**Autonomy and the Moral Authority of Advance Directives**

ERIC VOGELSTEIN

(forthcoming in the *Journal of Medicine and Philosophy*)

I. INTRODUCTION

Advance directives are commonly praised as an important way to safeguard the autonomy of incompetent medical patients; nevertheless, important questions remain about their moral authority.[[1]](#footnote-1) In addition to practical concerns about adequate informed consent, the vagueness and generality of advance directive forms, and the difficulties involved in imagining and applying one’s values to far-removed medical situations, among other concerns,[[2]](#footnote-2) there is an important *philosophical* objection to the moral authority of advance directives in cases in which the incompetent patient has lost the desires, preferences, and values upon which her advance directive was based, as might occur with severe dementia or other conditions that involve serious mental deficits such as vegetative states.[[3]](#footnote-3) In this paper, I shall argue that in such cases honoring a patient’s advance directive does not serve her autonomy, thus the instructions described in the directive are not binding on medical personnel, and other moral values, such as the patient’s well-being, will take precedence.

I shall consider two initial arguments in favor of the view that in order to respect a patient’s autonomy we must honor her advance directive even when she has lost the relevant attitudes, and I will suggest that those arguments are not compelling. I will then argue by analogy that respecting a person’s autonomy requires honoring only those desires that are currently attributable to that person. I shall end by responding to two additional counter-arguments: one based on advance decision-making in cases of temporary incompetence, and one based on the claim that honoring a patient’s directive in the kind of case at issue is in the patient’s best interests.

II. ADVANCE DIRECTIVES AND AUTONOMY

Autonomy is self-determination. To be autonomous is to live one’s life in accordance with how one *wants* to live it, i.e., to live in concert with one’s preferences, desires, values, intentions, plans, etc. To simplify discussion, I will use the term ‘desire’, in its technical philosophical sense, to refer to any such “motivational” or “pro-” attitude that can reflect one’s self-determination and upon which one’s self-determined choices can be based. Thus, to respect a person’s autonomy is to honor that person’s desires.[[4]](#footnote-4)

Two caveats are in order. First, desires that are outweighed by a *stronger* desire are not the right sort of desire to honor, if we wish to respect a person’s autonomy. Rather, we respect a person’s autonomy by honoring that person’s *strongest* desires, i.e. by acting in the way the person desires *most*. For example, if I desire pizza and I desire sushi, and there is only time for one option, then my autonomy is respected only by helping me get whichever option I desire *more*.[[5]](#footnote-5), [[6]](#footnote-6) Second, the principle of respect for autonomy does not require that we honor desires that are *not* *competently-held.* This is usually understood to include desires that are based on insufficient ‘understanding and appreciation’ of relevant information, or on a significant lack of reasoning or deliberation (Buchanan and Brock 1989; Grisso and Appelbaum 1998; Beauchamp and Childress 2009; Jonsen, Siegler, and Winslade 2010). Incompetently-held desires might also include those desires that do not cohere with the person’s own beliefs about what is best, all things considered (Gert, Culver, and Clouser 1997; Culver and Gert 2004), or with her deeply-held values (Buchanan and Brock 1989; Dworkin 1993; Charland 2001, 2011; Tan, Stewart, and Hope 2009). In any case, whatever the precise nature of incompetently-held desires, it is important to flag that class of desires, as they do not contribute to a person’s autonomy.

There is a question, however, about the *scope* of the principle of respect for autonomy that is directly relevant to the moral authority of advance directives, in certain cases. The kind of case at issue is one in which an incompetent patient’s advance directive describes a decision based on her *former* desires—desires that she used to have but no longer does—and in which honoring that decision neither serves nor frustrates any of the patient’s current competently-held desires. Whether advance directives have moral authority in such cases is controversial, and is, at least in part, a matter of whether former desires can contribute to a person’s autonomy, or whether the desires that are relevant to autonomy must currently be attributable to the agent. That is, the issue is whether the following thesis is true:

P1: Respecting a person’s autonomy requires only that one honor that person’s

*current* (strongest competently-held) desires.

P1 entails that honoring an advance directive in the kind of case at issue does not serve the patient’s autonomy; and indeed, some medical conditions that make a patient incompetent to make his or her own medical decisions, such as severe dementia, may result in just such a case. Ironically, many of the conditions that seem to call for the execution of an advance directive may in fact negate the moral authority of that directive.[[7]](#footnote-7)

An example will give some context to the above remarks. Suppose that Jane has severe dementia. She no longer remembers her family or friends, is easily confused, cannot care for herself, and lacks the level of intellectual ability and understanding required in order to have a *prima facie* right to make decisions about her medical care (or at least, the right against paternalistic intervention)—in other words, Jane is incompetent to make any treatment-decisions. Jane lives in a nursing home, and despite her condition maintains a pleasant affect. In fact, Jane appears genuinely happy. She enjoys playing games with the staff and other residents, is excited to watch certain shows on TV, and finds pleasure in various other activities in her daily life. She is not anxious about or frustrated with her limitations, and has no serious chronic illnesses or pain. It is obvious to everyone who knows Jane, and learns what her life is like, that her life is definitively worth living—taking into account her current quality of life, her best interests are clearly served by continued life.

Suppose that Jane is found to have a bacterial infection that is easily curable with antibiotics yet fatal if left untreated. The staff is preparing for treatment when a nurse finds an advance directive Jane issued years earlier, while competent. In the directive, Jane clearly states her decision that if she were ever to be in a state of severe dementia, she would want no life-saving treatment, including antibiotics. While she was competent, Jane was a proud and powerful figure, and valued her intellect and independence fiercely. She did not value life in a dependent and demented state, and did not want to be remembered as such a person—someone who, in her words, “withered away.” While competent, she would have rather been dead than live in her current condition. Furthermore, this was no fleeting sentiment—she frequently repeated her wishes on this matter to family and friends. Finally, suppose that there is currently no semblance of Jane’s prior values—the values Jane had while competent. For all we can tell, Jane genuinely no longer possesses her prior aversion to “withering away,” no longer views dementia and dependence as undesirable, no longer values what she previously called her “dignity”—indeed, she no longer seems to possess a conception of dignity at all, or any of the higher-order social concepts and values upon which her advance directive was based.[[8]](#footnote-8)

There is significant controversy about what to do in cases like Jane’s. Many peoples’ intuitive reaction is that it is immoral not to provide simple antibiotic treatment to Jane—but justification for that view differs. Some have argued that Jane is not the same person she was when she made the choice described in her advance directive, and since one person’s choice is not binding upon a different person, Jane’s advance directive does not apply currently (Dresser 1989; King 1996; Quante 1999). This argument is controversial, however, because it relies on a particular view of personal identity (a *psychological* or *neo-Lockean* account of persons). Others have argued that even if Jane is the same person now as she was when she initiated her advance directive, in this kind of case Jane’s well-being should trump the promotion of her autonomy, and thus we should treat her (Dresser and Robertson 1989; Dresser 1992). The problem with this approach is that it provides no principled rationale for ignoring someone’s autonomous choice—it simply advocates paternalistic intervention *in this kind of case*. But paternalism in medical contexts is generally considered to be unacceptable: it is not permissible to override a competent patient’s wishes merely on the basis of her own best interests. Unless there is some further explanation for why the moral injunction against paternalism has an exception in cases like Jane’s, this kind of justification seems unacceptably *ad hoc*.

A less common, but I believe much better argument, takes P1 as its central premise. In cases like Jane’s, the truth of P1 takes autonomy out of the picture. That is, because Jane currently has no competently-held desires that would either be served or frustrated by treatment, if P1 is true then Jane has no autonomy to respect, with regard to decisions about treatment, and other moral values, such as Jane’s well-being, will be dispositive. In what follows, I defend this line of argument.[[9]](#footnote-9) In the following section, I address two arguments against P1 and argue that neither is convincing. In section IV, I offer an argument in favor of P1 and respond to objections. Finally, in sections V and VI, I reply to two further arguments against my view.

III. ARGUMENTS AGAINST P1

*Argument 1: Respect for the desires of the deceased*

An initial argument against P1 begins with the claim that we ought morally, at least in some cases, to act so as to satisfy the desires of a deceased person (i.e., the desires she had while alive). Since a deceased person no longer exists (we may assume), her desires are former desires. Thus, it seems, in cases in which we ought to respect the wishes of the dead, we respect a person’s autonomy by honoring her former desires. If this is correct, then it is a counterexample to P1.

The clearest sort of case in which we are morally required to honor the wishes of the deceased involves *wills.* Consider, for example, a man who, via his will, leaves his entire estate to Doctors Without Borders (DWB); presumably, we ought to honor this person’s former desires and transfer his estate to DWB. This example is problematic, however, if it is meant to demonstrate that respect for autonomy (sometimes) requires honoring former desires, because the man’s desire involves the transfer of property. In making out a will, one effectively transfers property-rights to another entity (in this case, DWB), under certain conditions (the current owner’s death), at the time the will is made. Therefore, the nature of the property has been altered prior to the man’s death—the man has given up unconditional property rights to his estate, and DWB has gained conditional property rights to the estate. At the very least, this is a plausible way of viewing the case. But if that is correct, then the fact that in transferring his estate to DWB we are respecting the man’s former desires may be incidental—the obligation to transfer his estate may simply derive from the fact that the estate rightfully belongs, at that point, to another entity. Alternatively, we might view the man’s will as enacting a societal promise to transfer the man’s assets to DWB upon his death, in which case the obligation to make the transfer might derive simply from the obligation to keep our societal promises, rather than from any obligation to respect the autonomy of the deceased.

Despite the problems with using wills as an analogy, it is plausible that there is, in general, at least some moral pressure to honor the desires of the dead. The problem, however, is with the inference from that claim to the thesis that the moral weightiness of such desires is grounded inrespect for the deceased’s autonomy. If that inference is a good one, then there must be a further premise connecting those two propositions. The most plausible such premise seems to be something like this: the *best explanation* of the fact that the desires of the dead have moral weight is that that weight is grounded on respect for the deceased’s autonomy. But that should be a highly controversial claim; it may be that the desires of the dead have moral weight for another reason altogether. For example, perhaps the right way to think about respect for the wishes of the dead involves broader appeal to the principle of *respect for persons,* from which the principle of respect for autonomy is derived, but which is broader than and therefore distinct from it. The principle of respect for persons grounds a myriad of moral principles—for example, the principle of fidelity (which grounds duties to keep promises, to refrain from cheating, to refrain from betraying others’ trust, etc.) and the principle of justice (which grounds duties to distribute benefits based upon merit or desert, to refrain from free-riding, etc.)—that are not obviously grounded on the principle of respect for autonomy. It is plausible that a principle of respect for the dead is another such principle. For example, we believe it to be a moral transgression to desecrate a person’s grave; and a plausible explanation is that in doing so one demonstrates flagrant disrespect for the person who has died. That requirement seems valid even if the deceased person had no desire that his grave not be desecrated, and therefore is not plausibly based on respect for the deceased’s autonomy. Similarly, it is plausible that a principle of respect for the dead grounds a *prima facie* duty to honor the desires of the deceased; indeed, that seems to be as good an explanation as any for the moral weightiness of those desires. There is no need, therefore, to appeal to the principle of respect for autonomy in explaining that weightiness, and thus the argument under consideration provides no convincing reason to believe that respecting a person’s autonomy sometimes requires honoring her former desires.

*Argument 2: Shifting the burden of proof*

In a series of articles, John K. Davis argues that the principle of respect for autonomy applies equally to *precedent autonomy*—the kind of autonomy which would derive from a person’s former desires (Davis 2002, 2004, 2007).[[10]](#footnote-10) Davis, however, recognizes a *prima facie* problem facing the view that we respect a person’s autonomy by honoring her former desires. Commenting on Allen Buchanan and Dan Brock’s claim that ‘following an advance directive can be viewed as a case of respecting self-determination, even if the individual has no self-determination to respect at the time the advance directive is carried out’ (Buchanan and Brock 1989: 98-9) Davis says, ‘It is true that trying to influence one’s future is an attempt at self-determination, but does it follow that respecting such earlier efforts amounts to respecting that person’s autonomy *now,* after he or she ‘has no self-determination to respect’?’ (Davis 2007: 360) Davis rightly recognizes that things aren’t as simple as Buchanan and Brock would have it. Indeed, Davis acknowledges that there is a *prima facie* case to be made *against* a principle of respect for precedent autonomy: ‘…[T]o respect an agent’s act of precedent autonomy, we must respect a preference that is no longer attributable to the agent. Therefore, the principle of respect for autonomy seems not to apply to precedent autonomy: How can we respect an agent by respecting an act and preference that are no longer his?’ (Davis 2002: 130) Thus, the thesis that respect for autonomy involves honoring former desires is in need of an argument; and Davis is happy to provide one.

Davis’s argument is an attempt to place the burden of proof back onto those who would reject precedent autonomy. Davis begins by noting, rightly, that it is possible to respect or honor former desires (Davis 2004). Doing so simply requires acting in such a way as to make the propositional object of those desires come true, or to make it more likely that that is the case. So, for example, if I used to desire that I go to every Red Sox game, but now I lack such a desire, my former desire is honored by acting so as to make it the case, or increase the odds, that I go to every Red Sox game—the fact that I no longer have such a desire does not entail that the desire that *did* exist cannot be respected or honored, even now. Of course, it is another question entirely whether former desires can ever *command* respect under the principle of respect for autonomy, i.e. whether such desires can currently contribute to the autonomy of the person whose desires they were.

Davis argues that such desires indeed command respect, by arguing, essentially, that the *prima facie* case against precedent autonomy can be *debunked*. In particular, he argues that the reason why it (erroneously) seems as if former desires do not contribute to a person’s autonomy is that in almost all cases of former desires, those desires are trumped by current competently-held desires for something else. For example, if I no longer desire to attend every Red Sox game, that is because I now desire to do something else*,* e.g. watch the game on TV from time to time, spend time with my family, sleep, etc. (Davis 2004: 280-1).[[11]](#footnote-11) Thus, the usual cases that feature in one’s imagination and serve as the relevant exemplars when considering in general whether former desires are relevant to autonomy do not include cases like Jane’s, in which the person currently lacks any competently-held desire about the issue in question. When we ask ourselves whether former desires command respect vis-à-vis, or contribute to, a person’s autonomy, it is the normal cases upon which we implicitly rely, and so it is no surprise that we come down against precedent autonomy. Indeed, on this view, that is the best explanation of the intuitive reaction against precedent autonomy. And according to Davis, there is no other*,* legitimatereason to discount the relevance to autonomy of former desires, because they have all of the usual features that we think command respect under the principle of respect for autonomy, and the present/former distinction is, in and of itself, morally irrelevant. At the very least, according to Davis’ argument, that is where we should stand absent a convincing argument to the contrary (Davis 2004).

An initial problem with Davis’ argument is that there may be no reason to suppose that the debunking explanation is the *best* explanation as opposed to a *plausible* explanation of the intuition against precedent autonomy. After all, it stands to reason that in order to respect someone’s autonomy *now,* one must only honor the desires that a person has *now*. Furthermore, the intuitive appeal of that idea plausibly survives recognition of the (potentially) debunking explanation; and that fact provides further support for the intuition’s veracity.

Of course, if the debunking explanation is equally as plausible as the view that the intuition against precedent autonomy is veridical, then the *prima facie* case against precedent autonomy fails—it would then be equally likely that precedent autonomy demands respect and that it does not. But Davis’s aim is not simply to undermine the case against precedent autonomy; he is arguing *in favor* of precedent autonomy, and it is that argument that is my target here (I argue *against* precedent autonomy in the following section). For that, Davis needs to show that the intuition in question is not veridical (plus—what we can accept for purposes here—that the default position should be one in which we accept precedent autonomy). It is dubious whether his debunking explanation is sufficient to the task.

But even if that is wrong, and Davis has indeed debunked the *prima facie* case against precedent autonomy, thus successfully passing the burden of proof to his opponents, I believe that that burden can be successfully picked up: that a positive argument against precedent autonomy can be provided. In the following section, I explicate and defend such an argument.

IV. AGAINST PRECEDENT AUTONOMY: THE CASE OF JIM

It is important to note that despite its appeal, the *prima facie* case against precedent autonomy is only as strong as the intuition that grounds it. It is debatable just how strong that intuition is, and the intuition will likely be rejected or not felt strongly by many of those who accept precedent autonomy. Thus, even ignoring any potentially debunking explanations of the source of that intuition, the *prima facie* case against precedent autonomy is not a particularly strong one. I believe, however, that there is very good reason to reject precedent autonomy. I shall present a case which, I argue, is in all relevant respects analogous to the case of Jane, and in which respect for autonomy intuitively does *not* require honoring the person’s former desires. If successful, my example will go a long way towards showing that P1 is true—that former desires do not ground moral obligations based on the principle of respect for autonomy. At the very least, it will place the burden on defenders of the moral authority of advance directives in cases like Jane’s to explain why Jane’s case is relevantly different—why Jane’s former desires ground autonomy-based requirements while others’ former desires do not.

Here is the case:

On Monday, Jim purchased a new car. Jim has selected a special color for his car: blue. Jim has selected this color not simply because he enjoys the way blue looks, but also because he attaches deep significance to the color. For Jim, the color blue has deep symbolic value; blue exemplifies to Jim all that is good and holy. But the car that Jim wants does not usually come in blue, so it must be painted specially for Jim (at no extra cost), which will happen on Wednesday.

On Tuesday, however, Jim suffers from a very rare illness that permanently causes full color-blindness *and* permanently robs a person of all color-concepts as well as any color-memories and memories specifically associated with particular colors. Thus, on Tuesday, Jim has no idea what blue is, or what it would be to have a blue car, and thus no longer values the color blue, nor desires that his car be blue.

On Tuesday night, while Jim is in the hospital and is incapacitated, the car dealership calls Jim’s wife, Anne, to confirm that Jim wants the special paint job on his new car; furthermore, if she doesn’t confirm at that time, the opportunity for the special paint job will be lost. Anne knows of Jim’s condition, and wonders whether she is morally required to opt for the blue paint.

The question is, does respecting Jim’s autonomy require honoring his former desire for a blue car, even though he no longer cares about the color blue, and never will (since he will never know what blue *is*)? Now, if Jim currently desires *that his former desires are satisfied*, and that desire is strongest and competently-held, then we respect Jim’s autonomy by honoring his former desire for a blue car regardless of whether P1 is true or false. So let us assume that Jim lacks the desire that his former desires are satisfied, and also lacks the desire that his former desires are *not* satisfied. In general, let us assume that Jim currently has no desire that would be served or frustrated by getting a blue car as opposed to a car with some other color.

In this case, if respecting a person’s autonomy requires honoring his former desires then Anne should tell the dealership to stay with the color blue. But the fact that Jim no longer cares about the color of his car, nor has any other desire that would be served by getting a blue car, seems to imply that his autonomy is not promoted any *further* by staying with blue than it would be by choosing some other color. More generally: the fact that Jim has no desires that would be served or frustrated by the choice of his car’s color seems to imply that his autonomy is neither served nor violated by any choice of color that Anne might make. And Jim’s case plausibly generalizes. If what I have said about the case is correct, then the case strongly suggests that, in general, respecting a person’s autonomy does not require honoring her former desires. In particular, I suggest that there is no relevant difference between this case and the case of Jane, such that respecting Jane’s autonomy requires honoring her former desires but respecting Jim’s autonomy does not. If that is right, then there is very good reason to believe advance directives in cases like Jane’s indeed lack moral authority.

In addition, our reaction against precedent autonomy in Jim’s case cannot be explained away using Davis’s debunking explanation, because Jim’s case rules out the basis for that debunking. Recall, the debunking explanation is that when considering the relevance to autonomy of former desires, we implicitly assume that a former desire has been *replaced* with a current desire for something else. But that explanation is not available with the case of Jim, because it is built into the case that Jim has no current desire for something else. At the very least, invoking Davis’s debunking explanation here would be highly uncharitable, because it would imply that in our reaction to the case of Jim we are assuming, however implicitly, that the case has features that are *explicitly* ruled out in its description. We would, in essence, be ignoring the case itself (and, presumably, unable to remedy the error); and that seems unlikely. Thus, I submit, the case of Jim successfully picks up the burden of proof laid out by Davis, and strongly suggests that former desires *per se* do not command respect under the principle of respect for autonomy.

*Objection 1*

It might be objected that Jim does possess an attitude that Jane lacks which explains why his autonomy is neither respected nor thwarted by choosing a blue car: *indifference.* Indifference about the truth of some proposition *p* is plausibly understood as an attitude that involves (1) understanding what it is for *p* to be true, and (2) lacking any desire about the truth of *p*, i.e. one desires neither that *p* is true nor that it is false. Thus, one might claim, Jim is indifferent about the satisfaction of his former desires(read *de dicto*),[[12]](#footnote-12) and that being indifferent about the truth of *p* entails that one’s autonomy is not violated by seeing to it that *p* (as long as in seeing to it that *p* one does not thwart some othercurrent, strongest competently-held desire).[[13]](#footnote-13) Jane, on the other hand, does *not* understand the nature and implications of her proposed medical treatment (that is why she is incompetent to make a decision about that treatment), and therefore is not indifferent about the prospect of being treated. Thus, a relevant difference between Jim and Jane seems to have been secured—one that is poised to explain why respecting Jim’s autonomy does not require honoring his former desire for a blue car while respecting Jane’s autonomy does require honoring her former desire against medical treatment.

There are two problems with this argument. The first problem is that there is nothing about the case of Jim that compels us to believe that Jim *is* indifferent about the satisfaction of his former desires, because nothing in the case implies that he understands what it is to satisfy former desires. We can simply build into the case that he does *not* possess that understanding, and doing so does not alter our evaluation of the case. We might suppose, for example, that although Jim understands the concept *former* and the concept *desires,* when he attempts to combine those concepts Jim undergoes a kind of mental glitch that impedes grasping the concept *former desires* (suppose, e.g., that it seemsto Jim as if ‘former desires’ describes a category mistake). Thus, just as Jim fails to understand the proposition that his car is blue, we can assume that he fails to understand the proposition that his former desires are satisfied; and adding that assumption leaves intact the intuition that Anne does not violate Jim’s autonomy by not choosing blue as the color of his car.

But even if Jim is indeed indifferent about the satisfaction of his former desires, a second problem emerges. The problem is that the objection under consideration relies on (something like) the following principle:

**Indifference:** If by doing *x*, person A makes it the case that *p*, and person B (1) is indifferent about the truth of *p* and (2) has no current (strongest competently-held) desires that are thwarted by A doing *x,* then A does not violate B’s autonomy by doing *x*.

I do not deny that **Indifference** is true; however, my opponent cannot accept **Indifference**, because it implies that the moral authority of Jane’s former desires is on shaky ground indeed. All it would take to nullify that authority, given **Indifference**, is for there to be *some* proposition *p* with respect to which Jane is indifferent, such that treating Jane makes it the case that *p*. And such a scenario is easy to imagine. Suppose that Jane is indifferent about swallowing pills (i.e. she fully understands what it is to swallow a pill, and has no desires or aversions regarding performing such an act), and that the relevant antibiotic treatment requires swallowing a pill. In that case, Jane is on par with Jim: Jane is indifferent about one upshot of treatment—that it involves pill-swallowing—just as Jim is indifferent (we may suppose) about one upshot of getting a blue car—that it satisfies his former desires. According to **Indifference**, neither the autonomy of Jane nor that of Jim would be violated by the actions in question. But this is not as my opponent would have it—Jane’s precedent autonomy should not be so easily extinguishable. Indeed, most people in Jane’s condition *would* be indifferent about *some* mundane aspect of their treatment, such as the fact the medicine is a certain color, or that it is given at a certain time of day. Thus, the objection under consideration fails to secure the moral authority of advance directives in the wide range of cases to which their proponents believe they apply.

*Objection 2*

It might be claimed that Jim’s case is relevantly different from the case of Jane because Jim did not state his wishes in advance, as Jane did. In order to make the cases analogous, Jim should have a sort of advance directive outlining his desire for a blue car *in the future,* even in the case in which he loses such a desire. So, let us imagine that Jim had foreseen his impending illness, and that he wanted to make sure his blue-based decisions survive through it. Thus, he stated clearly and unequivocally prior to the onset of his illness that he wants a blue car even after he loses his desire for one. According to the objection under consideration, when we modify the case in such a way, our intuitive reaction shifts in favor of honoring Jim’s former desires—now, it seems that we *should* choose blue as the color of his car, and that it would be violating Jim’s autonomy to do otherwise. At least, it is plausible that the breakdown of reactions to the modified case will fall roughly along the lines of the reactions to the case of Jane, and thus, on this objection, the case of Jim, when properly filled out, cannot serve as any dialectical boost to those who would reject precedent autonomy.

In response, we might question the extent to which our intuitive reaction to the modified case is indeed as my opponent would suggest. Suppose we told Jim that he used to value the color blue and desire strongly that his car be blue. Of course, to Jim, the term ‘blue’ is incomprehensible—but suppose in this case that he understands what former desires are, and thus understands that there is *something* that he used to desire and no longer does. Recall that Jim does not care at all about his former desires. Thus, if he were asked whether he wants a blue car, Jim would respond, ‘I don’t care.’ Intuitively, that implies that we do not violate Jim’s autonomy by failing to choose blue—if one no longer cares about satisfying one’s former desires, then any former desire, no matter how strongly held in the past, or how clearly codified in an advance directive, does not currently contribute to one’s autonomy. To the extent that that intuition is strong and widespread, the modified case of Jim fails to justify the moral authority of Jane’s advance directive.

But let us suppose that such a reaction is not widespread, and that the modified case generates a range of intuitive reactions that fall roughly along the lines of those in response to the case of Jane. Even then, we should not favor the modified case over the original case—the fact that the modified case is more similar to the case of Jane is not in fact relevant. Rather, our intuitive reaction to each case provides a piece of evidence about the truth or falsity of P1, i.e. about whether or not former desires contribute to peoples’ autonomy; thus we must still account for the intuition *in favor* ofP1 in response to the original case of Jim. And if our reaction to the modified case falls along the lines of our reaction to the case of Jane, then the modified case fails to provide significant evidence *against* P1, while the original case still provides evidence in its favor, and thus the balance of evidence favors P1. That is: the original case gives us relatively widespread results—plausibly, most people will agree that we do not violate Jim’s autonomy in that case by failing to choose blue as the color of his car; but if reaction to the modified case is highly divergent, as we are assuming, then the intuitive force of the case, and therefore the evidential force of our collective reaction to it, fails to support precedent autonomy to any degree sufficient to outweigh the prevalent intuition against precedent autonomy found in response to the original case.

Furthermore, even if our collective reaction to the modified case is as my opponents would ideally have it, i.e. even if most people are inclined to think that in such a case Jim’s former desire for a blue car should be honored, we then have *conflicting* intuitions, and thus conflicting evidence, about whether to endorse P1. The appropriate thing to do at that point is attempt to adjudicate between those pieces of evidence, and determine which is flawed.

That said, my opponent might claim (1) that our collective reaction to the modified case indeed consistently favors precedent autonomy, and (2) that *both* our reaction to the original case of Jim and our reaction to the modified case are correct—that Jim’s former desires contribute to his autonomy in the modified case but not in the original case. If that is correct then P1 is false, since former desires would *sometimes* contribute to a person’s autonomy; moreover, in that case it is plausible that we should indeed rely on our reaction to the case that is mostanalogous to the case of Jane, if Jane’s case is the one at issue. Such a view is problematic, however, because it implies that the *content* of a desire can determine whether that desire contributes to a person’s autonomy, and that is implausible. The only relevant difference between the original and modified cases of Jim is that in the original case the desire at issue is Jim’s desire *for a blue car*, while in the modified case the relevant desire is Jim’s desire *for a blue car* *even* *after he loses the desire for a blue car*. But whether a former desire contributes to a person’s autonomy should not depend upon what the desire was *for.* Thus, assuming that there is a widespread intuition in favor of precedent autonomy in response to the modified case of Jim, we must suppose that either that reaction or our reaction to the original case of Jim is mistaken.

And there is very good reason to think that our reaction to the original case is the correct one. Indeed, there is good reason to be suspicious of our reaction to cases involving advance directives, whether medical (e.g. Jane’s case) or not (e.g. Jim’s case). The reason is that we are not disinterested in the matter; presumably we want our own advance directives adhered to, and thus find it troubling to imagine that they lack moral authority—to think that they should not, and perhaps will not, be followed. We are therefore *biased* in favor of their authority. This is a plausible way to explain any differing intuitions between the original and modified cases of Jim: in the original case there is no advance directive, and thus our own choices, as reflected in possible or actual advance directives, remain unthreatened; in the modified case, Jim has an advance directive, and thus the suggestion that that directive lacks moral authority is a direct threat to our own choices about how we are to be treated in the future. But whether our current choices are threatened is irrelevant to whether former desires contribute to a person’s autonomy—we may *want* our current desires for our future to be honored even if we lose those desires, but that does not imply that such desires demand respect after they have genuinely been lost. Thus, due to our likely bias in the matter, we should be far more skeptical of a reaction *in favor* of precedent autonomy to the modified case of Jim than of a reaction *against* precedent autonomy to the original case.

Finally, for those who are still inclined to think that Jim’s former desire for a blue car matters morally, it should be noted that my position does not entail that former desires do not matter *at all*, i.e. that they have no moral weight whatsoever. But the principle of respect for autonomy is central and powerful—it brings to bear considerable moral weight, in particular moral weight that (most people believe) outweighs a person’s own well-being. It is simply that kind and degree of moral weight that I would deny to former desires. Nevertheless, we can capture *some* moral weight that might attach to former desires simply in virtue of the principle of respect for persons: simply put, respecting people might require attaching *some* significance to their former desires (even in cases like Jane’s). What respect for persons does *not* require is attaching such strong weight to former desires, as they would have if they contribute to a person’s autonomy, that they would override a person’s own best interests, and would require letting a happy and otherwise healthy Jane pass away.

V. TEMPORARY INCOMPETENCE

Ronald Dworkin has argued that P1 suffers from counterexamples in cases of temporary incompetence (Dworkin 1993: 226-228); a full defense of P1 thus requires showing why his argument is unconvincing. That is my aim in this section.

Dworkin suggests that P1 licenses unacceptable breaches of autonomy when patients have lost competence on a temporary basis. As a case in point, he offers the example of a devout Jehovah’s Witness who requires a blood transfusion, but is currently incompetent to consent to or refuse treatment, and is demanding treatment while showing no signs of his prior religious aversion to transfusion. Dworkin argues that if we respect a person’s autonomy only by honoring *current* desires, we do not violate the Witness’s autonomy by administering a transfusion. But clearly that’s wrong, argues Dworkin—that we *do* violate his autonomy in such a case becomes clear if we consider the case in which the patient *regains* competence and is appalled at what has been done. Indeed, he would be *rightly* appalled, because we had violated his autonomy. (Dworkin 1993: 227)

Whether this kind of case provides a counterexample to P1 depends crucially upon whether the Witness maintains the desire not to be transfused while incompetent, and Dworkin recognizes that—he says that it is *not* the case that reason why it is wrong to administer the transfusion is that ‘we think he really continues to want what he wanted before…’ (Dworkin 1993: 227) The problem with Dworkin’s claim is that in ordinary cases of temporary incompetence it *is* the case that the patient maintains the desire in question.[[14]](#footnote-14) After all, what other plausible explanation is there for the fact that the patient *does* possess that desire *after* regaining competence? The way to make sense of this kind of case is notby supposing that the person genuinely *loses* the desire not to be transfused, and then mysteriously reacquires the very same desire upon regaining competence; rather, it is by supposing that the person has the desire all along. Here, it is helpful to distinguish between desires in their *dispositional* and *occurrent* forms. One has an occurrent desire when one is introspectively aware of that desire, or when the desire displays its motivational or affective features; one has a dispositional desire when the desire is not currently operative, such as when one is asleep. One does not lose one’s desires while in deep sleep and then regain them once one wakes. Rather, while asleep one’s desires are simply in their dispositional state. Likewise, temporary incompetence, even when there is no sign of one’s competent desires, does not obliterate those desires, but simply renders them dispositional. There is no other reasonable, non-magical explanation of the fact that such desires “come back” once competence is regained.

Thus, Dworkin’s case is not a counterexample to P1, because it does not involve a former desire (but merely a dispositional one). And if we alter the example such that the Witness *does* genuinely lose the desire not to be transfused (and then magically regains it), then it is *not* clear that providing the transfusion is wrong; in fact, in such a case, it seems wrong *not* to provide the transfusion, because at the time of treatment the patient *does not have the desire against transfusion*. In effect, the patient undergoes the functional equivalent of renouncing his religion. The fact that he later develops a desire against transfusion is an unfortunate coincidence, but fails to bear morally on the decision to transfuse. Thus, neither Dworkin’s original case nor the modified case is a counterexample to P1.

VI. WELL-BEING AND FORMER DESIRES

It might be objected that respect for autonomy is not the only moral value to be realized by following an advance directive in cases like Jane’s. In particular, one might argue that even if a person’s autonomy is not respected by honoring her former desires, a person’s *well-being* can be promoted by honoring her former desires, especially when those desires reflect the person’s deeply held convictions about how her life is to be lived—what we may call her *central values.* Dworkin refers to the interests that derive from one’s central values as one’s *critical* interests (Dworkin 1993).The objection, then, is that based on Jane’s *former* central values, Jane has significant and ultimately dispositive critical interests in being allowed to pass away. On this view, it is best *for Jane*, all things considered, if we treat her in the way that reflects her prior central values, including the values that prompted her directive to refuse life-saving treatment. If that is correct, then advance directives in cases like Jane’s have moral authority because they promote a person’s well-being, via one’s critical interests, regardless of whether or not honoring such directives is required by the principle of respect for autonomy.[[15]](#footnote-15)

The first thing that should be noted about this kind of view is that it requires ruling out many prominent theories of well-being. The philosophical literature is rife with theories of well-being that are incompatible with the existence of critical interests. For example, the objection rules out all forms of *hedonism*: the view that well-being is determined by the balance of pleasures and pains (Bentham 1907/1789; Mill 2002/1863; Crisp 2006a, 2006b; Feldman 2002, 2004). Because following her advance directive does not increase Jane’s balance of pleasure over pain, the view that her well-being is promoted by following that directive is incompatible with hedonism. The objection is also incompatible with theories according to which well-being consists in one’s overall *life-satisfaction* (Sumner 1996),because Jane is not made more satisfied with her life as a whole by having the instructions in her advance directive honored. Furthermore, although the objection is compatible with certain *desire satisfaction* theories of well-being, it is incompatible with many versions of such a theory, such as *concurrent* desire satisfaction theories (according to which desire-satisfaction promotes well-being only if one has the desire and it is satisfied *at the same time*) and *subjective* desire-satisfaction theories (according to which well-being is promoted only if one *believes* that one’s desired state of affairs obtains).[[16]](#footnote-16) Whether to accept the existence of critical interests thus depends upon the relative merits of various theories of well-being that rule them out. That is something that cannot be adjudicated here, but it suffices to say that there is no consensus among philosophers regarding the plausibility of those theories. The upshot is that the existence of critical interests is highly controversial, and thus it is problematic to rely on their existence as a key premise in any argument.

One might respond that the existence of critical interests is highly *intuitively* plausible; so plausible, in fact, that their existence must be countenanced by any adequate theory of well-being. The problem with this is that many people will simply not find critical interests to be so intuitively compelling; after all, many philosophers knowingly accept theories of well-being that plainly rule them out. At the very least, it would be extremely controversial to claim that the intuitive support for critical interests is *so* strong that it automatically outweighs *any* countervailing intuitive data or theoretical virtues that might be enjoyed by other theories of well-being, such that critical interests constitute a criterion of adequacy for such theories.

Thus, the argument under consideration is unconvincing. That said, critical interests may still exist; indeed, many people find such an aspect of well-being to be intuitive. Thus, although the argument is unpersuasive, more needs to be said in order to show that its conclusion is implausible—that Jane’s well-being does not, in all likelihood, require honoring her advance directive. The proper way to do so, in my view, involves consideration of the relative *weight* of critical interests in cases like Jane’s, compared with what Dworkin calls one’s *experiential* interests: the aspects of well-being that derive from one’s valuable experiences, e.g. Jane’s interest in continuing her happy life (Dworkin 1993).

All parties should accept that Jane has an interest in continued life; Dworkin’s view is that that interest is *outweighed* by her critical interest in dying. Let us assume that Jane indeed has a critical interest in dying; is it nevertheless plausible to suppose that Jane’s *best* interests are served by dying? Making such a claim is equivalent to claiming that Jane would be *better-off dead,* or that her life is *not worth living.* Even keeping in mind Jane’s critical interest in dying, it will seem implausible to many, given her happy life and excellent prospects for a continued happy life in the future, that she would be better-off dead or that her life is not worth living.

Of course, some may not share that view. But now the defender of the authority of Jane’s advance directive must have it not only that there *are* critical interests—which is controversial, even if there is not sufficient reason to reject such a view—but also that Jane’s critical interests *outweigh* her interest in staying alive—an additional controversial position. The upshot is that the number of controversial positions one must accept in order to defend, in this way, the moral authority of Jane’s advance directive is adding up; and that is a significant cost of the view. Put differently, honoring Jane’s advance directive can fail to promote her best interests in either of two ways: (1) if there is no such thing as critical interests, or (2) if there are such interests but they do not outweigh Jane’s interest in continued life. On the other hand, there is a narrower path to the view that honoring Jane’s directive promotes her best interests: it must be *both* that critical interests exist, *and* that they outweigh Jane’s experiential interest in living. Because each of these positions is controversial in its own right, and because a view incurs a cost for each controversial position to which it is committed, my opponent’s view is the more costly one.

Moreover, even if Jane *is* better off dead, it is highly plausible that there are *possible* cases in which a demented patient’s experiential interests outweigh her critical interests. If that is correct, then the relevant question is really one of *scope*, i.e. in *which* cases are advance directives morally binding? The answer will depend upon what level of experiential harm caused by honoring a directive is sufficient to outweigh the well-being contributed by one’s critical interests in cases like Jane’s. But it seems that there must be *some* amount of harm that would rise to that level. Imagine, for example, that refusing medical care in Jane’s case will result in unrelenting agony for one year prior to her death. If one is not persuaded by that case, we can simply increase the level of pain, or its duration, and we will eventually reach an intuitively compelling point—there is *some* degree of agony for *some* amount of time sufficient to outweigh Jane’s critical interest in dying. Thus, even if Jane possesses a critical interest in dying that outweighs her experiential interest in living, there exists some class of cases in which advance directives lack the moral authority their advocates believe them to possess, and the authority they are given under current policy and law. At the very least, the view that critical interests *necessarily* trump experiential interests will be highly controversial, indeed even more so than the logically weaker position that critical interests (a) exist and (b) outweigh experiential interests in Jane’s case. Commitment to that view, then, is a very high cost of the position that advance directives have moral authority in the wide range of cases to which their proponents wish to apply them—a cost that significantly calls into question that position’s plausibility.

VII. CONCLUSION

I have argued that the most plausible way to understand the principle of respect for autonomy is that it requires honoring the desires that a person *has,* rather than the desires that a person *used* to have. Cases like Jim’s strongly suggest that that is the case; after all, if respecting a person’s autonomy requires honoring former desires, then it requires doing so in Jim’s case—there is nothing special about Jim’s case to imply that respecting Jim’s autonomy does *not* require honoring his strongest competently-held former desires, while in other kinds of cases (such as the case of Jane) respect for autonomy requires that we *do* honor those desires.

Thus, absent a compelling argument against P1, or an argument that some moral consideration other than respect for autonomy compels us to honor advance directives in cases like Jane’s, we should accept that advance directives in such cases indeed lack moral authority. I have suggested that there are no such arguments—arguments that are based on the moral importance of respecting posthumous wishes do not compel us to accept that the principle of respect for autonomygrounds that importance; Davis’s debunking explanation does not apply to the case of Jim, since Jim lacks the sort of current desire on which that explanation depends; arguments according to which ordinary cases of temporary incompetence provide counterexamples to P1 fail because temporary incompetence does not ordinarily involve the loss of one’s desires; and arguments based on the idea that one’s well-being is best promoted by a life lived in accordance with one’s former values are unconvincing because they rely upon highly controversial assumptions about the nature of well-being and the relative weight of its components. Therefore, we have good reason to accept that when a person no longer possesses the desires upon which her advance directive was based (or no longer possesses them competently), the directive in question no longer possesses moral authority.

ACKNOWLEDGMENTS

For helpful comments on earlier versions of this paper, I thank John K. Davis, Amy Reed-Sandoval, audiences at the 2013 Pacific Division Meeting of the American Philosophical Association and the 2012 meeting of the North Carolina Philosophical Society, and an anonymous reviewer for this journal. Initial work for this project was funded through a Scholarly Development Grant from Jefferson College of Health Sciences.

REFERENCES

Beauchamp, T. L., and J. F. Childress. 2009. *Principles of Biomedical Ethics (6th Edition).* New

York: Oxford University Press.

Buchanan, A.E., and D.W. Brock. 1989. *Deciding for Others: The Ethics of Surrogate Decision*

*Making*. Cambridge: Cambridge University Press.

Bentham, J. (1907/1789) *An Introduction to the Principles of Morals and Legislation*, Oxford:

Clarendon Press.

Charland, L. 2001. Mental competence and value: the problem of normativity in the assessment

of decisional capacity. *Psychiatry, Psychology, and Law* 8: 135–145.

Charland, L. 2011. Decision-making capacity and addiction. In: *Addiction and Responsibility*

(pp. 139-158), G. Graham and J. Poland (eds). London: MIT Press.

Crisp, R. 2006a. Hedonism reconsidered. *Philosophy and Phenomenological Research* 73: 619–

645.

Crisp, R. 2006b. *Reasons and the Good*. New York: Oxford University Press.

Culver, C.M., and B. Gert. 2004. Competence. In: *The Philosophy of Psychiatry: A Companion*

(258-270), J. Radden (ed). New York: Oxford University Press.

Davis, J.K. 2002. The concept of precedent autonomy. *Bioethics* 16: 114-133.

Davis, J.K. 2004. Precedent autonomy and subsequent consent. *Ethical Theory and Moral*

*Practice* 7: 267-291.

Davis, J.K. 2007. Precedent autonomy, advance directives, and end-of-life care.’ In: *The*

*Oxford Handbook of Bioethics* (349-374), B. Steinbock (ed). New York: Oxford

University Press.

Dresser, R. 1989. Advance directives, self-determination, and personal identity. In: *Advance*

*Directives in Medicine* (155-170), C. Hackler, R. Moseley, and D. Vawter (eds).New York: Praeger Publishers.

Dresser, R. 1992. Autonomy revisited: the limits of anticipatory choices. In: *Dementia and*

*Aging: Ethics, Values, and Policy Choices* (71-85), R. Binstock, S. Post, and P. Whitehouse P (eds). Baltimore: Johns Hopkins University Press.

Dresser, R., and J. Robertson. 1989. Quality of life and non-treatment decisions for incompetent patients: a critique of the orthodox approach.’ *Law, Medicine & Health Care* 17: 234-244.

# Dworkin, R. 1993. *Life’s Dominion: An Argument About Abortion, Euthanasia, and Individual*

# *Freedom.* New York: Knopf.

Fagerlin, A., C.E. Schneider. 2004. Enough: the failure of the living will. *Hastings Center Report* 34: 30–42.

Forrow, L. 1994. The green eggs and ham phenomenon. *Hastings Center Report* 24: S29–S32.

Feldman, F. 2002. The good life: a defense of attitudinal hedonism. *Philosophy and*

*Phenomenological Research* 65: 604-628.

Feldman, F. 2004. *Pleasure and the Good Life: On the Nature, Varieties, and Plausibility of*

*Hedonism*. New York: Oxford University Press.

Gert, B., C.M Culver, and K.D. Clouser. 1997. *Bioethics: A Return to Fundamentals*. New York:

Oxford University Press

Grisso, T., and P.A. Appelbaum,. 1998. *The Assessment of Decision-Making Capacity: A Guide*

*for Physicians and Other Health Professionals*. New York: Oxford University Press.

Heathwood, C. 2006. Desire satisfactionism and hedonism. Philosophical Studies 128: 539-563.

Jaworska, A. 1999. Respecting the margins of agency: Alzheimer’s patients and the capacity to

value. *Philosophy and Public Affairs* 28: 105-138.

Jonsen, A., M. Sigler, and W. Winslade. 2010. *Clinical Ethics: A Practical Approach* *to Ethical*

*Decisions in Clinical Medicine (7th Edition*). New York: McGraw-Hill.

King, N.M.P. 1996. *Making Sense of Advance Directives* (rev. ed.). Washington, DC: Georgetown University Press.

Mill, J. S. 2002/1863. *Utilitarianism*. Indianapolis, IN: Hackett.

Quante, M. 1999. Precedent autonomy and personal identity. *Kennedy Institute of Ethics Journal* 9: 365-381.

Shiffrin, S. 2004. Autonomy, beneficence, and the permanently demented. In: Ronald Dworkin and His Critics (195-217), J. Burley (ed). Malden, MA: Blackwell Publishers.

Sumner, L.W. 1996. *Welfare, Happiness, and Ethics.* New York: Oxford University Press.

Tan, J.O.A., A. Stewart, and T. Hope. 2009. Decision-making as a broader concept. *Philosophy,*

*Psychiatry, and Psychology* 16: 345–349.

Wrigley, A. 2007. Personal identity, autonomy, and advance statements.’ *Journal of Applied*

*Philosophy* 24: 381-396.

1. As I use the term, an advance directive has *moral authority* just in case the directive ought, morally, to be honored, in the case that its author becomes incompetent. [↑](#footnote-ref-1)
2. For discussion of some of the practical problems with advance directives, see Buchanan and Brock (1989), Forrow (1994), Fagerlin and Schneider (2004), and Wrigley (2007). [↑](#footnote-ref-2)
3. It is an empirical question whether the relevant desires, preferences, values, etc. have genuinely been lost in particular cases, or whether, for example, they are merely inaccessible, overwhelmed, or blocked in some way by the conditions at issue. That said, in certain cases of severe dementia, such as the kind of case I describe in section II, it is highly probable that the patient has indeed lost the relevant attitudes. In particular, it is likely that one has lost such attitudes when one consistently fails to understand, remember, or affirm them. It may be more controversial whether other conditions that *prima facie* suggest the loss of such attitudes, such as vegetative state or minimal consciousness, do indeed involve such loss, because, unlike severe dementia, people do occasionally “wake up” from such states with their prior attitudes intact. [↑](#footnote-ref-3)
4. Perhaps the desires relevant to autonomy should be restricted to those that affect the person in a certain way; for example, it might be claimed that the satisfaction of a desire for something utterly removed from one’s life does not promote one’s autonomy (e.g., a desire that humans colonize Mars by the year 3000). For the purposes of this paper we may ignore this issue, since the desires at issue here fall squarely within the sphere of desires that are intuitively relevant to a person’s autonomy. [↑](#footnote-ref-4)
5. To be clear, what matters for respecting a person’s autonomy is a matter of one’s strongest desires *within a group of conflicting desires*. For example, if I desire that *p*, and more strongly desire that *q*, then my autonomy may be respected by honoring *both* of those desires if both desires can indeed be satisfied. But if those desires conflict, i.e. if *p* and *q* cannot both be true, then my autonomy is promoted by honoring my desire that *q*, and not my desire that *p* (given that I have no stronger conflicting desire). [↑](#footnote-ref-5)
6. The notion of desire-strength is, at least in part, pre-theoretical (e.g. we understand pre-theoretically what it means to desire pizza more strongly than sushi, to want Anna to win the race more than Beatrice, etc.). Theoretical disputes may arise, however, about the *nature* of desire-strength, e.g. about whether strength is determined solely by the raw motivational force of a desire, or whether more “authentic” desires, or higher-order desires, garner special weight, and such issues may have implications for difficult cases (e.g. desires grounded in addiction). But those disputes need not concern us here—I flag the fact that only one’s strongest desires matter to respect for autonomy simply for the sake of identifying *in general* whichdesires are the right ones to honor if we wish to respect autonomy. Defending a complete theory of desire-strength, or of autonomy itself, is outside the scope of this paper. (The same goes, *mutatis mutandis*, for what I say subsequently about the *competence* of desires.) [↑](#footnote-ref-6)
7. To be clear: the factors at issue that would negate the moral authority of a person’s advance directive are involved in a limited class of situations that leave intact the authority of advance directives in a wide range of cases. Only a relatively small proportion of incompetent patients have genuinely lost the desires that prompted their advance directives, and advance directives are of use when that condition does not hold. Advance directives are correctly followed, for example, when a patient is unable to communicate, has become unconscious, is delirious, has moderate or waxing and waning dementia, or has any of a host of other conditions that render someone incompetent to make medical decisions but leave their desires intact (even if it renders those desires non-occurrent). Thus, my intention is not to argue that advance directives are *generally* inapplicable, nor does my argument, if successful, prove that much. [↑](#footnote-ref-7)
8. Let us also assume that Jane has no competently-held desires that would be served by treating her (e.g. the competently-held desire to continue living). If there were such desires then Jane’s autonomy would be respected by treating her regardless of whether P1 is true. That is why the kind of case at issue involves *severe* dementia. It is plausible that in more moderate forms, dementia is compatible with the sort of desires that ground autonomy. See e.g. Jaworska (1999) and Shiffrin (2004). [↑](#footnote-ref-8)
9. My argument will focus on cases like Jane’s, in which a person has lost the desires that prompted her advance directive; nevertheless, my argument will apply, *mutatis mutandis,* to cases in which a person has lost the *competency* of those desires but not the desires themselves, since P1 implies that neither *former* desires nor *formerly competent* desires contribute to a person’s autonomy. [↑](#footnote-ref-9)
10. See also Dworkin (1993). [↑](#footnote-ref-10)
11. Davis adds that current desires are normally coupled with what he calls a *resolution preference*—a higher-order desire that a particular desire be satisfied *over* another desire—in favor of the current desire, and Davis takes that to be part of the explanation of the authority of current desires in such cases. But resolution preferences are unnecessary: all that should be required is that the relevant desire is *current*. For example, if I used to want chocolate but now I want strawberry, my autonomy is respected by facilitating me getting strawberry regardless of whether I have any knowledge of my previous desire for chocolate or a preference favoring my current desire over my former desire. [↑](#footnote-ref-11)
12. It would be implausible to suppose that Jim is indifferent about *the color of his car*, since he doesn’t understand what colors are, and thus doesn’t understand the relevant propositions (i.e., the propositions that his car is blue, and that his car is not blue) [↑](#footnote-ref-12)
13. An alternative conception of indifference is that indifference about *p* simply involves lacking any desires about the truth of *p*, without the requirement that one understand *p*. This conception, however, is unavailable to my opponent, because it is unable to ground a relevant distinction between Jim and Jane. That is because on the alternative view, Jane might herself be indifferent about medical treatment (if she lacks any desire for or against treatment), which, on this objection, would imply that her autonomy is not violated by providing treatment. [↑](#footnote-ref-13)
14. Davis (2007) recognizes this, as well. [↑](#footnote-ref-14)
15. Davis (2007) and Dworkin (1993) defend versions of this argument. [↑](#footnote-ref-15)
16. For discussion of various kinds of desire-satisfaction theories of well-being, see Heathwood (2006). [↑](#footnote-ref-16)