Abstract

In this paper, I argue that the dominant conceptions of autonomy have become problematically over-intellectualized. The conditions they propose for an agent to count as autonomous require a level of intellectual sophistication that is demanding, restrictive, and ends up excluding ordinary choosers. Further, dominant conceptions of autonomy focus exclusively on sophisticated cognitive capacities required for the agent to count as autonomous, without considering other capacities that are necessary for autonomy, such as the capacity to care. The problematic consequence of over-intellectualization is that render persons who ought to be considered autonomous, non-autonomous. In practical contexts such as health care, this has consequences for which agents are considered to be autonomous, and whose decisions therefore warrant respect. In this paper, I show how autonomy can persist in meaningful ways in the absence of intellectual sophistication, and argue further that this type of autonomy is deserving of respect in health care contexts.

Paper

In this paper, I argue that the dominant conceptions of autonomy, as they pertain to bioethics and as they are deployed in health care contexts, has become problematically over-intellectualized. The dominant conceptions of autonomy are over-intellectualized in two primary ways. First, the conditions they propose for an agent to count as autonomous require a level of intellectual sophistication from the agent that is overly demanding and unrealistic. Second, theories of autonomy tend to focus exclusively on sophisticated cognitive capacities required of the agent, without considering other capacities that are also relevant and necessary to autonomy. By sophisticated cognitive capacities, I mean a high degree of reasoning, answerability, coherence and consistency in one’s life narrative, and critical reflection. The ‘other capacities’ that are relevant in decision-making are our imagination, and our capacity to care, or value. The worrisome consequence of theories of autonomy that are over-intellectualized is that they render persons non-autonomous who ought to be considered autonomous. Our concepts of what autonomy is, and what it requires, have direct consequences in practical contexts such as health care, where “respect for autonomy” governs how health care practitioners (HCP’s) engage with patients.

I begin with some clarificatory remarks. Then, I consider two different views on autonomy that are representative of both the philosophical and bioethical literature. This will show that our dominant views of autonomy are, in fact, over-intellectualized. Then, I present a theory of autonomy that shows how autonomy can persist even in the absence of sophisticated cognitive capacities. Borrowing from Jaworska’s work (1999), I call this “minimal autonomy,” and argue further that minimal autonomy is meaningful, and deserves respect in health care contexts.
I. Clarificatory Remarks:

What is similar across most, if not all, definitions of autonomy is that autonomy is understood as a special kind of self-governance. The literature on autonomy identifies two kinds of conditions that are necessary to ensure that autonomy obtains: competency, and authenticity. Competency conditions spell out the “cognitive, volitional, normative, or other competences deemed necessary to act effectively on one’s motives, values, or reasons” such as the capacity to understand information, reason and deliberate among alternatives, and communicate a choice (Mackenzie, 17). Authenticity conditions focus on two things: the agent’s values, and the relationship between an agent’s action and values. To the first, authenticity conditions ensure that the values that inform a particular course of action are themselves endorsed by and accepted by the agent as truly their own; second, authenticity conditions safeguard the correct relationship between one’s actions and their values. Autonomous action that meets the authenticity conditions will be action that issues from one’s values, and will be based on a value set the agent has truly taken as her own.¹ Further, some specification of ‘non-control’ is always included as a necessary condition for autonomous action. For the purposes of this paper, I take this as uncontroversial, and instead focus on the roles of competency and authenticity in autonomy.²

In the next section, I consider two accounts of autonomy. The first, taken from Ronald Dworkin’s work in *Life’s Dominion*, represents the view on autonomy often found in the philosophical literature. The second, taken from both Faden and Beauchamp’s *A History and Theory of Informed Consent*, and Beauchamp and Childress’s *Principles of Biomedical Ethics*, represents the dominant stance on autonomy in the bioethical literature.

II (a) Philosophical Conception of Autonomy

What Dworkin takes autonomy to require can be inferred from his comments about successfully autonomous choices within the context of a successfully autonomous life. Autonomous choices are expressed in our pursuit of “critical interests” (201, 1993). Critical interests express our “critical judgments” about what makes life meaningful, and counterfactually, they matter because their absence would make us “genuinely worse off” (*ibid*).³ Dworkin further argues that we have an overarching critical


² Of course, it is not uncontroversial. Accounts differ on what actually counts as non-control, and while there are clear-cut cases like force and coercion, there are borderline cases such as manipulation or nudging. However, addressing this issue requires a separate paper.

³ These are distinguished from “experiential interests,” and while the distinction is controversial (see Dresser, 1995), by critical interests Dworkin seems to mean interests in roles that have a transformative, or stage setting effect, on our lives. Things like
interest in maintaining integrity, as evidenced by the (alleged) fact that we aim to construct a coherent, consistent, narrative structure in our lives (ibid, 202). The idea seems to be that choices made on the basis of our critical interests count as local instances of autonomous action, and actions that undermine or conflict with our critical interests fail on that basis to be autonomous. Global autonomy then obtains to the extent that one’s narrative arc is a consistent and coherent expression of one’s critical interests over a lifetime. While Dworkin does not put his view in these terms, his notion of ‘critical interests’ is presumably analogous to what other autonomy theorists mean by the ‘values’ or ‘value-ordering’ that needs to be informing our choices if they are to count as autonomous, and we can therefore understand this as the ‘authenticity’ condition of his view.

Views like these are over-intellectualized in the overly demanding sense: the self-knowledge and critical reflection required to (a) know what one’s critical interests are in the first place, (b) ensure that one’s local choices are consistent with those critical interests, and (c) that one’s life as a whole takes on a coherent narrative arc on the basis of (a) and (b), effectively, need to be staggeringly sophisticated, and highly rational and intellectual. Views like Dworkin’s seem to suggest that people are, or ought to be, as careful with respect to their personal lives as philosophers are with respect to their research. While this sets a standard for autonomy that is obviously too high, views like Dworkin are abundant in the philosophical literature.

In fact, this is precisely what Faden, Beauchamp, and Childress are concerned with when dealing with philosophical conceptions of autonomy that include ‘authenticity’ conditions. They acknowledge that becoming a parent, consistent career goals, an interest in being, and being known as, a certain kind of person (successful, motivated, patient, kind, etc.), or perhaps adopting a social or character role as identity-constituting (an athlete, academic, scientist, influencer, etc.).

4 Benson distinguishes between local and global autonomy in the following way: local autonomy is “the condition of being self-governing in the performance of particular actions and the formation of the particular intentions that motivate them,” while global autonomy is autonomy throughout “extended portions of one’s life” (120, 2005). The standards for global autonomy tend to be much higher than those for local autonomy, and this distinction will be important in section 3, on the Values Argument.

5 This also requires a robustly stable sense of self. While this is certainly a psychological ideal, it cannot be that persons who do not possess such a stable sense of self are on this basis regularly precluded from acting autonomously.

6 Stated this way, this statement is admittedly intuition mongering that Dworkin’s view is too strong. However, it’s worth noting that the philosophical commitments that ground his view are expressed in health care policies in Canada. This can be seen particularly in documents like the HCCA, regarding how we treat advanced directives and surrogate decision-making in the context of conscious patients who are no longer competent to make decisions regarding their own care. If a “prior capable wish” has been expressed (either by way of a formal advanced directive, or any verified less formal expression), it takes absolute priority. What is in the patient’s current ‘best interests’ comes second. This expresses a nearly absolute commitment to the autonomy (i.e., the critical interests) of the patient’s ‘former’ self. That is, the wishes of the autonomous, former self take priority over what might be in the best interests of the non-competent, current self, out of respect for autonomy (Health Care Consent Act, II. 21 (1)). For more about the debate philosophically, see Dresser and Robertson, 1989; Dresser and Whitehouse, 1994; Dresser, 1995.

7 Accounts of autonomy that I have in mind, but do not have time to explore in depth here, are the following: Christman’s historical non-alienation account, Meyer’s competency account, Westlund and Benson’s dialogical or answerability account, and Mackenzie’s normative authority account.
views like Dworkin’s give us an “aspirational ideal of autonomy,” but they ultimate reject these views because they are overly demanding and end up being restrictive (104, 2009). The worry is that if agents were held to the standards presented in these theories, “few decision makers and few choices would be autonomous” (ibid). Going forward, I will refer to this as the Exclusion Problem. There also seems to be the worry that views that include both competency – that is, one’s ability to make a decision – and authenticity – ensuring that one’s decision actually reflects their true self – would make it impossible to assess whether agents are actually autonomous. This matters specifically in health care contexts, and I will call this the Practical Problem.

II (b) Bioethical Conception of Autonomy

In the interest of developing an account of autonomy that is both practical, and does not exclude “ordinary, competent agents and choosers,” Faden, Beauchamp, and Childress reject the inclusion of authenticity conditions, and focus only on competency. They argue that autonomous action must meet three conditions: intentionality, understanding, and non-control (238, 1986; 104-105, 2013). They concede that autonomous action can be more or less “substantially” autonomous, given that both understanding and non-control are matters of degree (238-9, 1986). This account of autonomy produces a conception of autonomy that is virtually indistinguishable from a conception of competence. Indeed, the ‘capacity’ Beauchamp and Childress identify as “closely connected to” and, it seems, the necessary condition for “autonomous choice” just is competence (114, 2013). Given that authenticity is what distinguishes autonomy from competence, the fact that Faden, Beauchamp, and Childress exclude authenticity is likely why their notions of autonomy seem to be reducible to basic competence to make a decision.

Applying this to the health care context, whether or not autonomy is respected, then, is simply a matter of making sure that the agent has the requisite decision-making capacity, or cognitive competence. Whether the decision is an ‘authentic’ expression of their true selves is not considered. So, Faden, Beauchamp, and Childress’s view is over intellectualized in the exclusive sense: it considers only capacities of cognitive competency as relevant to autonomy.

While I agree with Faden, Beauchamp, and Childress that dominant views in the philosophical literature are overly-demanding and restrictive, I argue they are wrong to think the remedy to this problem is to exclude considerations of authenticity altogether. First, not all views on autonomy that include authenticity are overly demanding and restrictive. Second, in reducing autonomy to a question of cognitive

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8 Other views Faden, Beauchamp, and Childress have in mind are hierarchical views proposed by Frankfurt and Bratman, and reflective endorsement accounts found in Watson.

9 Indeed, in the chapter on respect for autonomy (pp. 100-149), there is no explanation offered of what makes autonomy distinct from cognitive competence. The rest of the chapter covers more detail about what is required for competence and informed consent than ‘autonomy’ specifically. It therefore largely proceeds as though they take autonomy to be reducible to competence (also called decision-making capacity) in practical contexts.
competency, Faden, Beauchamp, and Childress end up facing a problem they sought to avoid: the Exclusion Problem. In not incorporating a consideration of what agents care about, or value, in their conception of autonomy, they have ignored a necessary and important source of autonomous action. This ends up excluding persons who might lack the sophisticated cognitive capacity to meet muster on their proposed view. The population I am concerned with, and who often are found to not count as autonomous, are persons with severe mental illness.10

It should also be noted that the theorists considered above are both aware of, and explicitly accept, this exclusion. Dworkin argues that because persons with dementia lack the sophisticated cognitive ability to either form new critical interests, or to reflectively endorse their old ones, they fail to have autonomy altogether (226).11 He argues that “patients like Mary (a person with Alzheimer’s) have no right that any decision be respected just out of concern for their autonomy” given that autonomy is “a capacity [s]he does not and cannot have” (ibid). This conclusion can presumably be applied in cases of other severe mental illnesses for the same reasons as well. However, Dworkin does not provide a separate argument for why it is that ‘critical interests’ are the only way in which autonomy could meaningfully be grounded, or expressed.12 As for Faden, Beauchamp, and Childress, they argue that mental illness can be an internal constraint that undermines the non-control condition for autonomy. They cite conditions like “psychiatric disorders, and drug addiction,” as forces that can “diminish or destroy voluntariness, thereby precluding autonomous choice and action” (138, 2013).

In what follows, I will offer a view of autonomy that incorporates authenticity and value, but does not do so in an overly demanding way. I will then explain why the exclusion of persons who lack sophisticated cognitive competence is in fact, problematic, when it comes to conceptualizing, assessing, and respecting, autonomy.

III. The Capacity to Care and Minimal Autonomy

In opposition to views of autonomy that “privilege the power of critical reflection,” Mullin argues that local instances of genuine autonomy require something much less robust. What grounds autonomy is our “volitional self,” which is defined as “the attachments that contribute meaning to our lives,” whether these be “ideals, things, or people” (537, 539). Importantly, even small children have relatively stable

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10 While this is not worked out here, this argument applies to other populations typically left out in theories of autonomy, such as young children.

11 This theoretical commitment is inferred from his downstream claims that in these cases we are obligated to respect a patients “precedent autonomy” – that is, the critical interest they expressed when they were cognitively competent to do so, rather than consider them in their current state. The previous person is more truly them, because it was an expression of their autonomous self. For the sake of maintaining integrity throughout a lifetime, health care providers ought to defer to precedent autonomy rather than current best interest.

12 That his view is over-intellectualized is also evidenced in the title of the chapter wherein the discussion of patients with dementia is found: “Life Past Reason” – as though reason, or giving reasons, of any kind were unavailable to patients who lacked sophisticated cognitive capacity.
volitional selves, as do persons who are not able to operate to the level of cognitive sophistication required by most theories of autonomy.\textsuperscript{13} According to this view, to count as autonomous, the action must be an expression of what the agent cares about, or what matters to them (\textit{ibid}, 537).

Jaworska offers a similar view, wherein the capacity to value grounds our ability to act autonomously (1999).\textsuperscript{14} She draws on the neuroscientific literature on patients who have suffered particular kinds of brain trauma (primarily found in Antonio Damasio’s work), and who, as a result, have had their emotional capacities damaged or destroyed.\textsuperscript{15} In cases like these, patients tend to perform very well on psychological assessments that test for cognitive competence – intelligence, memory, language, attention, comprehension, etc., – but their emotional responses were significantly blunted. They possess all the “means-end reasoning and problem solving” competency one would think is necessary to make a decision (Jaworska, 122). But they are unable to \textit{actually} make a decision because they lack the capacity to value an outcome among alternatives, and they do not choose. We can conclude from this that in the absence of our capacity to value, our “decision-making landscapes” become “hopelessly flat” (Damasio, 51). If we were to cash this out in the terms of the autonomy debate, we can conclude that the capacity to care, or to value, is a necessary condition for autonomy, because without it, we will simply not be motivated to act \textit{at all}, much less autonomously, in the first place.

However, the idea that value is necessary for autonomous action is not the primary point of either Mullin or Jaworska’s work. While patients like the ones considered in Damasio’s work retain sophisticated cognitive capacity but lack the capacity to value, the target population of both Mullin and Jaworska’s work are persons who \textit{lack} sophisticated cognitive capacity, but retain the capacity to value. Both Mullin and Jaworska argue that in these cases, the persons in mind – respectively, young children, and patients with dementia – the capacity to value is sufficient to ground autonomy in a meaningful way. Our volitional self can exist “before rational and reflective capacities are well developed” (Mullin, 547, 2007), and as Jaworska argues, it is a capacity that can remain stable, either in the case that sophisticated reflective capacities never develop in the first place, or in the event that they deteriorate. While the capacity to value

\textsuperscript{13} Mullin’s target population in these arguments about autonomy are specifically young children, between the ages of 3 and 8 (2007, 2014).

\textsuperscript{14} For brevity, going forward I will be using “volitional stability,” “the capacity to care,” and “the capacity to value” interchangeably. While there are slight differences between the views offered by Mullin and Jaworska, they agree on what matters for the general purpose of including persons who lack sophisticated cognitive capacity as, in some meaningful way, autonomous.

\textsuperscript{15} The brain damage in the primary case study was the result of a brain tumor removal, which left the ventromedial prefrontal cortices damaged (Damasio, pp. 34-51). Damasio writes that damage to this region of the human brain results in “consistently compromises, in as pure a fashion as one is likely to find, both reasoning/decision making, and emotion/feeling, especially in the personal and social domain. One might say, metaphorically that reason and emotion “intersect” in the ventromedial prefrontal cortices, and that they also intersect in the amygdala” (70).
in the absence of full developed and sophisticated cognitive capacity is not enough to ground what we might call full-fledged autonomy, it is enough to ground what Jaworska calls “minimal autonomy” (130). Jaworska gives a number of sufficient conditions for valuing, all of which require high level cognitive capacity, but the necessary condition is something that agents who lack this sophisticated cognitive capacity are completely capable of experiencing: an agent values object x, when x is ineliminable without considerable remorse (ibid).

IV. Why Autonomy Matters & Practical Recommendations

One might at this point object that while I have given reasons to think that persons who lack sophisticated cognitive capacity are capable of valuing, I have not shown (a) how or why this ought to count as a genuine expression of autonomy, or, further downstream, (b) how or why this ought to be respected in the context of medical decision making. That is, I have not shown why valuing ought to count as a sufficient condition for autonomy to be respected. This conceptual concern is compounded when we take into account the fact that it would make things in health care contexts considerably more complicated; that is, we run into what I above called the Practical Problem.

First, I offer a conceptual response, which will inform my response to the practical problem. To the first, if we reflect on why we place such a high value on autonomy in the first place, we can see that views of autonomy that exclude those who lack sophisticated cognitive competency miss the point. We do not respect autonomy because we think people always make the best, most rational choice, from an ‘objective’ perspective. While an exhaustive list or justification of the reasons we take autonomy to be important cannot be given here, I will briefly consider three types of justifications: philosophical, psychological, and practical.

Philosophically, our rational capabilities are often picked out as the morally salient feature of persons. This, in turn, generates a *prima facie* obligation to nurture, support, and facilitate its exercise. Using the arguments made above, I argue that the capacity to care, or to value, is an equally morally salient feature that warrants nurture, support, and respect in the same way.\(^{16}\) Drawing on the psychological literature on self-determination theory (SDT), autonomy is considered to be one of the three “basic psychological needs,” the others being competence, and relatedness (183, 2008b). Deci and Ryan have found that atmospheres that facilitate and support autonomy predict better outcomes particularly in psychotherapeutic contexts, and that in general, “autonomous motivation” yields “greater psychological

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\(^{16}\) I follow Jaworska in adopting an alternative to the standard Kantian approach to what grounds “full moral standing” (2007). Jaworska argues that “the emotional capacity to care is a sufficient condition of an individual’s FMS as a person” (460, 2007). The view Jaworska is arguing against grounds FMS in “Kantian autonomy,” where the distinctive mark of persons is our “ability to employ reason in the practical domain” (ibid, 477-478).
health and more effective performance” than “controlled motivation” (188, 2008a; 182-183, 2008b). Conceptualizing respect for autonomy, and environments of “autonomy support” as a basic need reframes the discussion. Rather than being an achievement, and a threshold concept, where the ideal, sophisticated, intellectual agents earn the “right” to have their autonomy respected given their ability to give higher order reasons for their actions, it is a capacity that exists in degrees, even the lowest of which warrants nurture, support, and respect. Finally, from a practical perspective in a health care context, what often goes unarticulated is that it is the patients themselves who will have to live with the consequences of the health care decision. Therefore, it is imperative that their perspective on the matter is heard and taken into account in a meaningful way.

The overarching argument here is that none of these reasons – philosophical, psychological, or practical – carry less moral force when the person in question does not have sophisticated cognitive capacity required by many theories of autonomy. It is therefore incumbent upon us to make sure we are doing what we can to respect autonomy, even when cognitive capacity is impaired and the patient is deemed to be globally incompetent to make high stakes decisions.

How to respect autonomy when a patient is deemed to be globally incompetent brings me to my response to the Practical Problem. Because the dominant principle of respect for autonomy has been understood in the context of cognitively competent decision makers, we tend to think of “respect for autonomy” as a matter of deferring to a patient’s capably made choice. What I am arguing is that the lack of sophisticated cognitive capacity – however severe, whatever the duration – does not reduce the person to a patient without a perspective on their own life and care. Respect for minimal autonomy, then, is a matter of taking that perspective seriously. What “taking that perspective seriously” amounts to will be context dependent. It can be as small stakes as permitting a person who lives in a care home to decide

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17 Autonomous motivation is defined as intrinsic and extrinsic motivation for action that “people have identified with,” where the “activity’s value” will “ideally have integrated into their sense of self” (182, 2008b). Controlled motivation is defined as instances where the persons behaviour is controlled by “external contingencies of reward or punishment,” as well as internalized coping mechanisms like “approval motive, avoidance of shame,” as well as “contingent self-esteem, and ego-involvements” (the latter is also called “introjected regulation”) (ibid). This roughly maps onto theories of autonomy I am interested in and endorse: views that incorporate value, but which have not collected the over-intellectualized baggage.

18 SDT, and particularly approaches that are autonomy supportive (such as motivational interviewing), have been found to be especially fruitful in therapeutic contexts. These are people that, depending on their condition (whether it be an outpatient receiving treatment for schizophrenia, a person with anorexia that wants to refuse life saving treatment, etc.), would not count as autonomous on many philosophical and bioethical views. SDT shows why it is important to take an approach that sees autonomy as a matter of degrees, and respects the autonomy the person does retain, even if it is not full-fledged, global, or otherwise ideal.

19 Of course in many cases health care decisions impact caretakers and relevant others (that is, HCP’s as well as relatives, significant others, friends, etc.). However, it is the patient themselves who has to live with and in the body in which these treatments happen. The experiential, physiological, psychological, and emotional impact is therefore the most profound on the patient.
when they eat their meals, when to shower or bathe, or deciding what they wear, to as high stakes as granting a patient with schizophrenia a say in whether or not they take psychiatric medication.

The danger in reducing autonomy to a question of cognitive capacity is that we then think respect for autonomy is exhausted by non-interference in the patient’s “autonomous choice.” As I have argued here, this is a mistake. A superior conception of autonomy – both theoretically and practically – will include even persons who are minimally autonomous, and propose meaningful ways to respect that autonomy.

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