in the confrontation of patients. *Mayo Clin Proc* 2012; 87:63–66
38. Kukla R: Conscientious autonomy: displacing decisions in health care. *Hastings Center Rep* 2005; 35:34–44
39. Schei E: Doctoring as leadership: the power to heal. *Perspect Biol Med* 2006; 49:393–406
40. Rawls J: Justice as fairness. *Philos Rev* 1958; 67:164–194
41. Veatch RM, Haddad AM, English DC. *Case Studies in Biomedical Ethics*. New York, NY: Oxford University Press, 2010
42. Schneiderman LJ: Rationing just medical care. *Am J Bioeth* 2011; 11:7–14
43. Bloche MG: Beyond the "r word"? Medicine's new frugality. *N Engl J Med* 2012; 366:1951–1953
44. Brandt AM: Behavior, disease, and health in the 20th-century United States: the moral valence of individual risk. *Morality and Health*. Brandt AM, Rozin P, Eds. New York, NY: Routledge 1997, pp 53–77
45. Minkler M: Personal responsibility for health: contexts and controversies: Promoting healthy behavior: how much freedom? *Whose Responsibility?* Callahan D (Ed). Washington, DC: Georgetown University Press, 2000, pp 1–22
46. Steinbrook R: Imposing personal responsibility for health. *N Engl J Med* 2006; 355:753–756
47. Brook RH: Rights and responsibilities in health care: striking a balance. *JAMA* 2010; 303:2289–2290
48. Buchanan AE, Brock DW. *Deciding for Others: The Ethics of Surrogate Decision Making*. New York, NY: Cambridge University Press, 1989, pp 36–44
49. Schneider CE. *The Practice of Autonomy: Patients, Doctors, and Medical Decisions*. New York, NY: Oxford University Press, 1998, pp 4
50. Campbell AV: Dependency: the foundational value in medical ethics. *Medicine and Moral Reasoning*. Fulford KWM, Gillett G, Soskice JM, Eds. New York, NY: Cambridge University Press, 1994, pp 184–192
51. Ho A: Relational autonomy or undue pressure? Family's role in medical decision-making. *Scand J Caring Sci* 2008; 22:128–135
52. Charland LC: Appreciation and emotion: theoretical reflections on the MacArthur treatment competency study. *Kennedy Inst Ethics J* 1998; 8:359–376
53. Appelbaum PS: Ought we to require emotional capacity as part of decisional competence? *Kennedy Inst Ethics J* 1998; 8:377–387
54. Halpern J: When concretized emotion-belief complexes derail decision-making capacity. *Bioethics* 2012; 26:108–116
55. Fricchione GL. *Compassion and Healing in Medicine and Society: On the Nature and Use of Attachment Solutions to Separation Challenges*. Baltimore, MD: Johns Hopkins University Press, 2011
56. Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press, 2001
57. Sanghavi D: My dog ate my prescription: should slacker patients get special treatment? Available at: <http://www.slate.com/id/2299228>. Accessed July 15, 2011

Dilemmas Underlying Capacity Evaluation Requests

58. Appelbaum PS. *Almost a Revolution: Mental Health Law and the Limits of Change*. New York, NY: Oxford University Press, 1994, pp 41–44
59. Lederberg MS: Making a situational diagnosis: psychiatrists at the interface of psychiatry and ethics in the consultation-liaison setting. *Psychosomatics* 1997; 38:327–338
60. Schneider PL, Bramstedt KA: When psychiatry and bioethics disagree about patient decision making capacity. *J Med Ethics* 2006; 32:90–93
61. Yoder SD: The nature of ethical expertise. *Hastings Center Rep* 1998; 28:11–19
62. Gesang B: Are moral philosophers moral experts? *Bioethics* 2010; 24:153–159
63. Wear S: Ethical expertise in the clinical setting. *Ethics Expertise*. Rasmussen L, Ed. The Netherlands: Springer 2005, pp 243–258
64. Murray GB: The liaison psychiatrist as busybody. *Ann Clin Psychiatry*. 1989; 265–268