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# Respecting an Incompetent Person's Autonomy

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# RESPECTING AN INCOMPETENT PERSON'S AUTONOMY

by

ERICA RONNING

Under the Direction of Andrew I. Cohen, PhD

## ABSTRACT

In this thesis, I will argue that in cases of surrogate decision making, proxies better respect an incompetent person's autonomy when using the current values approach only in very specific cases where the loss of competence has rendered someone an entirely new person. In all other cases, I believe that the counterfactual view provides a better basis for respecting an incompetent person's autonomy.

INDEX WORDS: Autonomy, Competence, Surrogate decision making, Incompetence,  
Counterfactual view, Current values view

RESPECTING AN INCOMPETENT PERSON'S AUTONOMY

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ERICA RONNING

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RESPECTING AN INCOMPETENT PERSON'S AUTONOMY

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## **DEDICATION**

I would like to dedicate this thesis to all of the close friends that I've made in the philosophy department at Georgia State University. I would not have been able to finish this thesis without all of your love and support. In particular, I dedicate this thesis to Emily Tilton, Matt Kelley, and Maggie Owens. The three of you helped me more than you will ever know.

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## 1 INTRODUCTION

Many people believe that the autonomous choices of competent adults must be respected, provided such choices do not harm anyone else. However we might theorize autonomy, it becomes unclear what the demands of autonomy are when deciding on behalf of a temporarily or permanently incompetent person. In this thesis, I discuss the process of surrogate medical decision making for incompetent individuals. I specifically focus on what method a surrogate-decision-maker should use to best respect an incompetent person's autonomy in situations where the incompetent person's previously held autonomous views are known.

I set out and detail two rival views that provide different methods for surrogate decision makers to use to respect an incompetent person's autonomy.<sup>1</sup> First, there is a "prior values" view, which appeals to counterfactuals to settle cases involving incompetent patients.<sup>2</sup> Second, I set out the "current values" view, which urges surrogates to appeal to an incompetent person's current values to make proxy decisions. I argue that neither view should be applied in *all* situations that require a surrogate decision maker. Rather, either view may be better at respecting an incompetent person's autonomy, given certain details, and if one view is better than the other in a given situation, then the better view should be used by the surrogate in that specific situation. The views that I present in this paper can be tools for surrogate decision makers who are assessing how to respect an incompetent person's autonomy when they make their proxy decisions. I will argue that, in certain situations, one view is more effective at respecting the

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<sup>1</sup> There is a third view that could be discussed, the well-being view. While I recognize that the well-being view has been greatly influential to the field, I omit it from this comparison because I believe the view is most appropriate for incompetent patients who have neither prior nor current values, and in this paper I will focus on situations where an incompetent person's prior value can be known. The well-being view will be briefly addressed later in the paper.

<sup>2</sup> In this paper, before it is called the "prior values view", this view will first be referred to as the substituted judgement standard, and then as the counterfactual view.

incompetent persons' autonomy than the other, and therefore if a surrogate decision maker finds themselves in these certain situations, they ought to use the view that I argue is best.

Throughout this paper, I will discuss the normative significance of the status of the incompetent person's identity. I believe that whether the incompetent person's identity has changed or not is crucial. It is a vital consideration for determining which method a surrogate decision maker should use to respect the incompetent person's autonomy. I will conclude that the current values view is definitively better at respecting the autonomy of the person who is currently incompetent *only* in situations where the currently incompetent person has become a different person from who they were before becoming incompetent. To support this conclusion, I set out briefly the normatively significant sense in which personhood may change. Because determining which method is better for a surrogate to use in any given situation requires careful evaluation of the incompetent person's identity, I conclude that all situations that demand a surrogate decision maker require careful evaluation by relevant parties to determine the status of the incompetent person's identity.

I begin this thesis by defining several relevant terms. Specifically, I discuss autonomy, general competency, and how the state defines and determines competency. I then focus on situations where a surrogate decision maker knows the patient's prior values. Because I focus on these specific situations, I first discuss the substituted judgement standard, which is traditionally formulated in terms of counterfactuals. I will not attempt to defend the substituted judgement standard from critiques, as doing so would be out of the scope of this paper.<sup>3</sup> Next, I discuss an alternative to the substituted judgement standard (later called the prior values view), the current

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<sup>3</sup> I acknowledge that there are arguments challenging the value of the substituted judgement standard. However, this paper will focus on the applicability of the current values method, so I will not spend time defending the substituted judgement standard and I take for granted that the method is generally accepted by medical professionals and academics.

values view. After that, I offer my critique of the current values view. Next, I briefly look at situations where a surrogate decision maker does not know the incompetent person's prior values, either because the surrogate decision maker does not have access to that information, or because the person has no competently held prior views to reference because they have never been fully competent. In these situations, surrogate decision makers typically use, and appropriately so, a method called the "best interests" method. Here, surrogate decision makers may make proxy decisions based on what they justifiably believe will best advance the interests of the incompetent person. In this paper, I make no normative claims regarding how the best interest model should be used or what method a surrogate decision maker should use in situations where the incompetent person's previous values are unknown. I only discuss these situations to fill out the picture of what the decision-making flow chart looks like to proxies. Overall, I will conclude that, at best, the current values view will better respect an incompetent person's autonomy in very specific and rare situations, i.e. when the incompetent person's identity has changed, and the prior values view is a better decision procedure for respecting autonomy in most other situations where the surrogate decision maker knows the incompetent person's prior values.

## **2 KEY TERMS**

At the beginning of any philosophical inquiry, a person must first be familiar with key terms, specific definitions, and any background information that is relevant to the field of discussion. To discuss surrogate decision making methods, one must first understand what it means to be autonomous, how to respect one's autonomy, and what it means to be competent. One must also understand key features of the process by which the state determines competency.

Before I define and discuss autonomy and competency, we should first understand why it is important to understand how discussions of surrogacy norms crucially involve the state.

Autonomy is certainly relevant to the discussion, but I will focus on how the state understands competency. This is because the modern liberal state is a key party in determining the distribution and content of crucial rights and duties. The state claims the authority to determine a person's competency and whether the person needs a surrogate decision maker.

The state frequently determines how to allocate significant burdens and benefits to persons in light of their competency. These distributive decisions sometimes crucially depend on determinations of a person's will, or, absent such explicit determinations by the person, then those of some substitute or proxy. The state assigns incompetent citizens a surrogate or proxy, which can reduce the chances a person might risk harming themselves or others. Assigning incompetent persons a surrogate may help the state to protect its citizens from harm, and one could plausibly assume that protecting its citizens may be one of the state's ultimate goals. One could, of course, critically assess whether the state is justified in determining competency in some or any case. In our current institutional environment, however, the state commands significant resources and opportunities and does so at least sometimes in light of its assessments of competency. Consequently, the state must appeal to some criteria when evaluating competence. While the state might be the deciding entity, it should regularly consult with medical and psychological professionals when determining an individual's level of competency, as these doctors seem most able to assess a person's mental capacities. However, this paper is not concerned with adjudicating the validity of the state's claims to make such decisions. Instead, this paper focuses on the surrogates themselves and what standards ought to govern those surrogates when they decide on behalf of incompetent persons.

Generally, people believe that for someone to be qualified to make major decisions, they must at least have the mental capacities to be able to understand and accept the inevitable and potential consequences. Whether or not a person who has the mental capacities to understand consequences of actions actually uses that capacity is not necessarily relevant. If a person cannot grasp the real or possible long-term effects of a decision, but makes the decision anyway, this person may be harmed by their decisions. More specifically, persons who are incompetent are vulnerable to risks of greater harm in virtue of their incompetence, so, many other persons might argue that the state can and should address these possible risks by appointing a surrogate who can decide on someone else's behalf, when someone is not in a position to do so themselves. Returning to the state, because a person can be harmed when they try to make decisions that are far too complex for them to understand, the state has been observed trying to minimize that harm by assigning incompetent people surrogate decision makers. Because the state assigns surrogate decision makers, the state must therefore determine whether a particular person is competent or not.<sup>4</sup> If the state finds a person to be incompetent in some respect, then the state might appoint a surrogate decision maker to make proxy decisions for the incompetent person. To understand the arguments of this paper, one must first understand the process through which surrogate decision makers are determined necessary and subsequently assigned. Now that we have a basic understanding of the importance of the state, I will move on to discuss what autonomy is and how to respect someone's autonomous choices, and I will return to a discussion of the state when I discuss competency.

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<sup>4</sup> Discussing the state's process of determining competency is beyond the scope of this paper. It is only relevant to note that the state actually does the determining of competency. Examining whether or not the state is the correct entity to be determining competency is again beyond the scope of this paper.

I next present a conception of autonomy that is consistent with the common concerns in medical ethics for respecting this capacity of persons. To be autonomous “is to be self-ruled” (Taylor 97). A person is autonomous if “their decisions and consequent actions are governed by desires that are truly their own” (Taylor 98). I understand this to mean that if a person makes decisions that they were not coerced into making, or if they then perform some action based on those decisions that they were also not coerced into making, then their decisions were made autonomously, and this person is self-ruled. Of course, my understanding of autonomy requires a discussion about what it means to not be coerced. Before I begin my discussion of coercion, it is necessary to mention that being non-coerced is not sufficient on some accounts for being autonomous. This paper is only identifying coercion as a necessary but not sufficient condition for autonomy

On my account, an autonomous decision is, minimally, one that a person makes free of undue force or threats. If, for example, a woman is told “Do X or I will punch you in the face”, and then she does X to avoid being punched in the face, then she has been coerced into doing X because her decision of whether or not to do X is influenced by the (we may suppose) undue threat of violence that someone else has made against her. It is also necessary that the threat made against someone is credible, and the threat must be something that she actually does not want to happen to her. Therefore, for her to be coerced into doing x, she must actually believe that the person threatening her will in fact punch her in the face if she does not do x, and she must want to actually avoid being punched in the face, and the threat of the punch must be somehow impermissible or undue. On the other hand, if she decided to do X without being threatened with undue violence or force of some kind, then, *ceteris paribus*, she has not been

coerced into doing X.<sup>5</sup> Let us look at some examples to better understand what it means to be coerced. This will help to become clearer on the types of decisions that ought to be respected by others, namely, decisions that one was not coerced into making.

Regarding an action itself, if a person performs some action that they did not intend to, then it is not a self-ruled action. For example, reflex movements are not self-ruled actions because they are involuntary movements.

It is often the case that people make choices and perform actions based on their desires. Furthermore, it is of course true that a person's desires and resulting choices can be influenced by other people, the media, society generally, and countless other sources. However, being influenced by external forces does not necessarily make choices non-autonomous.<sup>6</sup> For example, if I decide to get breast enhancement surgery because I think doing so will make me feel more confident, look more sexually attractive, will allow me to wear the types of clothes I want, will perhaps help me get a job promotion, and because I simply like how large breasts look on other women, I have made an autonomous choice, even though the choice I made was certainly influenced by societal norms.<sup>7</sup> However, it is not an autonomous choice for me to receive breast enhancement surgery if the reason why I decided to was because my friend told me that I must get the surgery or else she will punch me in the face (again, assuming I neither want that nor that

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<sup>5</sup> I acknowledge that my discussion of coercion is only a gloss over the complex terrain. I have given a basic understanding of coercion that does not get into the nuanced debates about the term's meaning. For further discussion of coercion, look to Robert Nozick's "Coercion", Alan Wertheimer's book *Coercion*, and Scott Anderson's article "The Enforcement Approach to Coercion".

<sup>6</sup> One may be concerned with the possible existence of choices that a person made autonomously but was coerced into making. However, discussing the possibility of actions that are both autonomously made and coercive in nature is beyond the scope of this paper.

<sup>7</sup> I recognize that there is significant feminist literature that argues that some choices, which are based on desires that are formed from societal influence, are not autonomous choices. However, this is not the case for all choices made that are influenced by societal norms, so I will not address cases where autonomy is questioned regarding such choices.

she would be justified in making such a credible threat). In this case, an external entity has figuratively forced my hand, and this makes my choice non-autonomous.

It is important to understand what autonomy is and how it relates to the methods surrogate decision makers use to make proxy decisions. Understanding autonomy is essential because when a surrogate makes their proxy decision, respecting the incompetent person's autonomy is typically a fundamental value. Now that we understand what it means to be autonomous, I will now discuss what it means to respect an incompetent person's autonomy.

While both methods presented in this paper are designed to help the surrogate decision maker respect the autonomy of the incompetent person as much as possible, it is not always immediately apparent which view would be better at accomplishing that goal. Before we can try to determine which method is better, we must first understand how to respect an incompetent person's autonomy. Therefore, when I say that each method can be a tool to help the surrogate decision maker make their proxy decision in a way that best respects the incompetent person's autonomy, I mean that each view can help the surrogate decision maker incorporate and be influenced by the incompetent person's autonomously held desires and values while making their proxy decision. For a surrogate decision maker to respect the incompetent person's autonomy, their proxy decisions should not overtly contradict the incompetent person's autonomously held desires and values, and the proxy decision should at least be influenced by the incompetent person's autonomously held desires and values. For example, suppose a surrogate must make a proxy decision about the diet of an incompetent person. The surrogate knows that the incompetent person, when previously competent, was a die-hard vegetarian who constantly condemned meat eaters. In this example, for the surrogate to respect the incompetent person's autonomy, the surrogate should select a vegetarian diet for the incompetent person. However,

making decisions that respect an incompetent person's autonomy is not always as obvious as this.

One can understand the idea of respecting an incompetent person's autonomy as a scalar characteristic, as opposed to a binary one. A surrogate decision maker may weakly or strongly respect an incompetent person's autonomy, based on how many of the incompetent person's autonomous choices and desires they take into account when making their proxy decision. The more autonomous desires of an incompetent person that the surrogate takes into account, the more they are respecting that person's autonomy. However, there may be some situations where, at best, a surrogate can only mildly respect an incompetent person's autonomy. Therefore, we should not be concerned with whether either view can help a surrogate decision maker strongly respect the incompetent person's autonomy. Rather, we should be concerned with, when comparing both decision methods presented in this paper, which view will allow the surrogate decision maker to respect the incompetent person's autonomy *more*.<sup>8</sup>

Both views that will be presented later assist a surrogate decision maker to select proxy decisions that will respect the incompetent person's autonomy in different and distinct ways. The two views give different instructions on how a surrogate decision maker can respect an incompetent person's autonomy, but they both are based in the idea that a surrogate's proxy decisions cannot overtly contradict the incompetent person's autonomously held values and desires.<sup>9</sup> Because these two views provide different ways of respecting an incompetent person's autonomy, it seems that, in certain situations, one view may be more effective than the other at

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<sup>8</sup> It is important to note that this paper is only making a modest claim about respecting autonomy, as opposed to a robust conception of what it means to respect autonomy that might include rigid definitions of what it means to strongly or weakly respect autonomy.

<sup>9</sup> Consider both views to be tools to get the same job done, respecting an incompetent person's autonomy, but that one view may get the job done better, depending on the situation.

helping a surrogate decision maker respect an incompetent person's autonomy. If, given certain details, one can determine which method a surrogate decision maker should use to most effectively respect an incompetent person's autonomy in a given situation, then that view is better than the other view, in that specific situation.

Here and throughout the paper, when I say that one view is the "better" view, I only mean that the specific view is more effective than the other view at helping a surrogate decision maker select a proxy decision that respects the incompetent person's autonomy in the specific situation. If the surrogate can determine which view is better than the other, depending on the specific situation they are in, then they should make their proxy decision by using that view. Therefore, determining which view is better is a step in the procedure that ultimately results in the surrogate respecting the incompetent person's autonomy in the most effective way.

So far, I have discussed how the state is involved in surrogate decision making and what autonomy is and how to respect it. I will now move on to discuss competency and how the state is involved with determining competency. Having an understanding of what it means to be competent is necessary because to be able to discuss surrogate decision making, we must have a general idea of the kinds of people who have surrogate decisions makers, namely, incompetent persons.

A person is competent to make decisions when "her ends are those that a competent person would pursue, and... she is able to identify those courses of action that are sufficiently likely to achieve these (approved) ends" (Taylor 96).<sup>10</sup> Therefore, if a person makes decisions that other competent people in her situation would also choose, and those decisions have a reasonable likelihood of allowing her to achieve her goals, then she should be considered

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<sup>10</sup> It is important to acknowledge that there are some cultures and societies that have had/currently have a different understanding of what is required to be competent.

competent.<sup>11</sup> Thinking particularly about state determinations, the state often regards all adult people as autonomous and competent until the person is proven to be otherwise. In other words, an adult is competent in virtue of being an adult, and no one formally questions anyone else's autonomy or competency unless a judge has deemed someone incompetent in some capacity.<sup>12</sup>

If the state deems a person incompetent in relation to some kind of specific decision-making capacity, then the incompetent person will be assigned a surrogate decision maker to make proxy decisions for them.<sup>13</sup> But how does the state determine whether someone is incompetent or not?

One can observe the state deem a person incompetent if the person is making decisions that are not ones that other competent people would make in the same situation, or if the decisions that they are making cannot help them achieve their goals.<sup>14</sup> For example, suppose that someone questions a person's competency, and brings the matter before a judge. To show that the person in question lacks competency, someone else may provide as evidence the fact that the person in question constantly expresses interest in lighting herself on fire and believes that eating excessive amounts of gummy bears would achieve that goal. Evidence such as this may give the

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<sup>11</sup> I acknowledge the vague-ness of "reasonable likelihood", but to determine a rigorous understanding of how likely a chance a choice must have in achieving a person's goal to be considered "reasonable" is out of the scope of this paper. For the purposes of this paper, for a decision to have a reasonable likelihood of allowing someone to achieve her goals, the decision must provide a more likely than not chance of allowing someone to achieve their goals. I also recognize that vague-ness of "other competent people", as this implies that all competent people in the same situation would make the exact same decision. While I do not think this is the case, it is beyond the scope of this paper to discuss how similarly competent people in the same situation may make different choices.

<sup>12</sup> While there will be no formal questions of competency or autonomy, there may still be informal ones (e.g. someone questions their elderly parent's competency).

<sup>13</sup> While anyone can believe that anyone else is incompetent in some respect, a person can only be officially deemed incompetent by the state. There is a massive amount of philosophical literature regarding the qualifications a state should use to determine whether a person is incompetent or not, but to explore such literature is, again, beyond the scope of this paper. This paper is solely focused on the competence needed to make decisions regarding medical care. Furthermore, a person can be deemed incompetent by a judge in relation to specific decisions, and not others. A person could be found totally incompetent, or they could be found incompetent only in one or several aspects.

<sup>14</sup> For a more extensive discussion, look to James Stacey Taylor's piece *Autonomy, Competence, and End of Life*.

state reason to consider her incompetent. However, the act that a person chooses to perform may itself be foolish, but that does not necessarily mean that the foolish act will not help them achieve their goals. Therefore, simply performing foolish actions should not necessarily indicate to a judge that a person is incompetent. Furthermore, some people may just be odd. There are citizens who act in different ways than the “average” person would. While these people are outliers, simply being an outlier does not absolutely indicate that a person is incompetent in some respect.<sup>15</sup> For example, if a person chooses to eat a jar of mayonnaise for breakfast every morning, they may be labeled as “odd” by the average citizen, because this is not typical behavior. However, *ceteris paribus*, eating a jar of mayonnaise for breakfast every day does not definitively indicate incompetence. Eating a jar of mayonnaise for breakfast every day may be an indication of incompetence, but it is certainly not a conclusive reason to determine a person to be incompetent.

It is important here to remember that competency and autonomy are two separate characteristics. An incompetent person can have autonomous values and desires, as long as they were not coerced into adopting these values and desires. It may be argued that incompetent people do not have autonomy, but rather only preferences. Regrettably, to fully address such an objection is beyond the scope of this paper. It is worth mentioning, however, that it *may* be true that incompetent persons do not have autonomous values and desires, but rather only simple preferences. If that is true, and it is then further determined that others are not obligated to respect an incompetent person’s preferences, then being concerned about respecting an incompetent person’s current values and desires would cease to be a concern. Nonetheless, even if that were true, society’s current interest in respecting an incompetent person’s previously held

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<sup>15</sup> I recognize the ambiguity here, but to completely flush out what it means to be “odd” is beyond the scope of this paper.

autonomous values and desires would remain, and in cases where incompetent persons don't have previously held autonomous values and desires, then the well-being view would be applicable. Regardless, for the purposes of this paper, I take it for granted that incompetent persons can have autonomous values and desires, and I narrow my focus to those cases where patients really do have autonomous values and desires.

In this section, I have defined and explained several key terms and discussed how they are related to issues surrounding surrogates making proxy decisions for incompetent people. I have discussed the state generally and the process that one goes through when being appointed a surrogate decision maker. I have also discussed autonomy, competency and several conceptual issues related to each term. Now that I have provided the background knowledge necessary to understand the arguments made in this paper, I will move on to discuss the first of the two views presented in this paper, the substituted judgement standard.

### **3 PRIOR VALUES VIEW**

Before I begin this section, I must note that this view will be referred to in this paper by several names: the substituted judgement standard, the counterfactual view, and ultimately the prior values view.

Because many people consider respecting a person's autonomy to be a fundamental value, surrogate-decision makers usually try to make their proxy decisions for an incompetent person in such a way as to respect the incompetent person's autonomy, as best as they can. Here I stipulate this claim. Certainly, some surrogates might not have such a goal. Some surrogates might fail to pursue such a goal because of mistaken empirical beliefs or perhaps because of negligence or malice. However, it seems that typical surrogates would profess support for respecting a patient's autonomy as a key desideratum in making decisions.

Surrogates might draw on various heuristics when attempting to respect a patient's autonomy. Among the leading heuristics is the substituted judgment standard (SJS). "Substitute decision making is an attempt...to extend patient's control over their own healthcare after they can no longer exert direct control" (Pearlman 59). According to this method, "the person actually making the decision ("the surrogate" or "the proxy") should make that decision which the patient *would* have made if he or she *had* been competent" (Johansson/Brostrom 244). In other words, according to SJS, the surrogate-decision maker should make their proxy decision based on what they think the incompetent person would choose for themselves, not what the surrogate personally thinks is best (Pearlman 58-59). SJS is also often called the counterfactual view or method, and is often referenced as a view that rests on counterfactual wishes or desires.<sup>16</sup> The counterfactual view requires the surrogate decision maker to picture the incompetent person in a counterfactual situation, namely, that the patient is in the exact same medical condition, except that they are competent and are able to make decisions for themselves. A surrogate decision maker who uses this view will imagine that, for at least moment, the incompetent person becomes competent again. The surrogate decision maker would then try to figure out what the incompetent person would decide for themselves during that moment of regained competence. To do this, a surrogate decision maker should consider the patient's relevant past values and desires (assuming they can be known) and make their proxy decision for the incompetent person in a way that aligns with the incompetent person's previously held values and desires (Barnbaum 170-171). Because the surrogate decision maker takes the incompetent person's relevant prior values and desires into account, they should give priority to the incompetent person's advanced directive, if there was one. This means that the surrogate decision maker would make their proxy

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<sup>16</sup> Refer to Edward Wierenga's *Proxy Consent and Counterfactual Wishes*, Yujin Nagasawa's *Proxy Consent and Counterfactuals*, and Deborah Barnbaum's *Interpreting Surrogate Consent using Counterfactuals*.

decision in accordance to the incompetent person's advanced directive, if they have one. An advanced directive is a legal document where a person makes decisions regarding possible healthcare options in their future. These advanced directives "are invoked in the event that the patient loses [their] decision making capacity" (Tulsky et al 65).

The counterfactual view has been the subject of various objections. Some worry that the counterfactual view is not the best method a surrogate decision maker could use to respect an incompetent person's autonomy. Eric Vogelstein is one such philosopher. In his chapter called *Deciding for the Incompetent*, which is within the anthology *Ethics at the End of Life: New Issues and Arguments*, Vogelstein discusses several critiques and amendments to the counterfactual view. Vogelstein brings up two main objections to the counterfactual view. First, he describes Edward Wierenga's classic objection, which argues that the counterfactual view cannot accommodate instances when a person's values changes between the time that they become incompetent and the imagined counterfactual moment that they become competent again, which is the instance that a surrogate decision maker imagines when trying to figure out what the incompetent person would decide for themselves (Wierenga 409-412). It seems entirely possible that a person's competently held values and desires could change, so if the counterfactual view cannot account for that, that is a problem.

The second objection to the counterfactual view that Vogelstein discusses is argued for in a piece by Johansson and Brostrom. They argue that the counterfactual view cannot account for situations where a person would make choices in ways that go *against* their values and desires. Sometimes, "one's choice in the moment might reflect irrationality or weakness of will, and thus the choice one would have made might not be the right way to serve one's values and desires" (Vogelstein 114). For example, imagine a woman, Mary, who has been in a coma for

several years, but has just been pronounced brain-dead. When she was alive, Mary made it abundantly clear that she loved her son, Alex, more than anything else in the world, and she often vowed that she would do absolutely anything to help Alex. Mary is not registered as an organ donor, never expressed any desire to be an organ donor, and, when alive, expressed disapproval of the act of donating organs by describing the act as “unholy” and “unnatural”.

Suppose again that while Mary was comatose, Alex began suffering from liver failure that would eventually kill him if he did not receive a liver transplant. Now that Mary has been pronounced brain-dead, she could donate her liver to Alex and save his life. In this scenario, if one is to use the traditional understanding of the counterfactual view to make a medical decision on Mary’s behalf, one would assume that she would choose to not donate her organs, as this is in line with her goals and desire to not be an organ donor. But this action would conflict with Mary’s ultimate avowed desire to do anything for Alex, no matter what. In such a situation, it seems that using the counterfactual view would have the surrogate decision maker select a choice that goes against Mary’s ultimate goals and desires. Therefore, the counterfactual view seems unable to best respect an incompetent person’s autonomy.

In light of these objections against the counterfactual view, Vogelstein provides his own, more specific understanding of the counterfactual view in a way that can save the view from these two objections. He ultimately decides that the best account of the counterfactual view is to understand it as a surrogate-decision maker basing her decision on “*what [the patient], when last competent, would have chosen for herself in her actual, current situation, were she to have chosen in concert with her ultimate values and desires*” (italics and bold in original, Vogelstein 115). This new definition avoids the problems regarding situations where an incompetent person might change her mind regarding her values and desires and it also side-steps the problems that

arise when it is not clear if the incompetent person would choose in ways that go against her ultimate desires.

However, with this new account, Vogelstein believes that the counterfactual view becomes superfluous. When we understand it in this way, he suggests calling it the “prior values view” (Vogelstein 115). On the prior values view, “in order to respect the autonomy of an incompetent patient, we must treat that patient in concert with the values and desires the person had prior to becoming incompetent” (Vogelstein 115). The prior values view does not require the surrogate decision maker to imagine what the incompetent person would choose for themselves if they became momentarily competent. According to this method, a surrogate-decision maker would follow a patient’s advanced directive without hesitation. If the patient does not have an advanced directive, the surrogate decision maker should make their decisions based on the values and desires that the patient had before they were rendered incompetent and give little to no weight to the incompetent person’s current avowed desires. However, Vogelstein objects to his own new understanding of the counterfactual view, now called the prior values view. Indicated by its name, the prior values view privileges a person’s earlier autonomous self. As Vogelstein writes, on this approach “we can respect a person’s autonomy by honoring her *former* values—that is, the values that one used to have but no longer does” (Vogelstein 116). Vogelstein believes that privileging a person’s previous autonomous values is a problem because a person can change or lose their ultimate values and desires, either by choice or possibly by the same medical condition that causes their incompetence. If this is the case, then using the prior values view has surrogate decision makers selecting choices based on values and desires that the incompetent person no longer has.

Vogelstein also considers situations where a person simply ceases to have the same values and desires, without replacing them with contradicting values and desires. On page 117 of his chapter, Vogelstein provides an example of such a situation. Suppose that Jon wanted to have a single grey hair. Now, Jon no longer wants a single grey hair – in fact, he no longer understands the concept of grey hair. However, Jon’s friend Rachel has the ability to give Jon a single grey hair. If Rachel were to give Jon a single grey hair, would she be respecting his autonomy? Vogelstein believes that the intuitive answer is “no”- Rachel does not respect Jon’s autonomy if Rachel gives him the single grey hair, but his autonomy is also not disrespected by her not doing so. However, according to the prior values view, Rachel ought to give Jon a single grey hair because that desire is his former and most recent desire, as it has not been replaced with any conflicting desire. Based on these two objections, Vogelstein believes that the “rejection of precedent autonomy is a view worth taking seriously” (Vogelstein 117). And because the prior values view rests on the idea of privileging precedent autonomy, Vogelstein believes that rejecting the prior values view is also worth taking seriously. Ultimately, Vogelstein concludes that if using the prior values view to respect an incompetent person’s autonomy is invalid, “we ought to adopt the *current values view*” (Vogelstein 117).

Before I move on to discuss the current values view, it is important to mention that my discussion of SJS (also called the counterfactual view and the prior values view), is by no means a complete compilation of all of the philosophical literature on the view. The goal of this paper is not to analyze all scholarly work on SJS or to defend the theory from all objections posed against it. I only intend to provide a brief but thorough explanation of SJS so that my later critique of the

current values view is better understood.<sup>17</sup> I will now turn to a discussion of the current values view.

#### 4 CURRENT VALUES VIEW

A supporter of the current values view believes that, to best respect the autonomy of an incompetent person, a surrogate-decision maker must act “in concert with [the patient’s] *current* desires and values” (Vogelstein 117). To do so is to disregard any advanced directives that a person may have made and to ignore any previous values that a person used to have, and only focus on what the incompetent person wants at that exact moment.

Vogelstein offers two arguments in defense of the current values view. He begins his defense by arguing that incompetent people *may* competently hold desires and values that they are unaware of and incapable of basing decisions on. In other words, according to Vogelstein, an incompetent person can have some competently held views, but having these competently held views does not mean that the person is competent.<sup>18</sup> He calls these views dispositional views and says that they are views that are “unconscious—that is, not present in awareness—or is not currently operative—that is, it is not currently causing its characteristic mental or physical effects” (Vogelstein 117-118). So, an incompetent person may have some dispositional views that they are unaware of, and their current desires and wants may be influenced or rooted in these dispositional views. If their dispositional views are competently held, whether the incompetent person knows it or not, and these dispositional views are the cause of an incompetent person’s current desires, then, according to Vogelstein, the surrogate ought to respect an incompetent

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<sup>17</sup> For further discussions on the substituted judgement standard, look to Yujin Nagasawa’s “Proxy Consent and Counterfactuals”, Allen Buchanan and Dan Brock’s book *Deciding for Others: The Ethics of Surrogate Decision Making*, Edward Wierenga’s “Proxy Consent and Counterfactual Wishes”, and Deborah Barnbaum’s “Interpreting Surrogate Consent using Counterfactuals”.

<sup>18</sup> Vogelstein does not discuss how many competently held views an incompetent person needs to be considered competent, or whether this line of reasoning is appropriate or not for determining competency.

person's dispositional views by adhering to the current values view when making their proxy decisions. Vogelstein believes that incompetent people could have an abundance of dispositional views and that the only way to respect these competently held views is to use the current values view, as the current values and desires of an incompetent person may be manifested from dispositional views.

Vogelstein's second argument in defense of the current values view relies on the psychological view of personal identity.<sup>19</sup> This theory argues that what defines a person's identity is a continuity of their psychological features (Vogelstein 119). Based on this theory of personal identity, Vogelstein argues that when a person becomes incompetent, their psychological features can be altered so much that they are no longer the same person that they were before losing their competence. If this is the case, and the incompetent person has truly developed a new identity, then the best way to respect the incompetent person's autonomy is to use the current values view. To use the prior values view would be to allow someone who no longer exists make crucial decisions for a totally different human being. Surely this could not respect the incompetent person's autonomy because "one person's values and desires do not determine how to respect the autonomy of a different person" (Vogelstein 119).

Now that I have articulated the current values view, I will offer my critique of it.

## 5 CRITIQUE

My first objection comes in two parts and both are in regards to the idea of "dispositional views" – the competently held, "unconscious" views that incompetent people hold that influence and direct their current values and desires. I believe that this attempt at defending the current

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<sup>19</sup> It is important to note that this view is certainly not the only theory that attempts to define personal identity. There are many different theories regarding how one should understand identity, e.g. ecumenical theories.

values view is weak at best. First, it is not clear that incompetent people really do have dispositional views, and it is certainly unclear that *all* incompetent people, or even *most*, have such views. Furthermore, a main feature of dispositional views is that they are unconscious, meaning that the incompetent people who have them do not know that they have them. So, there is no way an incompetent person could tell anyone else that they have dispositional views, because if they knew that they had these views and could articulate them, then the views they would be discussing are no longer dispositional ones by virtue of the incompetent person being able to discuss them. Furthermore, if dispositional views are views that an incompetent person cannot consciously act from, then 3<sup>rd</sup> parties cannot even observe an incompetent person's behavior and then infer something about their dispositional views, as a person's behavior does not always stem from some deep, unconscious, belief. In other words, while we can observe an incompetent person's behavior, we cannot simply assume that it is rooted in a dispositional view. Therefore, incompetent people cannot inform others of their dispositional views and others cannot infer anything about an incompetent person's dispositional views based on their actions, so it seems as though we have no way of knowing if incompetent people have dispositional views at all. If this is true, then basing the support of the current values view on the possibility of dispositional views seems problematic, as we have no way of knowing if dispositional views exist. This is because the current values view would be used by surrogate decision makers to respect the incompetent person's autonomy, but the use of this view would be based on several assumptions: that dispositional views even exist, that all or even most incompetent people have them, and that dispositional views *actually* influence an incompetent person's current desires and values. It seems unreasonable to me to base the use of the current value view on several large and highly questionable assumptions.

Second, it is unclear how the current values view truly respects these dispositional views. If dispositional views are unconscious views that an incompetent person does not consciously base decisions on, then it is unclear to me how these dispositional views can influence how an incompetent person behaves. In other words, while it seems possible to me that an incompetent person has dispositional views, I worry about the claim that these views actually influence or impact their lives in any way – almost like a freckle deep inside your eye; something that exists inside you that you are unaware of and that does not influence your decisions in any way. And, if dispositional views do not necessarily influence the decisions that an incompetent person makes, then I do not see how the current values view best respects dispositional views. For example, it seems perfectly coherent to imagine an incompetent person who has a dispositional view that would normally influence one to seek out opportunities to participate in the activity of bird watching. However, for this particular incompetent person, this dispositional view does not influence their behavior at all. Because this view is an unconscious view (one that the incompetent person is unaware of) that the incompetent person cannot base decisions on, and the view does not influence the incompetent person's behavior, the incompetent person says that they do not enjoy being outside, they dislike nature, and they find birds to be generally aesthetically displeasing. In this case, it seems like acting from the current values view and not taking the incompetent person outside goes against their dispositional views and therefore does not respect them. After all, a surrogate wouldn't know that the dispositional view exists, and the surrogate would be making proxy decisions in alignment with the incompetent person's wishes (so they think), because the incompetent person expresses the desire to not be outside, but again this expressed desire is not rooted in the incompetent person's dispositional view. If the conclusion from my example is correct, then it seems like sometimes, even if incompetent

persons have dispositional views, attempting to respect them by using the current values view does not always work. I therefore find this defense of the current values view to be lacking. At best, this defense shows that using the current values view can respect an incompetent person's dispositional views *sometimes*.

My second critique refers to Vogelstein's use of the psychological view of personal identity. He argues that when a person becomes incompetent, their psychological features can be altered so much that they are no longer the same person that they were before losing their competence and therefore to make proxy decisions based on the incompetent person's previous wishes is like allowing someone who does not exist anymore make crucial decisions for a different person. While I find that this argument is the strongest argument in favor of the current values view, I do not think it is as strong of an argument as Vogelstein thinks it is. For the sake of my argument, let us assume that the psychological view of personal identity is correct. On this view, a person's psychological characteristics can change so much that the person develops a new identity and their old identity ceases to exist.<sup>20</sup> Even if it is possible that a person can become so incompetent that they truly transform into a new person (i.e. the person who they were before losing their competency no longer exists and a new person has come to take the previous person's place), this surely does not happen *every* time a person becomes incompetent. Sure, losing competency may change a person, perhaps even significantly, but simply changing is not the same as developing a new identity. After all, each of us changes continuously but can remain the same person. Furthermore, if someone is rendered only partially incompetent, it seems even *less* likely that the person has become a new person. If this is the case, then only sometimes will someone become a new person as a result of losing their competence. And if this

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<sup>20</sup> I acknowledge that this assumption bypasses the philosophical argument of how best to understand personal identity.

is the case, then the current values view will only best respect an incompetent person's autonomy *sometimes*, in these very specific situations. If a person has become incompetent, but has maintained their personal identity, there seems to be no reason to think that the current values view would be better at respecting their autonomy than the prior values view. I therefore conclude that of the two views I have discussed, the current values view is the best method at respecting an incompetent person's autonomy *only* in situations where the incompetent person has become a new person, due to significant changes in their psychological features. In most other situations, it seems as though the prior values view will be better at respecting the incompetent person's autonomy than the current values view. Therefore, each situation must be individually evaluated to determine what method a surrogate-decision maker should use to best respect an incompetent person's autonomy, as it must be determined whether the incompetent person has developed a new identity or not. These individual evaluations would involve things such as determining the incompetent person's previously held autonomous values and desires, determining the incompetent person's current values and desires, and determining whether the incompetent person has changed so much that their previous identity is gone and they have developed a new identity.<sup>21</sup>

In this section, I have offered my critique of the current values view. Now that I have explained and offered my critique of situations where an incompetent person's previously held autonomous values and desires are known, I will now briefly discuss another type of situation where surrogate decision makers are needed to make proxy decisions.

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<sup>21</sup> It is important to note that this is not meant to be an exhaustive list of what needs to be done when evaluating a situation where a surrogate decision maker needs to make a proxy decision. I am only beginning to indicate the relevant criteria is.

## 6 WELL-BEING VIEW

Up until now, this paper has only focused on situations where the incompetent person's prior values can be known. However, this does not account for all situations that require a surrogate decision maker. There are some situations where an incompetent person's prior values are not known, simply because the evidence is lacking. There are other situations where a person has never been competent, and they therefore have no prior competently held values and desires to base decisions from. In these situations, "the standard view is to act based in the patient's *well-being*, taking into account those aspects of well-being that would apply to most people, such as pleasure and the absence of pain, mobility and independence, cognitive and communicative ability, and so forth" (Vogelstein 120). When an incompetent person's prior values cannot be known (or have never existed), it seems as though a surrogate is unable to use the prior values view, simply because they cannot reference the incompetent person's prior values. This means that surrogates in these situations can only use the current values view, assuming the incompetent person is conscious and has views they express, or the well-being view. It is beyond the scope of this paper to offer a thorough analysis of which view might be better in situations where an incompetent person's prior values cannot be known. I only discuss these situations to give the reader more context surrounding the issues of surrogate decision making.<sup>22</sup>

## 7 CONCLUSION

Respecting autonomy seems to be a fundamental value in many contexts of medical decision making. However, there is some debate about what method a surrogate-decision maker should use to best respect an incompetent person's autonomy. In this paper, I have presented two

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<sup>22</sup> For further discussion of this view, look to Allen Buchanan and Dan Brock's book *Deciding for Others: The Ethics of Surrogate Decision Making*, or Erica Stonestreet's article "Love as a Regulative Ideal in Surrogate Decision Making".

possible methods: the prior values view and the current values view. In situations where the incompetent person's prior values can be known, I have argued that in cases of surrogate decision making, proxies better respect an incompetent person's autonomy when using the current values approach only in very specific cases where the loss of competence has rendered someone an entirely new person. In all other cases, I believe that the counterfactual view provides a better basis for respecting an incompetent person's autonomy. Therefore, all cases that require a surrogate-decision maker must be evaluated on an individual basis, so that the best method for respecting an incompetent person's autonomy can be used.

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