

Respect for *Rational* Autonomy

ABSTRACT. The standard notion of autonomy in medical ethics does not require that autonomous choices not be irrational. The paper gives three examples of seemingly irrational patient choices and discusses how a rational autonomy analysis differs from the standard view. It then considers whether a switch to the rational autonomy view would lead to overriding more patient decisions but concludes that this should not be the case. Rather, a determination of whether individual patient decisions are autonomous is much less relevant than usually considered in determining whether health care providers must abide by these decisions. Furthermore, respect for rational autonomy entails strong positive requirements of respect for the autonomy of the person as a rational decision maker. The rationality view of autonomy is conceptually stronger than the standard view, allows for a more nuanced understanding of the practical moral calculus involved in respecting patient autonomy, and promotes positive respect for patient autonomy.

Despite much disagreement over the precise role and significance of the principle of respect for autonomy within medical ethics, the claim that there is a general moral requirement to respect patients' autonomous choices is little disputed. The specific details of that requirement are determined as much by the concept of autonomy at work as by the context and manner in which the principle is applied. Yet there is less conceptual debate about autonomy within the medical ethics literature than this fact calls for.¹In this paper, I contrast the standard view of autonomy in medical ethics with a view that requires that autonomous choices not be irrational. This modification of the view of autonomy is highly significant, both conceptually for the view of autonomy, and practically for the principle of respect for autonomy. Conceptually, it allows one to classify a range of seemingly nonautonomous decisions *as* nonautonomous—in contrast to the standard view—and to understand the reason for that

classification as stemming from errors in a process of self-determination. The practical significance is quite different from what might be expected. Rather than offering a more strict interpretation of which choices ought to be abided, my interpretation of the rationality view of autonomy helps one to understand why focusing on the autonomy of specific choices in medical ethics often is misguided.²

In the first section of the paper, I discuss both the standard view of autonomy and the rationality view. Next, I present three cases that seem conceptually problematic for the standard view of autonomy. Following a discussion of these specific cases, I address issues about the practical application of the rational autonomy view. I conclude that, since the rational autonomy view has some significant normative and conceptual benefits, it may be time for a shift in the medical ethics perspective on autonomy.

VIEWS OF AUTONOMY

The Standard View

Unfortunately, there is often little explicit discussion of what is meant by “autonomy” or “respect for autonomy” in the medical ethics literature. Generally speaking, autonomy is seen as a matter of individual self-determination on the basis of one’s own values and goals. Yet, a more specific account will help to set the stage for a contrast with rational autonomy. Fortunately, for this purpose, there is a view of autonomy that is generally accepted as the paradigm view within medical ethics. This is the view in Tom Beauchamp and James Childress’s (2009) *Principles of Biomedical Ethics*, now in its sixth edition.³

In this work, autonomy is characterized as, minimally, “self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice” (Beauchamp and Childress 2009, p. 99). Autonomous action is further analyzed “in terms of normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action” (p. 101). Although intentionality does not admit of degrees, the second and third conditions do, and so “actions therefore can be autonomous by degrees” (p. 101). Nor should an action be considered autonomous only when it fulfills the highest standard of autonomy. “For an action to be autonomous . . . it needs only a substantial degree of understanding and freedom from constraint” (p. 101). Diminished autonomy, on the other hand, occurs when a person, “is in some respect controlled by others or incapable of deliberating or acting on the basis of his or her plans” (p. 99).

Rational Autonomy

There is no general requirement that actions and choices be rational on Beauchamp and Childress' view of autonomy nor is such a requirement usually appealed to in discussions of autonomy within the medical ethics literature.⁴ The view I focus on requires that autonomous choices not be irrational.⁵ As will be elaborated, irrational choices evidence certain types of errors in the process of self-determination or self-rule and thus, with respect to rationality, the view of autonomy I discuss does not admit of degrees since a lack of irrationality is a threshold criterion for autonomous choice. However, to leave open the possibility of autonomous nonrational choice, the requirement discussed here is intentionally phrased in the negative—i.e., that autonomous choices not be irrational, although I refer to the view in general as the “rational autonomy” view. I also remain neutral about what else may be required for a choice to count as autonomous. For example, some hold that autonomous choices must be authentic, and, less often discussed, that such choices must instantiate some level of emotional maturity. Thus what I am calling the “rational autonomy” view simply requires that whatever other criteria are necessary for autonomy, the choice also must not be irrational. In this section, I describe some aspects of rationality that are particularly germane for health-related decision making and then consider why rationality should be considered a requirement of autonomous choice.

Rationality is a norm governing reasoning both about what to do (practical rationality) and about what to believe (theoretical rationality). Clearly these types of reasoning are closely connected, as reasoning about what to do relies in many ways on what one believes. Likewise, one's beliefs may be influenced by one's aims or goals in acting. However, in so far as each type of reasoning is oriented to a different type of problem—e.g., “what is there evidence for?” versus “what do I care most about?”—it may be helpful to distinguish them for illustrative purposes.⁶ As employed in this paper, the distinction between theoretical and practical rationality simply helps to introduce various ways in which irrational choice might occur in health-related decision making. In particular, the distinction does not necessarily bear any weight in a determination of whether overriding irrational decisions is morally justified. However, there may be other important practical implications, for example regarding how to address the source of the irrational decision when promoting positive respect for autonomy. I shall return to these points about positive respect for autonomy and whether health care providers can be justified in overriding irrational deci-

sions in the final section of the paper. In the rest of this section, I provide a brief description of theoretical and practical rationality as relevant to health-related decision making and then consider why rational choice is important for autonomy.

Theoretical Rationality

In terms of a skill set, theoretical rationality involves forming and supporting beliefs by drawing logical conclusions from accepted propositions, inferring proper implications from matters of fact, and substantiating claims with supporting argument. With respect to substantial norms of rationality, it is uncontroversial that theoretical rationality requires one to hold largely coherent beliefs or sets of beliefs. So if I believe that (1) an aspirin is likely to cure my headache and that (2) I am holding an aspirin pill in my hand, then if I am theoretically rational, I ought to believe that the pill I am holding in my hand (*other things being equal*) is likely to cure my headache. In contrast, it would be irrational to believe 1 and 2 and yet deny the conclusion. Thus if I choose not to take the pill *solely on the grounds* that I do not believe this pill is of a kind that will cure my headache, I choose irrationally.

Theoretical rationality also pertains to the ability to draw general conclusions from experience or knowledge of particular instances. So if I have knowledge that past accumulated evidence shows that every collection of colonic polyps of a specific type (call it CPM) will become malignant if left untreated and I believe that Mr. Q has a collection of colonic polyps of type CPM, then I should reason that these will also become malignant if left untreated. It at least would be theoretically irrational to *deny* that these polyps will become malignant without any further reason for that denial.

Another area of theoretical rationality that is significant for health care is the ability to reason based on probability and statistics. For example, it is irrational to accept that a surgery has only a 25 percent chance of success, but not to accept that it also has a 75 percent chance of not succeeding.

Practical Rationality

While theoretical rationality addresses belief, practical rationality addresses the means taken to achieve one's ends or goals and which ends one should pursue. Among the ends that people have or choose, some will be contingently true of the person while others may be necessary. For example, having the goal of losing 10 pounds may be a contingent

fact about James who is 6 feet tall and within a “medically ideal” weight range. There is nothing necessarily irrational or rational about the goal itself. Rather, practical rationality becomes relevant in the means James uses to achieve this goal and in the willing of these means. If James tries to lose 10 pounds by increasing his overall calorie consumption (and making no other changes in his lifestyle), he is acting irrationally (assuming, of course, that he knows the facts about the relationship between calorie consumption and weight gain). It is also practically irrational to will a goal but not to will the means required to achieve this goal. If James truly wills the goal of losing 10 pounds, but does not will the means (such as eating fewer calories and/or engaging in additional physical activity), his will is practically irrational.

Other goals or ends may be rationally necessary or prohibited for us as human beings. If there are ends like this, then simply failing to recognize and choose in accordance with these requirements may constitute a kind of irrationality. An example of a necessary goal may be happiness or at least “living well.” Although there is dispute about whether any ends are rationally prohibited, having the goal of self-destruction, for example, seems *prima facie* irrational.⁷ One may be perfectly rational in understanding and willing the means to the end of self-destruction, but if the goal itself is irrational, one would be acting irrationally in pursuing this end.⁸

Rationality and Autonomy

Choices that are irrational evidence an error of either practical or theoretical reasoning (or both). There is no disagreement on this point. However, there is disagreement about what makes a choice, or the belief or intention grounding a choice, irrational. With regard to practical reason, at one end of a spectrum there might be a view according to which immoral intentions are necessarily irrational. At the other end, only choices for which there is a direct failure of means-ends reasoning with respect to immediate goals might count as irrational. With respect to theoretical reason, one might hold that only consistency between presently held and “actively considered” beliefs is required or one might hold that theoretical reason requires that one hold only beliefs that are in keeping with “best evidence” among other desideratum. The best view of rationality for practical purposes, such as use in medical ethics, is one that is both well supported and can be agreed upon fairly widely. I imagine such an understanding will fall closer to the less demanding end of the spectrum, and I have chosen examples to illustrate the rational autonomy view that

are largely consistent with that expectation. However, I do not argue for any particular substantive notion of rational belief or intention. Rather, the suggestion is that, on most plausible views about what rational beliefs and intentions are, decisions that count as irrational because of failure in these regards will also fail to be autonomous.⁹

So why think it is a requirement of autonomy that a choice not be irrational? At the outset, one must be clear about the relationship between rationality and autonomy. The claim is not that rationality is itself necessarily what contributes to the autonomous nature of one's choices—i.e., it is not a claim that the rationality of the choice necessarily makes for the autonomy of a choice, although it could.¹⁰ Rather, the claim is that a lack of irrationality is a desideratum of a choice counting as autonomous. In this way, the rationality requirement plays the type of role that Beauchamp and Childress give to a lack of “control” of a choice. However, unlike a lack of control, which I have argued elsewhere is not plausibly a desideratum of autonomous choice (Walker 2008), a lack of irrationality is plausibly such a desideratum.

On the rationality view of autonomy, irrational choice is inconsistent with autonomous choice on the straightforward grounds that choosing irrationally is choosing on the basis of an error—either of belief grounding the choice or in the intended end of action or in the selection of the means to that end—and thus is inappropriate grounds for self-determination. Choices that are autonomous evidence the determination of the self by itself. If a choice is made as the result of a rational error, it is less a result of “self-determination” and more like choices that can be attributed to external or internal compulsion. In this case the issue is not necessarily one of compulsion, however, but rather a misalignment between the will—or whatever feature of the self to which one wants to attribute self-determining action—and the choice at issue.

If one thinks of choices made on the basis of rational error—either founded on irrational beliefs or failing to be appropriate to the ends of action—as autonomous then it is not clear why one should think of any other kind of problem with self-determination as interfering with autonomy. It is even plausible that choices made on the basis of rational error are more clearly nonautonomous than choices that are made on the basis of coercion. Choices made as a response to coercive measures are choices that a person makes in response to difficult external circumstances and are in a sense autonomous—they are self-determined albeit in unfortunately

constrained circumstances. When a person makes an irrational choice, he aims at something that is not possible to gain with his actions or in some other way makes a mistake in the process of self-determination.

If irrational choices result from errors in a process of self-determination, why should one necessarily consider them nonautonomous? To see why, consider the significance of information for autonomous choice. There is wide agreement that obtaining information adequate to a particular medical decision—e.g., of probable outcomes with or without treatment—is crucial to supporting the autonomous quality of those decisions. But the information itself is not what allows the patient to make an autonomous decision. Rather, it is how that information is processed and applied as relevant (or not) to a patient's goals in seeking medical care—or how the information results in, or relates to, a particular set of beliefs regarding treatment—that is important in supporting autonomous decision making. Thus, if the information is important to autonomous choice it is important in so far as it contributes to a patient's decision-making process.¹¹ Where that process breaks down because of rational error, the information itself serves no separate utility—its value depends on its proper employment. If this were not the case one would not qualify the necessity of information as information “adequate to” the patient's decision.

Which information a patient needs in order to make an autonomous decision depends in part on what her goals are in seeking treatment, and by the same token, when that information is mistakenly applied to those goals, it no longer serves to support autonomous decision making. Indeed, in this sort of case the information has, in a sense, become “mis-information.” In short, irrational choices are no more plausibly autonomous than uninformed or misinformed choices, but there is little dispute that information adequate to a decision is required for autonomous choice, thus it is hard to see how there could be any greater dispute that a lack of irrational application or interpretation of that information is also required.¹²

The point I have been emphasizing is that, as long as one understands irrational choice as resulting from error in the formation or maintenance of beliefs or intentions leading to that choice, then this is also error that occurs in the process of self-determination. It is at least as reasonable to view errors affecting the process of self-determination as undermining the autonomy of a choice as it is to view lack of information or presence of misinformation, or other external constraints to autonomy—such as coercion—as undermining the autonomy of a choice. If one agrees that autonomy is “self-rule that is free from both controlling interference by

others and from limitations, such as inadequate understanding, that prevent meaningful choice” (Beauchamp and Childress 2009, p. 99), then I think one must see irrational decision making as a core limitation that prevents meaningful choice. As illustrated by the following examples, it is a limitation that cannot be subsumed under the other features of the standard view of autonomy.

THREE CASES: AUTONOMOUS OR NOT?

In this section, I present three cases that seem problematic for the standard view of autonomy. On the standard view of autonomy each patient’s decision would count as autonomous, yet they do not seem to be autonomous. On the rationality view of autonomy, none of the decisions are in fact autonomous. The examples, which highlight both refusals of and a request for treatment, illustrate cases of both practical and theoretical irrationality.

Lackluster Jim

Twenty-nine-year-old Jim has been called into his doctor’s office for a consultation about some test results. Jim is told that he has aggressive colon cancer but that with immediate surgery and follow-up therapy his chances of recovery are extremely high. Jim thanks his doctor for the information, but says that he is not interested in treatment. His doctor is surprised and emphasizes that delay in treatment will cut Jim’s chances of survival significantly and that failure to act will mean a death sentence in less than one year. Jim remains steadfast in his refusal. When the doctor presses further, Jim admits that he has lost his taste for living and thinks that the cancer is rather fortuitous given his independent wish to die. He has been engrossed in reading existential philosophy and has come to see living as a moment-to-moment choice. He is not willing to make the choice to live in this moment, and predicts that the same will hold true as long as he is engaged in his reading project. Jim’s doctor asks him to undergo a psychiatric examination, to which he agrees willingly. The next day, the psychiatrist reports that Jim’s only apparent psychiatric abnormalities are his wish not to continue living and his strong tendency to be influenced by other people’s ideas. The psychiatrist is tempted to call Jim’s wish not to live a “phase” and assures the doctor that Jim is not suffering from depression. All indications suggest that Jim will most assuredly “grow out” of this phase and reacquire his will to live in six months or so. As it turns out, Jim predicts the same thing, yet he is at this time unwilling to choose treatment.¹³

Exceptional Maureen

Maureen has been diagnosed with HIV/AIDS and her doctor recommends an aggressive medication regimen. Maureen's doctor explains that Maureen's chances of continuing to live a relatively normal life for at least the next 10 years are very high with this regimen, but that the chances of death within 10 years from her disease are quite high without it. Maureen considers her doctor's advice carefully but refuses the medication. Surprisingly, Maureen tells her doctor that since she will either die or not in the next ten years, the statistical chances of survival with and without treatment are not really relevant to her. Given this perspective, Maureen does not see why she should bother with all of the pills and doctor visits. The doctor carefully explains why the statistical information is relevant to Maureen's case. Maureen seems to have no trouble understanding the relevant principles of statistics and how this information applies to individual rates of disease, yet she does not accept the doctor's claim that this information is relevant to her own decision. Instead, she sees herself as "either living or dying" in the next 10 years and although the disease could be what kills her she "could get struck down by lightning too." In other words, she continues to view her chances at life as "on" or "off" in a way that keeps her from adequately applying the statistical evidence presented to her.

Insistent Ivan

Ivan has been diagnosed with advanced brain cancer. His doctors explain to Ivan that in his condition he is likely to continue living for another year with relatively little discomfort and likely will deteriorate rapidly after that, undergoing relatively little pain overall. His chances for survival past a year are about one in ten. The cancer is so advanced that it is inoperable, and the radiation that would be required to kill the cancer almost certainly would kill Ivan first. Moreover, with radiation treatment his life expectancy and quality of life would be dramatically lessened as he could expect to become very ill quite quickly. With surgery or radiation, Ivan is told that his overall chance of immediate survival is vanishingly small, and if he does survive the treatment, his longer-term chances are no better than without treatment because of the aggressive way in which this particular type of cancer recurs. In short, although the doctors are loath to do nothing, they feel that in Ivan's case it is definitely best. To their surprise, however, Ivan disagrees and insists on surgery and,

if he survives the surgery, aggressive radiation treatment. After speaking with Ivan more, his doctors learn that Ivan feels that doing nothing is the same as just giving up. Although Ivan is not a religious man in general, he always has lived by the motto that God only helps those who help themselves. If Ivan fails to pursue aggressive treatment, he feels that he will not have earned the “miracle” that it would take to keep him alive as long as possible.

Standard Analysis

Under the usual understanding of autonomy in medical ethics, Jim, Maureen, and Ivan’s choices should count as autonomous. All three patients are normal decision makers who choose intentionally, with understanding, and without controlling influence.

It might be argued that Jim is not competent and that therefore his decision is not autonomous because he is not, in this context, a “normal decision maker.” In some cases, clinical depression might be thought to undermine competence. However, although his friends generally characterize him as “morose,” Jim’s only psychiatric indication of depression is his wish not to live. This wish on its own is not enough for a diagnosis of clinical depression. Moreover, there is no good reason to think a preference to stop living itself should count against Jim’s competence. Jim seems to understand fully the implications of forgoing treatment, and his choice is freely made. Making a declaration of incompetence simply because one disagrees with a patient’s particular choice undermines the point of a determination of competence. For this decision-making power to be meaningful, determinations of competence and incompetence must be established independently of the specific decision at issue.¹⁴

Although it seems clear that Maureen is not properly applying the relevant statistical information to her own case, her decision also should count as autonomous on the standard view. Although autonomous decisions are only possible when the patient is both informed of the relevant medical information and also understands that information, these conditions are met in Maureen’s case. She *understands* the information but does not accept the relevance to her own case.

Yet it could be argued that this is precisely a problem with understanding. According to Beauchamp and Childress’s view, conditions that can limit understanding include problems processing information, such as information overload and framing effects, nonacceptance of relevant information, and false beliefs about one’s condition despite evidence to

the contrary (Beauchamp and Childress 2009, pp. 129–31). One might plausibly claim, then, that Maureen’s failure to apply the statistical information to her own situation is evidence of her nonacceptance of relevant information and therefore reveals a failure of understanding.

However, although I agree that Maureen’s failure to properly apply the statistical information to her own case is evidence in some sense that she does not adequately accept this information, I disagree that this therefore reveals a failure of understanding. To see why, consider that the hypothetical case could stipulate simply that Maureen does understand the relevance of statistics to her own case in the everyday sense of “understand.” That is, she comprehends the statistical information presented and how this information relates to individual rates of disease. Yet, at the same time, she does not apply this information to her own situation in a way that leads her to accept it as relevant to her decision making. Contrary to Beauchamp and Childress’s claim regarding conditions on understanding, I think it is highly implausible that understanding actually requires adequate acceptance. Consider first whether acceptance is required for understanding. Some people understand the theory of evolution, but do not thereby accept it. There may be some conceptual truths that cannot be understood without also being accepted, but surely the kind of medical information under discussion is not of this type. Still, there is a colloquial use of the term “understand” as a synonym for “accept” that Beauchamp and Childress might be trading on. Sometimes when people disagree, one might say, “You just don’t understand what I’m saying.” But if this is the sense of understanding meant, then it is surely too strong a requirement for autonomy. Decisions may be made autonomously without the agent accepting the truth of all relevant medical information.

Of course, on Beauchamp and Childress’s view, understanding does not need to be complete for the relevant choice to be considered autonomous, but simply adequate to the case (Beauchamp and Childress 2009, p. 127). So, perhaps Maureen needs only an “adequate” acceptance of the information presented to have understanding sufficient for autonomy on their view. However, it is often difficult to determine what counts as sufficient or adequate understanding. Maureen understands the relevant principles of statistics and how the information presented applies to individual rates of disease. Maureen also understands both her doctors’ advice and the rationale behind it. Furthermore, Maureen understands both what would be involved in taking the medication and what is involved in the progression of her illness. If Maureen’s understanding is still not adequate, it is for the

sole reason that she irrationally fails to apply the statistical information to her own case. It is the *irrationality* of the decision that is the guiding principle here, not the question begging supposition that she must accept information “adequate” to making an autonomous decision. My concern, then, is that Beauchamp and Childress’s view of “understanding” either incorporates a “back-door” requirement of rationality that does not fit well with a more common sense notion of understanding or else does not account for cases of irrational belief like Maureen’s.

Given the dire prognosis that he is faced with, Ivan prefers that he and his doctors act aggressively rather than not act, and he prefers this despite the fact that action offers a significantly lower overall chance of survival. Ivan’s choices seem to be autonomous under the standard model, as they reflect Ivan’s own values and ideals despite the fact that they do not represent his best interests in terms of overall chances for survival.

Indeed, it is probably easy for us and for his doctors to understand Ivan’s reaction. Given the dire prognosis, it would be difficult for anyone simply to sit by in the hopes that they will be one of the lucky 10 percent to survive more than one year. The psychological appeal of action makes sense, but does not change the fact that his chance of survival with intervention is radically less with treatment than without. Perhaps, then, the problem with Ivan’s choice is one of “controlling” influence in the form of an internal compulsion to act when faced with such difficult news. Ivan feels, after all, that he needs to act because God only helps those who help themselves. Yet there is nothing about the case that *requires* that Ivan’s choice is driven by a compulsion that rises to the level of “controlling influence” necessary to undermine autonomy.

Of course, under the standard view of autonomy, the fact that the patients described in the above cases make autonomous choices does not necessitate that the doctors act in accordance with the patients’ wishes. Since the principle of respect for autonomy creates a *pro tanto* obligation, the fact that a decision is made autonomously does not necessarily determine the proper moral response.¹⁵

Jim and Maureen’s cases, for example, would present instances of conflict between the principles of respect for autonomy and beneficence. Beneficence seems to require that the doctors act in Jim’s and in Maureen’s best interests, even if this means acting against their wishes. Respect for autonomy, on the other hand, requires respecting their wishes to avoid treatment, even if this means failing to act in their best interests. Which principle “wins out” in the standard model is a matter of specifying the

requirements of the principles in context and (potentially) balancing them against one another.¹⁶

Under the standard view of respect for autonomy, at least three kinds of reasons could be given for refusing Ivan's request for treatment. First, a doctor's duty to avoid doing more harm than good is inconsistent with operating on Ivan since the operation is both very dangerous and medically contraindicated. Second, spending the time and resources on Ivan's procedure seems to represent an illegitimate distribution of medical resources and so would counter the principle of justice.¹⁷ Third, weighing against acting on Ivan's request is a *generally* accepted precept that duties of noninterference are stronger than duties of assistance.

Rational Autonomy Analysis

I have argued that under the view of autonomy that is most commonly accepted within medical ethics, Jim, Maureen, and Ivan's decisions should be interpreted as autonomous, and yet the question of whether to abide by these choices would remain. The decision about whether to abide by the patients' various choices would be determined, at least in large part, by balancing a specified notion of respect for autonomy in the individual case against a similarly specified principle of beneficence, nonmaleficence, or justice as appropriate. The problem is that this sort of normative analysis of the cases starts with a faulty assumption since something has gone wrong with these patients' self-rule, or autonomy, in the first instance. In contrast, on the rationality view of autonomy, Jim, Maureen, and Ivan all make nonautonomous decisions because they manifest various forms of irrationality. Yet, as discussed in the next section, even if their choices are nonautonomous, it does not necessarily follow that they should be overridden. Thus, the moral calculus involved in determining the proper response in each case is not one of balancing respect for the autonomy of the individual choices against other specified moral principles. Before this discussion, however, I briefly analyze each choice according to the rational autonomy view.

In what way are these patients' choices irrational? Maureen's choice exhibits impaired theoretical rationality, specifically with respect to the ability to reason using statistical information. Although she understands the principles of statistics as they apply to the general population, and indeed how this information relates to individual rates of disease, she still fails to apply the statistical information properly to her own case. It is true that for any individual, general statistical information may not be

particularly helpful. Some facts impact appropriate care for individuals but cannot be accounted for in statistical information about patients in general. Furthermore, although in some cases the probability of efficacy for a treatment is spread fairly evenly in a population, in other cases it may cluster in a subgroup that cannot be identified in advance of the attempt to treat. In that case, if patient P is one of the people taking the medication without likely benefit, P has the hassle and potential side effects and no benefits. But Maureen's case, the chance that she will be helped by the medication is in fact extremely high. Thus, although it is true that she will either die or not in the next 10 years, it is not true that the statistical evidence that the medication will help her is irrelevant to her prospect for survival.

Jim's rational failing may be located either in the content of his ends, or in the means to those ends, depending on the interpretation. One could argue that Jim's wish to die is itself irrational, since self-preservation is a necessary, rather than a contingent, end of rational human life. Thus, Jim would have an irrational end, but given that end, would be rational in the means he chose to achieve it. Alternatively, one could argue that continued life is Jim's own more stable end despite the fact that he currently does not endorse it. Because Jim consistently has had the goal of continued life in the past and would continue to have this goal in the very near future if he lives (as Jim himself agrees is the case), his choice at this moment is inconsistent with pursuit of his own more stable end as an individual persisting through time.

Of the examples I have given, Jim's choice is the most controversial with respect to whether it is in fact irrational. If one endorses a view of rationality according to which only belief coherence and means ends reasoning with respect to immediate preferences or goals is required, then his decision will not count as irrational. However, a view of rationality that endorses no constitutive ends and that does not take into account the stability of a person's ends or goals over time seems too thin to account for generally accepted norms of reasoning.¹⁸ In either case, what matters for the claim in this paper is not really whether Jim's choice is irrational, but the tight connection between whether it is irrational and whether it is autonomous. In other words, the deliberations over whether Jim chooses rationally are, in part, also deliberations over whether his choice is autonomous.

Ivan's request for the surgery despite the significantly reduced possibility of survival when compared with no intervention, is a request inconsistent with his own endorsed end. The aim of Ivan's choice (longer life) is a

perfectly rational end, however, since the means that he intends to take to reach this end are in fact contrary to furthering this end, choosing these means is irrational. Since Ivan will be more likely to achieve his end by not having the surgery or radiation, this is the most rational course of action.

These cases present examples of intuitively nonautonomous decisions based on irrational beliefs and/or intentions. Their role in this paper is to offer an exposition and analysis of the types of cases that could be considered nonautonomous on the rational autonomy view in contrast to the standard view of autonomy in medical ethics. Still, there are other relevant types of cases that have not been discussed here—e.g., some kinds of weakness of will—that may be more compelling to some. Further, my claim in this paper does not rely heavily on agreement with whether, or in what sense, these particular cases offer examples of irrational choice or on whether the standard view might be able to account for some of these examples. My argument does rely on the claim that there are significant cases of irrational decision making based on error in the process of self-determination—in forming or sustaining belief or in forming or acting on intentions—and that the nonautonomous nature of these choices is not accounted for on the standard view of autonomy.

RATIONAL AUTONOMY AND RESPECT FOR AUTONOMY

If Jim, Maureen, and Ivan in fact make nonautonomous choices, is the question of whether to abide by their decisions already settled? Recall that on the standard view of autonomy the moral question about whether to abide by their decisions requires balancing a specified notion of respect for autonomy against other similarly specified relevant moral principles—e.g., beneficence, nonmaleficence, and/or justice. If the decisions these patients make are not autonomous, there seems to be nothing to balance against the moral requirements presented by the other principles. Thus it would appear that moving to a rationality requirement for autonomy would result in health care providers overriding more patient decisions.

There is some important truth to this apparent practical implication of the rational autonomy view. Adopting this view, if it adds one *further* desideratum for autonomous choice, would result in fewer decisions counting as autonomous than under the standard model. Furthermore, if a determination of whether individual decisions are autonomous plays the role now presumed in medical ethics, then the practical implication of this view would seem to be that health care providers ought to abide

by fewer patient decisions than under the standard model. This apparent practical implication of the rational autonomy view no doubt will make some readers uncomfortable and might seem to offer an intuitive basis for rejecting the view itself.

However, I argue for a quite different interpretation of the practical significance of the rational autonomy view. On my interpretation, the practical significance of the rational autonomy view is that it: (1) challenges the notion that an obligation to abide by the individual decisions of otherwise autonomous persons necessarily should be based on an assessment of whether those decisions are autonomous, (2) makes clear why a requirement to *abide* by the freely made decisions of competent and informed patients is not necessarily the same as a requirement to *respect* the autonomy of those decisions, and (3) promotes positive respect for the autonomous *person* as a rational decision maker. In other words, instead of thinking of the rational autonomy view as a way of adding to the cache of patient decisions that may be overridden because they are not autonomous, bioethicists and health care providers ought to reconsider the practical role of respect for autonomy in medical ethics and reflection on the rational autonomy view can tell us how to do so.

Autonomous Persons and Nonautonomous Choices

A fundamental requirement of autonomy is that an autonomous choice or action must be freely elected—no one can be “made” to act or choose autonomously. For this reason, one might agree that a policy of noninterference with autonomous patients’ freely made and informed decisions, autonomous or not, is consistent with a general attitude and ideal of respect for autonomy. But when otherwise autonomous agents make nonautonomous decisions that conflict with other significant values or ends, such as in the three cases previously discussed, what should be done? Does the fact that the individual decision is not autonomous make interference permissible?

The standard view of autonomy avoids this difficult question in cases such as those discussed by classifying the decisions at issue as autonomous and thereby deserving of respect. However, as I have argued that the rational autonomy view allows the appropriate classification of irrational choices as nonautonomous, it also must address how practically to respond to such decisions. Significantly, focus on this question allows one to attend to the moral complexities that underlie a potential obligation to abide by the freely made decisions of autonomous persons regardless

of the autonomy status of their individual decisions. In particular, such moral complexities include accepting the epistemic difficulty of determining when a choice is irrational and duly attending to the moral harm of violations of bodily integrity independent of autonomous decision making. Thus, in a way, by appropriately classifying irrational decisions as nonautonomous, the rational autonomy view also allows one to focus on what is important in determining whether to abide by the individual decisions of autonomous persons *independently* of an assessment of whether the decisions themselves are autonomous.

On the rational autonomy view, what evidence of irrationality is needed to justify interference with a patient's choice on those grounds? Initially there is the question of what criteria of rational choice one should use. There is room for some significant disagreement on this front and, on the rational autonomy view, that disagreement is also disagreement over which choices are autonomous. Yet despite disagreement there is overlap between the various views of irrational choice and general agreement on at least the thin standards of rationality—i.e., belief coherence required for theoretical rationality and proper means/ends reasoning required within practical rationality.

The more significant epistemological hurdle is the availability of autonomy restoring explanations for actions and choices when these are made by real, rather than hypothetical, patients. It is appropriate for heuristic purposes to insist that Maureen irrationally refuses to apply relevant statistical information to her own case, but a real patient who makes choices just like Maureen's may well be motivated by other (perfectly rational) beliefs. Perhaps the real Maureen so dislikes taking medication that the number and frequency of pill-taking events involved in treatment would lower the overall quality of her life experience sufficiently to counter the benefit of an increased chance of survival.

Whether an accurate autonomy restoring explanation of a seemingly irrational choice is practically available to an observer of the choice depends in part on the observer. Observers with more intimate knowledge of the relevant individual's beliefs, goals, and life situation, will be better positioned to see how a seemingly irrational choice in fact may be rational. In a context in which health care providers tend to differ from their patients on various measures of health related goals and, of practical necessity, often lack any seriously intimate knowledge of their patients' belief sets and life situations, it is especially important not to underestimate the significance of the epistemological hurdle to identifying truly irrational

choices.¹⁹ If, as one can assume, there is great moral harm in wrongly interfering with autonomous decisions regarding medical treatment, then the epistemological hurdles to getting the kind of evidence needed to establish irrational choice *generally* offers reason enough to avoid interfering with an action or choice *that one would not also be justified in interfering with if autonomous*.

Suppose one ignores, for the sake of argument, the significant epistemological hurdles to determining when patient choices are irrational and therefore nonautonomous. Would it then be clear that on the rational autonomy view, irrational decisions with serious negative consequences should not be abided by? In fact, there are moral considerations other than respect for the autonomy of individual decisions that protect a competent patient's right to make choices about medical treatment. These moral considerations may hold sway regardless of whether the choice is also autonomous. An example is a right to avoid unwanted and invasive interference with one's body. This moral precept finds legal voice in the widely cited 1914 opinion of Justice Cardozo in *Schloendorff v. New York Hospital* (211 N.Y. 125, 105 N.E. 92 (1914)): "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault." There is no requirement in this statement that such determinations are autonomously made, only that the decision maker is an adult of sound mind. Although this is a legal opinion, it encapsulates a widely shared moral principle regarding the rights that competent people have to avoid unwanted treatment. Although one might simply conflate decisions that are freely made by competent adults with "autonomous" decisions, even under the standard view of autonomy this is a serious conceptual error.

It is precisely a moral consideration such as that found in *Schloendorff* that might keep one from advocating forced treatment in Jim's case, for example. Although one may consider Jim's decision to be lacking in autonomy, this does not substantially (if at all) decrease the sense of moral violation that would stem from his forced treatment. Furthermore, if for some reason Jim's choice counted as nonautonomous even on the standard view, say because of some problem with understanding, then I think one would have the same reaction regarding the moral violation involved in treatment as long as Jim is an adult "of sound mind" who in some relevantly robust sense chooses freely. Although I think the prohibition against medical assault is decisive in ruling out forced treatment in this

case, I admit this is a controversial claim and that some will want to say that *if* Jim's decision is in fact nonautonomous this is moral reason enough to overturn even the free choice of an otherwise autonomous person.

Importantly, however, I doubt there will be significant disagreement over whether Jim's choice, *if* irrational, is also nonautonomous. Instead I think there will be agreement that a consideration of whether Jim's choice is irrational is also, at least in part, a consideration of whether it is autonomous. The important disagreement in this case is likely to focus on what is required in the way of adequate *evidence* that Jim's choice is irrational, on the relative moral strength of the prohibition against medical assault in comparison with the other values at stake—e.g., most likely beneficence—and on what the likely impact on Jim as autonomous *person* would be if treatment is forced on him. In particular, perhaps, what the impact would be on Jim's *general* capacity as a rational decision maker.

Thus, on my interpretation at least, the rational autonomy view provides an opportunity to focus on the practical moral considerations relevant to this case in a way that the standard view avoids. On the standard view, sufficient evidence of irrationality does not necessarily offer a reason for counting the choice as nonautonomous. Furthermore, the view does not pay due attention to the question of when interference with the nonautonomous choices of otherwise autonomous persons is morally permissible. Indeed, since the specific moral obligation to abide by patient choices stems from the obligation to respect individual autonomous decisions, it is hard to see how to incorporate an obligation to abide by at least some nonautonomous patient decisions that conflict with other significant moral values. On the view of rational autonomy that I promote, there may be good moral reasons to abide by a decision other than the autonomy of that specific decision.

Unlike overriding a refusal of treatment, failure to comply with a nonautonomous request for treatment does not violate a moral norm prohibiting medical assault. Thus one might think that on the rationality view of autonomy one should treat nonautonomous requests for treatment, like Ivan's, quite differently from nonautonomous refusals. Is this the case?

As with seemingly nonautonomous refusals of treatment, seemingly nonautonomous requests for treatment might in fact be autonomous, albeit perhaps surprising, unconventional, or downright disturbing.²⁰ For example, some requests for body modification might appear irrational to physicians who hold standard medical norms of health and well-being, but they in fact may be rational on a more holistic model of these goals. Even Ivan's surprising preference for surgery *could* be rational if it turns

out that the anxiety of “waiting to see” whether he will be one of the lucky 10 percent to survive without the surgery will be so intolerable that it will itself make his life not worth living. Thus, seeing autonomy as constrained by rational decision making might invite physicians to gain increased understanding of their patients as rational decision makers in light of non-medical values, goals, and beliefs. As with refusals of treatment, the epistemological hurdles to determining when a request for treatment is irrational can hardly be overstressed in most modern medical decision-making contexts.

Still, if, for the sake of argument, one clears away the epistemological considerations, it seems that health care providers have no obvious moral obligation to assist patients in the pursuit of irrational ends or otherwise materially support decisions based on irrational beliefs or a mistaken fit between goals and intentions. Thus, although health care providers may be prohibited from overturning irrational decisions when doing so would involve violating a moral prohibition against medical assault, it does seem reasonable to assert an asymmetry thesis between requirements to abide by irrational requests for treatment versus refusals of treatment, in particular when these requests conflict with other significant moral obligations.²¹ In short, then, the rational autonomy view dovetails in practice with the standard view of autonomy with respect to specific cases of irrational requests for treatment—where epistemological issues are somehow taken care of—but offers stronger grounds for this practice, namely that the requests are irrational. Unlike in many cases of treatment refusal, the fact that the requests are not autonomously made because they are irrational seems to serve as sufficient grounds for the refusal to comply with them.

Respect vs. Abidance

Thus far I have argued in some detail for the first claim regarding the practical significance of the rational autonomy view, namely, that focus on this view allows one to see how representing respect for patient autonomy as respect for individual autonomous choices can be misguided. What is often more important for practical purposes is to abide by the informed and freely made choices of autonomous persons and, as I argue next, to engage in positive respect for the autonomous person as a rational decision maker. Before making that third and final point, however, it is important to note the second implication of the rational autonomy view for the principle of respect for autonomy, namely the distinction between *abiding by* and *respecting* the decisions of autonomous persons.

It is commonplace within medical ethics literature and practices to conflate a moral requirement to abide by patient decisions with respect for those decisions. In fact, when an autonomous person makes a choice that must be abided by, it may or may not be the case that the *choice* itself also should be respected, even if the *person* making the choice always should be. Because of the distance introduced in the previous discussion between requirements to abide by patient decisions and determinations of the autonomy or lack of autonomy of those individual choices, on my interpretation at least, the rationality view of autonomy supports an important distinction between *abidance by* and *respect for* patient decisions. The conceptual benefit of this distinction is that the rationality view leaves room for abidance by choices that would otherwise be labeled as “autonomous” and therefore themselves due respect. The practical benefit is that it counters a use of the term “respect” that can only be called jaded. When health care providers believe that all autonomous patients’ freely made and informed choices are to be “respected” then that term necessarily loses both some of its proper meaning and some of its normative power.

Since respect for autonomy in medical practice is not necessarily respect for the autonomy of individual decisions and since the requirement to abide by patient decisions is not the same as the requirement to respect those decisions, it would seem that the role of autonomy as a key concept in medical ethics is diminished if one accepts my interpretation of the rational autonomy view. In some sense this is the correct conclusion. However, there is a crucial role for positive respect for autonomy that the rational autonomy view highlights and that is easier to overlook on the standard view of autonomy.

Positive Respect for Autonomous Persons

What is distinctive about positive respect for autonomy on the rational autonomy view is focus on the capacity of individuals as rational decision makers involved in complex processes of self-determination. Given this focus, health care providers would seem to have a much richer responsibility in gaining informed consent or refusal, for example, than is represented by standard practices. Simply informing patients about treatment options and probable outcomes cannot be said to respect patient autonomy when this notion pays heed to the patient as a rational decision maker. Rather, an informed refusal or acceptance of treatment is often the beginning of a dialogue that aims at respect for autonomy rather than the end point.

Far from interfering with patient autonomy, as is sometimes supposed, rational persuasion and argumentation in the right contexts respects autonomy.²² For example, respect for autonomy sometimes requires engaging in a discussion of the patient's own reasons for accepting a treatment in helping to draw out whether these are connected in a rational way to the medical goals of the treatment. Or, in the case of seemingly irrational refusal with serious health consequences, engaging in rational persuasion and addressing the root cause(s) of the irrational decision making both seem morally required.²³ Indeed, this way of respecting Jim and Maureen, for example, as rational decision makers is obviously what is called for over and above any consideration of overriding their specific refusals of treatment. If this approach is taken with appropriate care and respect for the patient as a rational person, it is hard to imagine a real (rather than hypothetical) case where continued refusal would actually amount to isolated irrational refusal. Rather, the outlier cases are likely ones in which either the *person* is not in fact otherwise substantially autonomous or the epistemological hurdles already discussed are keeping the health care providers from seeing the patient's choice *as* rational.

It may be argued that the claims I have made regarding the practical implications of the rational autonomy view undermine the view itself. After all, I have held both that irrational choices are not autonomous and that a determination of whether individual choices are irrational is not necessarily good grounds for deciding whether to abide by those choices. However, the claim that this interpretation of the rational autonomy view is self-undermining relies on a model of respect for autonomy in which determining whether individual decisions are autonomous is highly morally relevant. What I have argued instead is that if one takes a conceptually more adequate view of when individual choices are autonomous, such as the rational autonomy view offers, one should see what is wrong with this very model of respect for patient autonomy. Although it may often be required that health care providers abide by the freely made and informed choices of competent patients, this is not the same as respecting the autonomy of those individual decisions. Furthermore, positive respect for patients as autonomous persons requires promotion of, and respect for, their capacities as rational decision makers involved in complex processes of self-determination.

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NOTES

1. There are important exceptions. The most notable is Onora O'Neill's support of "principled autonomy" (O'Neill 2002; see also Stirrat and Gill 2005). More recently, Rebecca Kukla (2005) has argued for "Conscientious Autonomy" and Sara Goering (2009) has argued for considerations of relational autonomy and self-trust. Yet, as Kukla and Stirrat and Gill also point out, the general conceptual assumptions about autonomy otherwise have remained largely unchallenged within medical ethics literature and practice.
2. Kukla and Goering, respectively, also argue that the focus of respect for autonomy should not be on discrete medical choices—or "punctuate decisions" (Kukla 2005, p. 35–36), however neither is specifically concerned with how rational decision making relates to such a claim. Kukla (2005, pp. 36–43) focuses on the nature of medical care itself such that what is required for autonomous decision making has more to do with the responsible acceptance of certain norms of self-regulation than with assent to, or rejection of, particular medical interventions. In so far as Goering (2009, p. 11) focuses on the development of "skills and competencies . . . that promote autonomy," I believe there might be room in her view for a consideration of rational decision making, however the skills that she focuses on are those of self-trust and trust of others.
3. The *Principles* view of autonomy has been identified as the standard view in medical ethics by other authors. Kukla (2005, p. 35) reviews these citations. The view in *Principles* is also very similar to the influential view offered in Faden and Beauchamp (1986).
4. There are exceptions. Julian Savulescu (1994) argues that desires must be rational in order to be an expression of autonomy. According to Savulescu, rational desiring requires a possession of relevant facts, no relevant logical error, and vivid imagination of likely consequences. With Richard Momeyer, Savulescu also argues both that autonomy requires that one's beliefs are

rational and that the Jehovah's Witness's stand on life-saving blood transfusions represents irrational belief (Savulescu and Momeyer 1997). In so far as O'Neill (2002) supports a Kantian conception of autonomy, this view also requires that autonomous choices be rational. In contrast to each of these views, I leave open the question of which particular substantive view of rationality ought to be endorsed.

5. Beauchamp and Childress move without special note between discussion of autonomous actions and choices. I assume my conclusions hold for both categories as well, however, for clarity I focus my argument on choices (or decisions). Thus it is possible that I have not argued that irrational actions are not autonomous.
6. For a helpful discussion of ways to characterize the distinction between practical and theoretical reason, see Wallace (2008). In this paper, I aim to give as neutral a description of the distinction as possible.
7. Bernard Gert and colleagues (2006, p. 8) argue explicitly for a view of practical rationality that focuses on what they term "content," in part because they believe such views are in keeping with common morality. On their view any action is irrational that "has as its intended result the agent's death, pain, disability, loss of freedom, or loss of pleasure, and [where] the agent does not believe that anyone, including himself, will thereby avoid any of these harms or gain any benefits . . ." (Gert, Culver, and Clouser 2006, p. 8). I take no ultimate stand in this paper on the important question of how and whether to understand specific goals as necessarily practically irrational, but nevertheless agree that at least some goals might be commonly viewed as irrational.
8. Self-destruction may, however, be a rational means to some other end, for example, the avoidance of extreme suffering.
9. I do not claim that each irrational belief or intention necessarily leads to irrational choice—or undermines autonomy—simply that *choices* that are irrational due to irrational beliefs or intentions are not autonomous.
10. I am open, for example, to the claim that the authenticity of a choice is what makes it autonomous. This is a clear difference, then, between my claim about the relationship between rationality and autonomy and O'Neill's Kantian view. As O'Neill (2002, p. 90) puts it, for Kant, the requirement of rationality is better understood as autonomy itself being the principle of reason. On my view, all that is required is that irrational choices do not count as autonomous.
11. In arguing that autonomy requires acting on the basis of rational beliefs, Savulescu and Momeyer (1997, pp. 283, 287) make a somewhat similar, but importantly different, argument. As I understand their argument, rational

deliberation is important for autonomy because, like being adequately informed, this increases the likelihood of holding true beliefs, and actions are only autonomous when they are based on true beliefs. Although I also argue that if information is important to autonomy, then so is rationality, I make no claim about whether autonomous actions must be based on *true* belief or whether rational beliefs are more likely to be true. Some beliefs are acquired rationally and yet are false. Other beliefs are true, but are acquired irrationally. Although Savulescu and Momeyer (1997, p. 287) state that “holding true beliefs is necessary to be autonomous,” it seems that if one acts on the basis of rationally acquired and held beliefs, then the action does not fail to be autonomous simply because the belief is false.

12. Beauchamp and Childress might agree with this point insofar as they rely on a fairly thick requirement of understanding for autonomous decision making. However, as I shall argue, their requirement of understanding either fails to capture relevant examples of irrational belief or offers a view of understanding that introduces a “back-door” requirement of rationality but is an implausibly thick notion of *understanding*. In either case, the requirement of understanding also fails to capture other significant examples of irrational choice.
13. I present a nearly identical case in Walker (2008, p. 598), but for a different purpose.
14. According to risk-related standards of competence, levels of competence required for a task should be adjusted relative to that task’s associated risks (see Buchanan and Brock 1989, pp. 51–55). Although such standards have been widely criticized already, my claim here takes no stand on that issue since I only claim that decisions about competence should not depend on the particular decision that the patient makes. That claim is consistent with the claim that decisions about competence should depend on the risks involved in the task.
15. “*Pro tanto*” moral obligations have a specific moral valence but may be overridden in particular circumstances. Beauchamp and Childress (2009) identify the principle of respect for autonomy as a “*prima facie*” moral obligation. However, if *prima facie* obligations only appear to be moral obligations but may in fact not be, then I take it that “respect for autonomy” on their view presents a *pro tanto* moral obligation.
16. For a description of the specification approach see Richardson (1990) and DeGrazia (1992). Beauchamp and Childress (2009, pp. 19–22) maintain that balancing should be considered separately from specification.
17. A consideration of distributive justice would not, on its own, determine the appropriate response.

18. Admittedly, the claim regarding “stability” is tricky in this case given partial reliance on counterfactual future goals.
19. The empirical literature comparing health care provider to patient measures of health related goals, values, and beliefs shows many different types of disagreement from how to assess quality of life with specific conditions (see Lenert et al. 2000; Wilson et al. 2001), to how to rate the relative value of disease as compared with side effects of medication (see Schackman et al. 2008; Lenert et al. 2000), to divergent assessments of the severity of individual health conditions (see Brouwer et al. 2005; Cvetkovski et al. 2005). There also are reported disagreements over what kind of evidence to “value” in medical decision making (see Verhoef et al. 2007). Clearly the rational autonomy assessment of the relationship between “evidence” and “value” would be complicated by what evidence rationally should be considered.
20. Savulescu (2007) discusses this topic in detail in “Autonomy, the Good Life, and Controversial Choices.”
21. Nancy King has suggested, and I agree, that in practice the asymmetry thesis might be difficult to uphold in the area of treatment abatement.
22. Savulescu (1995) also makes this point. Goering (2009, p. 16) also might agree insofar as she focuses on the skills involved in autonomous decision making and writes that in cultivating trust and demonstrating trustworthiness physicians ought to “take the time to get to know new parents, [and] invite them to discuss their goals and values.”
23. Savulescu and Momeyer (1997, pp. 287–88) suggest that physicians take seriously their role as educators and view acceptance of irrational patient belief as a form of “abandonment.” Although I agree with their general practical position, it is important to remember as well that any such engagement or “education” must be approached judiciously since aggressive questioning may intrude on a patient’s privacy if not her autonomy. Manipulative rather than rational persuasion also may interfere with a patient’s autonomous decision making. Finally, it should be remembered that patient decisions often are rational even if they are not choices one would make for oneself. From Savulescu’s (2007) position in “Autonomy, the Good Life, and Controversial Choices,” I take it that he would agree with this last point.

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