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**Decision-Making Capacity and Authenticity**

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**Abstract:** There is wide consensus among bioethicists about the importance of autonomy when determining whether or not a patient has the right to refuse life-saving treatment (LST). In this context, autonomy has typically been understood in terms of the patient’s ability to make an informed decision. According to the traditional view, decision-making capacity (DMC) is seen as both necessary and sufficient for the right to refuse LST. Recently, this view has been challenged by those who think that considerations of authenticity and putative counterexamples should lead us to revise the traditional account. In this paper, we respond to these revisionist arguments and we defend the traditional view according to which we have autonomy-based reasons to respect a patient’s decision to refuse LST if and only if she has DMC.

**Keywords:** Agency; autonomy; authenticity; decision-making capacity; right to refuse treatment

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1. **Introduction**

Some ethicists maintain that autonomy comprises at least two values: self-determination (sometimes also called sovereignty or agency) and authenticity (Christman 2009). Self-determination is the capacity to make choices on the basis of reasons. Authenticity, by contrast, is defined by some theorists as the capacity to live in accordance with one’s deeply held, or reflectively-endorsed, values. Others define it in grander terms, like the ability to live one’s distinctive life (Brudney and Lantos 2011, 221), coherent narrative (Brudney 2009, 35), or to be free from alienated desires (Christman 2009).

In bioethics, decision-making capacity (DMC) is the ability for patients to make informed choices, and is often thought to be a general proxy for autonomy, and self-determination more specifically (Brudney and Lantos 2011). And, ordinarily, when a patient has DMC to refuse life-saving treatment (LST) and wishes to do so, they are taken to have the right to decline such treatment. According to what we will call “the traditional view,” DMC is understood in terms of a set of capacities that are required for making informed decisions about treatment. The patient must be able to (1) “communicate choices,” (2) “appreciate the situation and its consequences,” (3) “understand relevant information” and (4) “manipulate information rationally” (Applebaum and Grisso 1998).

Some physicians are uncomfortable, however, when patients with DMC decline LST in cases where it seems these choices are inauthentic. Consider the case of a patient, Ms. G, described by Brudney and Lantos (2011), who in the past had accepted LST, but who now is declining it (Halpern 2001). Although Ms. G’s husband recently left her for another woman, her psychiatrist nevertheless believes that she has DMC, and that her wish to forgo LST ought to be respected. Other medical team members however disagree because, due to her emotional trauma, she is no longer living in accordance with her deeply held values.[[1]](#footnote-1)

Brudney and Lantos state that even though patients like Ms. G have the legal right to decline LST (in virtue of having DMC), that it may be morally justifiable to override her decision on account of the fact that her choice is inauthentic. They write, “In such situations, clinicians may intuit that mere decisional competence does not reflect a sufficiently robust value to justify going along with, say, the refusal of lifesaving treatment…they want to see such a refusal as part of a more or less stable and coherent set of beliefs and values, as flowing from who the patient is” (Brudney and Lantos 2011, 222). On this framing, the question at issue is whether or not physicians ought to respect the patient’s right to refuse treatment. According to their view, Ms. G has DMC but lacks authenticity, and this leads them to conclude that we are not required to respect her decision. If they are right, this would show that DMC alone is not *sufficient* for generating overriding, autonomy-based reasons for respecting her refusal of LST.

Others have challenged the claim that DMC is a necessary condition of the right to refuse treatment. Navin et al. (2022) present the case of Mrs. P, a patient who refuses LST but who lacks the abilities typically associated with DMC. For instance, she is not able to demonstrate a sufficient understanding of her treatment options; she “does not even understand why she is in the hospital” (2022, 75). Navin et al. argue that physicians nevertheless ought to respect her decision, even though she lacks DMC in the traditional sense. They argue that we should revise our conception of DMC, lowering the threshold that we use to determine a patient's capacities. They suggest that we should include what they call “burdens-based” and “goals-based” capacities in clinical assessments of DMC. If their argument is successful, it would show that traditional DMC is not *necessary* for the right to refuse LST.

In this paper, we will defend the traditional view of DMC from both of these revisionist objections. We begin in section 2 by considering Brudney and Lantos’s argument, which purports to show that DMC is not sufficient for the right to refuse. We agree with their claim that authenticity is morally relevant to autonomy, but we argue that they have set the bar too high. We distinguish between weak and strong conceptions of authenticity. It is plausible to suggest that weak authenticity is among the set of sufficient conditions for refusing LST, but we argue that the traditional view of DMC already accommodates this intuition. It would be less plausible, however, to require patients to possess strong authenticity. This would lead us to override the decisions of many patients whose right to refuse LST ought to be respected.

In section 3, we respond to the challenge posed by Mrs. P, which Navin et al. (2022) take as a reason to expand the concept of DMC. We suggest two different ways of dealing with this objection. First, it could be argued that Mrs. P does not in fact have the right to refuse LST. If Navin et al. are right about burdens-based and goals-based capacities, then this would allow us to find cases where we ought to respect the decision of patients who not only lack traditional DMC but who never had it in the first place. We present an example that is meant to show how this sets the bar too low. On the other hand, we could concede the point and claim that physicians ought to respect Mrs. P’s decision in virtue of her autonomy. But if this is the case, then we argue that traditional DMC already accounts for these reasons. This could be done in one of two ways. First, we could agree with Garrett et al. (2022) who argue that Mrs. P does in fact possess DMC. Or we could side with Koch (2022) who argues that our reasons to respect Mrs. P’s decision stem from the fact that she previously had DMC. Either way, this would vindicate the claim that traditional DMC is indeed a necessary condition for the right to refuse LST.

In section 4, we take stock of our defense and present some of the benefits of preserving the traditional view. If, *pace* Brudney and Lantos, Ms. G does *not* have the right to refuse treatment, then we no longer have to address difficult casuistical questions about when we are permitted to override the choices of capacitated patients. If strong authenticity is not sufficient for autonomy-based refusals, then we can simply say that Ms. G lacks the right to refuse treatment because she lacks DMC. And by resisting the expansion proposed by Navin et al., we can avoid “multiplying clinical standards without necessity,” as Garrett et al. put it (2022). We conclude by considering potential objections and offering replies. For instance, there are many discussions of what to do with patients suffering from anorexia nervosa. Some bioethicists use these examples to demonstrate the importance of authenticity, but we show how the traditional account is already equipped to deal with these cases.

1. **Why DMC is Sufficient to Refuse LST**

Recall that Brudney and Lantos claim that physicians need not respect the decisions of patients like Ms. G to decline LST, that is, patients who have DMC, but whose choices are inauthentic. Are Brudney and Lantos correct?

To answer this question, we need to clarify which definition of authenticity is the most appropriate for patient care. Here are two possible definitions: (1) the capacity to live in accordance with one’s deeply held, or reflectively-endorsed, values, and (2) the ability to live one’s distinctive life (Brudney and Lantos 221), or coherent narrative (Brudney 2009, 35), free from unalienated desires (Christman 2009). We call (1) weak authenticity and (2) strong authenticity. We think (2) cannot be the right definition, at least if distinctive life and coherent narrative mean that an individual’s conception of themselves is as an ongoing unique and unified story. For instance, some views of authenticity might suggest that a woman’s desire for cosmetic surgery is motivated by a “pervasive and oppressive societal ideal,” and this would lead us to “deny that a woman can be autonomous with respect to that desire, no matter how much she personally endorses it” (Pugh 2020, 6).[[2]](#footnote-2) We think this is far too lofty a conception of authenticity. Such a view might be fitting for the normative ideal of authenticity, but it is inappropriate for clinical contexts.

According to another prominent account of strong authenticity, desires are authentic if and only if they pass a historical test for nonalienation (Christman 1991, 2009). Agents must engage in a counterfactual test by asking whether or not they would repudiate their desire if they were to reflect rationally on the process that formed the desire. To see why this also sets the bar too high, consider a patient, Ms. M, who sincerely endorses her religious beliefs as a Jehovah’s Witness. She was raised as a Jehovah’s Witness and her family gave her no choice but to practice the religion. When she comes to the hospital, she refuses a blood transfusion for religious reasons. Even though Ms. M currently endorses her religious beliefs, it is possible that she would have resisted the formation of the desire if she were to reflect rationally on the manipulative or coercive behavior of her parents who inculcated her religious beliefs.[[3]](#footnote-3)

We contend that Ms. M demonstrates capacity; in particular, her decision satisfies the conditions of weak authenticity because it is consistent with her deeply held commitments. [[4]](#footnote-4) Therefore, in virtue of her DMC, her clinicians ought to respect her choice. Importantly, however, she falls short of strong authenticity. But that is not a good reason to override her decision. The concept of autonomy is used in a variety of ways. It is important to distinguish between the normative ideal of autonomy and the moral or political claims that one may assert when demanding that others respect her choices (Feinberg 1989). Conceptions of strong authenticity, such as that suggested by Brudney and Lantos (2011) or Christman (1991, 2009), might outline admirable goals for the former but they surely set the bar too high for latter. There are many cases where we ought to respect patients’ autonomous decisions even if we think that they are not living up to the highest ideals of self-government and authenticity.

If we reject strong authenticity as a condition of autonomy, that leaves us with weak authenticity. On this more earthly conception of authenticity, it is worth pointing out that the way Brudney and Lantos frame their discussion—that self-determination is the underlying value of DMC—is misleading. At first glance, however, their framing might seem right. After all, DMC is simply about making choices—exercising one’s will in an informed way (i.e., on the basis of understanding, appreciation, and reasons). But even though self-determination is clearly at stake in DMC, we believe it is not the only relevant value in play. To demonstrate, we wish to point out that DMC is not just about expressing a choice in a one-off way. Appelbaum and Grisso (1988) state that the capacitated patient should “maintain and communicate stable choices long enough for them to be implemented” (1635), and that “repeated reversals of intent … may suggest the presence of substantial impairment.”[[5]](#footnote-5) They go on to say that capacitated patients ought to reason by indicating “the major factors in their decisions” (1636), and demonstrate appreciation by reference to the values that one “genuinely holds” and applying that understanding to one’s medical situation. Similarly Lucie White points out that traditional DMC involves authenticity (White 2018). We believe it is possible to infer from these comments that DMC aims to capture how a patient applies their deeply held (i.e., authentic) values. If a patient fails to either communicate a stable choice, reason in accordance with their major (i.e., deeply held) values, or appreciate how the risks and benefits apply to themselves, then, according to the traditional view, this is prima facie evidence that their choice does not reflect their authentically endorsed values. For instance, in cases involving substance abuse, patients sometimes vacillate in ways that indicate the absence of a stable, authentic preference. The standard account of DMC is already equipped to handle cases of this kind.

Given our reading of Appelbaum and Grisso, we maintain, contra Brudney and Lantos, that a patient does not have DMC simply by virtue of having self-determination. In our view, therefore, Ms. G lacks DMC. Although she is self-determinative, she lacks DMC because her choice to forgo LST is sufficiently inauthentic. She lacks weak authenticity. So even though Brudney and Lantos are correct when they say that Ms. G’s wish to decline LST can permissibly be overruled, they are wrong to say that doing so would override her right to decline LST. Therefore, Ms. G lacks the right to decline LST in the first place.

It is worth noting that just because our view yields the verdict that Ms. G lacks capacity with respect to forgoing LST, it does not imply that no other autonomy considerations bear on her case.[[6]](#footnote-6) They certainly do. After all, she is self-determinative insofar as she is able to make a choice about LST on the basis of reasons. These reasons just are not the ones she reflectively endorses. The fact that she is self-determinative means that proxy decision makers ought to give her preference substantial non-instrumental weight when they make decisions on her behalf. To fail to do so would be to insult her as an autonomous (albeit somewhat compromised) person. When a proxy gives a patient’s preferences non-instrumental weight in their decision making, they assign these preferences what Dana Howard and David Wendler call “structural force” (Howard and Wendler 2018). The same goes for patients who maintain authentic preferences, but who lack the ability to make choices on the basis of reasons. Proxies should also give their wishes non-instrumental weight when making decisions. What explains the obligation to give their preferences non-instrumental weight is the fact that they stem from a component of autonomy.

Moreover, even if Ms. G was found to be incapable of fully expressing both self-determination and authenticity with respect to the choice at hand, she nevertheless might maintain sufficient self-determination and authenticity in many other aspects of her overall course of life. For instance, she might have DMC with respect to what to eat, who she wishes to spend time with, and whether to generally pursue or not pursue medical treatment.

At this point, one might wonder what the relevance of our thesis is. After all, if we agree with Brudney and Lantos that Ms. G’s refusal of LST could potentially be permissibly overruled, why does it matter that they believe she has the right to forgo LST, whereas we deny this claim? If, in the end, we agree that, all things considered, it might be permissible to override her refusal, what difference does it make to ascribe or deny her the right to forgo LST?

Two responses are in order. First, if, as we have argued, Ms. G does not have a right to forgo LST, then a proxy could give her preference less non-instrumental weight in their deliberation about whether her physicians should withhold or withdraw treatment. Again, this would not mean her proxy would be incapable of disrespect. It would only mean that it would be easier for a proxy to consider her well-being without disrespecting her.

Second, and relatedly, it matters whether Ms. G has the right to decline LST because ordinarily rights, especially rights to refuse invasive procedures, are understood to impose strong duties on others to refrain from infringing on those rights. And we believe our view does greater justice to rights talk than Brudney and Lantos’ by simply denying that Ms. G lacks the right to refuse LST. Moreover it readily explains why: she lacks this right in virtue of not having DMC; and she does not have DMC because her choice is inauthentic. Of course, her physicians should perhaps withhold LST in any case—perhaps giving her LST would be too traumatic for her—but not because she has the *right* to make this choice. Physicians often have well-being-based reasons to refuse treatment even when they lack autonomy-based reasons.

By contrast, if Ms. G was understood to have DMC with respect to refusing LST, and so had the right to refuse it, then one must amend the ordinary view of rights in the medical context by articulating thresholds for when it is permissible to override them. Perhaps this is a project worth pursuing. But surely, besides being a theoretical last resort, it also carries the practical risk, recognized by Brudney and Lantos, of inviting physicians to impermissibly override patients’ rights to refuse invasive procedures (2011, 224).

1. **Defending DMC as Necessary for the Right to Refuse**

Navin et al. (2022) describe the case of Mrs. P as representative of why patients need not have traditional DMC when declining LST. If they are right, this would demonstrate that Applebaumian DMC is not a necessary condition of the right to refuse LST. Mrs. P, they say, has multiple medical comorbidities, including chronic kidney disease, cerebral aneurysm, and dementia. She is admitted to the hospital with altered mental status, and does not understand why she is in the hospital. Her physicians believe that she is likely to survive with dialysis, medication, nutrition and hydration, but she refuses all treatments and simply wants to go home. Mrs. P’s attending physician determines that she lacks DMC at least in part because she does not comprehend the purpose of the team’s recommendations, and her daughter and surrogate consents to all of them.

Navin et al. argue that even though Mrs. P lacks traditional DMC, she nevertheless may have an overriding objection to the care team’s recommended treatments grounded in the burden they would impose on her. They call this “burdens-based capacity.” Navin et al. claim that Mrs. P may alternatively have an overriding goal that is inconsistent with LST (for example, to spend as much conscious time with her family as possible), which she cites as her primary reason to forgo LST. They label this “goals-based capacity.” They conclude that patients who have either burdens-based or goals-based capacity have the right to refuse LST, which entails that traditional DMC is not necessary to forgo LST.

We are skeptical that Navin et al’s argument succeeds, as it suggests that we ought to respect patients’ decisions who not only lack traditional DMC in the present, but who never had it to begin with. This is highly counterintuitive. If Mrs. P never had traditional DMC about LST in the past, and she is declining LST in the present for either a burdens-based or goals-based reason, then, per Navin et al.’s account, she imposes on her physicians an autonomy grounded (i.e., a backward-looking) duty to refrain from giving her LST. The problem is that if Mrs. P never had traditional DMC, it seems that there is no such duty. A more plausible justification to refrain from giving her LST, and one that does not require appealing to novel forms of purported decision-making capacity, is that her burdens or goals are at least in part grounded in her well-being, and offer forward-looking reasons against LST. Importantly, however, autonomy-based reasons would not ground a right of hers to decline LST.

Well-being considerations become weightier in situations like this precisely because the absence of DMC undermines the possibility of autonomy-based reasons. There may be other instances where a surrogate requests LST for a patient who lacks DMC in order to restore the patient’s capacities to decide for herself about continuing treatment. In such cases, there would indeed be autonomy-based reasons for intervening. But if we judge that a patient like Mrs. P does not have DMC, then our reasons for treating her cannot stem from her present capacities.

If, however, one has the intuition that Mrs. P’s physicians have a backward-looking obligation, grounded in her autonomy, to respect her decision, then we believe that it is necessary to refer to traditional DMC to explain why. Here, traditional DMC would enter the discussion in at least one of two ways. First, as Garrett et al. (2022) point out, Mrs. P does not obviously lack traditional DMC. One of the main reasons why Navin et al. think she lacks traditional DMC is because she fails to understand “the entire range of options presented” and make “systematic comparative judgments” about them. But, as Garrett et al. note, traditional DMC sets a significantly lower threshold of understanding than this; it only requires that patients have a basic understanding of the available options, and compare them. This is far from knowing the entire range of treatment options and engaging in systematic comparative deliberation, a threshold that most patients are able to meet. Therefore, once we see that Navin et al.’s argument rests on the questionable assumption that Mrs. P lacks traditional DMC, their proposal to lower the threshold for DMC seems less plausible.

Alternatively, even if we grant Navin et al.’s assumption that Mrs. P lacks traditional DMC at the time of assessment, it does not follow that we need additional kinds of DMC to make sense of her physicians’ obligation to respect her wish to decline LST. For as long as she previously had traditional DMC and made her wish known then that she would not want LST in at least roughly the circumstances that she is now in (Koch 2022), then her preference ought to be respected. Either way, the above-mentioned two reasons vindicate the claim that traditional DMC is indeed a necessary condition for the right to refuse LST.

What if the care team lacks knowledge about whether a patient ever previously had traditional DMC? One might think that Navin et al.’s argument is strongest with these patients in mind. After all, if one lacks knowledge about a patient’s history of either the presence or absence of DMC, and going against the patient’s wishes for non-treatment feels wrong, then one must explain why. And Navin et al. provide an explanation by appealing to burdens and goals-based DMC. Nevertheless, even with these kinds of patients, we still believe that Navin et al. set the bar too low. For instance, Mr. S is a homeless diabetic patient with an infected foot. This is his first time at the hospital, the medical team is unfamiliar with his previous medical history, and they recommend IV antibiotics. Mr. S however declines antibiotics for both burdens-based and goals-based reasons after demonstrating understanding of the risks and benefits of taking antibiotics versus forgoing them. He fails though to appreciate how the risks of declining antibiotics apply to him due to a grandiose belief in his invincibility. Navin et al. should be open to respecting Mr. S’s choice. And we certainly think the care team ought hesitate before overriding his choice, especially if doing so requires restraints (for reasons stemming from well-being). But because Mr. S lacks DMC as Applebaum and Grisso describe it, it is hard to understand why we should think that he has an autonomy-based right to refuse treatment. Therefore, to the extent that Navin et al.’s argument appears persuasive by seeming to provide reasons against treating Mr. S over his objections, we think there are non-autonomy grounded reasons that provide a more compelling argument against treatment.

1. **Benefits of the Traditional Account and Replies to Objections**

One objection to our view that authenticity is crucially relevant when making decisions to forgo LST is that it is unfeasible for physicians to determine whether a patient’s choice is authentic or not. As Brudney and Lantos put it,

The ideal of authenticity seems to presuppose doctors who have known their patients over many years or who can spend many hours with a new patient. In a modern medical system neither seems possible. Moreover, to facilitate authentic patient choice and to judge when it obtains…seems to require a kind of practical wisdom that we have little reason to believe doctors possess. (2011, 225)

In their response to this objection, Brudney and Lantos admit that making judgments about authenticity would be time intensive, but that this is simply what morality requires, just as morality demands that medical care accommodate the often burdensome practice of obtaining informed consent.

It is worth pointing out that if one has a strong conception of authenticity, as Brudney and Lantos do, this response is practically unsatisfying precisely because assessing strong authenticity requires extensive knowledge of a patient’s life, and how their values fit into their life, if at all, in a unifying way, which physicians almost always never have. Moreover, this is true, not simply in our non-ideal world where patients often do not have primary care providers, and thus, often lack a substantive relationship with their providers. It would also likely be true even under the most ideal of scenarios, where resources enable everyone to have a primary care provider, because physicians are not therapists, spiritual advisors, family members, or the like, nor should they be. And yet this kind of relationship—which is not what we think of as the proper physician-patient relationship—seems practically necessary to give physicians this kind of extensive knowledge. Therefore, according to Brudney and Lantos, morality would seem to demand of physicians either something they are extremely unlikely to be able to obtain—namely, detailed knowledge of their patient’s life story—or something that, even under the best scenarios, seems inconsistent with the physician-patient relationship. If, however, one has a weaker conception of authenticity in mind, as our view does, then it is easy to largely bypass the problem the objection points to. After all, if we are right, traditional DMC already incorporates a concern for authenticity. Therefore, physicians would likely not have to spend significantly more time with patients because, when they assess DMC, they already take authenticity into account.

Of course, when patients lack DMC, it is often friends and family that provide physicians with reflections about the patient’s beliefs and values. This alleviates the doctor from some of the investigative burden of judging authenticity, which family and friends are frequently in a better position to bear, at least regarding weak authenticity. After all, even close friends and family are sometimes unable to make determinations about strong authenticity, like whether a patient’s desires are unalienated or if their lives are sufficiently distinctive. And, in the end, it is still the physician who is left with the task of evaluating DMC, not friends and family. At best, loved ones can provide evidence that can assist the physician to make judgments about authenticity. It would be impractical to expect clinicians to make judgments about strong authenticity, even when presented with evidence from those who know the patient well.

Another objection to our view is motivated by cases involving seemingly capacitated patients whose values themselves are intuitively inauthentic. For instance, many severely anorexic patients refuse treatment even when they demonstrate an understanding that doing so may lead to death. Some critics believe that this is a problem for the traditional view that DMC is necessary and sufficient for the right to refuse LST. They claim that when capacitated anorexic patients’ choices result from their pathology and motivate them to choose in the manner they do, their decisions are inauthentic and thus fail to generate rights to decline treatment (Tan et al. 2006).

One difficulty for this view is that anorexic patients often forge a close connection between their disorder and their personal identity. For instance, take the following statements as documented by Tan et al:

Once you’ve taken that [the anorexia nervosa] away, you’ve taken away part of my identity, so I’m bound to feel a bit lost.’ (Tan et al. 2003, 23)

It [the anorexia nervosa] almost does become part of you and so in order to get it out of you I think you do have to kind of hurt you in the process, I think it’s almost inevitable. (Tan et al. 2003, 28)

It’s like you’re trying to take away the something that is a huge part of my life … and if that goes what am I left with? (Tan et al. 2003, 39)

These comments suggest that there is often no practical way to delineate what distinguishes the patient’s illness from their conception of themselves. Sometimes however a delineation seems possible. Consider the following patient’s testimony.

It feels like there’s two of you inside—like there’s another half of you, which is my anorexia, and then there’s the real K [own name], the real me, the logic part of me, and it’s a constant battle between the two. (Hope et al. 2011, 19)

In our view, patients who describe an internal conflict like this and who vacillate between wanting treatment and not wanting it demonstrate a lack of what we have called weak authenticity. In such cases, patients are unable to make a consistent choice in accordance with their deeply-held values. Therefore, in our view, this inability indicates a lack of DMC. So we deny this version of the objection insofar as it assumes, falsely in our view, that the patient has DMC in the first place. If anorexic patients are incapable of expressing consistent and stable choices, are unable to rationally manipulate information, or demonstrate sufficient appreciation of the implications of their choice, then they fail to live up to the standards of weak authenticity. Notably though cases of this kind no longer involve questions about the patient’s “true self.” Rather, they involve traditional issues of DMC.

1. **Conclusion**

We have defended the traditional account of decision-making capacity which states that DMC is both necessary and sufficient for the right to refuse life-saving treatment. We did this by responding to challenges to both sides of the claim. Against Brudney and Lantos (2011), we argued that DMC is indeed sufficient for the right to refuse LST. We suggested that their concern for authenticity is legitimate but that it can be folded into traditional capacity, understood in its properly expansive sense. Against Navin et al. (2022), we argued that DMC is necessary for the right to refuse LST. We offered a variety of responses to their discussion of Ms. P. For those who share the judgment that it is inappropriate to override her choice, we showed how this is true either because she has DMC or because she had it in the past. And for those who believe that we may permissibly override her decision, we showed how this would follow from the conclusion that she lacks DMC.

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1. Of course, patients can change their minds about which values are important to them, and this might be the case for Ms. G. However, we grant Brudney and Lantos the assumption that Ms. G’s choice to forgo LST is in some sense inauthentic. In other words, we assume that she maintains her previously endorsed values. [↑](#footnote-ref-1)
2. Pugh mentions this example in order to demonstrate the type of feminist concerns that have motivated “substantive” conceptions of autonomy, but he goes on to defend the use of procedural views in bioethics on the grounds that it would be objectionable to constrain patients’ choices for the sake of values that they do not necessarily endorse. [↑](#footnote-ref-2)
3. We do not wish to imply that the preferences of every Jehovah’s Witness are shaped by manipulation and coercion. We simply stipulate that Ms. M’s beliefs and values were the result of these forces, and she *would* repudiate her desires if she were to reflect on her upbringing. The lesson that we are meant to learn from Ms. M is that we ought to respect the decisions of patients who *have* weak authenticity but *lack* strong authenticity. This scenario was constructed in order to highlight this point, not to suggest that all such preferences about blood transfusions result from either manipulation or coercion. We would like to thank an anonymous reviewer for this clarification. [↑](#footnote-ref-3)
4. Brudney and Lantos also mention a less detailed Jehovah’s Witness case, Ms. W, who declines a blood transfusion. They assert Ms. W has authenticity; her choice “fits well with her deeply held and long-standing values and beliefs” (2011, 222). In other words, Ms. W has weak authenticity. Had they applied the strong account to Ms. M, we believe they would reach the same verdict we do: that she lacks authenticity because, given the manipulation in her childhood, it is implausible to say that her values are part of a life *she* made for herself. [↑](#footnote-ref-4)
5. For others who suggest that authenticity is necessary for DMC, see: Ganzini et al. (1992), Charland (1998), and Coverdale et al. (1996). Against this view of authenticity, see Hope et al. (2011). [↑](#footnote-ref-5)
6. Implying this would assume what Ben Schwann (2022) calls the “Gatekeeping Model,” according to which a patient’s decision generates autonomy concerns if and only if a patient has DMC. [↑](#footnote-ref-6)