Autonomy, thin and thick

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According to Marshall et al. (2024), some of the patients who refuse to stay in observation after being resuscitated following an opioid overdose are likely not making an autonomous choice. While I do not intend to dispute this claim, it merits discussion what is the concept of autonomy at play in making this assessment. I contend that the concept at work is more substantive than Marshall et al. acknowledge—and more substantive, too, than the form of autonomy usually thought to underpin the moral justification of the requirement of informed consent (cf. Beauchamp & Childress, 2012, ch. 4).

What is it for a choice to be autonomous? The prevailing view in bioethics, to which Marshall et al. are committed, conceives of autonomy in broadly *procedural* terms. Very roughly, this means that autonomous choices are those that appropriately reflect the chooser's own (deeply held, reflectively endorsed) evaluative perspective. There are, of course, different ways of filling in the details. But the gist of the view is that the only evaluative standard that can be appropriately brought to bear in assessing matters of autonomy is one that is somehow internal to the person's perspective. The procedural account thus purports to remain neutral on questions of value, requiring only that the person making the choice be in a position to exercise a relatively thin set of cognitive capacities. There are reasons to favor this approach. Among other things, it fits well with the observation that governing oneself does not necessarily mean doing it *well*. It must be possible, it seems, for a person who chooses autonomously to make bad decisions. On the other hand, procedural accounts of autonomy face a major problem in dealing with cases in which a person's ability to judge matters of value is undermined in ways that do not threaten internal coherence. Critics of procedural accounts have often focused on cases of manipulation and oppressive socialization (Mackenzie & Stoljar, 2000;

Oshana, 2015). A related worry concerning the ability to judge matters of value is raised by some types of mental disorder.

To illustrate, consider *anorexia nervosa*. People suffering from this condition typically perform well on comprehension and reasoning tasks and have the ability to make decisions that reflect their values. However, the condition can impair their ability to *care* about the right things, raising questions about their level of autonomy. (For instance, one participant in a study by Tan et al. reported to the interviewers: "[a]lthough I didn't mind dying, I really didn't want to, it's just that I wanted to lose weight, that was the main thing" (2003, p. 702)). In such cases, it seems warranted to question whether the person truly possesses the capacity to choose autonomously, even if they can provide reasons that cohere with their values in the way stipulated by procedural accounts (see Nelkin (2024) for discussion). Thus, to make sense of the idea that there is something *off* about the person's evaluative perspective, we seem to need a standard of adequacy that is external to the person herself. In other words, we need a more *substantive* conception of autonomy. Substantive theories come in many flavors too. Some require, in Susan Wolf's evocative terms, that agents can track 'the True and the Good' (1990, p. 71). Others pose less stringent conditions. Specifics aside, the main thrust of substantive approaches is that making autonomous choices requires the capacity to make evaluative judgments that are sufficiently sensitive to the relevant facts—including facts about value—pertaining to the situation at hand.

What are the grounds for thinking that some of the patients in the cases discussed by Marshall et al. may be choosing non-autonomously? One reason concerns the way that OUD undermines certain key capacities. As a rule, people with OUD tend to behave more impulsively than controls, make riskier choices even in matters unrelated to drug use, and have steeper discount curves. Importantly, these are things that can undermine the person's ability to appropriately weigh matters of value in the sense just discussed. The thought that a compromised ability to weigh matters of value may undermine autonomy naturally suggests a more substantive account. (To be fair, a broadly procedural approach has the resources to deal with some cases of this sort. A striking fact about the psychology of addiction is that it can in some cases result in shifting and unstable patterns of valuation, producing systematic preference reversals over time. When this happens, a decision that accords with the chooser's evaluative perspective from a synchronic point of view may still be portrayed as non-autonomous if it does not cohere in the right way with what the chooser considers valuable at most other times (Levy, 2006). This is consistent with a largely procedural view

of diachronic autonomy. However, there are other cases in which the person's evaluative judgments do not shift in this way over time, and so there may be no internal evaluative standard that the relevant choices can be said to violate. Nevertheless, given what we know about the psychology of valuation in addiction, it may still seem warranted to call into doubt whether the person is in a position to choose autonomously. In such cases, a purely procedural approach seems to yield the wrong verdict).

Marshall et al. discuss two other reasons for thinking that the choices under discussion may not be autonomous. These concern their analysis of the nature of the choice at hand and the 'gestalt impressions' of treating physicians. Concerning the former, they note the striking imbalance between the apparent costs of staying in observation for a limited time and the risks involved in non-compliance. The underlying thought is that it is difficult to picture how a competent decision-maker could come to any other conclusion than that staying in observation is the preferable course of action. (The situation resembles the case discussed by Beauchamp and Childress (2012, p. 136) of a patient who refused to believe that she had cancer despite being presented with unambiguous evidence by her doctors. Although she performed well on standardized tests for DMC, her refusal to accept her diagnosis was itself a reason to call into doubt whether she was in a position to make autonomous decisions). Of course, it is perilous to infer incapacity from a single decisional outcome. Ultimately, this risks ruling out by fiat the possibility of making an autonomous choice that is contrary to medical recommendation. Here, physicians' clinical impressions can be illuminating. It seems particularly noteworthy that some patients in the cases discussed by Marshall et al. appear undisturbed by the fact that they had narrowly escaped death (target article, p. 15). This reasonably raises concerns about their capacity to judge matters of value. The issue is not whether the choice being made is internally consistent with the chooser's evaluative perspective, but whether it stems from a sufficient capacity to discern and properly weigh the relevant (evaluative) facts pertaining to the situation at hand. This is a concern that is difficult to articulate in purely procedural terms.

Some may recoil at the prospect of endorsing a substantive account and prefer to revise the verdict on the case instead. Two brief observations can be made in response. First, a relatively *weak* substantive approach may suffice for present purposes. We might think, for instance, that the evaluative constraints at play in judgments of autonomy are roughly set by the capacity to value required to have the potential for a minimally meaningful or flourishing life, leaving enough room for the idea that people will find meaning in different things and flourish in different ways. In

practice, the presumption must always be that adult human beings have the capacity to choose autonomously (even if they are making a mistake), and only powerful reasons can override this presumption. Second, the distinction between procedural and substantive accounts is in some ways less stark than it might seem. Procedural accounts typically require that the decision in question reflects values that are reflectively endorsed. Upon closer examination, such requirements typically carry substantive undertones.

In sum, I have argued that Marshall et al.'s claim that some patients in the cases under consideration may be choosing non-autonomously is likely correct. Moreover, I have shown that the reasons they give for thinking so are more plausibly construed in terms of a substantive conception of autonomy. Since the principle of autonomy that underpins the requirement of informed consent is commonly understood to rest on a thinner procedural conception of autonomous choice, it might be argued that my point serves as a *reductio* of Marshall et al.'s view. My suggestion, however, runs in the opposite direction. I suspect that Marshall et al. are right in asserting that some patients in the target cases are not choosing autonomously. Therefore, a focus on such cases, I suggest, puts pressure on the standard assumption that the type of autonomy invoked in the justification of the informed consent requirement can be construed in purely value-neutral terms.

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