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## *A Critical Analysis of Joseph Fins' Mosaic Decisionmaking: A Response to "Mosaic Decisionmaking and Reemergent Agency after Severe Brain Injury" (CQ 27 (1))*

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**Abstract:** In this paper, the author argues that Joseph Fins' mosaic decisionmaking model for brain-injured patients is untenable. He supports this claim by identifying three problems with mosaic decisionmaking. First, that it is unclear whether a mosaic is a conceptually adequate metaphor for a decisionmaking process that is intended to promote patient autonomy. Second, that the proposed legal framework for mosaic decisionmaking is inappropriate. Third, that it is unclear how we ought to select patients for participation in mosaic decisionmaking.

**Keywords:** brain injury; brain-injured patients; mosaic decisionmaking; patient autonomy

### 1. Introduction

Brain injury is an international health problem that places a significant burden on patients, their families, and healthcare systems. Globally, it is estimated that 50–60 million traumatic brain injury cases occur annually, with 10% of these cases being classified as moderate to severe.<sup>1</sup> In the United States, incidence of traumatic brain injury is estimated at 3.5 million per year, with an annual cost-burden of at least \$76.5 billion.<sup>2,3</sup> Improvements in neurocritical care have increased survival rates following brain injury, but outcomes remain variable. Of those who survive in the United States, it is estimated that at least 3.17 million

are currently living with cognitive impairments associated with traumatic brain injury. These individuals often require specialized care from families or rehabilitation facilities for the rest of their lives.<sup>4,5</sup>

Ethical issues germane to the treatment of brain-injured patients are complex and multifaceted.<sup>6,7,8,9,10,11</sup> Among the most difficult of these issues is defining the role that brain-injured patients might play in healthcare decisionmaking.<sup>12,13,14,15,16,17</sup> In the acute phase of injury, a surrogate decisionmaker is appointed for brain-injured patients who have impaired decisionmaking capacity. However, over a period of weeks or months, such patients might

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recover cognitive function, and it might become apparent that they can—and should—participate in healthcare deliberations. The principle of autonomy requires that healthcare professionals respect the choices of people who possess decisionmaking capacity.<sup>18</sup> Yet cognitive impairments secondary to brain injury might raise questions regarding a patient's decisionmaking capacity. Clinicians must reconcile the principle of autonomy with their duty to protect patients from harm. But this might be difficult if a patient's capacity is marginal or fluctuates. How should clinicians and families proceed under such circumstances?

One response to this question is mosaic decisionmaking.<sup>19</sup> Mosaic decisionmaking is a model of healthcare decisionmaking that seeks to balance the competing ethical principles of autonomy and beneficence in healthcare deliberations with brain-injured patients. This model, proposed by Professor Joseph Fins in 2018, outlines a consensus decisionmaking process that is grounded in New York state legislation regarding healthcare decisions for incapable adults cared for by the state. The product of this model, according to Fins, is a decisionmaking process that respects the reemergent agency of brain-injured patients while also acknowledging a clinician's duty to protect patients from harm.

Contrary to Fins' account, I argue that mosaic decisionmaking is untenable. I support this claim by identifying three problems with mosaic decisionmaking. First, I argue that it is unclear whether a mosaic is a conceptually adequate metaphor for a decisionmaking model that is intended to promote patient autonomy. I demonstrate that, although the mosaic metaphor might support the aim of respecting the reemergent voices of brain-injured patients, it is also possible that it could silence them. Second, I argue that the proposed legal framework for

mosaic decisionmaking is inappropriate. The New York state legislation discussed by Fins was originally designed to expedite *pro forma* legal proceedings for incapable adults who lack a surrogate decisionmaker. Mosaic decisionmaking, however, is designed for a different purpose, and this discordance challenges its applicability. Third, I argue that it is unclear how we ought to select patients for participation in mosaic decisionmaking. Although the mosaic approach is intended to circumvent challenges raised by the standard model of surrogate consent, it also raises difficult questions regarding how we identify patients for whom mosaic decisionmaking is ethical.

I begin with an exegesis of mosaic decisionmaking and its proposed legal framework. I then address each of the above-outlined problems. I conclude that these problems suggest that mosaic decisionmaking should be abandoned.

## 2. Mosaic Decisionmaking

Mosaic decisionmaking is a model of healthcare decisionmaking that seeks to balance the competing ethical principles of autonomy and beneficence in healthcare deliberations with brain-injured patients. Clinicians have a duty to respect and promote patient autonomy, yet they also have a duty to protect patients from harm. These duties stem from the fiduciary relationship between patients and clinicians. Fiduciary relationships are characterized by structural inequality in which one party has more power or control than the other. This inequality engenders dependence and vulnerability.<sup>20</sup> Clinicians, by virtue of their knowledge, expertise, and authority to prescribe, have power over sick and vulnerable patients. Patients therefore place their trust in clinicians to treat them competently. Violation of this trust undermines the fiduciary relationship.

A standard approach to harmonizing the principles of autonomy and beneficence during consent is the assessment of a patient's decisionmaking capacity.<sup>21,22,23</sup> If a patient has decisionmaking capacity, then clinicians must respect her autonomy consistent with the duty of care. If a patient's capacity is impaired, then clinicians have a duty to protect the patient from harm. A surrogate decisionmaker is appointed under such circumstances.

Recovery from brain injury does not always comport to this standard approach. A patient's cognition might fluctuate, and it might not be clear whether or when a patient has decisionmaking capacity. What is evident is that brain-injured patients could have authentic preferences that emerge during recovery. Such preferences are not equivalent to an autonomous choice, but surrogates are still obligated to respect them, where possible. Lack of sensitivity to these preferences, according to Fins, could "silence [patient] voices and constitute an injustice to their reemergent agency."<sup>24</sup>

To address this problem, Fins proposes mosaic decisionmaking. Mosaic decisionmaking allows brain-injured patients to participate in healthcare decisions, but also introduces a number of "fail safes" to prevent decisions that undermine patient welfare. As Fins describes:

To accommodate a patient's reemergent voice, yet not let it speak beyond its range and capabilities, any normative framework of analysis would need to have fail safes and multiple sources of input before decisions were undertaken.<sup>25</sup>

Fins continues:

To that end, I will suggest a mosaic approach to decision making. [...] Like a mosaic's shards that coalesce to create discernable patterns, pieces of information and perspectives can come together to create a coherent

picture with the result being the inclusion of the patient's voice into the deliberative space [...].<sup>26</sup>

The metaphor of a mosaic is intended to capture a consensus process. Consensus can be interpreted here in at least two ways. First, the mosaic approach seeks consensus among interested parties, such as the patient, family members, and clinicians, who could be involved in the decisionmaking process. Second, the mosaic approach seeks consensus among pieces of information, such as differences in a patient's attitudes before and after injury, which might be used as reasons for selecting one therapy over another.

In practice, Fins proposes organizing decisionmaking committees, or mosaic ensembles, that include (at least) the patient, the patient's surrogate, a clinician, and a representative of a patient advocacy group. The committee addresses healthcare decisions together and seeks to merge competing interests into a unified healthcare decision. The decisionmaking authority of the committee would carry the same force as that of a surrogate. However, as Fins explains, individual committee members would have different authoritative roles:

Because of the surrogate's relationship to the patient, and the primacy of negative over positive rights which stem from the right to be left alone, the surrogate would have veto power over any decision emerging from mosaic deliberations.<sup>27</sup>

The surrogate's authority, however, would be balanced with that of the patient's reemergent agency and the views of other committee members. Fins states that:

Although the surrogate's agreement would be necessary, it might not be sufficient absent the integration of the views of the patient and the larger group.<sup>28</sup>

These structural features serve at least two purposes. First, the veto power of the surrogate ensures that no healthcare decision is made without her agreement. This feature stems from the principles of autonomy and beneficence, and operates under the assumption that a surrogate is in the best position to provide a substitute judgment; a surrogate's veto power is an extension of patient's right to dissent. Second, the consensus requirement for consent serves to temper unilateral surrogate decisions. As Fins describes, it is plausible that a surrogate might be insensitive to the reemergent agency of a patient. The consensus requirement thus assists the patient in reclaiming her autonomy while also ensuring that she is protected from harm.

The result of the mosaic approach, according to Fins, is a decisionmaking process that balances the patient's reemergent agency with the fiduciary obligations of other committee members. Like the checks and balances of the different branches of the United States government, the mosaic approach attempts to harmonize the decisionmaking authority of the surrogate, clinicians, and the recovering patient.

The proposed legal framework for mosaic decisionmaking is an approach to healthcare deliberations for incapable adults housed in New York state healthcare facilities. As Fins describes:

This consensus model for mosaic decision making is based on a process used by the New York State Commission on Quality of Care for the Mentally Ill, which makes decisions for isolated incapacitated patients with mental illness. In the absence of family members or other surrogates, the Commission assembles surrogate decision-making committees to reach a consensus on major medical decisions. [Surrogate decision-making committees] are made up of 12 members, and

operate in smaller groups of 4 members drawn from a larger panel [...].<sup>29</sup>

This approach, adopted as a pilot program in New York state in the 1980s, was motivated by a desire to circumvent legal proceedings designed to resolve adversarial disputes regarding healthcare decisions for incapable adults.<sup>30,31</sup> Prior to the program's adoption, a court order was required for healthcare decisions for incapable adults with no surrogate decisionmaker, even if all clinical staff agreed on the treatment plan. Such court orders were time-consuming, had little to do with the patient's treatment, and often resulted in legal fees. They were thus perceived as *pro forma* legal procedures rather than legal necessity.<sup>32,33</sup> Surrogate decisionmaking committees were adopted as an alternative to "fill the legal void."<sup>34</sup>

As described by Fins, the law stipulates that surrogate decisionmaking committees should be composed of at least 12 members. A 4-member subgroup is drawn from the larger group and must contain representatives of the following categories: clinicians, former patients or their family members, an attorney, and a member of a patient advocacy group. Healthcare decisions are made by the 4-member group and carry the same legal authority as that of a surrogate.<sup>35</sup> The committee's decisionmaking authority is limited to major healthcare procedures. Major healthcare procedures are defined as those that require general anesthesia or that could result in a violation of bodily integrity, pain, discomfort, and a lengthy recovery period.<sup>36</sup>

Studies following the implementation of this pilot program demonstrated success.<sup>37</sup> Of the 192 cases evaluated, the average duration between application for a surrogate decisionmaking committee and final decision was approximately

14 days, and the quality of review of healthcare decisions increased substantially. Indeed, one advocate of the program observed that, in some cases, committee review encouraged attending clinicians to modify proposed healthcare interventions to less invasive procedures with equivalent benefit. A 10-year follow-up study demonstrated continued success. Clarence Sundram and Paul Stavits observed that the program:

bears out the view [...] that in most healthcare decisions there is no need for adversarial proceedings and thus a court of law is not the ideal forum to decide what is in an incompetent person's best interests in such cases.<sup>38</sup>

Despite the reported success of surrogate decisionmaking committees, some have argued that ethical considerations regarding consent and autonomy have been ignored. For example, Tracy Miller and colleagues observed that committees followed clinician recommendations in all but a few cases.<sup>39,40</sup> As we shall see, this raises concerns about medical paternalism, which could impact the effectiveness of mosaic decisionmaking in promoting the reemergent agency of brain-injured patients.

### 3. A Critical Analysis of Mosaic Decisionmaking

Mosaic decisionmaking is a model of healthcare decisionmaking that is based on New York state law regarding surrogate decisionmaking committees. The approach seeks to incorporate brain-injured patients in healthcare deliberations while also introducing protections that prevent decisions that could undermine patient welfare. Although mosaic decisionmaking is, at first blush, a plausible approach to incorporating recovering brain-injured patients in healthcare

deliberations, I argue that the position is untenable. In what follows, I identify three problems with mosaic decisionmaking. These problems suggest that mosaic decisionmaking should be abandoned.

#### 3.1. *Is a Mosaic a Conceptually Adequate Metaphor for a Decisionmaking Process that is Intended to Promote Patient Autonomy?*

Fins uses the metaphor of a mosaic to capture at least two features of mosaic decisionmaking. First, the shards of a mosaic represent the multiple sources of information and perspectives that can be brought to bear on healthcare deliberations. Second, the way in which the collection of shards reveals a full image represents the consensus process of the mosaic ensemble. Although a mosaic is an effective rhetorical device, it is unclear whether it is a conceptually adequate metaphor for a decisionmaking process that is intended to promote patient autonomy.

Consider first the visual processing of a mosaic. Mosaics are constituted by colored glass or stone tiles of roughly the same size and shape. The artistic mechanism of a mosaic is to create a visual representation by arranging the tiles in patterns. The pointillist branch of Impressionism used a similar approach by arranging clusters of individual color points. The individual color points or tiles do not themselves represent. Rather, the visual representation emerges from their collective color, shape, and organization. Neuroscientists observe that such artistic approaches succeed by exploiting the two-stream processing of the human visual system.<sup>41,42</sup> Some aspects of our visual system are effective at processing color, but not at locating objects in space. When presented with a mosaic, our visual systems blend the tiles into a unified image.

Evidently, that mosaics succeed in generating unified visual images is due

to the processing features of the human brain and the artistic arrangement of colored tiles. But does this metaphor carry over to healthcare deliberations? Contrary to Fins' intuition, this unifying feature is not necessarily guaranteed in healthcare deliberations that include multiple—and potentially conflicting—attitudes of different parties. The mosaic is intended to capture a consensus decisionmaking process. But while consensus could promote patient autonomy, it is equally plausible that it could violate it.

To sharpen this point, consider deliberations for a cystoscopy for a 30-year-old male recovering from a severe brain injury. The patient has displayed signs of cognitive recovery over 5 months, including the ability to verbalize single words. Since injury the patient has been catheterized due to incontinence, but a progressive bout of hematuria has alarmed clinical staff and a cystoscopy is recommended. Sedation is required for the procedure. As Fins envisages, a mosaic ensemble would likely be organized to deliberate consent to the cystoscopy. The committee would include (at least) the patient, the patient's surrogate, a healthcare professional, and a member of a patient advocacy group.

Now suppose that all members of the committee, except the patient, agree to the cystoscopy. The patient consistently indicates, through broken communication and facial expressions, that he does not want the cystoscopy, as he has been catheterized multiple times in the past and has had poor experiences with catheterization and sedation.

According to mosaic decisionmaking, although the patient's preferences are considered, they represent only one aspect of the multiple pieces of information and perspectives that inform the healthcare decision.<sup>43</sup> The views of the patient advocate, healthcare professional, and surrogate would likely outweigh the objections of the patient, as the

patient's preferences (one might argue) are inconsistent with his own welfare. It is thus plausible that, although being incorporated within the deliberative space, the patient's preferences would be discounted relative to the views of other committee members. A mosaic decision has been made, but in spite of the patient's preferences, not in support of them.

Fins might argue that this is precisely the kind of healthcare scenario that warrants the protections of mosaic decisionmaking. After all, the patient could be harmed if an otherwise safe and effective treatment for a serious condition was declined. But this raises the following puzzle: is it ever possible for a patient's "voice to be heard" if her preferences are inconsistent with that of the majority view? The fact that the mosaic approach is oriented *toward the majority* suggests that the decisionmaking process could be biased toward paternalism, and the data on surrogate decisionmaking committees appear to suggest as much.<sup>44,45</sup> If autonomy is to mean anything, then surely it should mean that patients ought to have the authority to (at least) dissent to treatment. It is unclear if mosaic decisionmaking secures this right.

### 3.2 Is the Legal Framework for Mosaic Decisionmaking Appropriate?

Mosaic decisionmaking stems from New York state legislation, which establishes surrogate decisionmaking committees for major healthcare decisions involving incapable adults cared for by the state. Surrogate decisionmaking committees were designed to "fill the legal void" of apparent *pro forma* legal proceedings.<sup>46</sup> Although surrogate decisionmaking committees have been broadly successful, there are several reasons to doubt whether this is an appropriate legal framework for mosaic decisionmaking.

First, surrogate decisionmaking committees were designed to resolve healthcare decisions for incapable patients who lack family or individuals with sufficient knowledge to fulfill the role of a surrogate decisionmaker. By contrast, most—if not all—of the patients who Fins regards as potential candidates for mosaic decisionmaking do have surrogate decisionmakers. This is true of all the brain-injured patients enrolled in studies conducted by our lab at the University of Western Ontario.<sup>47</sup> And, to my knowledge, this is also true of the patients whom Fins describes in his own work: Maggie Worthen and Kenny Quigley.<sup>48,49</sup> It is therefore puzzling why mosaic decisionmaking stems from a legal framework designed for patients who lack a surrogate decisionmaker. What is the added benefit of a mosaic ensemble relative to a surrogate decisionmaker? If a surrogate decisionmaker is already faithfully gathering preferences from a patient to inform healthcare decisions, then presumably a mosaic ensemble provides no added benefit. In fact, involving more parties in the decisionmaking process could lead to healthcare decisions that are less efficient and less reflective of the patient's values.

Fins might argue that some brain-injured patients could lack a surrogate decisionmaker, and that guidance would be needed to address major healthcare decisions as these patients recover. I grant that a decisionmaking committee might be warranted in these cases. Yet Fins argues that, even if a surrogate is present, it is plausible that a mosaic ensemble would be warranted to prevent unilateral surrogate decisions.

Herein lies a critical flaw. What justifies placing restrictions on a surrogate decisionmaker's authority without running afoul of established surrogate laws? This question leads to a dilemma. On one hand, we could adhere to the received legal view of surrogate decisionmaking,

according to which a surrogate has ultimate decisionmaking authority over the patient. But this would suggest that mosaic ensembles are not warranted in overriding the authority of a surrogate in any case. On the other hand, we might acquiesce to Fins' proposal, but in doing so we abandon this received legal view. Indeed, on this view, the individual fulfilling the role of the surrogate ceases to be a surrogate decisionmaker in any meaningful sense once she is incorporated within a mosaic ensemble, for she no longer has ultimate decisionmaking authority. The very concept of a surrogate decisionmaker is thus incompatible with mosaic decisionmaking. To claim that a legally appointed surrogate decisionmaker can participate within a mosaic ensemble, while still retaining some—but not all—decisionmaking authority, is simply incoherent.

A second problem involves the appointment of the clinician to the mosaic ensemble. Who may permissibly serve as a clinician on the mosaic ensemble? Article 80.05 (h) of the New York surrogate decisionmaking committee law states that:

No member who is a provider of health services or an officer or employee of any provider of health services to a patient whose case is under consideration by a panel may serve with respect to such patient.<sup>50</sup>

This provision ensures that committee members avoid conflicts of interests. If the patient's attending clinician were to serve on a decisionmaking committee, her fiduciary obligations could be violated as she might be tempted to make healthcare decisions for the patient which result in her own financial or professional benefit. These decisions would be made in her best interests, not the patient's.

Fins, by contrast, is not explicit about this provision. In fact, he seems to

suggest that members of a patient's immediate clinical team might permissibly serve on a mosaic ensemble. While acknowledging that he has not yet developed a procedural solution for choosing the members of a committee, Fins asserts that the individuals fulfilling the roles of "[...] the patient, surrogate, and physician are *fixed by circumstances* [...]."51 A charitable interpretation of this passage might read it as consistent with New York state law. But what could "fixed by circumstances" mean other than the circumstantial relationships that the patient, surrogate, and physician are already in? This vagueness is worrisome, as it leaves open the possibility of conflicts of interests emerging from mosaic decisionmaking. A cardinal rule of the ethics of healthcare decisionmaking is that clinicians should never be allowed to provide consent on behalf of their own patients. Not only would this lead to potential violations of the fiduciary relationship, but it also constitutes the very essence of medical paternalism. If any member of a patient's immediate clinical team may permissibly serve on a mosaic ensemble, this alone would disqualify mosaic decisionmaking as an ethical practice.

Yet a third problem with using surrogate decisionmaking committees as a legal framework for mosaic decisionmaking is that such committees are oriented toward the protection of patient welfare, rather than the promotion of patient autonomy. Sundram notes that the final consideration of a surrogate decisionmaking committee is to determine whether a healthcare decision reflects the *best interests* of the patient. Sundram observes that, while such committees do not entirely reject the standard of substitute judgment, surrogate decisionmaking committees are oriented toward a best-interest standard in light of the fact that, "in many cases of institutionalized mentally disabled persons, [...] there may

be no basis on which to determine what the patient would have wanted."<sup>52</sup>

Fins might argue that mosaic decisionmaking modifies the legal framework to allow for the promotion of patient autonomy. Inclusion of the patient and her surrogate in the decisionmaking process could allow for a reorientation of the model toward substitute judgments—or current patient judgements, as the case may be—and this is an affirmation of the reemergent agency of the patient. But this brings us back to the difficult territory surveyed above: how do we weigh the preferences of the patient against the potentially conflicting attitudes of other members of the mosaic ensemble? And how does the committee justify overriding the authority of the surrogate in light of established surrogate decisionmaking laws? The New York state legislation raises no such problems because it was designed for incapable patients who *lack* a surrogate decisionmaker. Mosaic decisionmaking, by contrast, is not designed for this purpose.

### 3.3 For Whom is Mosaic Decisionmaking Ethical?

How do we determine which brain-injured patients should participate in the mosaic approach? Fins answers this question by sketching a method in which individual mosaic ensembles make these selections. "Collectively," Fins states:

[the committee] would seek to determine thresholds to help titrate the patient's voice. [...]. [T]he patient's ability to partake in decisions is tied to his or her ability to understand the question under consideration, integrate the relevant information, and evidence heightened degrees of "evidencing understanding."<sup>53</sup>

Fins elaborates on this method by describing a case in which a



brain-injured patient, Kenny Quigley, participated in a healthcare decision with his family. When deciding between different long-term care facilities, Kenny's mother, Elinor Quigley, asked her son if he preferred to move out of his group home. Elinor explained that Kenny wanted to stay. As evidence, Elinor pointed to the *persistence* of Kenny's views and their *consistency with his actions*. When asked whether he wished to move away from his group home, Kenny would consistently answer "no" and this complemented his positive behavior at the facility.

Fins endorses this approach, stating, "it was this combination of Kenny's words and deeds that showed that he understood the choice at hand and conveyed his desire to stay in the group home."<sup>54</sup> Fins argues further that Kenny's family viewed him as a moral person; they felt a duty to incorporate him in the decisionmaking process and to respect his preferences, where possible.

Although this is a plausible decisionmaking heuristic for the Quigley family, we should be cautious of using this example as justification for mosaic decisionmaking. First, the Quigley's decisionmaking process is not the mosaic approach. Mosaic decisionmaking involves a decisionmaking committee. The Quigley's decisionmaking process did not (at least as it is described by Fins). Rather, their decisionmaking process comported to the standard legal and ethical frameworks of surrogate decisionmaking, wherein surrogates are obliged to incorporate the preferences of a patient in healthcare decisions, where possible. To suggest that the Quigley's decisionmaking process is a genuine instance of mosaic decisionmaking is misleading.

Second, even if the Quigley's decisionmaking process is a genuine instance of mosaic decisionmaking, Fins' appeal to the consistency and persistence of a

patient's words and deeds as evidence of understanding is problematic. After all, many patients with demonstrably impaired understanding of their healthcare situation are still able to consistently and persistently express words and deeds regarding healthcare decisions. Patients diagnosed with somato-paraphrenia, for example, suffer from monothematic delusions that result in denial of ownership of bodily limbs.<sup>55,56</sup> Remarkably, such delusions are immune to explanation or proof. In severe cases, these patients will *persistently* request amputation, and this is *consistent* with certain pathological behaviors. Should we therefore respect these patients' preferences?

According to Fins' account, it seems that we might be obligated to incorporate these patients within the decisionmaking process. But this is counterintuitive. Although consistency and persistence of words and deeds should inform the interpretation of a patient's capacity to participate in mosaic decisionmaking, this alone is insufficient to conclude that a patient understands her healthcare situation.

One might argue that the above counterexample commits a strawman fallacy. The relative risks of moving to different long-term care facilities do not map onto the risks of amputation. And having preferences about different long-term care facilities is considerably different than making healthcare decisions on the basis of delusions.

One might also argue that the above criticism confuses *expressing preferences* with *making a choice*. Making a choice would require robust understanding of one's healthcare situation, whereas expressing a preference requires relatively less understanding. Jason Wasserman and Mark Navin recently argued that the capacity for preferences is distinct from the capacity to consent.<sup>57</sup> On their view, "a person

has a preference when there is something the person likes better, would sooner have, or would select over something else” in the context of a bounded choice. A bounded choice occurs when a patient is presented two or more treatment options, of which the differences in health outcomes are negligible, and is told that at least one of the treatments is going to happen. Wasserman and Navin argue further that an expression becomes a morally weighty preference in virtue of its reliability. Thus, although many brain-injured patients should not be allowed to make a healthcare choice autonomously, the fact that they consistently and persistently express preferences might imply that they should be incorporated in some healthcare deliberations.

These assertions resemble Fins’ assessment of Kenny Quigley’s preferences. On this view, the inclusion of Kenny in mosaic decisionmaking is justified because: (1) his expressions are reliable and are thus morally weighty preferences; (2) he is expressing a preference within a bounded choice of at least two long-term care facilities that, given the available information, are not significantly different in their impact on health outcome; and (3) the health risks of moving to either long-term care facility are low. If faithful to Fins’ account, I find this analysis helpful as it clarifies several ambiguities of mosaic decisionmaking. But this additional clarity invites several further problems.

Consider the following line of reasoning: we can grant that respecting the preferences of patients recovering from brain injury is justified because, *inter alia*, they are morally weighty preferences. Does it follow that a mosaic ensemble is required to respect these preferences? On the contrary, respect for preferences can be accomplished through a standard surrogate decisionmaking framework. A surrogate is obligated, where possible,

to incorporate the preferences of a patient in her decisionmaking process. This is precisely what Elinor Quigley did. This suggests again that mosaic decisionmaking might be unnecessary.

But suppose that mosaic decisionmaking is necessary in at least some cases. In those cases, how reliable should a patient’s preferences be, in order to justify their incorporation in mosaic decisionmaking? It is well known that cognition—particularly executive processing—can fluctuate during recovery from brain injury, and this could influence the reliability of a patient’s preferences. How should we account for this? Fins suggests that individual mosaic ensembles should be free to set thresholds, according to which patient preferences are either incorporated or excluded from mosaic deliberations. This is not a defensible position. Granting individual decisionmaking committees this authority could lead to *ad hoc* decisions regarding who benefits from mosaic decisionmaking and who does not. Given the constitution of mosaic ensembles, it is plausible that these decisions could be biased or fraught with disagreement. If mosaic decisionmaking is to be a serious response to the ethics of healthcare decisionmaking for brain-injured patients, a generalizable framework for setting such thresholds needs to be worked out in advance.

#### 4. Conclusion

I have argued that mosaic decisionmaking is untenable. I have supported this assertion by identifying three problems with mosaic decisionmaking. First, I argued that it is unclear whether a mosaic is the right kind of metaphor for a decisionmaking process that is intended to promote patient autonomy. Although a decisionmaking process based on a mosaic metaphor might

respect the reemergent voices of brain-injured patients, it is equally plausible that it could silence them. Second, I argued that the proposed legal framework for mosaic decisionmaking is inappropriate, as most—if not all—of the candidates for mosaic decisionmaking do not lack a surrogate. Mosaic decisionmaking would likely run afoul of established surrogate laws. Finally, I argued that it is unclear how we ought to select patients for participation in mosaic decisionmaking. I attempted to resolve this problem by appealing to a patient's capacity for preferences. But this line of reasoning revealed further problems with the decisionmaking model.

For these reasons, I conclude that mosaic decisionmaking is untenable and should be abandoned. I, for one, am highly sympathetic to Fins' project of affirming the rights of patients with severe brain injury. These patients are deserving of our care and consideration, and Fins has made significant and important contributions to this effort. Nevertheless, the devil is in the details. These details need to be addressed if any normative framework is to be a serious solution to the ethics of healthcare decisionmaking for brain-injured patients.

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