

Supported Decision-Making across Fluctuating Capacity: A Temporal Account of Patient Agency, Prior Commitments, and Surrogate Authority in Longitudinal Clinical Care

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Abstract

Clinical decision-making frameworks often treat decision-making capacity as a threshold question that determines whether authority remains with the patient or shifts toward a surrogate. That approach becomes ethically unstable when capacity fluctuates, support changes what a patient can understand or communicate, present wishes diverge from earlier commitments, or the consequences of a decision differ in reversibility. This conceptual and normative analysis develops a temporal account of longitudinal decision-making in which agency and authority are assessed across changing decisional states rather than fixed once for an entire episode of care. Drawing on contemporary work on supported decision-making, advance care planning, dementia, surrogate judgment, value change, reversibility, and institutional practice, the analysis distinguishes contemporaneous agency, supportability, prior commitments, and surrogate authority as related but non-equivalent sources of normative guidance. It argues that surrogate authority should ordinarily expand only to the degree required by the patient's current decision-making limitations and should remain open to reassessment when those limitations, available supports, expressed wishes, or decision consequences change. Prior commitments retain substantial normative weight but do not automatically extinguish ethically meaningful present expression. A temporal approach therefore treats authority as revisable across longitudinal care while retaining safeguards for serious, irreversible, and legally constrained decisions.

Keywords: Supported decision-making, Decision-making capacity, Advance care planning, Surrogate decision-making, Patient autonomy, Dementia

Introduction

Decision-making capacity performs several clinical and legal functions at once. It helps determine whether a patient can authorize or refuse a particular intervention, whether additional support is required, and when another person may acquire decisional authority. Yet the ethical work attributed to capacity assessment can exceed what

the concept itself resolves. Fogal and Schwan argue that conventional decision-making-capacity frameworks may obscure the underlying normative reasons for accepting or overriding a person's choice [1]. Clinical evidence reinforces the need for specificity: among older medical inpatients, capacity assessments and findings of incapacity vary with the decision being made and the cognitive or psychiatric conditions affecting the patient [2]. A finding made at one moment therefore cannot automatically function as a global description of a person's agency throughout a longitudinal episode of care.

Recent dementia and advance-care-planning scholarship increasingly treats decision-making as an extended communicative process. International consensus

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recommendations emphasize continuing engagement, adaptation to changing capacity, and involvement of patients and those close to them across the illness trajectory [3]. Supported decision-making extends this premise by asking what assistance can allow a person with cognitive impairment to remain the decision maker rather than immediately transferring the role to a surrogate [4]. This is ethically important because the relevant alternative is not always an autonomous patient versus an incapable patient. There are intermediate conditions in which understanding, expression, appreciation, or deliberation becomes possible only with trusted assistance, repetition, communication adaptation, environmental modification, or additional time.

Support is not a complete solution. Reviews of supported decision-making interventions identify substantial implementation barriers and heterogeneous outcome evidence across mental-health settings [5, 6]. The normative importance of preserving agency must therefore be separated from an unsupported assumption that any intervention labelled “supported decision-making” reliably achieves that aim. Similar difficulties arise when clinicians rely on advance directives. A recent meta-review of dementia care identified multidimensional tensions involving autonomy, interpretation, implementation, and changing circumstances [7]. Sergeant further argues that significant value change may weaken the moral authority of earlier directives in at least some cases, particularly when the later person retains meaningful capacities for valuation [8].

Surrogate decision-making creates another layer of uncertainty. Reconstructing what an incapacitated patient would have chosen does not by itself establish that the resulting choice respects autonomy in the same way as the patient’s own decision [9]. Experimental evidence also suggests that the presence of dementia and the content of known prior preferences can affect surrogate treatment recommendations [10]. These findings do not establish a single correct hierarchy among contemporaneous wishes, precedent commitments, welfare, and surrogate judgment. They instead reveal the central problem addressed here: when a patient’s decisional abilities change across time, the ethical allocation of authority must be capable of changing with them.

This article develops a temporal or multiple-states normative account for longitudinal clinical care. Its central claim is conditional. Capacity remains decision-

specific and clinically important, but longitudinal authority should not be treated as permanently transferred by one determination. The ethically relevant state at a given time also includes what agency the patient can presently exercise, which supports can increase that agency, what prior commitments remain applicable, how serious and reversible the decision is, and what authority a surrogate is justified in exercising. The analysis first clarifies fluctuating capacity and temporal patient agency, then separates supported decision-making, prior commitments, and surrogate authority before integrating them into a longitudinal account.

Fluctuating capacity and temporal patient agency

Longitudinal care is structured by repeated decisions rather than a single consent event. Symptoms evolve, cognitive functioning may improve or deteriorate, treatment options change, and clinical urgency may increase or recede. Adaptive care planning captures part of this reality by treating serious-illness planning as an iterative process responsive to changing circumstances rather than a fixed declaration made once and merely implemented later [11]. Cases involving advanced dementia illustrate the ethical intensity of this problem. In Dutch cases concerning advance euthanasia directives, decisions were shaped by multiple considerations including prior directives, current behavior, suffering, available alternatives, and the clinical and legal context [12]. Those cases are highly jurisdiction-specific and should not be generalized to ordinary treatment decisions, but they demonstrate why a prior capacity judgment cannot exhaust the normative analysis of a later state.

Temporal patient agency also requires a richer account of what counts as ethically relevant expression. Phenomenological analyses of dementia emphasize that selfhood and recognizable preferences may continue through embodied, relational, emotional, and narrative forms even when conventional cognitive performance deteriorates [13]. Such expressions are not equivalent to a formal finding of decision-making capacity. They nevertheless matter because the ethical significance of a patient’s present orientation cannot always be reduced to performance on an abstract cognitive test. A patient may be unable to independently execute a complex decision while still showing stable aversion, assent, attachment, fear, or value-laden preferences that should influence how others exercise authority.

The consequences of a decision also shape what can reasonably be done when capacity is uncertain. Hass argues that reversibility has normative relevance in capacity law because temporarily respecting a questionable choice may be more defensible when later correction remains possible than when the decision immediately forecloses important future options [14]. Reversibility should not be converted into a numerical threshold. Its significance lies in how it alters the consequences of uncertainty. Delay, repeated assessment, additional explanation, or supported deliberation may be ethically attractive when the clinical window permits them, whereas an irreversible and time-sensitive decision may demand stronger justification for relying on ambiguous expressions.

Relational interpretation adds a further dimension. Work on advance-care-planning concordance in dementia shows that understanding between patients and care partners cannot be reduced to whether a document exists; values, preferences, communication, and dyadic interpretation matter [15]. Implementation studies also show that the practices needed to support such

communication are culturally and institutionally situated. A Japanese dementia-specific advance-care-planning toolkit increased participating clinicians' reported confidence, while also illustrating that adaptation and acceptability depend on local practice conditions [16]. Neither finding establishes patient-level benefit, but both challenge an image of capacity as a property assessed independently of communicative environment.

A temporal decision state can therefore be understood through several interacting features: the patient's decision-specific abilities at that moment; the presence and intelligibility of contemporaneous expression; the extent to which additional support could alter participation; the applicability of prior commitments; and the seriousness and reversibility of what is at stake. This characterization does not replace formal capacity assessment. It prevents a formal assessment from being asked to answer questions it cannot settle alone.

The clinical relationship among these features is summarized below.

Table 1 summarizes the distinctions discussed above.

Table 1. Temporal decision states relevant to agency and authority when capacity fluctuates

Temporal decision state	Patient agency signal	Supportability at that state	Normative role of prior commitments	Reversibility and stakes	Provisional authority implication
Stable independent decision-making	Patient consistently understands, evaluates, chooses, and communicates concerning the specific decision	Ordinary communication is sufficient	Background evidence of values; ordinarily not needed to displace the current choice	Consider consequences through normal informed-consent practice	Patient retains decisional authority
Support-responsive decisional strain	Understanding or expression is limited but improves with explanation, communication adaptation, trusted assistance, or additional time	High if appropriate support is available and noncoercive	Helps contextualize values without replacing current participation	Reversible delay may permit fuller participation	Preserve patient authority while augmenting decision support
Fluctuating or uncertain decision-specific capacity	Abilities vary across encounters, fatigue, illness severity, medication effects, or context	Potentially variable across time and environment	Useful as longitudinal evidence when current preference is unstable or difficult to interpret	Reversibility may justify reassessment before authority transfer	Reassess rather than treat one determination as permanently controlling
Temporary impairment with plausible recovery	Present independent authorization is substantially compromised, but recovery or improvement is clinically plausible	Support may be partial until the impairment resolves	May guide interim decisions, especially where immediate action is unavoidable	Strong importance of whether action can safely wait	Use the least substitutive authority compatible with safety while preserving future patient choice

Persistent impairment with meaningful present expression	Independent complex decision-making is limited, but current values, assent, dissent, comfort, aversion, or preferences remain interpretable	Support remains relevant even when it cannot restore independent decision-making	Substantial weight, especially when specific and consistent with the present person's values; not automatically decisive	High-stakes irreversible interventions require particular caution	Surrogate role expands, but present patient agency remains ethically operative
Persistent impairment with minimal interpretable present expression	Current preferences cannot be reliably elicited despite appropriate support	Limited practical capacity to recover contemporaneous direction	Prior commitments and previously expressed values become more influential	Greater consequences increase the need for careful surrogate and institutional justification	Surrogate authority may carry greater weight, subject to law, and welfare considerations, and continuing reassessment

Supported decision-making, prior commitments, and surrogate authority

Supported decision-making, advance planning, and surrogate decision-making are sometimes described along a single continuum. That description can obscure their different normative functions. Supported decision-making seeks to preserve the patient's role as decision maker. Surrogate decision-making authorizes another person to decide when the patient cannot adequately do so. Prior commitments provide evidence—sometimes powerful evidence—about the patient's values, goals, and earlier decisions, but they are not themselves a person who can interpret a new clinical situation.

Implementation evidence makes these distinctions practically important. Qualitative evaluation of primary-care advance-care-planning interventions shows that successful implementation depends on facilitators, clinical workflows, patients, families, and organizational conditions [17]. Surrogate preparedness is also unequally distributed. In a study of named surrogate decision makers, preparedness and engagement differed among historically marginalized populations and reflected disparities in prior discussion and documentation [18]. These findings caution against assuming that the mere presence of family or a designated surrogate creates an adequately supported decision process.

Support can remain ethically relevant even when cognitive impairment is established. Telehealth serious-illness conversations have been implemented among older people with cognitive impairment who retained sufficient capacity to participate, demonstrating that communication strategies can extend meaningful involvement in appropriate circumstances [19]. At later stages, present expression may still matter after independent decisional capacity declines. A multidisciplinary Delphi study concerning advance euthanasia directives in dementia reached consensus on

several propositions requiring continued attention to behavioral expressions across declining capacity [20]. That finding arises from a specific Dutch legal context, but its broader ethical relevance is that incapacity does not necessarily make the living patient normatively silent.

Prior commitments therefore require interpretation rather than automatic execution. International recommendations on advance care planning in dementia emphasize personalization, repeated communication, timing, and adaptation as the disease progresses [21]. A prior directive can strongly constrain acceptable surrogate decisions when it is specific, informed, and clearly applicable. Its authority becomes more difficult to determine when circumstances differ from those anticipated, when the directive is vague, or when the patient later appears to hold interests and values that are in tension with the earlier instruction.

This tension is not merely practical. Competing philosophical arguments dispute whether earlier autonomous choices should control after profound cognitive transformation. Walsh argues that cognitive transformation complicates the moral force of precedent autonomy, while Lauridsen and colleagues advance an even stronger challenge to the claim that caregivers have an autonomy-based reason to obey advance directives in severe dementia [22, 23]. These arguments need not be accepted in their strongest forms to establish the point relevant here: the relation between a former competent chooser and the present patient cannot be settled by invoking "autonomy" without specifying which temporal expression of the person is being protected and why.

Clinical ethics scholarship similarly describes the limits of relying on advance directives to preserve autonomy in advanced dementia, particularly when the interests and experiences of the present patient differ from expectations embedded in an earlier document [24]. The

correct implication is not that directives lose their ethical force once capacity declines. A sufficiently clear directive may remain the strongest available evidence of a person's enduring commitments. The temporal question is instead whether its authority is strengthened, weakened, or qualified by the present decision state.

Surrogate authority should be analyzed in the same way. It is derivative rather than self-justifying: the surrogate acts because the patient cannot presently perform some decisional functions adequately, not because the patient has ceased to possess morally relevant agency. When supported communication enables the patient to perform more of those functions, the surrogate's practical role should contract accordingly. When support cannot recover meaningful participation, that role may expand. This produces a more precise relationship among the three concepts. Supported decision-making concerns how much authority can remain actively exercised by the patient; prior commitments concern what earlier autonomous agency contributes to the present decision; surrogate authority concerns which residual decisional functions must be exercised by another person.

A temporal account of longitudinal decision-making

A temporal account begins from the premise that the relevant unit of analysis is not "the patient's capacity" in the abstract but the relationship between a particular patient, a particular decision, and a particular time. The international consensus definition of advance care planning in dementia reflects this orientation by describing communication as something adapted to capacity and continued with family involvement as circumstances change [25]. Time therefore does more than mark disease progression. It changes which forms of agency are available and which actors are justified in exercising decisional functions.

Some determinants of a decision state are potentially modifiable. The DECIDE project, for example, treats person-environment fit as relevant to advance decision-making in Alzheimer disease and proposes that environmental and communicative conditions may influence how well a person can participate [26]. Because this work is a study protocol, it cannot establish that such modification improves outcomes. It nevertheless identifies an important conceptual possibility: what appears to be an intrinsic loss of agency can sometimes be partly produced by a poorly fitted decisional environment. A temporal account must therefore distinguish deterioration in the person from deterioration

in the conditions under which the person is being asked to decide.

Clinical practice already encounters this problem. Interviews with clinicians across US health systems describe dementia capacity as dynamic and sometimes difficult to assess, while also identifying workflow and resource barriers to effective advance-care-planning conversations [27]. These accounts are perceptions rather than prevalence estimates, but they show that longitudinal reassessment is not merely a philosophical refinement. It creates a governance problem: who notices change, who initiates reassessment, which supports are tried, and how current expressions are recorded so that later clinicians do not mistake yesterday's incapacity for today's complete absence of agency.

The available intervention evidence also places limits on what a temporal account can claim. A systematic review of interventions intended to enhance shared or surrogate decision-making in dementia found a small and heterogeneous evidence base and did not establish a uniform improvement in decision quality or values concordance [28]. The justification for temporal reassessment therefore cannot depend on asserting that a particular decision-support intervention reliably improves outcomes. Its basis is normative: where authority has been limited because of a state-dependent impairment, ethically relevant improvement, deterioration, or newly interpretable expression can change the justification for that limitation.

This yields the article's central temporal authorization principle. Longitudinal care should preserve supported contemporaneous agency to the greatest extent justified by the patient's current decision-specific abilities; treat prior commitments as time-indexed normative evidence whose weight depends on specificity, continuity, applicability, and the present state; and expand surrogate authority only to the degree needed to exercise decisional functions that the patient cannot presently perform. International consensus work on dementia advance care planning supports the underlying premise that communication should be continuing, personalized, and capacity-sensitive [3, 21]. Reversibility further affects the urgency and defensibility of substitution [14], while present behavioral expression can remain relevant after capacity declines [20].

The principle is deliberately revisable. A person who lacked capacity during delirium may later regain it. A patient who could decide with communication support may lose that ability as illness progresses. A previously

clear directive may become difficult to apply to circumstances never contemplated. Conversely, apparently inconsistent present behavior may become intelligible when interpreted over repeated encounters rather than a single assessment. Authority should track those changes rather than remain fixed merely because an earlier institutional decision allocated it.

This reasoning also prevents two opposite errors. The first is premature substitution, in which clinicians or families treat fluctuating or support-responsive limitations as sufficient reason to take over a decision. The second is temporal erasure of prior agency, in which present impairment or later preference change is assumed

automatically to nullify earlier commitments. Between them lies the ethically harder task of specifying which decisional functions the patient can presently exercise, what support can realistically restore, which earlier commitments remain applicable, what consequences may become irreversible, and what a surrogate is authorized to do on the patient's behalf.

The relationships developed across the preceding sections are represented in **Figure 1**. The visual logic is temporal without assuming that every patient follows the same linear trajectory: states can recur, improve, deteriorate, or become difficult to classify, and authority must remain responsive to those transitions.

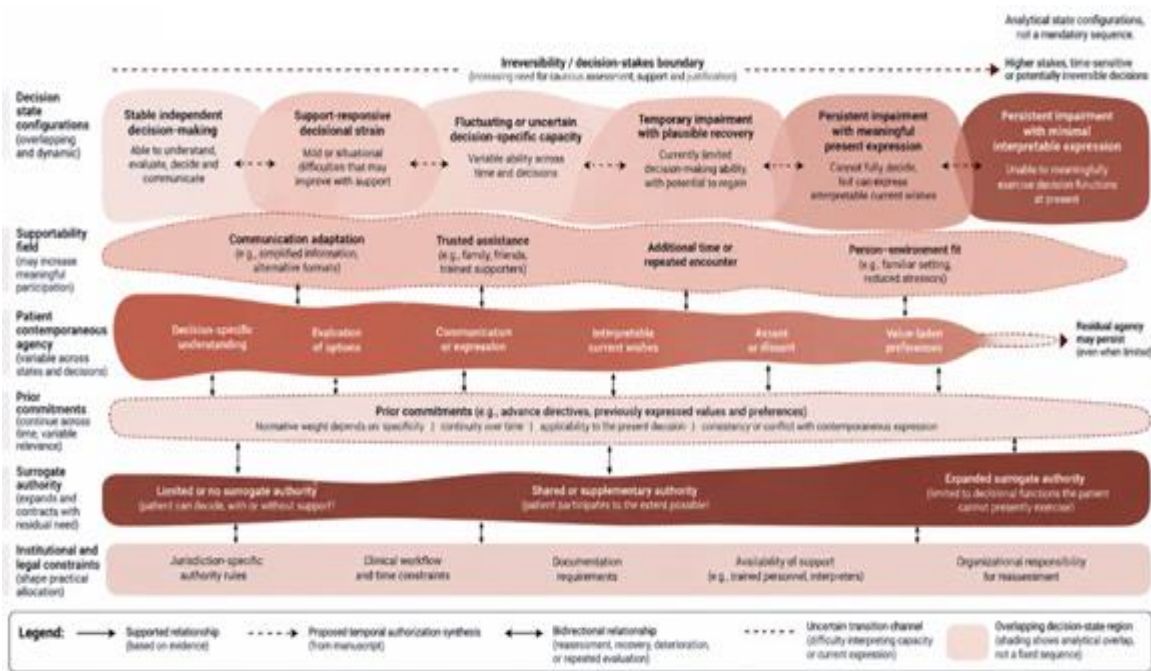


Figure 1. Agency and authority across changing decisional states in longitudinal clinical care

Clinical implications

A temporal account changes the clinical question from “Who is the decision maker?” to “Which decisional functions can this patient exercise now, with what support, and which functions—if any—must temporarily be exercised by someone else?” Dementia shared-decision-making research shows that meaningful participation can involve patients, families, and clinicians across heterogeneous healthcare and everyday decisions, but that such participation usually requires deliberate facilitation rather than occurring automatically [29]. Clinicians should therefore identify what the patient can understand, evaluate, communicate, and authorize at the

current encounter before presuming that a prior finding of incapacity still determines the allocation of authority. The same approach requires explicit documentation of surrogate roles. Qualitative evidence from long-term-care hospitals in South Korea illustrates how family expectations, professional responsibilities, institutional routines, resource constraints, and concerns about conflict can shape surrogate decision-making in practice [30]. These contextual influences should not silently determine whose voice prevails. Documentation should distinguish the patient's present expressions, the support attempted, the prior values or instructions considered, the legal or relational basis for surrogate authority, and the

particular decisional functions being exercised by the surrogate.

Jurisdiction also matters. Comparative clinical and legal analysis in serious illness demonstrates that pathways for supported decision-making, guardianship, and surrogate authorization differ across legal settings [31]. A temporal ethical account cannot therefore specify a universal legal trigger for authority transfer. Its practical function is narrower: it identifies information that clinicians and institutions should reassess when lawful authority is being interpreted or exercised. Local law determines who may formally decide; ethical analysis remains necessary to determine how that authority should be constrained by continuing patient agency.

Longitudinal practice should consequently include a reassessment trigger. A meaningful change in cognition, delirium, communication, clinical urgency, treatment

reversibility, expressed wishes, available support, or the applicability of an earlier directive should prompt reconsideration of the current authority arrangement. Training may improve clinicians' confidence in dementia-specific advance-care-planning conversations [16], while implementation evidence shows that workflow and organizational conditions affect whether such conversations occur [17]. Surrogate preparedness also cannot be assumed [18], and capacity-sensitive ACP recommendations emphasize continuing personalization across the disease course [21]. The resulting practice is not a validated checklist; it is a proposed responsibility structure for preventing temporary decisional limitations from becoming unexamined permanent transfers of authority.

Table 2 summarizes the distinctions discussed above.

Table 2. Clinical allocation of support, precedent commitments, and surrogate authority across changing decisional conditions

Clinical decisional condition	Patient participation to preserve	Immediate support task	Function of prior commitments	Proper surrogate remit	Reassessment trigger
Patient can decide with feasible support	Patient performs the substantive decision	Provide communication, environmental, relational, or temporal assistance	Contextualize enduring values without replacing the current choice	Advisory or supportive only	Change in abilities, clinical state, or support availability
Capacity is uncertain or fluctuating	Preserve every decision component the patient can presently perform	Repeat assessment at an appropriate time; reduce remediable barriers	Provide longitudinal evidence when current preference is unstable	Exercise only functions that cannot safely await or be supported	Improvement, deterioration, clearer expression, or change in urgency
Patient lacks independent capacity but expresses stable present wishes	Assent, dissent, comfort, aversion, values, and interpretable preferences remain operative	Facilitate expression and test consistency without demanding full independent decisional performance	Strongly relevant, especially when concordant with current expression	Integrate the patient's present agency with applicable prior commitments and welfare considerations	Persistent conflict, new treatment options, or altered consequences
Specific prior commitment is clearly applicable and present expression is weak or ambiguous	Continue efforts to identify meaningful contemporary response	Avoid treating silence or communication difficulty as preference absence	May carry substantial normative weight as evidence of earlier autonomous agency	Implement or interpret the commitment within lawful authority	Emergence of sustained meaningful present preference or changed clinical facts
Present preferences conflict meaningfully with an earlier commitment	Current expression must be interpreted rather than dismissed because capacity is impaired	Clarify stability, meaning, supportability, and possible distress	Remains important but cannot be assumed automatically decisive	Resolve the conflict using legal authority, present interests, prior values, proportionality, and institutional review where required	Persistence or resolution of the conflict; change in reversibility or stakes

Minimal interpretable present expression despite appropriate support	Preserve comfort, dignity, and opportunities for later participation	Confirm that support failure is genuine rather than environmental	Becomes increasingly important when specific and applicable	Greater substitutive role may be justified within legal and ethical constraints	Any recovery, new expression, new information, or major change in the proposed intervention
Decision is highly irreversible or time-sensitive	Preserve feasible participation without unsafe delay	Intensify support and assessment proportionate to what can still be changed	Evaluate applicability carefully because error may be difficult to reverse	Authority requires correspondingly stronger justification	Any material change before the irreversible step is taken

Results and Discussion

The temporal account has limits. Where a patient consistently possesses decision-specific capacity, ordinary informed consent and refusal remain sufficient; repeated temporal analysis would add complexity without ethical benefit. Likewise, replacing every conventional capacity assessment with an elaborate longitudinal inquiry would mistake a boundary problem for a universal defect. The value of the account arises where decisional ability, supportability, or interpretability actually changes across time. Critiques of capacity doctrine help identify why the formal threshold cannot by itself settle every authority question [1], while adaptive care-planning approaches show why repeated decisions may legitimately require revision [11].

The hardest cases arise when severe cognitive impairment produces conflict between prior

commitments and the experiences or preferences of the present patient. Value change can weaken the assumption that an earlier directive straightforwardly expresses what matters to the later person [8]. Real advanced-dementia cases also show that previous instructions, present behavior, suffering, alternatives, and institutional constraints can point in different directions [12]. Expert deliberation concerning advance directives similarly supports continued ethical attention to contemporaneous behavioral expression even after capacity has declined [20]. A temporal account therefore rejects an automatic lexical priority for either earlier autonomy or present preference. Their relative normative weight depends on what each expression means, how confidently it can be interpreted, the applicability of the earlier commitment, and the consequences of acting against either one.

Figure 2 illustrates the relationships discussed above.

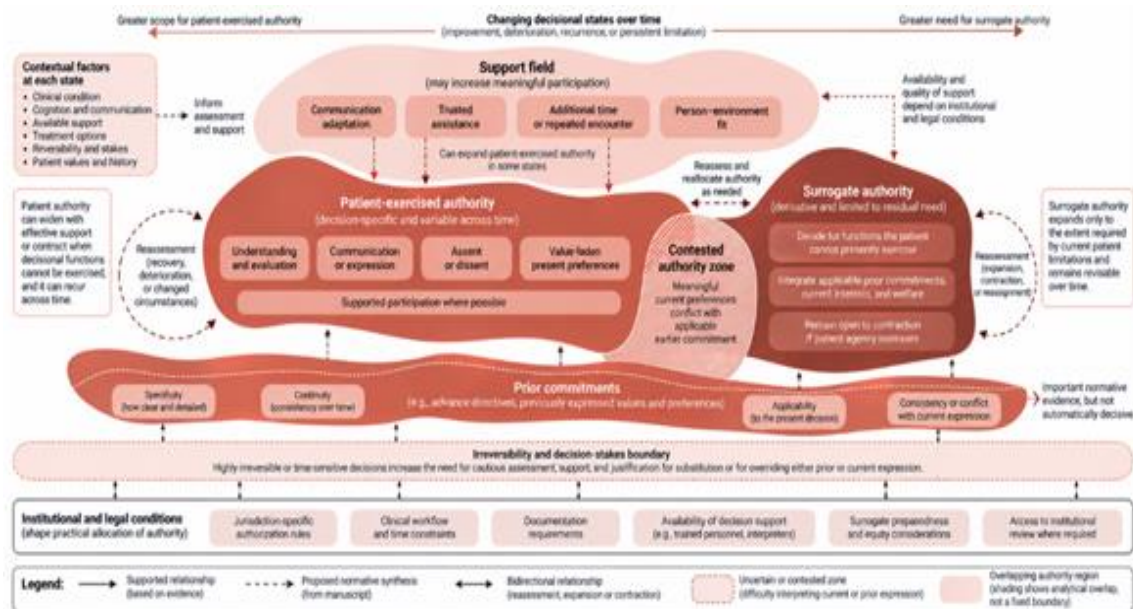


Figure 2. When decisional authority must widen, contract, or remain contested across changing states

The account is also sensitive to unequal access to the conditions needed for supported agency. Implementation barriers can make nominal support unavailable in practice [5]. Culturally adapted clinician preparation may change confidence and workflow without proving that a particular model improves patient outcomes [16]. Surrogates themselves may enter decision-making with markedly different levels of preparation and access to prior conversations [18]. “Supportability” must therefore include institutional capacity to provide accessible, noncoercive assistance; otherwise, clinicians risk describing system-produced exclusion as an intrinsic inability of the patient.

Finally, the present evidence does not validate the proposed temporal account as an effectiveness intervention. Strong philosophical arguments continue to dispute the moral authority of advance directives after profound cognitive change [23]. Intervention evidence in dementia remains limited and heterogeneous [28], while legal authorization varies across jurisdictions and patient populations [31]. These constraints define the article’s contribution. The temporal account is a normative allocation rule for deciding when patient authority should be preserved, supplemented, contracted, or reassessed; whether institutionalizing that rule improves decision quality, concordance, patient experience, or equity remains an empirical question.

Conclusion

Fluctuating capacity creates an ethical problem because decisional authority can change more slowly than the patient whose authority is being judged. A single finding of incapacity should not automatically convert a temporary or support-responsive limitation into permanent surrogate control, just as later impairment should not automatically erase serious commitments made while capacity was intact. Longitudinal decisions require attention to what the patient can presently exercise, what appropriate support can restore, what prior commitments remain applicable, what current expressions mean, and how reversible the contemplated action remains.

The resulting allocation of authority is necessarily conditional. Supported contemporaneous agency should remain operative wherever it can meaningfully guide the decision. Prior commitments should retain weight as evidence of the person’s earlier autonomous agency

without being assumed invariably decisive. Surrogate authority should expand only for decisional functions the patient cannot presently exercise and should remain open to contraction when capacity, communication, or support conditions improve. Where earlier and current expressions genuinely conflict, neither temporal standpoint can be assigned automatic priority independently of context, consequences, and governing law. A temporal account therefore protects patient agency not by fixing authority at one point in time, but by requiring its justification to remain responsive to the patient across time.

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