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Rational Decision-Making Capacity in End of Life Decision-Making

In this chapter I shall consider three cases of end of life decision-making that illuminate implications that my rationalist approach has for decision-making capacity (DMC). Although end of life decision-making is not the only medical context in which judgements of DMC can be contentious, the gravity of the consequences of refusing consent to medical treatment here makes the stakes of this debate particularly high.

At the outset, it is important to be clear about the scope of the implications of the claim that a patient lacks DMC in this context. Crucially, the mere fact that a patient lacks DMC does not entail that it is thereby permissible to treat that patient. First, there may be ways in which it would be possible to facilitate the patient's attaining the requisite DMC to provide valid consent.[1] However, even when it is not possible to enable a patient to acquire DMC for the material time at which the decision must be made, it may still not be permissible to initiate treatment in the absence of consent, because of other salient moral considerations. In particular, since non-consensual treatment can be a harrowing experience, and since some medical interventions may have only limited beneficial effects in the end of life context, a decision to refrain from providing non-consensual medical treatment may sometimes be grounded by considerations of well-being, rather than respect for autonomy per se.[2] Furthermore, patients may plausibly have a number of claim rights against bodily interference that do not depend on their status as autonomous agents.[3] Finally, there may also be

[1] Notably in this regard, one of the guiding principles of the MCA states that a patient should not be understood to lack capacity 'unless all practicable steps to help him to do so have been taken without success'. Mental Capacity Act 2005, 1(3). Furthermore, an individual is not to be precluded from DMC on the basis of inadequate understanding if he is able to understand an explanation of the treatment decision 'given to him in a way that is appropriate to his circumstances'. Mental Capacity Act 2005, 3(2).

[2] As Draper acknowledges, this is a particularly salient consideration in the context of anorexia nervosa. See Draper, 'Anorexia Nervosa and Respecting a Refusal of Life-Prolonging Therapy', 121. See also Geppert, 'Futility in Chronic Anorexia Nervosa'.

[3] Savulescu and Momeyer, 'Should Informed Consent Be Based on Rational Beliefs?' Rebecca Walker argues that we have moral reasons to abide by irrational choices made by competent individuals on the basis that a failure to abide by such choices would violate the rights held by these patients. Walker, 'Respect for Rational Autonomy', 356. Whilst I am sympathetic to the idea that unwaived rights claims may speak against involuntary treatment, I think Walker is mistaken to claim that this gives us a sufficient reason to abide by irrational choices. Part of the problem here is that, contrary to Walker's analysis, *non-competent* individuals also have a right to avoid unwanted and invasive bodily interference; and yet we believe it can be permissible to override this right. It is true that the Hohfeldian *incidents* incorporated into the right

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societal and biopolitical considerations that enter into wise decision-making in this context.[4]

I shall explore many of these considerations in more detail in the following chapter when I turn to consider the value of autonomy. Here though, it suffices to note that the absence of DMC is not a sufficient condition of the permissibility of non-consensual medical treatment. Nonetheless, the fact that a patient lacks DMC has important moral implications in this context, since a patient's right to refuse medical treatment can be understood to be conditional on their having DMC to make an autonomous decision to refuse treatment, for reasons that I explored in the previous chapter.[5] If a patient has DMC, and exercises their right to refuse treatment, and that decision does not pose a direct harm to others (as it might in the context of public health) then it is thought that medical professionals are typically obligated to refrain from providing treatment.[6] Accordingly, establishing whether or not a patient has DMC thus has a crucial bearing on this strong form of protection that many patients are thought to enjoy.[7]

plausibly differ between competent and non-competent individuals. Whilst both enjoy a claim right against bodily interference, only the right of competent individuals incorporates the further power to waive that claim. Why should this be the case? To my mind, the most plausible explanation of the different elements of the rights of competent individuals is that we believe that waivers should only have normative authority if the decision to exercise this power is made autonomously. But, if this is right, then we should reject Walker's claim that we should abide by irrational choices of otherwise competent individuals on the basis of the rights we would violate if we failed to do so. Contrary to Walker's analysis, the fact that we would override an individual's rights in failing to abide by their treatment choice is often *not* sufficient to justify abiding by that choice. Indeed, we do not always abide by the choices of non-competent patients, despite their claim rights against bodily interference. In the case of non-competent patients, we abide by their choices if the benefits of failing to do so are insufficient to outweigh the interest protected by their claim. In contrast, the reason that we abide by the treatment choices of competent patients (even when the benefits of failing to do so would outweigh the harms) is that we acknowledge the normative authority of the individual's status as a competent individual by affording *them* the power to decide whether to waive their claims and to authorize treatment. However, if the authority of this decision to exercise this power is undermined by a lack of decisional autonomy, then it is unclear to me why this decision *must* be abided by in a manner that we would not similarly apply in the case of a non-competent individual. Walker herself implicitly acknowledges that we can have reasons to not abide by some choices of competent individuals, since she later claims that we should only abide by competent treatment refusals if they are 'freely made and informed'. Ibid., 358. But why only these refusals? Why rule out unfree or uninformed refusals if not because of the fact that they are not made autonomously? If one rules out these threats to autonomy, why not also rule out the threat posed by irrationality? Why suppose competence can have further moral force outside of its contribution to autonomy?

[4] Garasic, *Guantanamo and Other Cases of Enforced Medical Treatment*; Savulescu and Momeyer, 'Should Informed Consent Be Based on Rational Beliefs?'

[5] For an alternative view, see footnote 3.

[6] In England and Wales, the Mental Health Act is a counterexample to this, in so far as it permits the involuntary treatment of individuals with DMC who have been diagnosed with a mental disorder. UK Department of Health, Mental Health Act 1983 (Revised 2007). As others have argued, it is far from clear that this is ethically justified. Szmukler and Holloway, 'Mental Health Legislation Is Now a Harmful Anachronism'; Dawson and Szmukler, 'Fusion of Mental Health and Incapacity Legislation'; Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law'.

[7] Contrary to this analysis, Giordano argues that the moral force of autonomy is weakened in the specific context of anorexia nervosa, to the extent that we should not necessarily respect refusals of treatment by anorexic patients with DMC. For Giordano, the explanation for this is that the harms evinced by anorexia are distinctive, because the condition is reversible, and death from the condition is avoidable.

To recap the problem we face in this regard when adopting a rationalist conception of DMC: a plausible procedural account must accommodate the possibility that patients can make an autonomous treatment decision that others believe to be unwise. However, contrary to Lord Donaldson's claims analysed in the previous chapter, the rationalist approach denies that patients can make autonomous decisions on the basis of 'irrational reasons' or no 'reasons' at all. Rather, the challenge in this regard is how we can ascertain whether the patient is using and weighing the material information in a process of deliberation that is rational.

I shall begin my analysis with a straightforward example of how my rationalist approach is compatible with the claim that rational patients can make apparently 'unwise' choices. In the second half of the chapter, I shall consider the implications of my approach for more controversial cases concerning the rationality of treatment refusal on religious grounds, and treatment refusal in the context of anorexia nervosa. In doing so, I shall suggest that my rationalist approach is broadly compatible with the widely adopted view that (i) many religious believers who have DMC can refuse treatment forbidden by their religion and (ii) some anorexic patients can lack DMC to refuse treatment. However, my analysis shall suggest that we should take a much more nuanced approach to these cases than this generalized position implies, and which appears to be apparent in the standard view of autonomy's understanding of the implications of psychiatric disorders for decisional autonomy.

1. Rational DMC and 'Unwise' Decisions

Isobel is a 60-year-old woman who has developed pneumonia. She lives independently, but, after her husband died five years ago, has no surviving family or close friends. Isobel's physician tells her that pneumonia can be fatal, but that she has luckily been diagnosed very quickly. As such, her pneumonia can be treated with a short course of antibiotics, and she is expected to make a full recovery and live for at least another ten years. However, Isobel refuses consent; she says that she has had a 'good innings' but that she is now tired of life, and is ready to die.[8]

Death, typically, is something that we have a very strong self-interested reason to avoid, but can it ever be rational to prefer death to continued existence? In some cases, it seems quite uncontroversial to claim that this can be rational. To see why, we need to consider further why it is typically rational to prefer one's continued existence to death. In one sense, individuals can be understood to have a strong reason to avoid death, grounded by the fact that, in dying, we forgo any future

Giordano, *Understanding Eating Disorders*, 249–50. Whilst I agree that reversibility of the condition and the avoidability of death bear on the degree of harm at stake in treatment refusals in anorexia nervosa, far more argument is needed to establish that considerations of autonomy can be outweighed by harms that are worse in this sense. Further, contrary to Giordano's analysis, I am not convinced that anorexia nervosa is unique in this regard. As the example of Isobel below suggests, anorexia nervosa is not the only condition in which we might have to consider treatment refusals where the condition is reversible and death avoidable.

[8] For a case raising comparable but more complex issues, see Re B (Adult, refusal of medical treatment) 2, 449.

opportunity for well-being:[9] we will no longer have the opportunity to experience pleasurable mental states, to attempt to fulfil our desires, or to achieve objective goods.

Accordingly, we have a self-interested reason to safeguard the possibility of a future of value. However, if continued existence will only involve irrevocable pain and suffering, then such reasons may not apply; a person in this situation does not expect to experience a future of value, but rather one of disvalue. We can thus recognize, as David Hume did in his famous essay 'On Suicide',[10] that, despite our natural inclination to avoid death, life itself can become a burden of such disvalue, that our reasons to avoid that burden can outweigh both our natural inclinations and indeed our reasons to stave off our own non-existence. Indeed, the prospect that continued survival can become such a burden has been considerably enhanced by the development of medical technologies that afford us remarkable abilities to artificially sustain life.[11] Furthermore, we may note that we can plausibly value the exercise of our autonomy in shaping the end of our own existence, given the significant contribution that the end of life makes to the story of our life as a whole.

The rationality of preferring death to continued existence becomes more controversial as the expected value of one's future increases.[12] The above considerations suggest that it can be rational to prefer death to a future of disvalue, but can it be rational to prefer death to a future of some low, yet positive value? A key element of the theory that I have developed in this book is that rational agents can disagree about the relative weight that they attribute to their reasons to pursue different goods. Accordingly, even if we can construe someone as having a future that incorporates some valuable aspects, a rational agent can plausibly place greater weight on her reasons to avoid other aspects of that future that she disvalues.[13] Moreover, third parties lack epistemic access to other agents' own assessment of the comparative *strength* of certain reasons, and the truths regarding the comparative strength of our self-interested reasons are imprecise. Accordingly, whilst physicians may advocate the value and pursuit of health, and the reasons that patients have to pursue outcomes related to this good, this does not entail that it is irrational for a patient to choose otherwise, if that choice is demonstrably grounded in the patient's own broad evaluative framework.

Consider the implications that this has for Isobel. It is likely that her medical team would claim that, by forgoing treatment, Isobel is forgoing a future of value: after all, she is expected to make a full recovery from her pneumonia, she is living independently, and she is able to exercise her cognitive capacities in her day-to-day life. According to the standard account of autonomy and informed consent, in this

[9] For a developed hedonistic account of this point, see Bradley, *Well-Being and Death*.

[10] Hume, *On Suicide*.

[11] Garasic, *Guantanamo and Other Cases of Enforced Medical Treatment*, 11.

[12] Hedonic adaptation can raise a different kind of concern about the rationality of a patient's assessment of the expected value of their future. See Savulescu, 'Rational Desires and the Limitation of Life Sustaining Treatment'.

[13] This is one way in which the refusal of treatment may differ from voluntary passive euthanasia; the latter but not the former must be in the patient's best interests. For further discussion of this point, see Draper, 'Anorexia Nervosa and Respecting a Refusal of Life-Prolonging Therapy', 123–5.

situation, the medical team must ensure that Isobel understands (*inter alia*) the implications of forgoing treatment, that her decision is intentional, and that she is not deciding under controlling influences of the sort discussed in Chapters 4 and 5.

The account of rationalist autonomy and DMC that I am offering here demands something further; the medical team must try to establish that her decision is grounded by a personally endorsed preference, and that it is not grounded by irrational beliefs. What does this entail? Simply that the medical team investigates the reasons underlying her decision, and how these reasons are related to her other core values and beliefs. Recall that Isobel says she is 'tired of life'; part of investigating the rationality of her decision is to consider *why* this is the case. For instance, perhaps Isobel highly values social interaction, and her treatment decision might be the result of her experiencing social isolation following the death of her husband. Yet this is something that could be remedied in other ways; perhaps she could be entered into a befriending scheme, or a social group scheme run by local health authorities. Has she considered this alternative, and imagined what it might be like? If so, does she have reasons why she doesn't want to enrol in these schemes? Perhaps such reasons might be grounded by false beliefs about the schemes that the medical team could remedy.

This is not intended to be an exhaustive illustration of the kind of considerations that might be required in considering the rationality of Isobel's decision. The point of this brief illustration is that far from being elitist, rationalist DMC simply enjoins medical teams to make enquiries that represent a quite natural, caring response to a treatment decision of this kind. However, if after such enquiries, Isobel maintains her decision, and is able to give reasons for why she still wants to forgo treatment, grounded by her own values, then she should qualify as having DMC for that decision. Accordingly, respect for autonomy demands that the medical team should respect her decision to forgo treatment.

2. Religious Views and Psychiatric Disorder: A Justified Inconsistency in DMC?

Jack is a 32-year-old man who has been in a serious car accident and has lost a lot of blood. Still conscious, but bleeding heavily, he is rushed to A&E where doctors tell him that he urgently needs a blood transfusion or he will die. However, Jack refuses; he has been a life-long Jehovah's Witness, and he believes that he will not be permitted to enter the afterlife if he accepts the blood of another person.[14]

Keira is 43 years old and is a chronic sufferer of severe and enduring anorexia nervosa; although she is extremely malnourished, she refuses to eat. Moreover, repeated attempts at cognitive behavioural therapy have had no success in changing her eating behaviours. Her condition has deteriorated over time, and she is now at acute risk of organ failure if she does not receive nourishment soon. Keira is an intelligent and articulate woman, who recognizes that she is dangerously underweight, and that her refusal to eat is putting her life is at risk. However, she maintains her refusal to eat.[15]

[14] For a case raising comparable issues, see Re T (Adult: Refusal of Medical Treatment).

[15] For a case raising comparable issues, see Re E (Medical Treatment Anorexia) EWHC 1639 (COP).

Both of these cases involve choices that are likely to be understood as unwise from a medical perspective. However, this fact alone is not sufficient to demonstrate that these patients lack DMC on the approach that I am defending, nor on procedural approaches more generally.

These cases raise something of a puzzle for any theory of DMC. Jules Holroyd concisely diagnoses the issue as follows:

> As it stands, intuitions seem to pull in different directions: it appears intuitively plausible that over-valuing food avoidance or under-valuing continued existence thwarts the ability to weigh information relevant to treatment decisions. On the other hand it is less intuitively compelling to think that under-valuing the risk of death or disability due to a commitment to religious doctrine undermines decisional capacity (although anecdotally, intuitions seem to vary significantly on this).[16]

Contrary to Holroyd's analysis here, I shall suggest that our intuitions in these contexts may be influenced by considerations of theoretical as well as practical rationality. Here though, we may note that the Mental Capacity Act (MCA) to some extent reflects Holroyd's assessment of our intuitions in this area. Recall that an individual who lacks one of the abilities outlined in the functional test of DMC in the MCA will *not* qualify as lacking DMC unless their lacking this ability is also attributable to an impairment of, or a disturbance in the functioning of, the mind or brain. Accordingly, from the perspective of the MCA, Jack (or for that matter Isobel from the previous case) would not be found to lack capacity unless it could be established that his putative inability to use and weigh material information was due to an impairment of, or a disturbance in, the functioning of his mind or brain (rather than merely an upshot of his religious way of life).[17] In contrast, if one could establish that Keira lacks of one of the functional criteria of DMC due to her anorexia nervosa, then she could qualify as lacking DMC on the MCA.

It is difficult to see how this supplementary diagnostic criterion of mental capacity can be justified by philosophical considerations of autonomy. I argued in the previous chapter that the abilities that constitute DMC are the abilities that are necessary to making a particular decision autonomously. If an individual lacks one of these abilities, they cannot make that decision autonomously (or communicate it); the causal explanation for *why* the individual lacks the relevant ability thus seems to matter little for whether or not they are able to make an autonomous decision. This suggests that the diagnostic criterion requires an alternative justification. I lack the space to consider this particular issue here.[18] In the remainder of this chapter, I shall be concerned with the question of whether this discrepancy in widespread intuitions about these cases can be philosophically justified. I shall begin by focusing on Jack's case, and considering whether there may be philosophical grounds for claiming that Jack lacks DMC, contrary to the view outlined by Holroyd above.

[16] Holroyd, 'Clarifying Capacity', 12.

[17] Note that the impairment here need not be one grounded by pathology per se; for instance, temporary intoxication could disturb the functioning of the mind or brain in the relevant sense.

[18] Mirko Garasic makes some suggestive remarks in this regard in claiming that justifications for involuntary treatment are partly biopolitical rather than simply ethical. Garasic, *Guantanamo and Other Cases of Enforced Medical Treatment*, 12–16.

3. Jehovah's Witnesses, Theoretical Rationality, and the Doxastic Status of Faith

Jack holds true beliefs about the nature of the procedure he is declining, and his decision in this case is also practically rational; he makes his decision on the basis of a belief about the consequences which, if true, would give him a strongly decisive reason to refuse treatment. To see why, consider the belief in question and the values at stake for Jack. As a Jehovah's Witness (henceforth JW), Jack accepts the claim that the Bible prohibits blood transfusions and that accepting one would preclude him from blissful eternity in the afterlife. This is an outcome that Jack has a strongly decisive apparent reason to avoid; even if we assume that Jack would live a long (mortal) life with a high level of well-being following a transfusion, the value of this pales into comparison with the value of the life of eternal bliss that he would thereby forgo (or so he thinks).

Accordingly, it is difficult to argue that Jack is being practically irrational (although I shall consider one basis for this claim in my discussion of anorexia nervosa); he is deciding on the basis of what he believes he has strongly decisive reasons to do.[19] On this basis, we might claim that it is intuitively compelling that Jack can have DMC. However, although Jack appears to be practically rational, he might yet lack DMC on a rationalist conception, on the basis that he lacks theoretical rationality in holding what appear to be the operative beliefs in his decision-making process. Indeed, one might provocatively ask if there is anything that distinguishes religious beliefs from the sorts of delusional beliefs that uncontroversially undermine DMC.[20]

Savulescu and Momeyer come close to advocating this position; they claim that '. . . being autonomous requires that a person hold rational beliefs', and they argue that JWs' beliefs about blood transfusion and matters eschatological are theoretically irrational. Crucially, this argument does not rely on the premise that theism is true; rather, Savulescu and Momeyer argue that the relevant beliefs are theoretically irrational on the basis that those beliefs are not responsive to evidence, and that the interpretation of the scripture they imply lacks internal consistency.[21] Adrienne Martin has advanced the stronger claim that medical practice is committed to understanding JWs as lacking capacity on the basis that standard medical practice assumes these individuals have false (and not merely irrational) beliefs. Her explanation for this is that standard medical practical assumes that blood transfusions do

[19] Savulescu and Momeyer draw the same conclusion on this point at Savulescu and Momeyer, 'Should Informed Consent Be Based on Rational Beliefs?', 284.

[20] In the absence of a further philosophical argument to distinguish delusions grounded by a mental impairment and irrational beliefs held on religious grounds, it may be argued that their different treatment in mental capacity law amounts to discrimination. See Herring, *Medical Law and Ethics*, 157; Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law'. See also Fulford and Jackson, 'Spiritual Experience and Psychopathology' for a discussion of the difficulties in drawing this distinction.

[21] Savulescu and Momeyer, 'Should Informed Consent Be Based on Rational Beliefs?', 284.

not put patients at risk of eternal damnation, so JWs' beliefs prevent them from arriving at 'an even remotely accurate assessment of the risks of blood transfusion'.[22]

Despite these arguments, these authors nonetheless maintain that we should *not* treat JWs involuntarily. Savulescu and Momeyer advert to some of the competing moral considerations I outlined in the introduction to this chapter, whilst Martin argues that we should divorce considerations of DMC from the value of autonomy, and instead claim that patients lacking DMC can qualify as autonomous.[23] On such a view, autonomy has little to do with theoretical rationality, and instead concerns the consistency and coherence of one's values.[24] Once DMC has been separated from considerations of autonomy in this way, one can plausibly have autonomy-based reasons to respect the choices of patients lacking DMC.

It should be clear from my preceding arguments in this book that Martin's strategy here is incongruous with the position that I have developed. Theoretical rationality and the coherence and consistency of one's values *both* matter for autonomy; indeed, if the former did not, it is difficult to understand why it should be construed as a requirement of DMC to provide valid consent, a requirement Martin herself implicitly accepts. In contrast, Savulescu and Momeyer's conclusion that we should not treat JWs without consent even if their decision is not autonomous (on account of its theoretical irrationality) is compatible with the account that I have advanced.

In light of the MCA functionalist criterion, and what appear to be widespread intuitions about the autonomy and DMC of JWs, Savulescu and Momeyer's theory calls for a revisionist approach towards our understanding of the autonomy and DMC of JWs. However, contrary to their analysis, I shall argue that it is possible for a rationalist theory of autonomy to accommodate the thought that we should respect treatment refusals of JWs like Jack because they can be made autonomously (and not just because of the other moral considerations in favour of doing so). To do so, however, one must also embrace some further views in religious epistemology.

Martin, and Savulescu and Momeyer all accept that JWs *believe* that they will be precluded from eternal bliss if they accept a blood transfusion. Once this claim is in place, it is straightforward to argue that JWs are unable to decide autonomously on a rationalist approach, since these beliefs fail to meet the same standard of theoretical rationality to which we hold other beliefs. However, it is overly simplistic to view the operative cognitive states for many religious individuals simply as beliefs per se. Instead, they may be *items of faith*. Although items of faith may be conflated with beliefs in colloquial discussions, such conflation overlooks an important distinction, as I shall now explain.

[22] Martin, 'Tales Publicly Allowed', 36. Contrary to Martin's analysis, I contend that the fact that medical professionals act on the (rationally justified) assumption that a belief is false is not a sufficient epistemic basis for establishing the falsity of the belief in question. Indeed, on one prominent understanding, religious beliefs are unfalsifiable. See Flew, Hare, and Mitchell, 'Theology and Falsification'. Accordingly, I shall phrase my analysis in the weaker terms of theoretical rationality.

[23] Martin also proposes a second argument that we ought to respect the treatment wishes of religious believers in order to safeguard the valuable social institution of religion. Martin, 'Tales Publicly Allowed', 39–40. For a convincing rebuttal of this instrumentalist view, see Holroyd, 'Clarifying Capacity'.

[24] Martin, 'Tales Publicly Allowed', 38.

Bernard Williams famously argued that belief-formation is not under our voluntary control—call this thesis 'doxastic involuntarism'. Doxastic involuntarism is widely (though not universally) accepted, and part of one prominent defence of the thesis appeals to the underlying aim of beliefs. For instance, Williams claims that the goal of our beliefs it to aim at the truth, and notes that if 'deciding to believe' was under our voluntary control, then this would entail that one could decide to believe a proposition that one knew to be false. This, according to Williams, would be a necessarily bizarre state of affairs, given the aforementioned constitutive aim of beliefs (even if there might conceivably be some cases in which one could have non-truth based motives for believing such a proposition).[25]

This defence of doxastic involuntarism has been criticized but the details of this need not concern us here.[26] The important point to acknowledge is that even if we accept that doxastic involuntarism is true of beliefs *in general* (given their aims), it need not be true of all the cognitive states that individuals adopt with respect to items of faith. The aim of items of faith may not always be the same as beliefs; that is they may have aims other than that of merely capturing truth in the way that a typical belief does.

This is not to say that religious faith does not incorporate *any* beliefs. For instance, when one has what Robert Audi calls 'propositional faith' that *P* (that is, faith that some proposition *P* is true), this often implies that one also believes that *P* is true.[27] But faith can also incorporate a number of non-doxastic states that are not necessarily subject to the same epistemic norms as beliefs. Indeed, Audi explicitly identifies 'fiducial faith' as a form of non-doxastic propositional faith that does *not* connote or require the corresponding belief (much less a rational belief) that *P* is true.[28] Similarly, Andrei Buckareff suggests that items of religious faith may be understood as sub-doxastic pragmatic assumptions that an individual adopts in order to achieve a religious goal, namely forming a relationship with God.[29]

The thought here is that as well as not being subject to the same epistemic norms, or sharing the same aims as beliefs, agents can plausibly adopt sub-doxastic assumptions as items of faith on the basis of non-epistemic reasons, and as a voluntary act of will. That is, one can *choose* to have faith that *P*, in a way that one cannot choose to decide to believe *P*, even when there is little evidence for the truth of *P*. Moreover, this can be rational when the assumption of *P* is necessary to achieving a goal that one takes to be reason-giving.[30]

Whilst this is not the place to get into deep debates about religious epistemology, these somewhat cursory remarks reveal an avenue for understanding how JWs can be understood to make autonomous treatment decisions, despite the ostensible theoretical irrationality of their occurrent beliefs. As long as the operative cognitive states

[25] Williams, 'Deciding to Believe'.

[26] See Winters, 'Believing at Will'. For defences of doxastic involuntarism, see Buckareff, 'Deciding to Believe Redux'; Alston, *Epistemic Justification*; Levy and Mandelbaum, 'The Powers That Bind'.

[27] Audi, 'Belief, Faith, and Acceptance'. For defences of doxastic voluntarism, see Steup, 'Doxastic Voluntarism and Epistemic Deontology'; Weatherson, 'Deontology and Descartes's Demon'.

[28] Audi, 'Belief, Faith, and Acceptance'.

[29] Buckareff, 'Can Faith Be a Doxastic Venture?'

[30] Ibid.

here are not strictly beliefs (held in a manner that fails to meet standards of theoretical rationality), but rather items of faith, and as long as doxastic involuntarism does not apply to such items of faith, then JWs' accepting and abiding by the tenets of their faith can be understood to signify their choice to commit to a practice they take to be valuable. Their choice is to commit themselves to a number of sub-rational, sub-doxastic states, as a necessary element of a broader evaluative commitment to following a particular religious way of life.[31] The fact that this goal requires the endorsement of cognitive states that may be (mis)construed as simply theoretically irrational *beliefs* does not entail that these individuals lack autonomy. Rather, this feature of religious faith is broadly analogous to Odysseus tying himself to the mast. Whilst Odysseus forgoes local negative liberty in order to effectively pursue a broader goal he values, so too can the Jehovah's Witness forgo the requirements of theoretical rationality with regards to key cognitive states, as part of a rationally endorsed global commitment.[32]

The above considerations also suggest how we might distinguish religious beliefs from delusional states. According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5), a delusional belief is:

> A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith).[33]

The distinction that the DSM draws between delusions and religious belief is unsatisfying for a number of reasons. First, as I highlighted in previous chapters, this definition is incorrect to assume that a delusional belief must be false. Furthermore, it is unclear why the fact that a demonstrably false belief is widely held is sufficient to prevent it from being a delusion.[34] Certainly, whether or not such a false and theoretically irrational belief is 'ordinarily accepted by other members of the person's culture', does not appear to be directly relevant to the implications that the belief in question has for the individual's autonomy. However, my discussion above suggests that one thing that *can* matter for the individual's autonomy is whether the operant 'belief' in question is truly a theoretically irrational belief, or whether it is instead a sub-doxastic state to which the individual has voluntarily committed herself.

[31] Savulescu briefly alludes to this sort of strategy (amongst others) in his discussion. Savulescu, 'Rational Desires and the Limitation of Life Sustaining Treatment'. However, in his discussion of it, Savulescu assumes that the relevant belief is false. I have not made this assumption partly in view of the thought that religious beliefs of this sort are unfalsifiable for those who hold them.

[32] Dworkin similarly refers to JWs as tying 'themselves to the mast of their faith'. Dworkin, 'Autonomy and the Demented Self', 11. Dworkin is primarily concerned with whether we should prioritize past autonomous decisions over current non-autonomous decisions. In contrast, my discussion of faith highlights how religious beliefs can be incorporated into autonomous decision-making at all.

[33] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th edition). For other criticisms see Bortolotti and Miyazono, 'Recent Work on the Nature and Development of Delusions'.

[34] Coltheart, 'The 33rd Sir Frederick Bartlett Lecture: Cognitive Neuropsychiatry and Delusional Belief'.

In accordance with the understanding of autonomy that I have developed here, voluntary commitment to the sub-doxastic states involved in some religious faith requires both (i) the understanding that one's item of faith amounts to adopting a sub-doxastic state that involves abandoning the norms of theoretical rationality and (ii) a rationale for doing so. That is, an individual who is to choose to commit to items of faith voluntarily must have insight into the fact that she lacks epistemic reasons that warrant *belief* in her item of faith, and that she must have practical reasons for maintaining this item of faith despite her lack of epistemic reasons. This is perhaps suggestive of one way in which delusional states, including religious delusional states, may come apart from sub-doxastic states that can be incorporated into religious faith.[35] If individuals suffering from delusional states lack this insight into the fact that they are not abiding by norms of theoretical rationality in holding their beliefs, then it is not clear that they consciously adopt or sustain these beliefs for any discernible practical reason.[36]

To conclude this discussion, let me briefly summarize its implications for the DMC of JWs. First, acknowledging that it is possible for JWs to decide autonomously about refusing blood transfusion on the basis of faith does not entail that they always do so. One particularly crucial question is whether their commitment to items of faith as part of a religious way of life is an autonomous one. There are of course a number of concerns about the voluntariness of an individual's adoption of a religious commitment, particularly amongst children who are vulnerable to what may amount to manipulative and coercive influence. At the individual level, we may note that in order for Jack's decision to refuse treatment to be a reflection of his autonomy, the operative belief about blood transfusions must be supported by a broader nexus of beliefs and values that serve to indicate that Jack is rationally committed to the life of a Jehovah's Witness. For instance, if Jack does not follow any other tenets of being a Witness, and lacks other relevant beliefs central to the religion, then it is less clear that his treatment choice is really a reflection of the sort of evaluative commitment that undergirds autonomous choice.[37] There is nothing elitist about the prescriptions of my rationalist theory here; in fact, these are precisely the sort of morally relevant

[35] One, but not the only difference. Bortolotti, quoting Siddle, suggests that religious delusions can be distinguished from religious beliefs because: (a) both the reported experience of the individual and her ensuing behaviour are accompanied by psychiatric symptoms; (b) other symptoms are observed in areas of the subject's experience or behaviour that are not necessarily related to the subject's religious beliefs; and (c) the individual's lifestyle after the event giving rise to the report indicates that the event has not been for the subject an enriching spiritual experience. Bortolotti, *Delusions and Other Irrational Beliefs*; Siddle et al., 'Religious Delusions in Patients Admitted to Hospital with Schizophrenia', 131.

[36] For difficulties distinguishing delusions from religious experience, see Fulford and Jackson, 'Spiritual Experience and Psychopathology'; Bortolotti, *Delusions and Other Irrational Beliefs*; Stephens and Graham, 'Reconceiving Delusion'. For a wide-ranging discussion of delusions, see Bortolotti, *Delusions and Other Irrational Beliefs*.

[37] Tellingly, in their discussion, Fulford and Jackson suggest that in order to distinguish between spiritual and pathological forms of psychotic phenomena, we must 'consider them as embedded in the structure of each individual's values and beliefs'. Fulford and Jackson, 'Spiritual Experience and Psychopathology', 60. My tentative suggestion is that the importance of this distinction is grounded by its implications for the voluntariness of the commitment to a sub-rational set of beliefs.

factors that have been taken into account by legal judgements in this area, including the judgement in the Re T case.[38]

Second, the approach that I have adopted is compatible with Savulescu and Momeyer's recommendation that physicians should draw attention to and seek to remedy any theoretical irrationality that JWs appear to evidence. More strikingly, it is also compatible with the fact that this strategy may succeed in changing the patient's mind. Savulescu and Momeyer suggest that many JWs would 'no doubt accept blood'[39] if they were to hold informed rational beliefs. On my approach, this may be true of those JWs whose propositional faith in the tenets of their religion is purely doxastic; that is, a JW who *believes* in the technical sense that a blood transfusion will rule them out of eternal bliss, a belief they aim to hold in accordance with the norms of theoretical rationality and which is thus sensitive to epistemic reasons. Such believers may respond to epistemic reasons to change their religious beliefs. However, the fact that some JWs would likely not change their minds, does not entail that they thereby lack autonomy on the approach I am outlining. The reason for this is that propositional faith can incorporate sub-doxastic elements that are less sensitive to epistemic considerations, and which can be voluntarily adopted.

4. Rationalist DMC in Anorexia Nervosa, Evaluative Delusions, and the Significance of Regret

It is sometimes claimed that there is an inextricable link between psychiatric disorders and irrationality.[40] In turn, this claim might lead one to conclude that individuals suffering from psychiatric disorders will always lack DMC. Indeed, it might be claimed that something like this assumption plays a role in the standard account of autonomy's stipulation that psychiatric disorders can amount to forms of controlling influence that undermine autonomous decision-making. However, irrationality is neither a necessary nor sufficient condition of psychiatric disorder. Individuals in non-clinical populations exhibit various forms of irrationality (undermining the claim that this is sufficient for psychiatric disorder), and some psychiatric disorders can obtain independently of manifestations of persistent irrationality.[41]

Furthermore, as Gavaghan notes in his discussion of depression and DMC, although depression *can* impact upon all of the standard elements of DMC (such as those identified in the MCA), '. . . to say that depression *can* result in these problems . . . is not to say that it invariably, or even usually, does so'.[42] Indeed, that a particular medical diagnosis (pertaining to mental disorder or otherwise) does not

[38] Re T (Adult: Refusal of Medical Treatment).

[39] Savulescu and Momeyer, 'Should Informed Consent Be Based on Rational Beliefs?', 286.

[40] For instance, see Edwards, 'Mental Health as Rational Autonomy'; Szasz, *Insanity*. For an excellent discussion of the relationship between rationality and psychiatric disorder, see Bortolotti, 'Rationality and Sanity'.

[41] Bortolotti, 'Rationality and Sanity'.

[42] Gavaghan, 'In Word, or Sigh, or Tear', 244; Giordano, *Understanding Eating Disorders*, 70; Garasic, *Guantanamo and Other Cases of Enforced Medical Treatment*, 26–7.

entail a lack of decision-making competence is explicitly recognized by the MCA.[43] In the context of clinical depression, this is supported by a burgeoning body of empirical data suggesting that sufferers of the disorder often qualify as competent on routinely employed competence assessment tests, and the observed phenomenon of depressive realism.[44]

Accordingly, in considering the DMC of patients suffering from psychiatric disorders, we cannot justifiably make generalized assumptions about the effects of 'psychiatric disorders' per se on DMC, and we cannot assume that a particular patient is irrational on the basis of their diagnosis alone.[45] Rather, in considering the DMC of patients suffering from psychiatric disorders, we must closely attend to the manner in which a particular disorder manifests itself in a particular individual, and whether this particular patient manifests either theoretical or practical irrationality in her treatment refusal. In short, we must go far beyond the standard account's stipulation than psychiatric disorders can amount to a form of controlling influence.

Whilst the most complex problems regarding DMC in the context of anorexia nervosa are grounded in concerns about the practical rationality of such patients, it should be acknowledged that these patients can also have deficits in theoretical rationality. According to DSM V, one necessary (but not sufficient) diagnostic criterion of anorexia nervosa is that the patient must display:

> Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.[46]

Notice that this necessary diagnostic criterion is disjunctive, and also that the first and third clause may refer to *descriptive* beliefs that the anorexic patient holds. A patient's experience of body weight or shape could be disturbed in the sense that they believe (incorrectly) that they are overweight. Alternatively, a patient could persistently 'fail to recognize the seriousness of low body weight' in a descriptive sense, if she simply fails to recognize that her low body weight could have fatal implications. Accordingly, on this definition of the disorder, a patient may meet this necessary diagnostic condition because she *believes* that she is overweight despite being a dangerously low weight, or because she fails to *appreciate* that her low weight is likely to lead to serious health complications in *her* case.

However, other patients might only meet this criterion when the clauses are understood in an evaluatively laden sense. For example, it might be argued that a

[43] Mental Capacity Act 2005, s. 2 (3[b]). See also Re C (Adult: Refusal of Treatment) FD (1994), in which a patient suffering from a mental disorder was not deemed to lack capacity to make a treatment decision for a condition that was not related to their mental disorder.

[44] Okai et al., 'Mental Capacity in Psychiatric Patients'; Appelbaum and Grisso, 'The MacArthur Treatment Competence Study, I'; Hindmarch, Hotopf, and Owen, 'Depression and Decision-Making Capacity for Treatment or Research'; Bortolotti, 'Rationality and Sanity'; Ackermann and DeRubeis, 'Is Depressive Realism Real?'; Radoilska, 'Depression, Decisional Capacity, and Personal Autonomy'.

[45] Whether or not the courts follow the MCA on this point is another question. See Kong, 'Beyond the Balancing Scales'.

[46] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th edition).

patient fails to 'recognize the seriousness of her low body weight' not because of a failure to hold relevant descriptive beliefs, but rather because she does not attribute a *proportionate* degree of consideration to this point in deciding what to do. I shall return to this point below.

It seems that a strong case can be made for the claim that anorexic patients who satisfy the above diagnostic criterion in either of the first two ways just outlined lack DMC. Such patients lack the ability to understand and appreciate material information about their condition, and the reasons they have to increase their food intake. Indeed, some have argued that the beliefs held by patients suffering from anorexia nervosa can in some cases be near-delusional, although the DSM refrains from using the terminology of delusional beliefs in the context of anorexia nervosa.[47] Regardless of whether we classify such beliefs as delusional, they are not only held in a theoretically irrational manner, they are also clearly false, and inimical to adequate understanding of the sort that decisional autonomy requires. Moreover, it seems that these beliefs are not typically voluntarily adopted as pragmatic sub-doxastic states in the same way as religious items of faith may be.[48] As such both the standard account of autonomy and the rationalist account that I have developed may be invoked to support the claim that such patients lack DMC.

However, an individual can meet the diagnostic criteria of anorexia nervosa without holding these kinds of false or theoretically irrational descriptive beliefs. A patient may be aware that she is dangerously underweight, and realize that this will have drastic implications for her health, and yet still qualify as suffering from anorexia nervosa. She will do so if body shape and weight are construed as having an 'undue influence' on her self-evaluation. The case of Keira outlined at the beginning of this chapter is plausibly an example of such a patient; should we also claim that Keira lacks DMC?

The DSM criterion of these considerations having 'undue influence' is suggestive of the possibility that anorexia nervosa can involve what Fulford calls an evaluative delusion. As I discussed in previous chapters, such delusions involve maintaining theoretically irrational (but not necessarily false) evaluative beliefs.[49] It seems highly plausible that anorexic patients can be theoretically irrational with respect to their evaluation of thinness; there is, for example, evidence of rigidity in the thinking patterns of anorexic patients,[50] as well as reports of cognitive dissonance

[47] Steinglass et al., 'Is Anorexia Nervosa a Delusional Disorder?'

[48] Interestingly, there is a long-standing relation between self-starvation and religious asceticism. See Bemporad, 'Self-Starvation through the Ages'; Davis and Nguyen, 'A Case Study of Anorexia Nervosa Driven by Religious Sacrifice'; Bell, *Holy Anorexia.* This speaks against viewing anorexia nervosa as simply a disorder grounded by ideals of thinness and beauty alone. It also suggests that it may not be possible to draw a sharp distinction between treatment refusals based on religious belief and those based on pathological thinking patterns associated with a psychiatric disorder. Whilst I lack the space to consider this point in further detail, we may note that the implications of my theory for 'holy' anorexic patients depends largely on whether they voluntary commit themselves to irrational and demonstrably false beliefs about their weight and body shape. If they merely commit themselves to a particular evaluation of fasting, but not to other irrational descriptive beliefs per se that their condition may involve, then these irrational beliefs can be understood to undermine their autonomous decision-making.

[49] Fulford, 'Evaluative Delusions'.

[50] Elzakkers et al., 'Mental Capacity to Consent to Treatment in Anorexia Nervosa'.

(as I shall explore below) that belie a failure to adhere to basic norms of theoretical rationality concerning responsiveness to evidence and internal consistency.

However, it is important to be careful about how we demarcate the boundaries of evaluative delusions in this context, given that delusions are typically understood to undermine DMC. The claim that one dimension of a person's self-conception (in this case, body shape or weight) exerts 'undue influence' over the patient's decision-making, invites the thought that there is an objective standard of proportionate influence that different values *should* have on one's self-conception. On this understanding, it might be tempting to claim that an individual holds an evaluative delusion if their evaluative beliefs do not accord with this standard. However, there are a number of reasons to reject this approach. First, as I have already mentioned, standard delusional beliefs are not necessarily false beliefs, so it is unclear why we should suppose that evaluative delusions must be 'false' in the sense that they do not match up to a known, objectively correct, ranking of values. Second, this view is in tension with the claim that rational agents can place different weight on different goods. To put the problem more starkly, if we endorse the claim that anorexic patients simply fail to track objective truths about proportionate evaluative weightings, then it is not clear why we should not also make similar claims about Isobel. For instance, Isobel's negative evaluation of social isolation is arguably disproportionate given the value of independence, and the value of other goods she might plausibly pursue if she consents to life-saving treatment.

The boundaries of evaluative delusions are better demarcated by claiming that such delusions obtain when agents lack epistemic mechanisms for reliably tracking what evaluative truths about the good there may be, in the way that individuals who are deluded about descriptive matters similarly seem to lack epistemic mechanisms for reliably tracking truths about descriptive matters of fact. However, differences between the spheres of the evaluative and the descriptive, and their respective relationships to rationality, suggest that our understanding of evaluative delusions is likely to be far more vague than our understanding of descriptive delusions. There is widespread agreement on what constitutes the truth about descriptive matters of fact, so we can normally agree upon whether an individual is delusional with respect to such matters, and identify their defective epistemic mechanisms. Whilst the objectivist about practical reasons will agree that there are also truths about value in the same way that there are truths about descriptive matters of fact, this point is attended by the significant caveat that these truths about value are far less precise, and less well-understood than truths about descriptive matters of fact. Accordingly, even if one accepts the objectivist tenor of demarcating the boundaries of evaluative delusions by appealing to mechanisms for tracking truths about value and objectivist reasons, such an approach will allow for only a very blurry demarcation of the concept.

With these remarks about evaluative delusions in mind, let us return to a more direct consideration of the question of DMC in anorexia nervosa. Although I have suggested that Keira's psychiatric diagnosis is not alone sufficient to justify the claim that she lacks DMC, we might wonder if there is something about the particular kinds of desires that anorexic patients hold that makes them particularly problematic from the point of view of autonomy. In this vein, Tan et al. have claimed that

anorexic patients can lack DMC to refuse treatment because their refusals are grounded by pathological values that are incorporated into the diagnostic criteria of their condition.[51]

However, it is not clear how much explanatory power this claim can have with regards to the question of whether such patients can decide autonomously. Of course, the mere fact that a particular behaviour is taken to be a constitutive element of a psychiatric disorder is not alone sufficient to establish that the behaviour is practically irrational. Irrationality is neither necessary nor sufficient for psychiatric disorder. More worryingly though, Tan et al.'s claim is problematically circular; the fact that the evaluative emphasis on low weight is part of the diagnostic criteria of the disorder we call anorexia nervosa is just to say that the evaluation is pathological.[52] However, this does not tell us anything about whether desires grounded by such pathological evaluations can be held autonomously.[53]

This is not to say that Tan et al.'s general conclusion that such patients lack DMC is incorrect; my point here is merely that the support offered for that view is not satisfactory. To support this claim, we would need some grounds for thinking that the values that are designated as pathological cannot ground autonomous decision-making. If there were a plausible story about how pathological desires bypassed or distorted rational reflection, then this would provide sufficient support for the claim; however, noting that a desire is pathological because it is incorporated into the diagnostic criteria of the condition under consideration does not provide us with this sort of explanatory story. To conclude that such desires cannot ground autonomous decisions in the absence of this explanation is thus to presume the very issue at stake.

The code of practice for the MCA offers a different rationale for suggesting that patients suffering from anorexia nervosa can lack DMC, even if they are able to understand relevant treatment information. According to this guidance, the problem in such cases is not that such a patient's values are pathological per se, but rather that their compulsion not to eat might be 'too strong for them to ignore'.[54]

Whilst this rationale is not circular, it too is unconvincing. Prima facie, we may find it appealing to claim that agents who decide on the basis of 'compulsions that they cannot ignore' are not autonomous with respect to those decisions. For instance, the example of Jane the unwilling addict in the introductory chapter seems to be a paradigm case of an individual who lacks autonomy in this way. Jane is compelled to act in ways that she does not rationally endorse because she finds her first-order desire to take drugs to be irresistible; there is a real sense in which she lacks a choice about how to act.[55]

[51] Tan et al., 'Competence to Make Treatment Decisions in Anorexia Nervosa'.

[52] Craigie, 'Competence, Practical Rationality and What a Patient Values'; Maslen, Pugh, and Savulescu, 'The Ethics of Deep Brain Stimulation for the Treatment of Anorexia Nervosa'.

[53] The problem of definitional circularity arising when competence assessments take into account diagnostic criteria also arises in the context of clinical depression, and the diagnostic criterion of suicidal ideation. See Gavaghan, 'In Word, or Sigh, or Tear', 253; McLean, *Assisted Dying*, 41.

[54] *Mental Capacity Act Code of Practice*, s 4.22.

[55] As Craigie and Davies note, this strong sense of compulsion is outlined in Foddy and Savulescu, 'Addiction and Autonomy'. Notably, the weakened sense of compulsion employed by the MCA code of

It may be that some sufferers of psychiatric disorders could be in a similar situation with respect to their pathological behaviour as Jane is to her drug-taking. That is, in some cases, sufferers of psychiatric disorders might be understood to engage in impulsive erratic episodic behaviours that they know to be incongruous with their evaluative judgements, such that these episodes of pathological behaviour can be appropriately designated as alien to the personality of the sufferer.[56] However, in many cases the situation is far more complex, because of the ego-synctonicity of some psychiatric disorders, whereby affected individuals identify with their pathological behaviours.[57] If such individuals are 'compelled', they are not compelled in the same way as Jane, who acknowledges the disparity between her actions and her values.

Indeed, the sense of compulsion that the MCA code of practice is interpreted to invoke with respect to anorexia nervosa is far broader than that which would be necessary to merely preclude individuals who are compelled in Jane's sense from qualifying for DMC. In their analysis of this feature of the MCA code of practice, Jillian Craigie and Alisa Davies write that:

> Where compulsion is given as grounds for incapacity due to anorexia, it is most often described in terms of extreme distortions and biases in the decision process, rather than the person being deprived of a choice.[58]

The relevant question in the present context then is thus whether this weaker sense of compulsion should be understood to be alone sufficient to undermine DMC.

It is telling that Craigie and Davies note that (weak) compulsions are typically taken as grounds for incapacity on the basis of something other than the fact that they are 'too strong to ignore'. This is important because this feature of (weak) compulsions alone is clearly not sufficient to undermine DMC. In fact, quite the opposite is true; rationality may often *require* that we ground our decisions on considerations that we cannot ignore, in the sense that they relate to facts that give us extremely strong reasons. For instance, suppose Sue suffers from very mild headaches once a year, so mild that she hardly notices them. A friend tells her about a highly experimental neurosurgical intervention that is being used in the treatment of life-threatening illnesses, which might cure her headaches, but which is extremely risky and dangerous, with a 90 per cent mortality rate. Sue has extremely strong reasons, ones that she plausibly cannot rationally ignore, to refuse to undergo the procedure. It would be absurd to deny that this sort of rational (weak)

practice would qualify as a form of coercive (rather than compulsive) influence on Feinberg's schema regarding the spectrum of force. Feinberg, *The Moral Limits of the Criminal Law*, 189. For discussion, see Bolton and Banner, 'Does Mental Disorder Involve Loss of Personal Autonomy?' However, in the case of chronic, non-episodic disorders such as anorexia nervosa, the questions are often more challenging, as patients' choices often cohere with their evaluative judgements, as I explore below.

[56] For further discussion of how episodic psychiatric disorders can undermine autonomy, see Bolton and Banner, 'Does Mental Disorder Involve Loss of Personal Autonomy?' Some evidence suggests that bulimia nervosa may begin as an impulsive disorder in this manner. See Pearson, Wonderlich, and Smith, 'A Risk and Maintenance Model for Bulimia Nervosa'.

[57] Tan et al., 'Competence to Make Treatment Decisions in Anorexia Nervosa'.

[58] Craigie and Davies, 'Problems of Control', 11.

compulsion is inimical to her making an autonomous decision to refuse treatment in this case.

Sue has a choice, but she is (weakly) compelled by considerations that she takes to imply very strong reasons. This distinguishes Sue from Jane the unwilling addict. However, it is not clear that it distinguishes Sue from Keira; Keira may also be understood to be (weakly) compelled by considerations that she takes to imply very strong reasons. Should we distinguish the two? The rationalist approach can offer two strategies here. First, in light of an objectivist account of reasons, one might claim that Sue's apparent reasons clearly track her real reasons, since Sue has a strongly decisive reason not to undergo the procedure. In contrast, Keira's apparent reasons do not similarly track what she has real reason to do. Whilst such a strategy allows us to distinguish the two cases, it relies on the claim that we have clear and precise understanding of the evaluative truths at stake in both of these contexts. Given the potential for doubt on this point, we might prefer a different rationalist strategy that does not rely on this objectivist claim, and instead appeals to internal deficiencies with the agent's practical rationality.

In fact, one may read the courts' interpretation of the MCA code of practice as adopting this latter strategy. As Craigie and Davies note in the quoted passage above, the courts' interpretation is typically grounded by the claim that anorexia nervosa appears to 'distort' or 'bias' the deliberation of sufferers. The focus here then is not on whether their decisions are grounded by considerations that sufferers cannot ignore, but rather on whether the disorder biases or distorts the considerations that sufferers take to imply reasons (of the sort that they cannot ignore).

Such bias and distortion would plausibly represent a morally significant difference between Sue and Keira with respect to their DMC for their treatment decision. However, if this strategy is to be a convincing proceduralist basis for claiming that sufferers of anorexia nervosa lack DMC, then we need an explanation for the manner in which anorexia distorts and biases practical decision-making. Given my discussion above, such an explanation cannot simply appeal to the notion of pathology alone, and it must serve to distinguish sufferers of anorexia from standard decision-makers.

A significant problem in attempting to account for the practical irrationality of anorexic patients is that in many cases such patients decide to refuse food in a manner that is rational *in light of their own values*. As Jillian Craigie notes, self-reports of recovered patients suggest a significant source of regret amongst such patients is:

> . . . not that they failed to *do what they wanted to do* – on the contrary they pursued the goal of thinness very effectively. It seems more likely that the regret these people express has its source primarily in *what they valued*.[59]

So the question for a rationalist approach to this issue is whether we can plausibly have grounds for supposing that anorexia nervosa serves to distort or bias the patient's practical rationality despite the fact that patients choose in accordance with values that they may endorse as part of a coherent character system.

[59] Craigie, 'Competence, Practical Rationality and What a Patient Values', 331.

Craigie herself endorses a rationalist approach to DMC that broadly aligns with my arguments in this book, and suggests three reasons for thinking that a rationalist approach can answer this question affirmatively.[60] First, she suggests that consistent evidence of retrospective regret amongst survivors of anorexia nervosa about their earlier decision-making would give us grounds for doubting the practical rationality of anorexic patients. Second, some sufferers report cognitive dissonance with respect to their evaluation of thinness, and there is evidence that individuals with anorexia nervosa come to develop powerful internal conflicts due to their distorted affective states.[61] Finally, neuropsychological research suggests that anorexia is associated with impaired emotional arousal in decision-making, similar to impairments that have also been observed in patients who have suffered damage to the ventromedial cortex.[62] Although she acknowledges that none of these three strands is alone sufficient to justify the claim that anorexic patients may be prone to practical irrationality, Craigie concludes that they jointly begin to present a robust case.

I am broadly sympathetic to Craigie's approach, and agree that some of this evidence might plausibly give us reasons to suppose that the practical rationality of anorexic patients has been distorted by their disorder. However, I shall conclude by raising some doubts about the strength of the evidence that we can obtain in favour of this claim from observations of regret. Whilst this is only one strand of evidence that bears on considerations of practical rationality, it is a particularly salient form of evidence in Craigie's analysis. As well as suggesting that it could go some way to justifying a general claim about a lack of ability to recognize certain reasons amongst anorexic patients, Craigie notes that evidence of regret amongst JWs can provide us with sufficient reason to suggest that our policies of abiding by treatment refusals of such patients may deserve re-examination.[63]

In considering the significance of regret amongst survivors of anorexia nervosa, it is important to separate the empirical and the moral issue. The extent to which regret is experienced by anorexic patients is under-studied, and we should certainly be cautious in assuming that future regret will be experienced by all anorexic patients.[64] However, let us assume, perhaps counterfactually, that there is reasonably consistent empirical evidence of regret amongst survivors of anorexia nervosa.

With this assumption in place, what moral work can it do? The first thing to acknowledge is that the mere possibility that an individual may regret a decision is not sufficient grounds for claiming that they cannot make that decision in a practically rational manner. It is quite possible for a person to make an autonomous decision that they will later regret, and indeed, part of respecting an individual's

[60] For another discussion of how the autonomy of anorexic patients may be undermined by defects in their use of information, see Giordano, *Understanding Eating Disorders*, ch. 12.

[61] See also Charland, 'Ethical and Conceptual Issues in Eating Disorders'; Charland et al., 'Anorexia Nervosa as a Passion' on this point.

[62] Craigie, 'Competence, Practical Rationality and What a Patient Values', 332. [63] Ibid., 333.

[64] Gavaghan makes a similar point in the context of depression in Gavaghan, 'In Word, or Sigh, or Tear', 250–1. Certainly, in considering only the regret of those who have *recovered* from the condition, there is a concern that the sample may be somewhat biased.

autonomy is that we allow them to make decisions that they could regret.[65] For instance, an individual can validly consent to having an inane tattoo as a 20-year-old that they are quite likely to regret when they are 50.

However, we might think that there are some exceptions to this general thought about the compatibility of autonomous decision-making and later regret. In some cases, our anticipation of another's future regret may be based on the fact that the individual lacks some crucial information. For instance, I might anticipate that Peter will regret deciding to cross a bridge to get to the other side of the river because I am (but he is not) aware that the bridge is about to collapse. In this case, the account of autonomy that I have developed here suggests that Peter may not make an autonomous decision about crossing the bridge, because of his failure to understand crucial features of the choice he is making.

Although we might plausibly deny DMC on the basis of anticipated regret when the latter is used a proxy for the individual's insufficient understanding at the time of their decision, it is not clear that this justification is applicable in the context of anorexia nervosa. Patients suffering from anorexia nervosa can (in some cases) have sufficient understanding of the implications of the choices that they make. In order for anticipated future regret to provide a plausible basis for denying DMC in such cases, we would need to have some basis for prioritizing the individual's future wishes over their (sufficiently informed) present wishes. As I explored above though, this runs contrary to how we think of DMC in standard cases, in which we respect the patient's present wishes, rather than the wishes we believe (even with good justification) that they will have in the future.

It might be argued that considering this question in the context of anorexia nervosa involves an obvious disanalogy with other contexts. When we are considering the present wishes of the anorexic patient, they are suffering from a psychiatric disorder, whilst the later regret we (might) observe amongst anorexic patients is expressed once they have recovered. Doesn't this give us reason to prioritize the later wishes over the earlier? However, given my discussion in this chapter, it should be clear that this argument is problematic. We would only have an autonomy-based reason to prioritize the individual's (anticipated) future wishes over their present wishes if we had some independent reason for believing that the individual's present wishes are not autonomous, but their future ones will be. For reasons I have discussed in this chapter, the individual's disease status alone does not provide this kind of reason, and nor does the content of their decision.

At best then, evidence of regret could only provide *supplementary* evidence of a lack of DMC amongst anorexic patients, once it has *already* been established that the individual's retrospective regret has greater agential authority than their past wishes had at the time of the decision. Although there is certainly also room for scepticism about the power of other strands of evidence that Craigie adverts to, it may be the case that further neuropsychological evidence and phenomenological evidence could help us to establish this. However, in the absence of another explanation for why we

[65] McQueen makes a similar point in his analysis of autonomy and regret. McQueen, 'Autonomy, Age and Sterilisation Requests'. See also Pugh, 'Legally Competent, But Too Young To Choose To Be Sterilized?'

should prioritize the individual's (anticipated) future wishes over their present wishes, appealing to considerations of regret as evidence of a lack of DMC is flawed. Furthermore, contrary to Craigie's suggestion, it is not sufficient to establish that JWs lack DMC, and there is danger in assuming that it would be alone sufficient in the case of anorexia nervosa. Such an assumption risks covertly basing claims about the absence of DMC on judgements about the individual's diagnostic status, or the content of the decision itself.

Perhaps more importantly though, even if we accept the claim that anorexic patients may be practically or theoretically irrational with respect to their pathological eating behaviours and beliefs, this does not entail that they lack DMC to refuse treatment. In order for that to be so, it must also be the case that it is these problematic beliefs and values that are primarily operative in the patient's decision-making process. Yet, this might not be the case. A chronically ill patient's refusal of treatment may be based on the quite rational belief that life-saving treatment is not in her long-term interests, by virtue of the suffering that living with a chronic and intractable disease can entail. In cases where there is a strong basis for claiming that the disorder is demonstrably intractable,[66] it seems that this decision could be rational, even if we deny that it would not be rational for a patient to refuse treatment on the basis of a distorted view that being thin is more important than survival.[67]

In view of the above limitations, where does this leave the rationalist approach to understanding DMC in anorexia nervosa? It certainly speaks in favour of clinicians compassionately seeking to investigate why the patient understands weight-loss or a particular body shape to be good in a reason-implying sense, and whether she takes her reasons to achieve this good to outweigh the strength of her reasons to pursue other incompatible goods. Investigation into these matters through the process of something like radical interpretation may sometimes reveal inconsistencies with other elements of that patient's character system, indicating that the patient does not in fact rationally endorse their overall commitment to this goal at a deep level.

However, suppose that for a particularly chronic sufferer of anorexia nervosa, such inconsistencies do not arise, and they are able to provide an account of why their goal is good in a reason-implying sense for them, and how it coheres with persisting elements of their character system without affective disturbance of the sort that might distort their practical rationality. Let us assume, perhaps contrary to clinical reality that such a patient could be presented as a hard case for a rationalist theory of autonomy. As I have suggested in outlining the strategies available to a rationalist account here, we are faced with a choice. First, we may concede that such a patient's decision can be rational if it is a reflection of the reason-giving facts in this context, such as those concerning the burden that both the disease and therapy have become

[66] Although for concerns about the concept of futility in this context, see Geppert, 'Futility in Chronic Anorexia Nervosa'.

[67] Giordano makes a similar point in observing that an anorexic patient's refusal may be grounded by beliefs about the quality of her life. See Giordano, *Understanding Eating Disorders*, 240–1. See also Draper, 'Anorexia Nervosa and Respecting a Refusal of Life-Prolonging Therapy', 122.

for the patient.[68] If it is rational in this way, then it ought to be respected. Such a strategy acknowledges both the lack of adequate explanatory support for the claim that the patient's 'pathological' desires undermine autonomy, the possibility that individuals can differ significantly on the weight they attribute to different goods, and the sad fact that continued existence can represent a significant burden for chronically ill patients.

The alternative is to maintain that such a decision can still be appropriately described as irrational, even if it does not appear to evidence distorted judgements or values that the individual does not recognize and accept as her own. How could such a claim be supported? On an objectivist approach, it might be argued that to claim that such a decision can be rational is to extend the tenet that 'individuals can attribute different weight to the pursuit of different goods' to a degree that stretches it beyond credulity. Although I have suggested that truths concerning the comparative strength of our self-interested reasons are often very imprecise, this is not to say that there are *no* circumstances in which we may say that someone is attributing disproportionate strength to a particular kind of reason.[69]

Which of these strategies should the rationalist adopt? The answer to this question depends on the deeper philosophical issue of just how imprecise the truths concerning the comparative strength of our self-interested reasons are. If we hold a strong version of this view, according to which these truths are so imprecise that we can rarely make an objective assessment of the relative strength of the reasons that others have to pursue different goals, then we should adopt the first strategy, and respect Keira's refusal. The question of the extent to which we can know these truths is thus a more fundamental epistemic barrier facing us when we attempt to make assessments of DMC in hard cases such as those presented here. On the second strategy, even allowing for variability in individual views about the comparative strength of reasons to pursue different goods (thus forestalling, to a considerable extent, the anti-paternalist objection against a rationalist criterion of DMC), we can claim that it is irrational to prefer certain goods (such as low weight) over others (such as survival). On this account, we may understand procedurally rational disagreements about the good to be possible only within broad substantive boundaries that outline the few 'known' truths regarding the comparative strength of different reasons, pertaining to goods at different ends of the spectrum with regards to their importance to well-being.

[68] Although we disagree on the semantics of the concept of rationality and how it features in DMC, the strategy I am outlining here coheres with Draper's practical conclusions. See Draper, 'Anorexia Nervosa and Respecting a Refusal of Life-Prolonging Therapy', 133.

[69] Culver and Gert similarly appeal to the importance of decisions being grounded by 'adequate reasons', where the notion of adequacy implicitly corresponds to an objective ranking of goods, and corresponding reasons. They write that 'A reason is an adequate reason when the harms avoided (or the goods gained) by suffering the harms of a contemplated act compensate for the harms caused by that act', and that 'a decision or action is irrational if the person making it knows (justifiably believes) or should know that its foreseeable results are that she will suffer any of the items on the following list: death, pain (either physical or mental), disabilities (physical, mental, or volitional), or loss of freedom, or loss of pleasure or be at increased risk of suffering any of these, and she has no adequate reason for her action or decision'. Culver and Gert, 'The Inadequacy of Incompetence', 630–1.

Which of these strategies we adopt will thus require substantial theoretical commitments in both the nature of well-being and epistemology. I confess to leaning towards the first strategy, but this requires far more defence than I can provide here. The difficulty of resolving this issue is, I suggest, precisely why we should find the case of Keira to be so complex. In this regard, it is worth contrasting the complexity that this approach raises with the problematic simplicity of the standard view of autonomy. In simply stipulating that psychiatric disorders can amount to a form of controlling influence that undermines autonomy, the standard account simply lacks the conceptual tools to adequately engage with this kind of hard case. In order to adequately assess DMC here, we must delve deeper into the decision-making procedure of such individuals, the nature of their beliefs, the reasons that they understand themselves to have, and these other deeper philosophical issues about the nature of well-being.

Finally, as my discussion here demonstrates, the rationalist can lend some theoretical support to widespread and diverging intuitions about DMC in cases of religious belief and psychiatry. Most importantly though, it shows that sound judgement on these cases requires a complex consideration of a wide range of factors, that we can ill-afford to leave to mere intuition alone.