Abstract

Individuals suffering from anorexia-nervosa experience dysmorphic perceptions of their body and desire to act on these perceptions by refusing food. In some cases, anorexics want to refuse food to the point of death. In this paper, I answer this question: if an anorexic, A, wants to refuse food when the food would either be life-saving or prevent serious bodily harm, can A's refusal be valid? I argue that there is compelling reason to think that anorexics can validly refuse food, even in these extreme circumstances

Of Blood Transfusions and Feeding Tubes: Anorexia-Nervosa and Consent

Individuals suffering from anorexia-nervosa experience dysmorphic perceptions of their body and desire to act on these perceptions by refusing food. In some cases, anorexics want to refuse food to the point of death. In this paper, I answer this question: if an anorexic, A, wants to refuse food when the food would either be life-saving or prevent serious bodily harm, can A's refusal be valid? I argue that there is compelling reason to think that anorexics can validly refuse food, even in these extreme circumstances. My argument is based on the following cases:

> **Jehovah's Witness**: a Jehovah's Witness (JW) is brought into the ER with a severe injury which will require her to get a blood transfusion to survive. She expresses her religious belief that this is not permissible. The doctors try to persuade her that she must get the transfusion, otherwise she will die. She persists in refusing, even after understanding all of the ramifications of her decision.
>
> **Anorexia**: an individual with anorexia (A) is so malnourished and thin that she is near death. She is brought to the ER. The doctors explain to her that she must eat if she is to remain alive. But, A explains to the doctors that she doesn't want to eat the food, even though she understands that she will die if she doesn't.

It seems clear that most people's initial intuitions are that JW can validly refuse the transfusion and that A cannot give validly refuse food.[i] Based on these cases, my argument will proceed as follows: I argue that there is no reason to believe *both* that JW can validly refuse and that A cannot validly refuse. Any purported reason for thinking that JW can refuse and that A cannot refuse either (1) applies equally to JW or (2) is independently implausible as a reason to invalidate A's refusal. This leads to the conclusion that, if JW can refuse a life-saving blood transfusion, then A can validly refuse life-saving food.[ii] And, because JW can validly refuse a life-saving blood transfusion, A should be able to validly refuse life-saving food. To be clear, my claim is not that all anorexics are competent; there are certainly incompetent anorexics. Rather, I aim to show that we should assume that anorexics, like everyone else, are competent until proven otherwise and that there are many cases in which they cannot shown to be incompetent.

In section I, I outline stipulations that will apply to my argument. In sections II and III, I outline and reject reasons one might give for thinking that A's refusal is not valid and that JW's is. In section IV, I address objections.

I. Stipulations:

First, I assume that a refusal is valid iff it is informed, rational/competent, and voluntary. I take it as a working assumption that if an individual's refusal is invalid, it is invalidated in virtue of being deceived, incompetent, or coerced. *Second*, I assume that both Jehovah's Witnesses and anorexics are not being coerced or deceived into refusing. Thus, I will only discuss the rationality/competence of these individuals. *Third*, in the cases that I discuss, the individuals with anorexia give concurrent agreement to refuse food. The question is whether the 'no' of an anorexic is morally transformative and rises from mere refusal to valid refusal. *Fourth,* I assume that the burden of proof lies with those who would limit consent. For that reason, I assume that if there is no compelling reason against an individual's competence to refuse, we should adopt the view that this person is competent. In short, competence should be innocent until proven guilty. *Fifth*, I don't assume a particular theory of the ontology of consent. *Sixth*, I assume that most people think that JW can refuse the blood transfusion. Given this, if a purported reason that A cannot refuse applies equally to JW, I take this as evidence to reject this reason against A's competence. *Seventh*, I assume that the standard for consent to an intervention is higher than refusing an intervention. This is the case because allowing someone to do something to one's body involves waiving rights against a bodily intrusion, while refusing intervention does not. I often switch between discussing examples of consent and examples refusal. Since they are two sides of the same coin, these examples illustrate relevant points. Unless noted, any example I give of consent could be flipped to be an example of refusal (and vice versa) while illustrating the same point.

Finally, a brief terminological note. There is a difference between refusal and valid refusal. Both involve saying 'no,' but valid refusal is the kind of refusal that makes an intervention impermissible when it otherwise would have been permissible. In this paper, whenever I discuss refusal, it should be assumed that I am discussing valid refusal, unless I explicitly distinguish between refusal and valid refusal at a given point.

II. Purported Reason That A's Refusal Is Not Valid, While JW's Is: A Is Rationally Impaired:

Here, I consider what I take to be an exhaustive list of reasons one might give to defend the view that JW can refuse and that A cannot. I argue that every reason one can give to undermine A's refusal either applies equally to JW or is independently implausible as a reason to invalidate A's refusal.

I consider two broad categories of objections: that A cannot refuse (i) because of irrationality and (ii) because of something bad about her values.

II.1. A's refusal is invalid because she is rationally impaired in a way that JW is not, because A's refusal-relevant beliefs are false, while JW's are true:

By 'refusal-relevant belief,' I mean the belief that the agents in question base their decisions on. For A, the refusal-relevant belief is something like, 'I am fat,' while JW's refusal-relevant belief is something like, 'God has commanded me to not get a blood transfusion.' In this version of the objection, the thought is that A's refusal is invalid, because she is irrational in virtue of possessing a false belief.

This view fails for two reasons. First, I and many others believe that JW's beliefs are also false. So, this objection, if successful, would invalidate JW's refusal, assuming his beliefs are false. Second, so long as no deception is involved, our refusal-relevant beliefs don't need to be true in order for our refusal to be valid. Surely, we can refuse on the basis of false beliefs, otherwise an absurd number of decisions would be nonconsensual. For example, if A buys a used car based on his belief that it will work for 100,000 more miles, his consent is not invalidated when it turns out that the car lasts for half of this time. In other words, A is not justified in returning to the dealer to demand his money back, yet he would be if his consent were invalid.

II. 2. A's refusal is invalid because she is rationally impaired in a way that JW is not, because her refusal-relevant beliefs are unjustified, while JW's are justified:

We can alter the objection to say that, although both A and JW's beliefs are false, A's beliefs are unjustified, while JW's are justified. Perhaps the fact that A's beliefs are unjustified shows why she cannot refuse while JW can.

I have two responses. First, we can construct versions of these cases where both A and JW's beliefs are equally unjustified or justified. This would make the argument, again, able to invalidate JW's refusal. It is not at all hard to conceive of a case of a Jehovah's Witness with unjustified beliefs in his faith, yet this lack of justification doesn't seem sufficient to override his wishes.

Second, in general, we can give valid refusal on the basis of unjustified beliefs. It's likely that most people have a substantial percentage of unjustified beliefs; thus, if this were sufficient to undermine consent, a great number of normal behaviors would be nonconsensual.

II. 3. A's refusal is invalid because she is rationally impaired in a way that JW is not, because A's refusal-relevant beliefs are both (1) unjustified and (2) caused by a pathological disorder:

We can further revise the objection to say that A cannot refuse, while JW can, because, even if both of their beliefs are false and equally unjustified, A's belief is caused by a pathological disorder, while JW's belief is not. After all, anorexia is a psychological disorder, and religious belief is not.

I have two responses. First, we can appeal to cases in which individuals with other pathological disorders can give valid refusal, despite their beliefs being unjustified and false. For example, individuals with OCD that centers on contamination anxiety are irrationally and obsessively afraid of certain kinds of germs or substances. The most commonly accepted treatment for OCD, exposure and response prevention, consists of the patient exposing herself to the feared contaminant and not allowing herself to perform her anxiety reducing rituals. Suppose that S has OCD and is horribly afraid of touching used dish towels. S's partner, E, knows this and knows that S has to get over this fear by exposure. Suppose that E tells S, "I'm going to touch you with a dirty dish towel," and A refuses. The fact that S's fear of dish towels is caused by a pathology does not mean that E is justified in overriding S's refusal. Yet, on the view proposed above, E would be justified in overriding S's refusal and touching him with the towel.

Second, we can ask why a pathological disorder might undermine consent/refusal. Upon reflection, if a pathological disorder undermines consent, it must do so in virtue of rendering A's

behavior involuntary, not simply in virtue of being the result of a disorder. To be more specific, the objection is not that A's behavior is involuntary. This is false for anorexics.[iii] Rather, the objection is that A's refusal-relevant belief ('I'm fat,' etc.) is involuntary because it is controlled by her disorder. In short, A's disorder causes her to endorse this belief, and she cannot help but believe it. She has no choice in the matter, making her belief unjustified and involuntary. Although this is certainly tragic, it does not undermine refusal for the simple reason that many of our beliefs are not within our control, but we can still act on the basis of them in consensual interactions. For example, if S cannot control his belief that he ought to donate money to Oxfam, but in fact he is not obligated to donate to Oxfam, Oxfam does not violate his consent by accepting his donation. Furthermore, although JW's refusal-relevant belief is not caused by a pathological disorder, his belief is similarly involuntary and out of his control as A's refusal-relevant belief. This is true for the simple reason that most, if not all, of our beliefs, especially our religious beliefs, are not under our voluntary control. In short, the only reason that a belief being caused by a pathology might undermine refusal is if this belief were somehow involuntary, but this also does not undermine refusal.

One might object that there is still a relevant difference between beliefs caused by a pathology and beliefs caused by other mechanisms, namely that pathologies are not reliably connected to the truth and are often positively unreliable at gaining true beliefs. First, this may not be true empirically. Many pathologies do not struggle with producing false beliefs; instead, they give sufferers the wrong affective response to certain stimuli. Individuals with OCD don't have false beliefs; they have anxious responses to uncertainty. Second, suppose it is true in the case of anorexia that this pathology is connected with forming false beliefs. This still would not undermine A's refusal. Suppose it turns out that JW's religious beliefs were formed on the basis of some positively unreliable mechanism; this does not seem like it's enough to make JW's refusal invalid.

Yet, many people persist in saying that there is just something different about beliefs and desires caused by diseases. Unless this position is to reduce to some kind of disease fetishism, the objector needs to give a reason for why something being caused by a disease should make us treat it differently. I see no such reason.

II. 4. *A's refusal is invalid because she is rationally impaired in a way that JW is not, because A is generally incompetent in a way that JW is not:*

Perhaps A is irrational in a way that goes beyond the features mentioned so far. It may be the case that A is generally incompetent in a way that JW is not. If this were the case, then A's decision to refuse food would certainly not be valid.

The empirical evidence runs contrary to this claim. Although there is no universally agreed upon competence test, on what is widely regarded as "the gold standard for assessment of competence in the psychiatric setting" (the Macarthur Competence Test or MacCAT-T), anorexics are ruled competent.[iv] The Macarthur test assesses four things: (1) ability to communicate a choice, (2) ability to understand the relevant information, (3) ability to appreciate the situation and its likely consequences, and (4) ability to manipulate information rationally.[v] There is evidence that many anorexics satisfy all four conditions.[vi]

The following passages state overall findings indicating that anorexics are ruled competent by the MacCAT-T:

> In terms of intellectual measures such as understanding and reasoning, as measured by instruments such as the MacCAT-T, even severe anorexia nervosa patients may be judged to be competent to make treatment decisions.[vii]

> Participants with anorexia nervosa scored well on the MacCAT-T…exhibiting excellent understanding, reasoning and ability to express choice, with generally high scores in each category.[viii]

> The participants performed on the MacCAT-T to a high standard, which was comparable to the healthy population control group in a previous study using the MacCAT-T (Grisso et al., 1997).[ix]

Here, I outline the evidence that anorexics satisfy all four conditions of the MacCAT-T.

First, anorexics are able to communicate a choice. This is not in dispute.

Second, anorexics are able to understand the information that is relevant to their situation and their condition. This is illustrated in the following findings:

> [Anorexics] often appear to have a very good understanding of the facts of their disorder and the risks involved and the ability to reason, which they can retain even at very low weights.[x]

> As all the participants were already highly conversant with the facts of their disorder, the exercise of going through information about anorexia nervosa and its treatment, with the systematic checking prescribed by the MacCAT-T, was experienced as onerous and patronising to the participants and awkward and painful to carry out for the interviewer.[xi]

> The participants generally had a good understanding of the facts of their illness, its consequences, and the treatment that was being offered…In the category of 'understanding,' participants had a median score of 6.0 out of a maximum of 6.0.[xii]

Third, anorexics, in most cases, exhibit appreciation of their condition. In the literature on cognitive competence, appreciation is understood as being importantly different from understanding information. To appreciate a mental condition is to understand not just that if one has this condition one needs the treatment; it is to understand that *I am* a person who has the condition and needs the treatment. For example, patients with schizophrenia understand perfectly well that schizophrenia is a mental condition with certain symptoms and agree it should be treated. But, they often do not believe that they have schizophrenia. This is a failure of appreciation, despite the ability to understand the relevant information. Anorexics appreciate that they have anorexia. This can be seen in these passages:

> In the category of 'appreciation of illness,' the participants had a median score of 4.0 out of a maximum possible score of 4.0.[xiii]

> Tan and her colleagues (2006) reported that persons with anorexia nervosa…usually neither denied that they had a disorder nor manifested distorted beliefs about the potential consequences of treatment for the disorder.[xiv]

It is, however, important to note that some patients do not appreciate that they have anorexia. In one of Tan's studies, "two participants [out of ten] did not show full appreciation that they had the disorder."[xv] As Tan says, "one of these participants agreed with the facts of her condition, but felt ambivalent about whether she had a disorder, and "the other was more fixed in her rejection of her diagnosis, with firm beliefs that she was too fat, despite the knowledge of her low weight."[xvi] In one particularly visceral interview, a patient said this:

> About the risk of death, do you think it could happen? "Not to me."...That's the opinion of doctors, and I wonder why you don't think it can happen to you. "Because you have to be really thin to die, and I'm fat, so it won't happen to me." (Participant B).[xvii]

It seems clear to me that such individuals are not competent to refuse, because they have a severely distorted picture of reality which causes them to not understand that they are at a severe risk of death. But, these are the minority cases and are easily spotted.

Fourth, patients with anorexia can reason and manipulate information. This can be seen in these passages:

> In the category of 'reasoning,' the participants had a median score of 6.0 out of a maximum of 8.0. These scores reflected the excellent performance of the participants in the MacCAT-T task.[xviii]

> [In reference to Tan's 2006 study] almost all of the anorexia patients in the study obtained adequate scores on reasoning, which examines the ability to process options and consequences when weighing a treatment decision.[xix]

Overall, we can conclude that A's refusal is not invalidated because she is generally incompetent in a way that JW is not.

II. 5. *A's refusal is invalid because she is rationally impaired in a way that JW is not, because A's refusal-relevant belief can be demonstrably shown to be false, while JW's refusal-relevant belief cannot be:*

Simply put, A's belief that she is fat can be easily objectively refuted by any remotely competent observer. However, even if JW's religious beliefs seem very unjustified, they cannot so easily be obviously and objectively demonstrated to be false. One would have to argue that JW's belief in his religion is irrational, whereas no argument is required to show that A is not fat.

Here, I argue that this standard is too strong and justifies too much paternalism. It seems commonplace in medicine that a doctor genuinely knows that a patient's beliefs are demonstrably false. But, if doctors were able to override these decisions, then paternalism would abound. For example, if a patient falsely believes that getting chemo for her cancer will cause her to go insane, this does not justify the doctor in forcing the patient into chemo.

II. 6. *A's refusal is invalid because she is rationally impaired in a way that JW is not, because A assigns irrational weights to certain values in a way that JW does not:*

The thought here is that A's ability to make inferences and predictions is not flawed, but the weights that she assigns to the variables in her mental utility function are in some way irrational. Specifically, many anorexics assign a higher weight to the value of being thin than they do to the value of being alive. For example, if asked if they would rather live fat or die thin, many anorexics would answer that they would prefer death over being fat. As one patient said, "I wasn't really bothered about dying, as long as I died thin."[xx] One might argue that an individual with this set of values is inherently irrational. How, after all, could someone think that a life is not worth living for no other reason than that one perceives oneself as being fat? While I agree that such a view of the world is irrational, it is not obvious that it is sufficiently irrational to render A incompetent. After all, the same could be said about JW. JW assigns a higher value to religious integrity than he does to life. So, if JW really wants to refuse the life-saving blood transfusion, then this means that he would choose death with religious integrity over life without such integrity. It doesn't seem like this is all that different than A's assignment of values. But, it seems clear that JW can reasonably make this decision and have it be respected.

One might object that JW's belief can very easily be rendered rational if we add to it some kind of belief in the afterlife. Suppose JW believes that getting a transfusion would cause him to go to hell; if this were what he believed, then it would make sense to value religious integrity over life.[xxi] But, so long as internal coherence is all that is necessary for one's beliefs to be rational, it seems that A can satisfy this standard as well. A may very well consistently believe that life without being thin is not worth living and that the disvalue of life while fat is worse than death. If this is the case, then both beliefs can be rendered rational in the sense of being internally consistent.

One might object that the difference is that A's valuation of life as less important than thinness is based on an irrational self-perception or herself as being fat, while JW's belief is not. But, again, irrational beliefs do not lead to judgments of incompetence, because we could construct a version of the JW case in which it is clear that JW's belief is irrational.

II. 7. A's refusal; is invalid because she is rationally impaired in a way that JW is not, because A's behavior is a failure of practical rationality, while JW's is not:

A's behavior is practically irrational, because she doesn't want to die but can't seem to avoid a decision that leads to her death. So, she is irrational, because she ultimately commits herself to a decision that is against her practical goals. It is important to note that, in general, anorexic patients do not want to commit suicide. As Tan says:

> These participants did not, however, view losing weight as a method of suicide, and there was little expression of an active wish to die. Suicidal ideas rooted in depressive feelings, therefore, were not generally the driving force of treatment refusal in these participants. However, the value attached to life was less than it might have otherwise been, and this

> made the risk of death from the disorder less of a motivator for these people to get well than might be hoped by mental health professionals warning them of the risks.[xxii]

In other words, A's behavior is irrational, because death is not among her goals, but it may be the result of her action. In that manner, she chooses an action that ultimately causes her to fail at one of her more important goals.

Yet, so described, this is also true of JW. JW doesn't want to die, but he chooses a course of action that ultimately leads to the frustration of his goal to remain alive. And, so long as A's condition is not stripping her agency from her, then her refusal is valid.

III. Purported Reason That A's Refusal Is Not Valid, While JW's Is: A Has Flawed Values:

Departing from considerations of rationality, the objector argues that A makes her decision to refuse food on the basis of a flawed set of values, which renders her refusal invalid.

There is something appealing and intuitive about this view. If there is some important way in which the values that inform my decisions are alien to me, or if they are not my own, it is difficult to say that I am the one who is deciding. Rather, some external influence is exerting undue force on my will. In the literature on anorexia and competence, the point that anorexics' values render them unable to refuse is most often put in the language of authenticity and inauthenticity. For example, as Hope puts it:

> Should those involved with the person with anorexia nervosa seek to respect her authentic wishes and override her inauthentic wishes where these are in conflict? Is there a potential justification for overriding treatment refusal along the following lines: mental disorder compromises authenticity, and inauthenticity compromises autonomy? Thus, in respecting autonomy, it is the authentic wishes that should be respected. This would be to give the idea of authenticity a role analogous to that of capacity (competence).[xxiii]

The thought appears to be that if A's desires are inauthentic, then she cannot refuse on the basis of them. However, this already takes for granted that a desire being inauthentic renders it sufficient to invalidate refusal. This needs to be argued for. It could very well be that authenticity has absolutely nothing to do with competence and vice versa. For this reason, when I discuss the flaws in A's values, I won't only use the language of authenticity. Instead, I will evaluate potential reasons that A's values are flawed that might make her unable to refuse, some of which will connect to authenticity and some of which won't.[xxiv] In this section, I go through what I take to be a sufficiently exhaustive list of potential flaws in A's values that might make her unable to refuse. I argue that each reason fails. Thus, there is no deficiency in A's values that renders her incompetent and unable to refuse.[xxv]

III. 1. A's refusal is invalid, because her values are objectively false:

We can see this view as saying that A cannot refuse on the basis of objectively false values. By 'false value,' I mean any proposition about values that is false, i.e. 'torture is good.'

This view fails, because it entails that anyone with false values cannot refuse if those false values influence their decisions. This is wildly implausible, as many people likely hold false values,

meaning that an absurd number of people cannot give valid consent in many situations. This reason would also apply equally to JW, as his values are also false.

In general, content-based views of competence or authenticity should be rejected. Views like this hold that a certain desire is inauthentic to a person simply in virtue of its content. Although some have defended these kinds of views, they seem intolerable, because they easily license paternalism. The point of autonomy is to do what individuals want, regardless of whether what someone wants is wise or rational. A content-based theory of authenticity would license paternalism toward people who may be otherwise competent but simply have a highly irregular set of values. This is too strong.

III. 2. A's refusal is invalid, because her values are bad for her:

It seems obvious to me that someone's values being bad for them is not, on its own, sufficient to render that person incompetent. This would entail that any decision that is misguided is incompetent. In other words, a decision based on values that are not good for an individual would thereby be rendered nonconsensual, which seems too strong.

III. 3. A's refusal is invalid, because her values are not rationally or reflectively endorsed:

According to this view, A's values are flawed in a way that render her unable to refuse if the values behind her decisions are not ones that she would endorse on reflection as being her own. As Ahlin says, according to this view, "a desire is authentic if the desire-holder identifies with it on a higher level of refection."[xxvi] Ahlin uses the terminology of authenticity to be synonymous with competency. Or, as Ahlin elsewhere puts this view, it can be expressed in this thesis:

> **The dissenting self-refection thesis**: Judgments of inauthenticity are justified if there is sufficient reason to believe that the desire-holder would disapprove of having the desire upon informed and critical self-refection.[xxvii]

This view fails for several reasons. First, according to this view, anorexic values would not be inauthentic or flawed in any problematic way. Many people with anorexia would not disapprove of their anorexic desires upon reflection. This view also fails, because it presents an implausible standard of when consent is invalid. Suppose that a person accepts a high-paying job working for a company that is actively against their values. Upon reflection, this person does not endorse the values at play in his new job, but it would be far too strong to say that, on this basis, he cannot consent to work for this company.

The defender of this view could revise it to say the following to accommodate this:

> **The Idealized/Hypothetical self-reflection thesis:** Judgments of inauthenticity are justified if there is sufficient reason to believe that the desire-holder would *[if sufficiently idealized]* disapprove of having the desire upon informed and critical self-refection.[xxviii]

One could argue that an anorexic, if sufficiently idealized (i.e. more rational, etc.), would reject anorexic values on reflection. However, if the goal of a theory of authenticity is to track whether a given desire is truly the agent's desire, it seems bizarre to idealize away from the agent in order to get a more accurate picture of what the agent herself wants. The desires of an idealized version

of me, however rational, are not *my* desires. For this reason, we should reject the idealized version of the thesis as well.

III. 4. A's refusal is invalid, because her values are unstably/inconsistently held:

According to this view, in order to be competent to consent, one's values must be stably and consistently endorsed over time, and A fails this requirement.

This fails for several reasons. First, there are anorexics for whom anorexic values are, sadly, stably and consistently endorsed over time. For such individuals, anorexia has characterized much of their lives. For example, in an interview, one anorexic patient said "it [anorexia] feels like my identity now," and when a different patient was asked if she would "wave a magic wand and [make it so] there wouldn't be anorexia any more," she replied "I couldn't."[xxix]

Another way to understand the objection is that A's values are flawed, because they are highly unstable and prone to rapid change. It seems plausible to suggest that, if an individual rapidly changes her mind from moment to moment, we cannot accept her token of consent. For example, if S says at some time that she wants to have sex with J, but if she continually alters her feelings at subsequent times, J ought to be unsure about whether this consent renders their sex permissible. Something similar might be true of anorexia. If anorexics experience frequent changes in desires about whether to eat food, then this would suggest that doctors cannot act on their refusal.

This response fails for several reasons. First, one of the tragic features of anorexia is that it is remarkably stable. Individuals with anorexia do not experience changes in their values. The previously referenced interview quotations suggest that this is true. While this is deeply saddening, it suggests that this cannot be a reason that anorexics have flawed values, because their values are not subject to rapid and unstable change. Second, even if there were an anorexic for whom this were the case, there are reasons to believe that having unstable values does not render us unable to consent. Consider the following case:

> **Rapid Conversion**: S is a Christian who believes that sex outside of wedlock is morally impermissible. S undergoes a rapid loss of faith and ceases to be a Christian. Now, S believes that casual sex is perfectly permissible. S decides to have sex with several partners. But, in a matter of weeks, S has a religious experience and returns to her Christian faith and its accompanying sexual morality.[xxx]

In this case, S underwent a rapid, unstable, and drastic shift in values. Despite this, it sounds implausible to say that the men she had sex with during the period in which she was not a Christian engaged in a seriously wrong and impermissible sexual act without her valid consent, even if they knew about her rapid shift in values.

III. 5. A's refusal is invalid, because her values are disconnected from her deep/true self:

According to this view, A's values are defective in a way that renders her incompetent, because these values are not connected with A's deep or true self. This view is committed to the existence of some kind of deep self and also to the view that decisions based on values that conflict with the deep self are not consensual.

Inspiration for this view can be found in passages like this one from Charles Taylor:

> There is a certain way of being human that is my way. I am called upon to live my life in this way, and not in imitation of anyone else's. But this gives a new importance to being true to myself. If I am not, I miss the point of my life, I miss what being human is for me. This is the powerful moral ideal that has come down to us. It accords crucial moral importance to a kind of contact with myself, with my own inner nature, which it sees as in danger of being lost, partly through the pressures towards outward conformity, and also because in taking an instrumental stance to myself, I may have lost the capacity to listen to this inner voice.[xxxi]

In short, views like this try to make sense of the fact that we sometimes talk as if there is a real me under the surface and that not everything I do is consistent with this real me. This view fails for several reasons. First, even if it is successful as a theory of authenticity as it connects to competence, many anorexics satisfy its conditions. Sadly, anorexics describe anorexia as being essential to their identity:

> Quite often, people with anorexia, they don't say, "I have anorexia," they say, "I am anorexic." And I think that's kind of, that explains it really, that shows what it is, people BECOME anorexic, they, and then they start saying, "I am anorexic," and it's this kind of, it becomes who you are, it defines who you are, as opposed to just an illness that you have.[xxxii]

> It's just a part of me now…it was my identity.[xxxiii]

> Some people said to me 'If I could wave a magic wand and get rid of anorexia, wouldn't you like that?' and I was like 'Well, no, because it's, I'm, it's safe, it's what you know.' And although it's killing you it's what you know and that's, that's my identity having anorexia ... I was too scared because that was who I was ... because I'd be losing ME. Who would I be if I didn't, if I wasn't that. I was too scared to make that decision to give it up.[xxxiv]

> If your anorexia nervosa magically disappeared, what would be different from right now?" she replied, "everything. My personality would be different. It's been, I know it's been such a big part of me, and – I don't think you can ever get rid of it, or the feelings, you always have a bit – in you.[xxxv]

In short, for some anorexics, their deep self may very well be connected with their anorexia.

However, even if this is not the case, this view fails, because it presents an implausible standard for when one's values render one incompetent. If every decision I make on the basis of values that do not connect from my deep self is nonconsensual, then it's likely that most of my decisions are not consensual. This seems too strong. For example, suppose that A's Christian identity is part of her deep self. Her deep self would not want to engage in adultery. Yet, this does not mean that A's consent to have extramarital sex with B is invalid.

Lastly, one can point out that the existence of a deep or core self is, at the very least, controversial.

III. 6. A's refusal is invalid, because her values are caused by external forces:

According to this version of the objection, if A's values are the result of some kind of pernicious external influence, then they render A incompetent. This objection can be parsed in several different ways, none of which are convincing.

First, the objector could very literally mean that whenever A's values are caused by any influence outside of her mind, they render her incompetent. Clearly, this is far too strong, because it would mean that any instance of persuasion leads to being unable to consent. It would also mean that any desire that is caused by a medication renders the agent incompetent.

Instead, the objection should be rendered in terms of a value being caused by an external force with the added condition that this external force has some kind of negative feature, specifically that it deviates from the person's overall values. Something like this view is endorsed by Ahlin:

> For persons whose medical condition may influence their decision-making so that they hurt themselves or others, it is justified to judge that an underlying desire is inauthentic to the extent that it is due to causal factors that are alien to the person and to the extent that it deviates from the person's practical identity.[xxxvi]

Ahlin offers this case as motivation for his view:

> Consider a 40-year old man who suddenly developed a sexual interest in children that was causally connected to a brain tumor…When the tumor was removed the pedophilic symptoms disappeared, and when the symptoms later returned it was found that the brain tumor had grown back. There is no doubt that the tumor caused the man's sexual interests. Thus, the causal factors of the man's desires were alien to how he was otherwise construed, which intuitively seems to justify the judgment that they are inauthentic.[xxxvii]

Ahlin's view is a plausible and interesting proposal. It seems clear that the man in the previous case is really not acting authentically and that it would be justified (and indeed respectful to the real him) to paternalistically intervene and stop him from engaging in pedophilia (obviously this intervention would be justified for other reasons as well). This is, to my mind, the strongest version of the objection. Applied to anorexia, the objector argues that A's values have been hijacked and that, as a result, she is being driven by some force alien to herself. To put it strongly, it is not A, but instead her condition, that is making the decisions. Despite the initial plausibility of this view, I think that it fails.

First, this view would have to argue that A's anorexic desires deviate from her practical identity, which I've already given ample reason to doubt. But, suppose that the objector is granted this premise. I argue that this view is still implausible.

Consider this case:

> **Controlling Pill:** Keith is a normal person who does not have suicidal thoughts. Josh gives him a pill that causes him to have an all-consuming and inescapable desire to commit suicide. Without the influence of this pill, Keith would never desire suicide, but he now is planning to kill himself.

It seems very clear that the causal story behind Keith's desire renders his decision to commit suicide nonconsensual, and paternalism is justified to prevent him from killing himself. This case fits exactly the proposal that Ahlin has put forth. While I agree with Ahlin's view when applied to a case like this, I think that this agreement comes from the fact that Keith is being coerced (in a manner of speaking) by the pill. The pill strips Keith of all agency and makes his behavior unfree. I argue that this lack of freedom, not the origin of Keith's desire, explains why he is incompetent. Once we remove the coercive feature of the case, we can see that Ahlin's proposal is not plausible. Consider these cases:

> **Voluntary Influencing Pill:** Keith is a normal person who does not have suicidal thoughts. Keith has a lot of anxiety. He knows that a particular kind of pill can be taken to temporarily sooth his anxieties, but he is distantly aware that this pill may, after years of use, lead to the development of strong but resistible suicidal desires. Knowing this possibility, Keith takes the pills for years anyway. Eventually, he develops the aforementioned strong but resistible desire to commit suicide.

In all of these cases, Keith has a desire that is bad for him, which is caused by an external influence, and which deviates from his practical identity. In Voluntary Influencing Pill, I have the intuition that paternalism is not justified to prevent Keith from killing himself. It seems clear to me that, so long as the pill is only influencing Keith, his competence is intact. The simple fact that the pill is external and causes alien desires is not sufficient to render him incompetent. It must also be the case that the pill robs him of free will. Thus, Ahlin's proposal fails. It is only plausible if it reduces to saying that our values render us unable to consent when our values are caused externally and exhibit coercive force. To return to Ahlin's tumor example, I am committed, then, to saying that so long as the man's pedophilic desires are resistible coercion is not justified against him in virtue of him being incompetent. Of course, coercion is justified against him because of the fact that pedophilia is impermissible to begin with, but it is important to note that what justifies preventing his actions is not that he is incompetent.

Now, the question is whether the influence of anorexia is more like Controlling Pill or Voluntary Influencing Pill? Although there are certainly cases in which anorexia is closer to Controlling Pill,[xxxviii] it seems to rarely exercise an all controlling influence over sufferers. Instead, anecdotal evidence from individuals with anorexia supports the view that anorexia exhibits a strong but ultimately resistible influence on the individual:

> 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.[xxxix]

> For many, anorexia nervosa was seen as separate from the real self, although the separation was experienced in various ways. Some articulated the idea of two parts to the self without distinguishing an authentic from an inauthentic self.[xl]

> It IS like another voice, it is like another, it's almost like having two bits of you that are you all the time. The bit of you that is really scared of food and everything that means and the rest of you that wants to be able to get on without it. I just feel like there's two voices in my head sometimes.[xli]

Overall, once we render Ahlin's proposal plausible, it no longer applies to anorexia. In short, Ahlin's view is only plausible if it reduces judgements of inauthenticity into claims about individuals being totally controlled by their desires. But, once we take this step, his account no longer applies to anorexia, as anorexic desires do not exhibit this kind of control over anorexics.

One might object that anorexia is importantly different from Voluntary Influencing Pill, in that Keith makes a conscious choice to take a pill that will have downstream effects. The objector might say that anorexia is not relevantly similar, in that its origin is not voluntary but is instead determined by one's biology. Certainly, if this were true, anorexia would be closer to Controlling Pill. But, the evidence seems to suggest that anorexia is not determined by one's biology but is caused by a broad mix of social and biological factors mixed with voluntary responses to anxiety. The evidence suggests that anorexia is the result of a complex web of social and biological features, including heritability, weight gain in puberty, the influence of male and female family members, social class, and more.[xlii] So, far from being determined by one's genes, the development of anorexia has a multifactorial origin that cannot be analyzed as being determined. Further evidence of this can be seen in historical rates of anorexia; Gowers and Shore note that "the evidence that eating disorders have increased in prevalence over the past 30 years, their predominance in females, and the changing roles of women in Western society has convinced many of the role of sociocultural factors in the aetiology of these disorders."[xliii] In short, the fact that rates of anorexia have increased as social influences have changed suggests that biology is *a* factor but not the *only* factor in the etiology of anorexia.[xliv] Anorexia originates from a complex web of biological and social influences, and it is too ambitious to say that the disorder is purely determined by factors outside of the anorexic's control. Along the way, the anorexic makes voluntary decisions in response to anxiety that lead, unintentionally and without awareness, to the formation of a pathology. Thus, anorexia is relevantly similar to Voluntary Influencing Pill.

One might object to the preceding discussion by noting that while the influence of anorexia is in principle resistible, it exhibits such a pervasive influence on A that her decisions are not autonomous. Anorexia is like a voice that is always tempting A and will exert such a powerful temptation that she feels helpless, despite retaining the physical ability to not give in. Perhaps decisions made under these conditions warrant paternalism. I disagree. So long as a patient maintains the physical ability to make a voluntary decision and is of sound mind, it is beyond the preview of physicians to act against her will. If paternalism were justified in this case, it would also be justified in cases of extreme weak will, compulsive eating, etc. That is too strong.

III. 7. A's refusal is invalid, because her values are pathological in nature:

This view has been proposed independently by Charland and Tan et al. On Tan et al.'s initial gloss, the view is the following:

> Those values that are both a result of mental disorder, and that underpin the dangerous decisions (such as refusal of beneficial treatment), [can be seen] as pathological. One

> implication of their being pathological is that these values do not represent the true or authentic views of the person. In respecting the autonomy of the person it is her 'authentic' views that should be respected – that is the views that she would have (or did have) if she did not suffer from the mental disorder. The concept of pathological values, linked to mental disorder, enables such values to be distinguished from the unreasonable, unusual or bizarre values that people are fully entitled to hold, and often do hold, in the course of everyday life.[xlv]

When they develop this proposal further, Tan et al. offer the following view:

> The justification therefore for overriding a current decision that results from values related to a mental disorder must be that the decision is not authentic (because it results from a mental disorder).[xlvi]

As I understand this view, Tan et al. argue that A's values make her decision overridable if (1) those values are caused by her anorexia, and if (2) this causality makes her values inauthentic (i.e. not genuinely hers). If this understanding of Tan et al.'s view is correct, then it seems to immediately reduce to the external causation view and is subject to the problems with that proposal.

With all of the preceding discussion, I conclude that the best reasons one can offer for why JW can refuse and A cannot all either (1) apply equally to JW or (2) are independently implausible reasons to undermine A's refusal.

III. Objections:

III. 1. Is paternalism justified against A, even if she can refuse?

The objector might argue that even if I am right that A can give valid refusal, this may be irrelevant, because paternalistic intervention may be justified against A even if she can give valid refusal. Consent is a moral transformative, meaning that it renders an action permissible when it otherwise would not have been. But, consent is not always a sufficient condition for the permissibility of an act. There are consensual actions that are all-things-considered wrong. For example, perhaps people can give valid consent to a slavery contract, but slavery may be so wrong that we are justified in preventing this contract. Perhaps A can consent to endure serious bodily harm, or even death, but these outcomes are so bad for A that they override the normative power of A's refusal and render her refusal all-things-considered impermissible.

This objection proves too much. If the arguments in sections II and III are correct, then there is no reason to think that A cannot refuse that does not equally apply to JW, because all of the purported reasons that A cannot refuse either independently failed or applied equally to JW. If this is correct, then we should apply the same standard in both cases for paternalistic intervention. If intervention is justified for A refusing live-saving food, then it must also be justified whenever JW refuses a life-saving transfusion. Thus, if the objector holds that A's actions are so harmful that paternalistic intervention is justified, she must say the same about JW, meaning that she is committed to the claim that JW should be forced to take the transfusion. This is too strong. Surely, the purpose of consent is to protect our autonomy, and to force the transfusion on JW is to violate his autonomy. Thus, because it seems clear that we are not justified in forcing JW to take the

transfusion, and because JW and A's consent abilities are on a par, I conclude that we are not justified in force-feeding A.

This is not a conclusion to delight in. Somebody dying because of misguided and disordered beliefs is a tragedy. But, it is just as tragic in the case of a Jehovah's Witness as it is in the case of an anorexic. Unless this tragedy is so great in the case of religious objections that it justifies paternalism, then it should not justify paternalism in the case of mental disorder.[xlvii]

In case this has not been convincing, we can appeal to even more cases that illustrate why paternalism is not justified against anorexics. Draper appeals to this case:

> The second example concerns those women who refuse to undergo radical breast surgery when they are diagnosed with breast cancer, because they consider that their breasts are so integral to their identity and/or quality of life that they would rather die with their breasts intact, than live without them. This is a view that attracts a great deal of sympathy, despite the fact that it seems irrational to give greater weight to one's body image than to one's life expectancy. But provided that she is competent and understands the dangers of refusing to consent, such a patient would never be compelled to undergo surgery. In this case, competence and irrationality are clearly differentiated.[xlviii]

Although there are differences between this case and anorexia, it is still worth noting that most people regard this woman's decision as within her rights but clearly misguided and irrational. It's telling that we do not have this reaction in the case of anorexia, despite the obvious similarities between the cases. I suggest that we treat our reaction to the case of cancer treatment refusal as more trustworthy than our initial reactions to the case of anorexia treatment refusal.

III. 2. Is Religion Different?

One might object that while there is no strict difference between A and JW in terms of competence, the fact that JW's refusal is based on a religious objection, while A's is not, makes a moral difference. As I see it, there are several ways of putting this objection:

> **Religion and Competence:** the fact that JW's refusal is based on a religious objection while A's is not makes JW competent in a way that A is not.

This seems obviously false. There is no necessary connection between a refusal being religious and it being competent or more likely to be competent.

The second way of putting the objection runs as follows:

> **Religion qua Religion:** religion is simply different in a way that justifies religious exemptions for refusals that would otherwise not be respected. It is religion qua religion that makes the difference.

On this view, religion is different and special in virtue of being religion. While there is considerable debate in philosophy of law about the special status of religion in a liberal society, it seems that in the context of one to one determinations of valid consent, the bare fact that something is religious doesn't seem to make a difference. Suppose that there are two equally unintelligent

people who both want to refuse a blood transfusion for bad reasons. One's objection is based on a disgust reaction to the thought of another's blood being in her veins while the other's is based on a religious reason. It does not seem obvious to me that the religious objection is more worthy of refusal in virtue of being religious. To insist to the contrary seems like a fetishistic preference for religion being special. In other words, if there is no reason to favor religious exemptions over non-religious ones, then the bare fact that an exemption is religious doesn't seem plausible as a reason to treat it specially.

The third way to put the objection is this:

> **Right to Religion:** JW's refusal is different, because we have a right to freedom of religion that justifies his refusal, but there is no such right for A.

While it is true that JW has the right to religious freedom, this freedom seems to be a more specific instance of the general right to freedom of association, expression, and conscience. A has these rights just as much as JW. If A's decision to refuse food is based on her rights to association, expression, and conscience, then her refusal can be just as valid as JW's.

Finally, it is important to note that for some, but certainly not all, anorexics, anorexia can be properly described as a religion. Shockingly, there are numerous anorexics who deify anorexia as a being called Ana and have formed a movement called pro-Ana. As Stapleton says, "pro-anorexia (pro-ana) is an Internet-based movement that provides support and advice for those wishing to develop or maintain an eating disorder (ED."[xlix] These websites "typically…contain message boards, discussion fora, blogs, dieting 'tips and tricks', body mass index…calculators and photo/video galleries providing 'thinspiration' for extreme weight loss."[l] There is a clear religious element of the pro-Ana movement. As Stapleton says, "many pro-ana websites contain an overtly 'religious' dimension, with creeds, psalms and commandments, and sometimes the invocation of a deity-like figure called Ana (and/or Mia), who personifies the ED and offers guidance and motivation to followers."[li] Ana is thought of as "a guardian, who can share the burden of anorexia and provide inspiration for her follower," and "Ana may also be presented in a punitive light: as demanding absolute loyalty and adherence to a strict behavioral code."[lii] The following quotations taken from pro-Ana forums graphically illustrate this:

> **Post**: So.. here I am. I know ana's the only way now. I don't want to be the failure I am any more.
>
> **Response**: Ana is absolutely the only way, shes the answer! Just trust & believe & u WILL b the thinner.
>
> **Post**: i need help. i just can't control my cravings. i need help.
>
> **Response**: getthinordietrying: You need ana!! If you stop eating NOW, ana will take you under her wing. Show ana you can ignore cravings and she will drop numbers off the scale, show ana you can run until you drop and she will give you tiny thighs, show ana you really want this and she will give you a flat stomach, Show ana you can say fuck you to food, work your ass off, and keep her a secret, and she will give you a thigh gap and make all the girls envy you.

> **Post:** RubyRedShoes: stay strong, keep in mind what you have set out to achieve, be dedicated, motivated and you'll get there, you can relise your dreams!!! show them… starve on in Ana's name.[liii]

It's not clear that pro-Ana followers literally believe that there is a supernatural being called Ana who exists. But, they clearly behave as if Ana is a deity and can be considered a religion just as much as some non-theistic sects of Buddhism are considered a religion.

III. 3. What About Future Desires?

Perhaps A would be happy in the future that the doctor coercively saved her life today. And, perhaps this is not true of JW. Does this difference in future desires make a difference in how we ought to treat these individuals in the present? There are several different ways to put the objection. The first version comes in terms of harm/benefit while the second comes in terms of subsequent consent. On the first version, if we have good reason to believe that A will later be happy to have been coercively kept alive, then this provides us a reason to override her current wishes. Note that this reason is based on harm and benefit, not on consent. The second version of the objection need not make use of harm or benefit but instead can appeal to the idea of subsequent consent. On this view, if we coerce A now to keep her alive, and she later gives her consent, this can make the intervention permissible in the past.[liv] I will address these objections one at a time.

Before proceeding, it's important to note that it is not always the case that future A would really prefer to have been coerced in the present. But, it is common for anorexics to later be thankful that they were coerced. As Watson et al. say:

> A substantial minority of patients with severe eating disorders will not seek treatment unless legally committed to an inpatient program. Despite the involuntary initiation of treatment, the short-term response of the legally committed patients was just as good as the response of the patients admitted for voluntary treatment. Further, the majority of those involuntarily treated later affirmed the necessity of their treatment and showed goodwill toward the treatment process. Only a long-term follow-up study will indicate whether these two populations differ in the enduring nature of their treatment response.[lv]

Not only this, there is evidence that coercive treatment can work:

> Despite the fact that the length of their hospitalization was significantly longer than that of the voluntary patients, the involuntary patients responded well to the treatment program…The overall mean weight of the involuntary group at discharge was not significantly lower than that of the voluntary group…Anecdotally, many of the involuntary patients reported to the treatment team at the time of discharge that they recognized and endorsed the need for treatment. Not a single patient in this study entered a legal complaint or complaint to a medical society after discharge regarding the inappropriateness of the involuntary commitment or even informally complained that the treatment was unnecessary. This change in attitude suggests that the initial negative attitude might have resulted from the patient's illness or an unrealistic appraisal of the usefulness of treatment.[lvi]

First, I doubt overall that coercive treatment is actually effective in the long term. As Dresser says, "the anorexic's overriding fear of losing control suggests…that she will accept treatment

only if she feels she has some degree of control over the process. Because of her need for control and her ability to defeat unwanted treatment, efforts by health professionals to win the anorexic's trust and to secure her cooperation are crucial to the success of any treatment program."[lvii] Second, it is important to note that the treatment is highly invasive and involves extreme amounts of coercion and manipulation. As Dresser says, coercive treatment can involve (1) tube feeding, which is highly invasive and can result in pneumonia if not done correctly, (2) an IV drip that feeds the patient, which can have severe side effects, and (3) behavioral modification therapy. Methods 1 and 2 either involve sedating the patient against her will or forcibly holding her down and performing the relevant procedure. As Dresser says, option 3:

> Initially requires the anorexic to remain in bed or in her room with few or no diversions available…as she gains weight, she earns such privileges as 'having visitors, making telephone calls, getting up for bath and toilet….Some programs individualize reinforcement by observing a patient's behavior to determine her preferences. In one such program…a patient highly concerned with cleanliness was not giver her toothbrush, comb or clean linens unless she gained weight.[lviii]

I say all of this to show that even if the treatment is successful, it involves a high degree of coercion. It seems to me that the burden of justification for coercion ought to go up in proportion to the severity of the coercion.

Against the subsequent consent objection, I'll note that I am skeptical of the idea of subsequent consent. At the very least, this is a highly controversial position to take that would, in effect, license huge amounts of paternalism.

According to the harm/benefit version of the objection, the fact that A would later be benefited by coercion provides a justification for this coercion. This immediately licenses a strong form of paternalism. If the principle is that coercion is justified when the patient would eventually be benefited by it, then far more than this intervention is justified. This proposal would justify intervention against JW, if it turns out that most Jehovah's Witnesses would be thankful to have been coerced. It does not seem like our obligation to respect JW's refusal depends on whether we have reason to believe that he will thank us in the future. We have an obligation to respect his wishes as they are now. Furthermore, consider a case in which an individual is in a severe car accident is faced with the decision to live permanently paralyzed or die by refusing treatment. Often, such individuals believe that their life would not be worth living with such a disability, but there is evidence to suggest that if they were coerced into remaining alive, they would value their lives and be happy to be alive.[lix] It seems to me that these individuals still have the right to refuse treatment as long as they are competent. The fact that a patient would later see that the coercion benefited them is not sufficient to render them incompetent right now.

For example, proponents of this strategy agree that it would potentially justify coercion against both JW and A. As Giordano says:

> Preventing death in anorexia might give the patient the chance to survive and, some time down the line, to recover. If the patient recovers, her priorities and beliefs will change…When anorexia is reversed, the patient abandons, at least to a significant degree, the fears and priorities for which she was refusing treatment. It is in fact reported that

> many anorexics who have been rescued against their wishes, will thank you for that (Watson, Bowers, and Andersen, 2000). Enforcing treatment on the Jehovah's Witness might not give him a chance of wanting to live with the foreign blood, because even if he recovers from the illness for which he requires blood, he might still hold his religious beliefs. Curing the illness has nothing to do with changing his beliefs and priorities…His religion does not go with recovery. Recovery from anorexia, instead, means that the values that hold anorexia and refusal of treatment are modified.[lx]

But, suppose that JW would likely change his beliefs after being coerced away from refusal? On Giordano's view, then coercion would be justified against him. He admits as much: "if the Jehovah's Witness was likely to change his religious beliefs after treatment and thank you for rescuing him, a similar reasoning to the one I applied to anorexics should stand for him."[lxi] This is too strong.

III. 4. What if A's condition is caused by social oppression?

One might argue that an important difference between A and JW is that A's belief is very likely heavily influenced by oppressive ideas about gender roles and body image, while JW's is not. The empirical evidence confirms that this is generally true of anorexics. As Dresser says,

> Extensive research documents a high incidence of anorexia among girls and women whose professions subject them to special pressures concerning their body size…two Canadian authorities on anorexia, surveyed groups of female dancers, models, university students, and music conservatory students as diagnosed anorexics. Dancers and models had significantly higher scores on assessments of anorexic symptoms than did the control group of university students and the comparison group of music students.[lxii]

If A's belief result from an unjust system that teaches women to hate their bodies, then her belief is caused by oppression. Perhaps beliefs caused by oppression are overridable.

I reject this for two reasons. First, it is possible that JW's beliefs are also caused by some kind of oppressive social system. Perhaps JW grew up in a highly authoritarian home which constantly impressed the message of his religion on him. To my view, this would not make his later consent invalid. Second, I am skeptical of broad claims about social forces invalidating the consent of entire groups of people. If A's anorexia is partially caused by oppressive cultural attitudes, this does not make her decision involuntary, deceived, or coerced; instead, her decision is heavily influenced by external forces. But, the same is true for most decisions. To take the view that A's consent is invalid due to broader social forces would commit one to saying that A suffers from some kind of false consciousness about her own situation. This seems dubious.

III. 5. Does it Matter that the Stakes are High?

One might object that A can be coerced into treatment, because the stakes are life and death. While this is plausible, it immediately applies back to JW, who is also making a life and death decision.

The objector might revise the point to say that A cannot refuse, because her choice is high stakes and is motivated by a disease, while JW's decision is equally high stakes but is not motivated by a disease. However, if, as I argued earlier, the fact that a desire originates in a pathology does not thereby make it overridable, then combining these two reasons will not be enough to override A's wishes.

Conclusion:

Although it is tragic, I argue that anorexics can validly refuse food, even to the point of death. This does not entail that we should desire such behavior, only that the importance of autonomy prevents us from stopping such behavior. Clearly, anorexia exerts force on those who suffer from it, but I have argued that this force is not sufficient to override their refusal. But, what are we to make of the obvious influence that anorexia has on patients? I suggest that we should conceive of anorexia as extreme akrasia. The following interview responses from anorexia sufferers illustrate quite well how anorexia appears to them as a powerful but resistible force, much like akrasia:

> 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.[lxiii]

> It IS like another voice, it is like another, it's almost like having two bits of you that are you all the time. The bit of you that is really scared of food and everything that means and the rest of you that wants to be able to get on without it. I just feel like there's two voices in my head sometimes.[lxiv]

> So I didn't really want treatment, but then there's this little voice deep down inside, which is kind of the complex part, that's saying "you know you do want treatment really," but then there's this kind of overriding big THING which is just like "no, you're FAT"…"you don't need to put on weight!"[lxv]

> But at the moment it's really hard, I want to eat the normal amounts, but it's really hard because at the moment, if I did eat the normal amounts I know that I wouldn't feel happy about it. But I want to be able to.[lxvi]

> One part of you says, like, you need some help . . . but the other part of you is screaming at you to run six hundred miles in.[lxvii]

> When it takes control, particularly when I'm at a very low weight, its voice if you like is loud, very, very loud, and I can't, the real me can't battle against it. . . . At a higher weight the real me is more able to challenge the anorexic me, as in, no, I'm not going to restrict here, no, I'm not going to overexercise . . . If, say, I was to draw a diagram of my head . . . at a low weight when the anorexia is very strong, it's taking up, like, 99 percent of my head, but there's still a little bit of me, whereas when I start to get better and put on

> weight and get well, then the real me gets stronger and so it goes down, and then I'm like 75/25, 50/50, and I'm hoping eventually 100/nothing.[lxviii]

It is a sad state of affairs that we are not allowed to coerce anorexics into saving their own lives. But, in just the way that we cannot coerce individuals with religious objections or weakness of will, we cannot coerce anorexics. What options are we left with for the clinical setting? Should doctors simply give up? Of course not. My proposal is perfectly compatible with A's doctors, family, and friends aggressively pursuing all non-coercive ways of getting A to accept treatment. These individuals should desperately plead with A to begin treatment, but they simply cannot coerce her. Of course, those who want to help A are free to use any other kind of non-consent invalidating influence to urge her toward treatment.

I want to remind the reader that while I believe my view is true, I recognize that it is controversial enough that I would not want clinicians to implement it overnight. Rather, my goal is to stimulate discussion with the goal of reaching the correct view for clinical practice.

Affiliation:

Samuel Director

Brown University (Political Theory Project)

References

Ahlin Marceta, Jesper. "a non-ideal authenticity-based conceptualization of personal autonomy." Medicine, Health Care and Philosophy 22 (2019): 387-95.

------ "The impossibility of reliably determining the authenticity of desires: implications for informed consent." Medicine, Health Care, and Philosophy 21 (2018b): 43-50.

------"What Justifies Judgments of Inauthenticity?" HEC Forum 30 (2018a): 3610377.

Appelbaum, Paul S. and Thomas Grisso. "The MacArthur Treatment Competence Study. I." Law and Human Behavior 19, no. 2 (1995a): 105-26.

Buss, Sarah. "Autonomous Action: Self-Determination in the Passive Mode." Ethics 122 (2012): 647-91.

Carney, Terry, David Tait, Alice Richardson, and Stephen Touyz. "Why (and When) Clinicians Compel Treatment of Anorexia Nervosa Patients." European Eating Disorders Review 16 (2008): 199-06.

Chwang, Eric. "In Defense of Subsequent Consent." Journal of Social Philosophy 40, no. 1 (2009): 117-31.

Draper, Heather. "Anorexia Nervosa and Respecting a Refusal to Life-Prolonging Therapy: A Limited Justification." Bioethics 14, no. 2 (2000): 120-33.

- - - "Treating Anorexics Without Consent: Some Reservations." Journal of Medical Ethics 24 (1998): 5-7.

Dresser, Rebecca. "Feeding the Hunger Artists: Legal Issues in Treating Anorexia Nervosa." Wisconsin Law Review 2 (1984): 297-74.

Giordano, Simona. "Anorexia and Refusal of Life-Saving Treatment: The Moral Place of Competence, Suffering, and the Family." Philosophy, Psychiatry, & Psychology 17, no. 2 (2010): 143-54.

Gowers, Simon G. and Alison Shore. "Development of weight and shape concerns in the aetiology of eating disorders." British Journal of Psychiatry 179 (2001): 236-42.

Grisso, Thomas and Paul S. Appelbaum. "Appreciating Anorexia: Decisional Capacity and thee Role of Values." Philosophy, Psychiatry, & Psychology 123, no. 4 (2006): 293-97.

Hanna, Jason. "'It Won't be as Bad as You Think': Autonomy and Adaptation to Disability," in Adaptation and Autonomy: Adaptive Preferences in Enhancing and Ending Life, ed. Juha Räikkä and Jukka Varelius (Heidelberg: Springer, 2013), pp. 49-68

Hope, Tony, Jactinta Tan, Anne Stewart, and Ray Fitzpatrick. "Anorexia Nervosa and the Language of Authenticity." Hasting Center Report 41, no. 6 (2011): 19-29.

Noggle, R. (2005). Autonomy and the paradox of self-creation: Infinite regresses, finite selves, and the limits of authenticity. In J. S. Taylor (Ed.), Personal autonomy: New essays on personal autonomy and its role in contemporary moral philosophy (87–08). Cambridge: Cambridge University Press

Stapleton, Karyn, Sarah L. Evans, and Catrin S Rhys. "Ana as god: Religion, interdiscursivity and identity on pro-ana websites." Discourse & Communication 13, no. 3 (2019): 320-41.

Tan, Jacinta, Tony Hope, and Anne Stewart. "Anorexia nervosa and personal identity: The accounts of patients and their parents." International Journal of Law and Psychiatry 26 (2003): 533-48.

Tan, Jacinta, Tony Hope, Anne Stewart, and Raymond Fitzpatrick. "Competence to make treatment decisions in anorexia nervosa: thinking processes and values." Philosophy, Psychiatry, and Psychology 13, no. 4 (2006): 267-82.

Tan, Jacinta, Tony Hope, Anne Stewart, and Raymond Fitzpatrick. "[pre-print version] Competence to make treatment decisions in anorexia nervosa: thinking processes and values." Philosophy, Psychiatry, and Psychology 13, no. 4 (2006): 1-31.

Tan, Jacinta, Tony Hope, and Anne Stewart. "Competence to refuse treatment in anorexia nervosa." International Journal of Law and Psychiatry 26 (2003): 697-07.

Taylor, Charles. The Ethics of Authenticity. Cambridge: Harvard University Press, 1991.

Vollmann, Jochen. "'But I Don't Feel It': Values and Emotions in the Assessment of Competence in Patients With Anorexia Nervosa." Philosophy, Psychiatry, & Psychology 13, no. 4 (2006): 289-91.

Watson, Tureka L., Wayne A. Bowers, and Arnold E. Andersen. "Involuntary Treatment of Eating Disorders." American Journal of Psychiatry 157 11 (2000): 1806-810.

I would like to thank the following people for their helpful comments and feedback on this paper: David Boonin, Chris Heathwood, Mike Huemer, Iskra Fileva, Ben Hale, Chris Freiman, Marcus Hunt, Jeff Carroll, Greg Robson, Wes Siscoe, Mario Ivan Juarez Garcia, Jason Hanna, Eric Chwang, Louis Charland, Connor Kianpour, audiences at the Center for Values and Social Policy, the 2020 Central APA, UNC-Wilmington, and to my bioethics students who let me process these ideas with them. As always, thanks are due to Emily Director for all her continuing support. Thanks are also due to the Institute for Humane Studies for funding I received while writing this article.

[i] For example, in a recent article, Buss includes anorexia as one of two "paradigm cases of nonautonomous agency" (Buss, "Autonomous Action," 681).

[ii] A limited version of this conclusion has been defended by Draper. It is important to note that Draper supports anorexic's refusal of treatment in a very narrow range of cases (Draper, "Anorexia Nervosa and Respecting," 122-123). Draper also uses a comparison between Jehovah's Witnesses and anorexics, but it seems to be only an off-hand remark and not essential to her argument or developed very far (Draper, "Anorexia Nervosa and Respecting," 128). A brief comparison to Jehovah's Witnesses also appears in Tan et al.: "There is however a major problem in relying on this third, external 'reasonableness' criterion. It opens the door to considering the beliefs and values held by people from alternative cultures or sub-cultures as unreasonable (for example Jehovah's Witnesses who refuse life-saving blood transfusions)" (Tan et al., "Competence to make [pre-print]," 19. Also, Giordano makes reference to the comparison between anorexia and Jehovah's Witnesses, arguing for the opposite conclusion from mine (Giordano, "Anorexia and Refusal"). None of these authors use this comparison as the central point of their argument.

[iii] I defend this claim at length later in the paper.

[iv] Tan et al., "Competence to Make [pre-print]," 2. As Vollmann argues, "the results of the study show that anorexia nervosa can have complex and variable effects on concentration, beliefs, and thought processing without affecting the ability to perform well on the MacCAT-T. At the same time, participants also report a change in their value system as well as in their personal identity. The authors argue that the results of their studies suggest that the competence to refuse treatment might be compromised in people with anorexia nervosa in ways that are not captured by the MacCAT-T" (Vollmann, "But I Don't," 290). It is important to note that Vollmann thinks that this reveals a problem with the Macarthur Test. I do not share that view but instead think that the Macarthur test is correctly identifying anorexics as being competent.

[v] Appelbaum and Grisso, "The MacArthur," 106.

[vi] Throughout the paper, I refer to anorexics as a group. When I do so, I mean to refer to most anorexics, not all anorexics.

[vii] Tan et al. "Competence to Make," 279.

[viii] Tan et al., "Competence to Make," 270.

[ix] Tan, Hope, and Stewart, "Competence to refuse," 704.

[x] Tan, Hope, and Stewart, "Anorexia nervosa and personal identity," 537. It is important to note that Tan et al. would disagree with the conclusion I'm reaching. They think that all of this shows a problem with the MacCAT-T

[xi] Tan, Hope, and Stewart, "Competence to refuse," 704.

[xii] Tan, Hope, and Stewart, "Competence to refuse," 701.

[xiii] Tan, Hope, and Stewart, "Competence to refuse," 701.

[xiv] Grisso and Appelbaum, "The MacArthur," 293.

[xv] Tan et al., "Competence to make,"270.

[xvi] Tan et al., "Competence to make," 270.
[xvii] Tan et al., "Competence to make," 271.
[xviii] Tan, Hope, and Stewart, "Competence to refuse," 701.
[xix] Grisso and Appelbaum, "The MacArthur," 293. Grisso and Appelbaum disagree with this analysis based on Tan's interviews: "if we accept these patients' assessments of their own conditions, we have reason to believe that at least some of them may have lacked capacity to make treatment decisions in the past, owing to the effects of their disorder on their capacity to reason about (process and think about) their treatment options. If clinicians had been using the MacCATT to evaluate these patients at those times and they had manifested these deficits, it is unlikely that these patients would have received the high scores on reasoning that they were awarded in this study" (295-296).
[xx] Tan et al., "Competence to make," 274.
[xxi] Jehovah's Witnesses do in fact, believe this.
[xxii] Tan et al., "Competence to make," 274.
[xxiii] Hope et al., "Anorexia Nervosa and the language," 27-28.
[xxiv] It is worth noting that Ahlin ("The impossibility of reliably") has argued that it is not possible to identify which of a patient's desires are authentic and that for this reason, authenticity should not be used to assess informed consent.
[xxv] Ahlin ("What Justifies") lists Noggle's taxonomy and his own taxonomy. For my purposes, these distinctions won't matter. Say that there are various taxonomies proposed of theories of authenticity and just say that I won't need to get that into the weeds. I will just canvas an exhaustive list of different features of values that might render them inauthentic and thus incompetent.
[xxvi] Ahlin, "What Justifies," 364-365.
[xxvii] Ahlin, "What Justifies," 368.
[xxviii] Ahlin, "What Justifies," 368.
[xxix] Tan, Hope, and Stewart, "Anorexia nervosa and personal identity," 539.
[xxx] Something very similar happens to this in Pawel Pawlikowski's 2013 film *Ida*, which involves a young nun who leaves her convent to experience secular life.
[xxxi] Taylor, The Ethics of Authenticity, 28-29.
[xxxii] Hope et al., "Anorexia Nervosa and the language," 25.
[xxxiii] Tan et al., "Competence to Make," 276.
[xxxiv] Hope et al., "Anorexia Nervosa and the language," 24.
[xxxv] Tan, Hope, and Stewart, "Anorexia nervosa and personal identity," 542.
[xxxvi] Ahlin, "A non-ideal," 391.
[xxxvii] Ahlin, "A non-ideal," 390.
[xxxviii] For example, "I couldn't stop [dieting]. Don't want to and couldn't anyway. (Participant B) As much as I want to get over it [anorexia nervosa], every time I come to eat I just can't, I think, I dream about when I can go running and I think, if only I could just manage to eat everything, and then I will, but when it comes to it I just can't face it. (Participant H)" (Tan, Hope, and Stewart, "Competence to refuse," 703)
[xxxix] Hope et al., "Anorexia Nervosa and the language," 19.
[xl] Hope et al., "Anorexia Nervosa and the language," 22.
[xli] Hope et al., "Anorexia Nervosa and the language," 22.
[xlii] See Gowers and Shore, "Development of weight." As Gowers and Shore note, twin studies have given estimates close to 50% heritability for anorexia ("Development of weight," 237).
[xliii] Gowers and Shore, "Development of weight," 238.
[xliv] It is important to note that many disagree with this view and do think that anorexia is determined by biological and social influences. "In summary, the literature contains two very different views of anorexia nervosa. Crisp expresses the dichotomy well: 'One cannot be involved in the business of [treating] anorexia nervosa for long without being starkly confronted by the problem of free will versus determinism. Is the anorectic free to choose an alternate way of life or is she simply a product of biological forces and previous social experiences[?]' 9 If anorexic behavior is freely chosen as a method of communicating, asserting power and coping with stress, the law could either refuse to authorize unwanted medical interference with that behavior or strictly limit such interference. Conversely, if the anorexic cannot control her behavior, the law might more easily sanction her involuntary treatment. 90 These alternatives exist whenever the legal system addresses the subject of involuntary treatment for individuals labeled mentally disordered or incapacitated.9 1 But in the case of anorexia, the choices are particularly well-defined because the literature so clearly expresses the two conflicting views of human behavior" (Dresser, "Feeding the Hunger," 308).
[xlv] Tan et al., "Competence to Make [pre-print]," 20.

[xlvi] Tan et al., "Competence to Make [pre-print]," 21.
[xlvii] It is also important to note that force-feeding, even if it were justified, is not a controversial treatment. As Tan et al. say, "one common argument that relates to efficacy is that it is harder, if not impossible, to engage patients in psychological therapies if their treatment is compulsory (Dresser, 1984; Rathner, 1998). A second argument involving efficacy is that re-feeding unwilling patients may lead to short term weight gain but is ineffective in the long run (Rathner, 1998)" ("Competence to Make," 3).
[xlviii] Draper, "Anorexia Nervosa and Respecting a Refusal," 131.
[xlix] Stapleton, Evans and Rhys, "Ana as god," 321.
[l] Stapleton, Evans and Rhys, "Ana as god," 321.
[li] Stapleton, Evans and Rhys, "Ana as god," 321. As Stapleton, Evans, and Rhys say, "in a larger content analysis of 180 websites, Borzekowski et al. (2010) showed that 16% [of pro-ana sites] contained a creed or oath to Ana and/or a statement of 'Thin Commandments'." ("Ana as god," 322). Ana's thin commandments can take this form: "Thou shall not eat without feeling guilty. Strict is my diet. I must not want. It maketh me to lie down at night hungry. It leadeth me past the confectioners. It trieth my willpower … I believe in calorie counters as the aspired word of God … I believe in bathroom scales as an indicator of my daily successes and failures. (Day and Keys, 2008: 8)" ("Ana as god," 337).
[lii] Stapleton, Evans and Rhys, "Ana as god," 322.
[liii] All of these excerpts are taken from Stapleton, Evans and Rhys, "Ana as god," 326-329.
[liv] For a defense of subsequent consent, see Chwang, "In Defense."
[lv] Watson, Bowers, and Andersen, "Involuntary Treatment," 1806
[lvi] Watson, Bowers, and Andersen, "Involuntary Treatment," 1809
[lvii] Dresser, "Feeding the Hunger," 322.
[lviii] Dresser, "Feeding the Hunger," 297.
[lix] This is referred to as the paradox of disability. For a thorough discussion of this issue, see Hanna, "It Won't Be As Bad."
[lx] Giordano, "Anorexia and Refusal," 150.
[lxi] Giordano, "Anorexia and Refusal," 151.
[lxii] Dresser, "Feeding the Hunger," 334.
[lxiii] Hope et al., "Anorexia Nervosa and the language," 19.
[lxiv] Hope et al., "Anorexia Nervosa and the language," 22.
[lxv] Hope et al., "Anorexia Nervosa and the language," 22.
[lxvi] Hope et al., "Anorexia Nervosa and the language," 24.
[lxvii] Hope et al., "Anorexia Nervosa and the language," 24.
[lxviii] Hope et al., "Anorexia Nervosa and the language," 22-23.