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Beyond Capacity: Relational Decision Authority in Supported and Fluctuating Decision-Making

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Abstract

Decision-making capacity is commonly treated as a threshold question: can this person make this decision now? That inquiry is indispensable in many clinical and legal settings, but it can obscure a second normative problem—who should exercise decision authority when ability is partial, support-sensitive, temporally unstable, or distributed across relationships. This article develops an original relational framework for analysing that problem without displacing functional capacity assessment or converting relational autonomy into collective control. It distinguishes decision-making capacity from decision authority, then differentiates supported, shared, delegated, prospective, and proposed provisional forms of authority. The analysis argues that authority can remain patient-centred while being relationally enabled, temporally revisable, and constrained by safeguards against coercion, epistemic displacement, and premature substitution. Fluctuation introduces a further requirement: authority allocation should be assessed not only at a decision point but also against feasible support, timing, restoration, and reassessment. On this basis, the article proposes a Relational Decision-Authority Framework that organizes authority around retained agency, support conditions, interpersonal influence, temporal status, and the justification for any transfer or displacement. The framework is normative and analytic rather than a validated assessment instrument, legal rule, or clinical protocol. It is intended to make visible questions that binary capacity determinations may leave unresolved while preserving jurisdiction-specific law, the possibility of genuine incapacity, the independent moral importance of a person's present voice, and the need for empirical, conceptual, and cross-jurisdictional validation.

Keywords: Decision-making capacity, Relational autonomy, Supported decision-making, Decision authority, Fluctuating capacity, Shared decision-making

Introduction

The limits of binary capacity

Clinical capacity assessment often begins with a practical binary: whether a person can make a particular decision at a particular time. That threshold matters because it can determine whether clinicians continue to seek the person's authorization or turn toward another decisional mechanism. Yet the justificatory work expected of capacity can exceed what a functional assessment can bear. Fogal and Schwan argue that decision-making capacity does not by itself settle when another person may permissibly override an individual's decision [1]. The difficulty is therefore not simply whether capacity is assessed well, but whether capacity is being asked to answer a different question: who should govern the decision.

Even within capacity theory, the relevant abilities are contested. Harcarik, Kim, and Millum argue that the conventional abilities model may inadequately capture a person's ability to value options, suggesting that

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evaluative agency may matter in ways not exhausted by understanding, appreciation, reasoning, and communication [2]. This does not establish a new validated criterion. It does show that the apparent clarity of a threshold can conceal disagreement about what the threshold represents.

Empirically, treatment decision-making capacity among psychiatric inpatients is heterogeneous, weakening any move from diagnosis directly to incapacity [3]. Supported decision-making research likewise indicates that participation depends partly on the availability and implementation of support, although intervention evidence remains heterogeneous and incomplete [4]. The evidence therefore supports treating decisional difficulty as heterogeneous and support-sensitive rather than as a diagnostic property alone [3, 4]. It also suggests that the conditions under which a decision is made can matter without proving that support will always restore sufficient ability.

A binary determination can still be necessary, especially where law demands a categorical answer. The problem arises when that answer is treated as a complete account of agency, support, legitimacy, and authority. A pragmatic review of English guidance shows substantial attention to decision support but also variation in how support and decisional difficulties are operationalized [5]. This article therefore asks a narrower question beyond capacity: when decision-making is supported, shared, delegated, prospective, or fluctuating, how should the authority to determine what happens be understood? The aim is not to replace capacity assessment, but to expose the additional normative work required once capacity no longer provides a sufficient description of the decision relationship.

Distinguishing decision-making capacity from decision authority

Decision-making capacity and decision authority should be separated analytically because they answer different questions. Capacity concerns whether a person possesses abilities relevant to making the decision. Authority concerns whose decision should govern, to what extent, for how long, and under what justification. The distinction does not deny that the two are connected. Rather, it prevents a functional finding from silently carrying normative conclusions that require additional argument. Capacity may bear on authority, but it is neither conceptually identical to authority nor a complete explanation of why control may be transferred.

Risk illustrates the problem. Pugh shows that capacity judgments can become entangled with the perceived danger of accepting or refusing treatment, even though risk is not itself a constituent ability [6]. High stakes may justify careful scrutiny, but they do not logically convert an unwanted or risky choice into incapacity. Once authority is distinguished from capacity, concern about consequences can be addressed openly as part of the justification for intervention rather than being hidden inside an ability judgment.

Credibility creates a second difficulty. Reed-Berendt and Ganguli-Mitra argue that epistemic injustice can affect how testimony, reasons, and self-knowledge are interpreted in capacity contexts [7]. A person whose account is discounted may appear less coherent or insightful partly because reduced credibility is assigned to what that person says. The authority question therefore requires attention not only to abilities but also to whether the decisional process fairly recognizes the person's epistemic position.

Supported decision-making makes the distinction especially visible. In dementia care, support may preserve self-determination even when decision-making abilities are vulnerable or declining [8]. Receiving assistance does not itself transfer authority to the supporter. Conversely, severe impairment may eventually justify substitution, but that conclusion requires more than observing dependence, disability, or the presence of another person in deliberation.

The distinction is also necessary because clinical, ethical, and legal concepts of capacity do not perform identical work. Ruck Keene and colleagues show that debates over mental and legal capacity involve competing normative paradigms rather than a single uncontested construct [9]. The framework proposed here therefore uses “decision authority” as an ethical analytic category, not as a substitute legal test. A person may lack formal authority in one jurisdiction while retaining ethically important agency, or may possess legal authority while needing substantial relational support to exercise it meaningfully.

Why decision authority can be relational

Calling decision authority relational does not mean that authority belongs automatically to a family, team, or social network. The claim is instead that a person's practical ability to exercise authority can be constituted, sustained, impaired, or redirected through relationships. Relational autonomy scholarship provides the conceptual basis for this move. Gómez-Vírseda and colleagues

describe autonomy in end-of-life care as contextual and relational rather than reducible to isolated independence [10]. On this account, dependence is not the opposite of autonomy; the ethical question is what kind of dependence enables or undermines agency.

Empirical synthesis reinforces that ambivalence. Le and colleagues found that relational autonomy in medical decision-making is affected by interpersonal support, information, communication, pressure, and domination [11]. Relationships therefore have no uniformly autonomy-promoting valence. A trusted supporter may help a person articulate values, retain information, tolerate distress, or compare options. The same relationship may narrow perceived choices, reward compliance, or substitute the supporter's narrative for the person's own. Relational analysis must therefore ask not merely whether another person is involved, but what that involvement does to the patient's practical authorship.

Joint decision-making makes the point more sharply. Osamor and Grady argue that healthcare choices made jointly by couples can remain compatible with individual autonomy [12]. Sharing deliberation does not necessarily mean surrendering authorship. Across conceptual and synthesized evidence, relationships can enable autonomy while also shaping how preferences are expressed and negotiated [10–12].

The proposed relational account therefore separates three phenomena that are often conflated: relational assistance, relational participation, and relational control. Assistance helps a person exercise her own decisional authority. Participation gives others a legitimate role in deliberation without necessarily determining the outcome. Control concerns who has the final normative or legally recognized power to decide. A patient may authoritatively decide after extensive family assistance; a patient and clinician may deliberate jointly while authority remains with the patient; or a surrogate may control a decision while still being obligated to preserve the person's voice.

Relational authority is thus not diluted authority. It is authority understood within the social conditions that make agency possible and vulnerable. Relationships matter because of their effects on agency, not because intimacy, professional expertise, caregiving labour, or familiarity automatically creates entitlement to govern another person's choices.

Supported, shared, delegated, and provisional authority

A relational account benefits from distinguishing several modes of authority rather than placing all non-independent decision-making on a single continuum. Supported decision-making is the clearest case in which assistance need not entail transfer. A systematic review of supported decision-making interventions in mental healthcare found promising but heterogeneous outcome evidence, reinforcing that structured support can increase participation without establishing a universal effectiveness claim [13]. Ethically, support is best understood as modifying the conditions under which the person exercises authority, not as evidence that authority has migrated to the supporter.

Shared decision-making is different. It organizes deliberation among patient and clinicians, and sometimes family, but shared deliberation does not by itself mean shared ultimate authority. The important distinction is between contributing reasons and possessing decisional control. This prevents the rhetoric of partnership from obscuring whose refusal, authorization, or preference ultimately governs. Shared deliberation may therefore coexist with retained patient authority, legally allocated proxy authority, or uncertainty that still requires clarification.

Delegated authority involves a more explicit transfer or prospective assignment. Substitute decision-makers may themselves need tools to identify values and reason through difficult choices; King and colleagues mapped a range of such decision-support tools for adults with impaired capacity [14]. These tools may improve the quality or structure of proxy deliberation, but they do not independently legitimate the proxy's authority. Advance directives create a different prospective form of authorization by extending previously expressed choices into future periods of impaired decision-making, although their scope and legal force remain context-dependent [15].

This article additionally proposes provisional authority. The term denotes a time-limited, revisable allocation of decisional control when the person cannot presently exercise sufficient authority for the decision, yet improved support, recovery, restoration, or reassessment could alter that position. Provisional authority is not an established legal status. Its ethical purpose is to resist a slippage from “cannot decide now” to “no longer governs this domain.” It therefore carries a presumption of narrow scope, minimum necessary displacement, preservation of the person's present voice, and active reconsideration.

These modes differ in the location, durability, and justification of control. **Table 1** summarizes the distinctions developed above without treating them as legal categories.

Table 1. Distinguishing modes of relational decision authority

Mode	Primary control	Role of others	Core justification	Principal risk
Supported	Person	Enable understanding, deliberation, communication, or value expression	Retained agency with assistance	Covert substitution
Shared deliberation	Usually person unless authority is otherwise allocated	Contribute expertise, reasons, and relational knowledge	Collaborative reasoning	Partnership language obscuring control
Delegated	Authorized proxy or recognized decision-maker	Decide within applicable mandate	Prior authorization or applicable mechanism	Proxy preference replacing the person's values
Prospective	Earlier decision or instruction	Interpret prior direction in later circumstances	Temporal extension of prior agency	Changed circumstances
Provisional — proposed	Temporarily allocated away from person	Protect immediate interests while preserving re-entry	Present insufficiency with plausible change	Temporary displacement becoming permanent

Note: "Provisional authority" is proposed here. Other rows synthesize supported, shared, proxy, and advance-decision distinctions and do not independently confer legal authority.

Fluctuation, timing, and reassessment

Fluctuation changes the ethical meaning of incapacity because the relevant question is no longer only who can decide, but when the decision must be made and whether the decisional position could change. Anticipatory decision-making in obstetric care demonstrates how authority can span different temporal states: a choice made while decisional abilities are intact may later govern when the person is unable to participate, yet altered circumstances can complicate interpretation and implementation [16]. Temporality therefore enters authority prospectively, through earlier instructions, and contemporaneously, through the timing of support, assessment, and action.

Fluctuation also exposes a methodological weakness. A systematic review of measures for shared decision-making among people with mental disorders and limited decisional capacity identified no instrument designed specifically to resolve this combined problem [17]. The absence of a dedicated measure does not mean reassessment is impossible or that existing capacity tools lack value. It means that a relational-authority framework cannot plausibly claim a validated threshold or algorithm for deciding when support has become sufficient, when temporary displacement is justified, or when authority should return.

The proposed response is a principle of revisability. Where delay is clinically and ethically feasible, a decision should be considered against the possibility that communication support, distress reduction, treatment of reversible contributors, environmental change, or a more suitable supporter could alter participation. Where delay is impossible, temporary displacement may be justified, but its scope should be no broader or longer than circumstances require. Reassessment should respond to reasons for expecting meaningful change rather than functioning as routine surveillance.

This temporal view prevents two opposite errors. One is premature permanence: treating present inability as evidence of enduring authority loss. The other is indefinite deferral: repeatedly postponing necessary decisions in the hope of improvement that is implausible or too slow for the circumstances. Revisability is therefore bounded by feasibility, urgency, burden, and the magnitude of the decision. **Table 2** organizes these temporal questions without converting them into clinical thresholds.

Table 2. Temporal conditions shaping support and reassessment

Situation	Immediate question	Support or timing response	Reassessment implication
Decision can wait	Can participation improve before authority shifts?	Modify communication, environment, distress, or support	Reassess after feasible support

Decision is urgent	What minimum displacement is justified now?	Use support that avoids unsafe delay	Review temporary allocation after urgency
Ability predictably varies	When is participation strongest?	Time deliberation accordingly where feasible	Reassess around meaningful fluctuation
Prior instruction exists	How does earlier agency apply now?	Examine specificity, applicability, and present voice	Reconsider if circumstances materially differ
Restoration is plausible	Should barriers be addressed before transfer?	Consider proportionate restorative measures	Return control when displacement loses justification

Note: This table is an original normative synthesis. It specifies no validated reassessment interval, capacity threshold, or legally binding priority rule.

The relational decision-authority framework

The preceding analysis supports a framework in which decision authority is neither inferred mechanically from capacity nor dissolved into collective choice. Supported decision-making at the margins of autonomy shows why meaningful agency can persist despite substantial decisional vulnerability [18]. Recent relational models further suggest that supported and shared decision-making can be integrated rather than treated as mutually exclusive alternatives [19], while procedural work on relational autonomy demonstrates that social conditions can be made explicit within ethical analysis without reducing autonomy to interpersonal preference [20].

On that foundation, the proposed Relational Decision-Authority Framework asks five linked questions. First, what agency does the person retain for this decision, including the ability to express values and participate meaningfully? Second, what feasible support could strengthen that agency without redirecting it? Third, what interpersonal influences are enabling, distorting, or controlling the decisional process? Fourth, what is the temporal status of the difficulty—stable, fluctuating, urgent, reversible, or prospectively addressed? Fifth, if authority is displaced, what exactly justifies the displacement, how narrow is its scope, and what conditions should trigger reconsideration?

The ordering matters analytically but is not an algorithm. Retained agency is considered before displacement because the framework is designed to preserve the person's authorship where possible. Support follows because apparent inability may be partly interactional or remediable. Influence is then examined because the same relational environment that enables agency can also distort it. Temporality tests whether a current allocation should persist. Only then is displacement analysed as a separate justificatory step. This sequence is a proposed normative discipline, not evidence that every clinical decision can or should proceed through identical stages.

No single component produces an authority verdict. A person can need extensive support yet retain authority; strong relational involvement can coexist with patient control; and temporary inability to decide one matter need not justify domain-wide or enduring displacement. Conversely, relational framing must not romanticize dependence or deny situations in which another decision-maker is genuinely required. The framework also leaves room for a person's autonomous wish to delegate, because preserving agency includes respecting choices about how agency is exercised.

Decision authority is therefore treated as a layered normative status: grounded in retained agency, enabled or constrained by relational conditions, situated in time, and bounded by the justification for any transfer. The framework's distinctive claim is not that authority is always shared, but that its ethical legitimacy can depend on relations and temporal conditions even when final control remains individual. **Figure 1** presents this architecture as an original conceptual synthesis rather than a validated causal model.

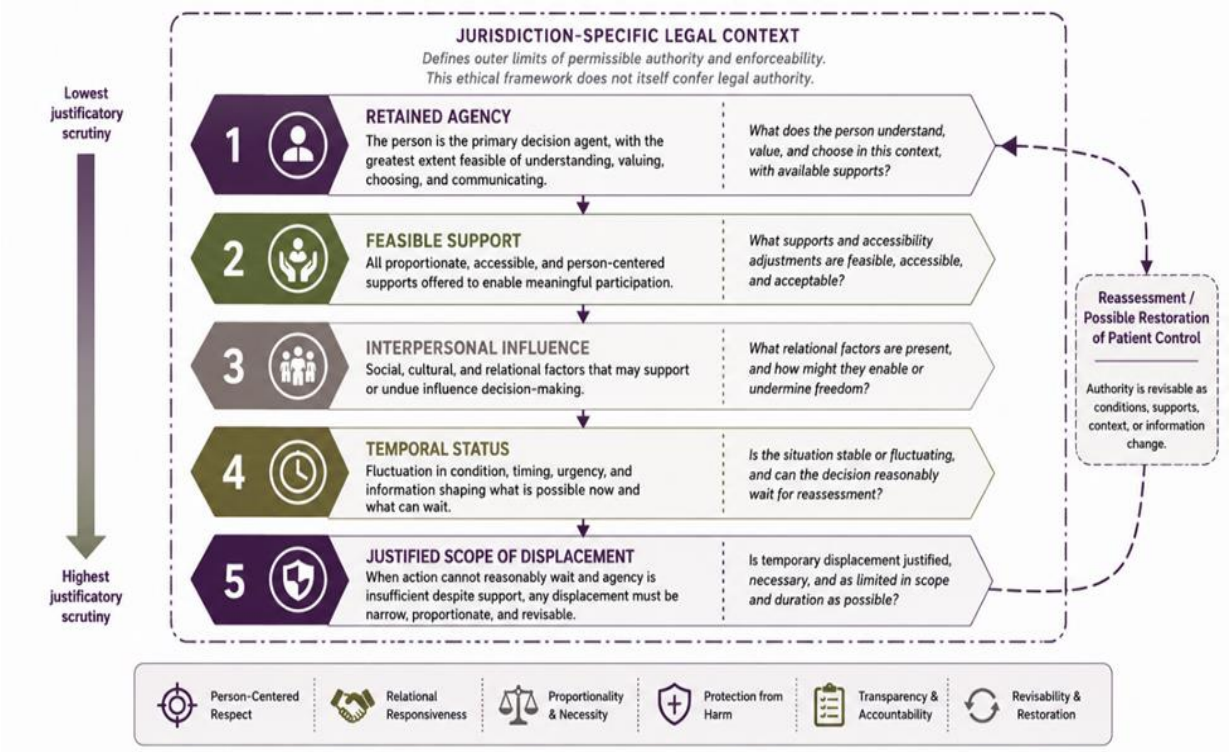

Figure 1. Layered Relational Decision-Authority Architecture

Safeguards against undue influence and displacement

A relational account of authority carries an immediate danger: the same relationships that make choice possible can also redirect it. The relevant safeguard cannot therefore be independence from influence, because ordinary decision-making is saturated with advice, emotion, trust, dependence, and persuasion. Craigie argues that interpersonal influence in supported decision-making must be distinguished from undue influence rather than treated as inherently autonomy-defeating [21]. The normative question is whether influence helps the person understand, deliberate, and express values or instead exploits vulnerability, suppresses alternatives, or substitutes another person's ends.

Court judgments provide a useful, though jurisdictionally limited, view of how such influence appears in practice. Ariyo and colleagues identified several mechanisms through which interpersonal relationships can affect the abilities considered in capacity disputes, including effects on understanding, using or weighing information, and communicating a choice [22]. Because litigated cases are atypical, these findings cannot establish prevalence. They nevertheless show why a supporter should not be classified as benign or coercive simply by role: a spouse, clinician, parent, or advocate can facilitate agency in one respect and constrain it in another.

The framework therefore proposes safeguards against both undue influence and displacement. Support should remain transparent about whose values are being advanced; disagreement should not itself be recoded as incapacity; the patient's own account should remain visible when others speak; and any transfer of control should be no broader than its justification. The existence of interpersonal influence does not itself establish undue influence; the ethical task is to distinguish enabling influence from influence that compromises agency or decision-making [21, 22]. Equally, protection cannot become a reason to eliminate relationships that the person values. The goal is not relational purity but relational accountability: assistance should enlarge the person's practical authorship where possible and make any departure from it explicit, contestable, and revisable. Where supporters disagree, the conflict should trigger closer examination of the person's own reasons and the basis claimed for influence rather than an informal vote among relationships.

Application to supported and fluctuating decisions

The framework's practical value lies in changing the order of questions asked when decisional ability is uncertain. For people with intellectual disability, a systematic review identified the importance of accessible information, communication adjustments, and appropriate support within consent processes [23]. Accordingly, observed difficulty should first prompt inquiry into whether the decision environment is creating avoidable barriers. Simplifying information, changing communication format, involving a trusted supporter, or allowing more processing time can alter participation without implying that accommodation itself guarantees capacity.

Mental healthcare illustrates why support must also be evaluated for power. A qualitative meta-summary found that stigma and power imbalances can hinder patients' participation in shared decision-making [24]. A formally collaborative encounter may therefore remain substantively displaced if professional authority determines which reasons are heard, which options are treated as realistic, or whether disagreement is interpreted as pathology. The relational framework asks whether support increases the person's ability to author the decision or merely produces compliance in a more participatory vocabulary.

Fluctuating cases add a temporal question. Cheung argues that capacity-restoring interventions deserve explicit consideration within analysis of the Mental Capacity Act 2005 [25]. The argument is jurisdiction-specific and does not establish a universal duty to restore capacity, still less a mandate for burdensome intervention. It nevertheless supports a broader ethical question: when a reversible barrier can feasibly be addressed, should authority be displaced before reasonable restoration has been attempted? In the proposed framework, restoration is relevant only when proportionate to urgency, burden, expected benefit, and the person's own values.

Hard cases expose the limits of any simple hierarchy. An urgent irreversible decision may not permit delay. A prior directive may conflict with a present preference expressed under impaired ability. Family members may disagree about what support means. A person may autonomously prefer delegation. In such cases the framework does not supply a score. It requires the decision-makers to state what agency remains, what support has been tried, what influence is operating, why timing matters, and why any displacement is justified now rather than assumed indefinitely. **Figure 2** depicts this application as a recursive temporal sequence in which support, allocation, and reassessment remain connected.

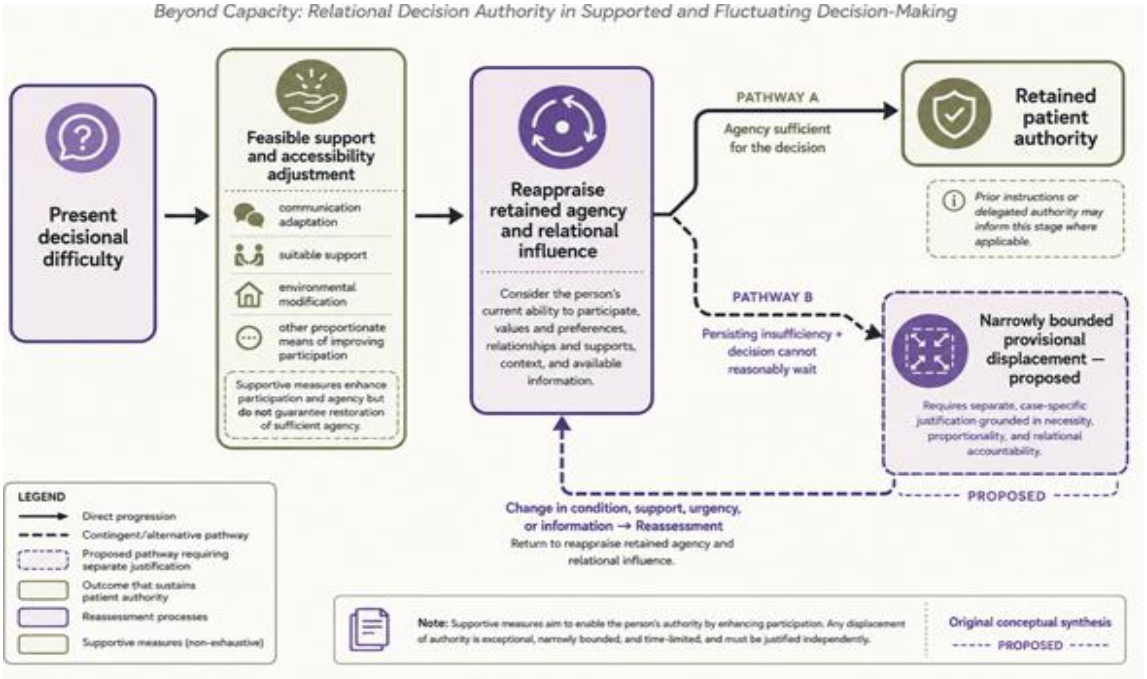

Figure 2. Recursive Authority Reassessment Sequence

Legal and jurisdictional boundaries

Relational decision authority is an ethical framework, not a new source of legal power. That distinction is essential because apparently similar capacity statutes can acquire different meanings through doctrine, institutions, professional practice, and social context. Chua, Kong, and Dunn show that the Mental Capacity Act model has developed differently in England and Wales and Singapore, challenging simple assumptions that statutory similarity produces equivalent decisional practice [26]. The framework therefore cannot determine who is legally entitled to consent, refuse, appoint a proxy, or bind future decision-makers. Those questions remain jurisdiction-specific.

Law also operates within material institutions. Birchley and Finnerty argue that resource constraints can restrict the realization of person-centred best-interests decision-making under the Mental Capacity Act [27]. Time, staffing, access to communication expertise, continuity of relationships, and availability of suitable supporters can therefore affect whether relationally attentive decision-making is feasible. Scarcity does not itself justify stripping a person of authority, but a framework that ignores scarcity would mistake an ethical ideal for an available practice.

The proposed framework should consequently function as a second-order analytic aid: it can identify ethically relevant features that formal capacity or best-interests rules may not make sufficiently visible, while applicable law still governs formal authority. Its concepts should be translated cautiously across jurisdictions, especially where legal capacity, substitute decision-making, advance directives, emergency treatment, and supported decision-making have different statutory meanings. Ethical criticism may reveal reasons to reform law, but it cannot be presented as law merely because its normative argument is persuasive. Nor can the framework displace emergency powers, procedural safeguards, advance-directive rules, or statutory definitions simply because a different relational allocation appears ethically preferable.

Limitations

This framework synthesizes heterogeneous normative, legal, and empirical literatures and has not been validated as an assessment instrument. Equity is a particular concern. Garrett and colleagues found racial disparities in referral for psychiatric decisional-capacity consultation in a single US tertiary centre [28]. The study cannot establish universal discrimination, but it shows that unequal scrutiny may arise before the eventual capacity judgment. A relational framework could reproduce rather than reduce such inequity if judgments about credibility, support, risk, or "appropriate" relationships are applied selectively.

Assessment itself also requires caution. Mirza and Appel argue that capacity evaluation can function as a clinical intervention rather than a neutral measurement event [29]. Repeated reassessment may therefore carry burdens as well as benefits. The absence of a dedicated measure for shared decision-making under limited decisional capacity further limits claims of operational precision [17]. Equity concerns remain context-sensitive rather than quantified universally [28], and the intervention-like effects of assessment remain conceptually argued rather than clinically validated [29]. The framework consequently requires participatory refinement, construct testing, inter-rater study, longitudinal evaluation in fluctuating states, and cross-jurisdictional research before any claim of clinical utility or implementation readiness. Its categories may also require revision where decisional authority is collective by law, culturally configured differently, or practically inseparable from institutional constraint.

Conclusion

Decision-making capacity answers an important but incomplete question. Supported and fluctuating decisions also require attention to who exercises authority, how relationships shape that exercise, how long any displacement should last, and what would justify returning control. The Relational Decision-Authority Framework proposed here separates those questions without denying the continuing importance of functional capacity assessment or jurisdiction-specific law.

Its central claim is modest but consequential: decision authority can remain patient-centred while being relationally enabled and temporally revisable. Support does not automatically transfer control; shared deliberation does not automatically create shared authority; and present inability does not automatically justify permanent displacement. Conversely, relationality offers no immunity from coercion, domination, or genuine incapacity. The framework therefore treats safeguards, timing, reassessment, and the justification of transfer as integral to authority rather than peripheral additions. Its value remains conceptual until

tested across populations, professions, hard cases, and legal systems. That limitation is integral to the proposal: the framework is intended to improve the questions asked about authority, not to predetermine their answers or replace the judgment required in particular decisions.

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