**<CT>Consent for others</CT>**

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<H1>**1. Introduction**</H1>

Providing consent for those unable to do so for themselves has received comparatively little attention in the bioethics literature.[[1]](#endnote-1) Despite this, there is pressing need to make decisions for others. An aging population with an increasing incidence of dementia and other cognitive impairments, medical science’s ability to keep people alive for longer, the ever-advancing range of treatment options available, concerns as to how we should treat those with a mental disorder that compromises their autonomy, and changing social attitudes towards determining our future care have all contributed to this need. All cases raise similar sorts of questions: who should make these decisions, what sort of decisions about consenting should be made, when should we seek consent from others, and how should decision-makers go about making such decisions?[[2]](#endnote-2)

Underpinning this is a question as to the basis of providing consent for others. It is widely held that autonomous (adult) individuals have a right to self-determination and are free to make any decision they like about their treatment.[[3]](#endnote-3) Yet, in preparation for when they may lose their autonomy, many individuals seek means to maintain control over their lives, rather than accept the instigation of a blanket paternalistic approach.[[4]](#endnote-4) This has given rise to conceptions of extended autonomy, whereby a currently autonomous individual seeks to make provision to determine important decisions about them for when they are no longer able to do so for themselves.

Whether or not autonomy can actually be so extended is a matter of philosophical debate, with questions ranging from the nature of personhood, to limits on the scope of autonomy, and what might constitute decision-making authority by a third party.[[5]](#endnote-5) Although there are practical and legal dimensions that also surround consenting for others, arising from the pressing demand for decisions needing to be made about individuals and pressures on the state to safeguard the welfare of the vulnerable, these philosophical questions play an important role in clarifying key conceptual issues and establishing the moral basis for such consent.

**<H2>1.1. Precedent autonomy and extended decision-making</H2>**

The central normative foundation for consenting for others is often based on the “extension view” of precedent autonomy.[[6]](#endnote-6) Drawing on conceptions of personal autonomy, precedent autonomy is the right of an autonomous individual to make decisions for a time in the future when they are no longer autonomous, such as through loss of competence due to cognitive decline. This right is derived from a simple extension of our current autonomy to cover future times. The moral authority of decisions based on our precedent autonomy is thereby considered no different to that of our usual, contemporaneously made autonomous decisions. What rights and authority this imparts on someone else to consent on behalf of another will therefore depend upon what conception of autonomy we are relying on. If autonomy, seen as something akin to a “right to make decisions for and about yourself”, allows us virtually unlimited authority to make decisions about our own lives, then this right requires respect for decisions about our future selves. On this view, autonomy grants us an important degree of self-governance or sovereignty over ourselves; hence our decisions can equally cover all future aspects of the self.

The philosophical literature is, however, replete with varying accounts as to what autonomy is, and only some can serve as a basis for an account of precedent autonomy.[[7]](#endnote-7) Accordingly, although the extension view just outlined is generally seen as the “orthodox” position, slightly different explanations have also been offered, depending upon the conception of autonomy being used as a basis for the account of precedent autonomy. These other explanations of precedent autonomy include allowing people to develop integrity of character whilst currently autonomous and allowing people to pursue “whole of life” wishes that allow them to live and shape their lives by values they hold as most important.[[8]](#endnote-8) Regardless as to which interpretation is held, a failure to respect past decisions would be seen as a violation of autonomy.

The importance of respect for precedent autonomy is also explained through another distinction, introduced by Dworkin (1993), between “experiential” and “critical” interests. Experiential interests are the sort of thing we have in the present moment; they are felt or thought and so are often described as “welfare interests”. Critical interests, on the other hand, are those concerning the values one holds, such as living in accordance with a view of what it is to have a dignified life. The desire to avoid the perceived indignity of living with dementia, for example, can be satisfied even if the individual is no longer able to understand what this critical interest is in their current state. The distinction highlights a tension that exists between making decisions in accord with the previous wishes of an individual who is no longer autonomous and making decisions that respond to welfare concerns affecting their immediate circumstances. Critical interests are what an individual is often seeking to protect when they make provision for consent to be made on their behalf, so that the course of action they indicated as being of most value to them can be adhered to, even should it not appear to be in their most immediate best interest. Precedent autonomy is therefore seen to protect an individual’s critical interests by allowing them the scope to live their entire life in the way they wished it to be lived rather than have paternalistic decisions made about them.

**<H2>1.2. Determining who to consent for</H2>**

Knowing when we need to provide consent for others is a question of whether an individual is an autonomous agent. In practice, this has primarily (although not exclusively) been about determining whether a person is sufficiently competent to consent.[[9]](#endnote-9) Although competence is a necessary feature of autonomy, it is important to proceed with some caution when considering this. How we understand competence does not always capture all the aspects one might consider important in a relevant determination of autonomy, which may include, for example, emotional maturity, aspects of authenticity, or ability to communicate.[[10]](#endnote-10) The picture is further confused because there is no universally accepted account of what competence is, although it is generally considered to involve a number of capacities or abilities. Whether this is characterised in terms of meeting some absolute minimum threshold of intellectual capacity, as relative to individual decisions, or some other means, is not a settled matter. [[11]](#endnote-11)

There are a wide range of people for whom decisions need to be made because they are not autonomous. Broad groupings include: (i) previously autonomous adults who have made provisions for their wishes and views to be known concerning future decisions; (ii) previously autonomous adults who have not made such provisions; (iii) adults who have never been autonomous; (iv) adults with fluctuating capacity, such as those with a mental illness or addiction; and (v) children. Some of these may involve clear-cut cases where there is no possibility of consent, or even communication, taking place, such as when dealing with comatose patients or very young children. There are, however, large numbers of cases where it is much more difficult to determine whether or not consent is required on behalf of another. Many of these involve people with a gradation of abilities to communicate and consent that can make the determination much more challenging as to whether or not, at any particular point in time and for any particular type of decision, consent on their behalf is required. This includes those in various stages of cognitive decline as well as children in various stages of cognitive and emotional development, where the boundaries between being and not being autonomous are unclear.

**<H1>2. Approaches to consenting for others</H1>**

Where it is considered that an individual is unable to provide consent for themselves, different approaches can be taken to determine decisions about their treatment. There are two major approaches that seek to allow an individual to exercise their precedent autonomy and make provision for future decisions: (i) appointing a surrogate or “proxy” decision-maker or (ii) creating an advance directive. In other cases where provision has not or could not be made, a range of alternative decision-making options arise.

**<H2>2.1. Proxy decision-maker</H2>**

A proxy decision-maker is an individual who is appointed to assume decision-making power for another person. In some cases, the proxy will have been appointed whilst the individual they will be consenting for was still an autonomous agent. Alternatively, it may be the identification of an individual (such as a family member, friend, or trusted associate) to indicate any known wishes they may have about medical interventions, although such cases are more about an attempt to discover the wishes of an individual rather than a strict extension of their precedent autonomy and, as such, are not the focus of discussion here. Where there is no legal authority attached to the proxy, their views are only advisory even if a proponent of precedent autonomy considers them to have moral authority, and it is up to those charged with making the treatment decisions to determine what weight to give the proxy’s judgements in practice. Whether there are or should be limitations as to the nature and scope of the sorts of decisions a proxy can make forms a significant part of the philosophical debates surrounding their use.

The authority of a proxy to make decisions for another person can be seen in terms of legal provision, practical requirements for someone to fill the role of decision-maker (such as determining immediate medical attention), and moral authority. Moral authority is a difficult concept to delineate but a simple account of it can be given as a normative relation between persons, such that the decision of a person is sufficient to give us a moral obligation to assent to, obey or respect that decision.[[12]](#endnote-12) The (still autonomous) appointing individual is relying on precedent autonomy to establish that the proxy has their authority to make decisions on their behalf. The proxy’s decision-making thereby becomes a direct extension of the subsequently incapacitated individual’s contemporaneous autonomous decision-making in virtue of this appointment.

**<H2>2.2. Advance directives</H2>**

An advance directive, also known as an advance statement or living will, allows an autonomous person to record their values, wishes, and preferences for decisions regarding their treatment for when they are no longer autonomous agents. A legally binding advance directive is a written document containing instructions that outline the sorts of treatment options that may be carried out, continued, or refused, and under what circumstances. The moral basis for adhering to the instructions contained in an advance directive are much the same as those for respecting the decisions of a proxy – an individual is extending their autonomous decision-making to allow them to consent at a future time when they are no longer autonomous.

Although it is supposed to be a direct record of the wishes of an individual, a written document containing these can cause problems. This is largely due to the need for someone to understand and interpret the content of the document so that it can be applied in practice. Therefore, they need to be sufficiently clear to help provide a determinate answer as to what is being consented to. If the content is too specific then the directive will apply only in very limited circumstances or may not sufficiently resemble circumstances that actually arise. If too general, advance directives can be difficult to interpret or apply. However, it is widely held that a clear, properly constructed advance directive provides the most accurate account of a person’s wishes that it is possible to reasonably obtain.

Concerns over the validity of an advance directive might arise in cases where it was thought that a person’s views had changed from those contained in the directive. The static nature of advance directives is one of the reasons for the growing use of proxy decision-makers, either as an alternative to or used in tandem with an advance directive. Proxies are seen to provide a more dynamic response to changes in situation and circumstance that may not have been foreseen at the time an advance directive was created.

**<H2>2.3. Other approaches to decision-making for others</H2>**

Not all approaches to decision-making for individuals lacking autonomy will be explicitly authorised by the individual they concern. The basis for determining such a role is usually found in social and legal precedents in virtue of a role or relationship that people or groups have towards an individual who is unable to consent. This includes a reliance on family members, medical teams, or direct decisions from the courts. However, it is questionable whether any of these methods constitute genuine consent as opposed to presenting us with various legal or practical solutions to having to make decisions about someone.

Historically, a great deal of weight was placed on the views of family members when it came to making medical decisions for an incompetent individual as they were the default, presumptive decision-maker. Often, close family members are taken to be the most knowledgeable about the incompetent individual’s values and preferences, as well as having a vested interest in promoting the welfare and good of that individual. There are also well-established social norms that treat families as important units of personal relationships which make decisions about their members on a regular basis. Of course, this will not hold true of all families or family members and it may be stronger in certain relationships (such as parent–child) than others. Moreover, decisions in terms of views about best interests or preferences would not necessarily be seen as consent but only an indication of a preferred course of action. So, although seen as an important source – and often the most practical means – of establishing a patient’s wishes, they are not a source of consent for another but only of advice about them.

Allowing medical treatment decisions to be made by physicians or medical teams has certain practical advantages for the immediacy of decisions and the utilisation of specialist knowledge as to the nature and implications of various treatment options. However, most decisions require not only an understanding of the medical effects but also an appreciation of the effects of the treatment upon any known values and interests the patient might have previously expressed. It is also unlikely that a medical team would make a judgement about medical options that go beyond day-to-day treatment, such as the decision to withdraw life-sustaining medication, without further ratification due to the significant moral dimensions that attach to that sort of decision. This also acts as a form of safeguard that any such decisions are in the patient’s interests.

A court is, in many ways, the ultimate arbiter of decision-making for an incompetent person simply because they are the final mechanism of determining who has the legal authority to consent for another person. What sorts of decisions a court is willing or able to make will depend upon individual cases as well as the constraints imposed by statute. Where a patient is deemed incompetent due to a diagnosable mental illness, for example, even a court may be limited in what medical treatments it can authorise consent for.

Although legal authority to determine who can consent for another – and for what purpose – is in the hands of the courts, there is also a normative underpinning to much of their decision-making that lends court judgments moral authority to determine such cases. This includes a highly precautionary approach to maintaining bodily integrity, with court judgments often being guided by the view that only the least invasive and most vital treatment options should be considered. That an intervention is considered to be in the best interests of the patient is therefore not sufficient reason to authorise it by itself; it must also conform to preserving bodily integrity as much as is reasonably possible. For example, the forced sterilisation of an incompetent individual may be deemed in their best interests but would unlikely be countenanced unless there was some pressing need for it to maintain that individual’s health due to the extremely invasive nature of the procedure. Furthermore, cases with a strong moral as well as medical dimension, such as cessation of life-sustaining treatments, are often seen as falling within the province of the justice system because they provide the best route to obtaining an open and impartial judgement as to the acceptability of such an action whilst also providing an important safeguard to both the patient and the medical institution.

<H1>**3. Different standards of consent for others**</H1>

Aside from questions of who can consent for another, there are standards that guide the way in which a proxy makes their decision. The two most commonly recognised guidance principles are substituted judgement and best interests. There is also scope in certain cases to account for the assent or dissent of the individual for whom consent is being given, which can be important influences as to how decisions should be made.

**<H2>3.1. Substituted judgement and best-interests standards of consent</H2>**

The substituted judgement standard requires the proxy to use their special knowledge of the incapacitated individual’s preferences to make decisions that the individual would have made, were they still able. The best-interests standard allows the proxy to make an assessment of the various interests a patient may have and determines what they think will be best overall to promote those interests. Opinion is divided as to which principle should be followed, depending upon how one balances the relative merits of one against the other.[[13]](#endnote-13)

With substituted judgements, as an attempt is made to replicate the actual decision-making process of the incapacitated person, it is often considered the closest we can get to determining what their wishes would have been, were they still competent. Accordingly, it is often described as the “gold-standard” of surrogate decision-making. Whether such forms of judgement are possible or coherent will be discussed in section 4.

With best-interests judgements, although the proxy may use their knowledge of the patient’s preferences and values, their judgement is not supposed to be a direct reflection of the patient’s wishes. Instead, the basis for the decision is what the proxy would consider best for the patient in a particular set of circumstances. This means it does not require the proxy to get inside the complex psychology of another person (except insofar as this is necessary to determine what may be in the best interests of that person, such as an understanding of their relevant desires, views, etc.) and can allow decisions to take into account the nuances of the particular circumstances the patient is in without having to strictly adhere to a set of values or principles a patient may have possessed.

**<H2>3.2 Assent and dissent</H2>**

Assent or dissent is a form of agreement or disagreement that assumes a lower standard of information assimilation, voluntariness, and decision-making to that of consent. However, they are concepts that are not well defined in the literature and their use can lead to some confusion.[[14]](#endnote-14) They are used with those individuals who are not fully autonomous and so cannot give valid consent but who can still grasp something of the nature of the decision to be made and thereby communicate their preferences. Although not fully autonomous, individuals may have a limited or developing autonomy that can be respected through seeking their assent or dissent. Assent is not simply a modest version of consent but something to allow an individual involvement with a situation over which he or she has no direct authority to determine by being able to consent. The satisfaction of these preferences is also likely to form an important element of a best-interests assessment by indicating experiential states of that individual, giving further reason to seek and respect them where these preferences do not conflict with other central interests. Conflict may occur in situations where an individual’s assent or dissent appears to be at odds with their overall best interests; for example, when a young child refuses an injection that is part of their treatment. In such circumstances, it may be appropriate to override their dissent in pursuit of their overall best interests. The challenge for the appointed decision-maker is to determine the extent to which the person’s interests will be advanced by respecting their assent or dissent.

This raises an important issue where assent and dissent may be at odds with an advance directive or the judgements of a proxy. This is the tension that lies between experiential interests and critical interests raised in section 1. The case of an individual whose experiential interests are in conflict with their previously acknowledged wishes is one that tests exactly how much weight we are willing to give to someone’s precedent autonomy. Just such a concern is presented in Dworkin’s (1993) famous example of the Alzheimer sufferer Margo, which has become something of a paradigm case in the literature. Dworkin’s example is used to support his argument that respecting precedent autonomy is part of a broader “integrity” view of autonomy: that the general value of autonomy is to be distinguished from the particular consequences for a particular person that arise as a result of autonomous decisions. Therefore, although there may be a conflict between the precedent autonomy of a demented person, such as Margo, and their contemporary experiential interests, respecting their precedent autonomy is consistent with their critical interests. As these critical interests were present when fully autonomous, Dworkin argues that to resist or reject them when the individual is no longer autonomous would be to fail to respect their autonomy in the same way that it would were they still competent. This is not to say Dworkin fails to recognise the tension that may arise as a result of this concerning an individual’s care, only that he considers critical interests should be judged as they were at the time they were made and treated with the same respect as all forward-looking autonomous decisions. However, as I shall go on to discuss in the next section, there are other arguments that may lend weight to an opposing view.

<H1>**4. Philosophical issues with consenting for others**</H1>

A variety of philosophical problems surrounding consenting for others exist, including concerns over how we can represent the views of another person, how we determine the validity of a proxy’s judgements, disagreement over the best course of action, the lack of continuity of interests over time, and moral authority. I here focus on three of the most prominent issues: questions of identity, epistemic concerns, and the nature of transferring or “bequeathing” decision-making authority to another person.

**<H2>4.1. Personal identity objections</H2>**

Personal identity is one of the more widely discussed concerns about the moral authority of advance directives, although it may also apply to the appointment of a proxy. Metaphysical accounts of personal identity are combined with ethical reflections about autonomy and authority to raise questions as to whether an individual is the same person, or whether they become a different person (or even lose personhood altogether), after a substantial loss of competence. The pertinent question for consent becomes whether the wishes of a patient who might be considered a previous, different person before the loss of competence should have any authority over the current individual. The thought being that, as one’s autonomous decision-making only has moral authority over oneself, then a necessary condition for the moral authority of an advance directive or appointment of a proxy would be that the person who issued it is identical with the one to whom it applies.

Quite what constitutes personal identity can be a matter of lengthy philosophical debate.[[15]](#endnote-15) The concept of personal identity relevant to this discussion is primarily one about persistence: how do we determine whether or not we are referring to the same or different person between two points in time? It is not to be confused with other uses of “personal identity”, which are used to describe what we think are our most important properties with which we identify ourselves (that “make you the person that you are”). Moreover, talk of persons being those things that have the “highest moral status” does not mean that anything which is not a person has no moral status; rather, it means persons are the sort of thing that we associate as having properties from which this status is derived.[[16]](#endnote-16)

There are two major accounts of personal identity, the Psychological view and the biological or “Animalist” view.[[17]](#endnote-17) The Psychological account is derived from early discussion by Locke (1690), who characterised our personal identity in terms of psychological continuity and reflective self-consciousness. Locke was concerned with a range of complex psychological attributes but perhaps the one that is most salient is continuity of consciousness, or memory, of one’s psychological processes and experiences.[[18]](#endnote-18) Accordingly, a person at time t­1 and a person at a later time t2 are the same person if and only if there is a sufficient level of psychological continuity between them. This approach is often seen as attractive because it allows a strong connection to our moral concerns and our intuitions about what is most important: that we identify more closely with our minds than our bodies.[[19]](#endnote-19)

The alternative view of personal identity takes a biological criterion as primary. This is the “Animalist” theory supported by Olsen (1997), Snowdon (1990), Wiggins (2001), and DeGrazia (1999). What is crucial to personal identity on this view is that we can lay claim to being a certain natural kind of animal of the species *Homo sapiens*. Our identity conditions are now those of this particular animal, and are decided in terms of biological properties rather than any account of our psychological continuity. Accordingly, a person at time t­1 and a person at a later time t2 are the same person if and only if there is a continuity of vital biological functions (often associated with some basic functionality of the brain).

Which account we follow impacts on how we might view the moral authority of advance directives and the appointment of proxies. With the Psychological account, the substantial loss of psychological continuity –a process that typically renders the individual incompetent and brings the advance directive or proxy into use – also determines that we are no longer dealing with the same person as the one who originally made the directive or appointed the proxy. Where the psychological disruption is severe and permanent, the claim would be that we were no longer dealing with a person at all. This is referred to by DeGrazia (1999) as “The Somebody Else Problem”. The problem is that the preferences of an autonomous individual do not extend over that of another individual. Hence the wishes conveyed by a person prior to their becoming incompetent lose any moral authority to determine decisions for the individual who remains after the loss of competence just at the very point they are meant to come into use. Either a new person succeeds the old one, so the previous person has no moral authority to determine treatment options over this new person, or there is no person left, in which case there is an end to moral authority altogether – it stops at the point where the necessary conditions to hold it cease. Although in practice many considerations of an individual over their future body are taken to have legal or moral authority, such as concerning organ donation or one’s will, these must ultimately have a different basis to that of extension of autonomous wishes.[[20]](#endnote-20)

Animalist accounts, by contrast, would hold that such a loss of psychological continuity would not result in a loss of personhood and hence would not be subject to the same identity concerns about moral authority as the psychological account. The same person continues to survive just so long as their animal functions continue to surround their most fundamental biological processes, such as metabolism, capacity to breathe, and circulation. However, even if one were to take an Animalist approach, concerns over authority may linger for other reasons, such as those in the next two sections.

**<H2>4.2. Epistemic concerns: knowledge of the future and representation of another’s thoughts</H2>**

Challenges to the coherence of relying on precedent autonomy, creating advance directives, or making substituted judgements are all raised by appeal to our concerns about our epistemic states. The first of these, initially raised by Buchanan (1988), are variations of concerns about lack of information on our future conditions, attitudes, treatment options, and suchlike, and our ability to gather such information. The most basic is a worry about information provision. This is largely based on an analogy with the demands of valid consent: that a person needs to be adequately informed before consent can be given. The simplified argument can be laid out in a series of steps:

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(1) Patient decision-making is only ethically valid if it is adequately informed.

(2) A patient can never be adequately informed about all the possible future medical conditions they might suffer from, or all the possible treatments that may become available.

(3) Therefore, it follows from (1–2) that treatment decisions based on precedent autonomy may not be informed (if, for example, new treatment options become available after the person has become incapacitated).

(4) Therefore, it follows from (1), (2), and (3) that decisions based on precedent autonomy may not be ethically valid.

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This argument, however, has only a limited application, as it won’t include very specific advance directives that cover treatment areas of which the patient was well-informed when they made the directive and for which the information still holds. At the very least, however, it does provide good reason as to why advance directives should be regularly updated to avoid concerns surrounding the levels of relevant information informing those decisions.

The other significant epistemological challenge concerns our ability to represent the thoughts of another. The issue is partly practical and partly an ongoing debate in Epistemology and the Philosophy of Mind that is relevant to how well a proxy can make a substituted judgement. On a practical level, the few studies available seem to indicate that we are not particularly good at making accurate substituted judgements for other people, even in the case of close relatives.[[21]](#endnote-21) Although this may be simply reflective of the lack of discussion about personal values and the lack of experience at making such judgements, there is a more substantial concern that, given our best theories of representation and simulation of another person’s decision-making process, it is virtually impossible to do this accurately in a substituted judgement setting. [[22]](#endnote-22)

The difficulty faced by a proxy in capturing there being some “fact of the matter” as to what decisions a person would have made, were they able, impacts on the way we might understand proxy authority. It seems unlikely that the moral authority of a proxy can be established on the basis of their having epistemic privilege over others that allows them to capture the decisions that would have been made.[[23]](#endnote-23) Although this does not rule out their being endowed or bequeathed the authority to simply make their own decisions on behalf of someone else, it does make the perceived “gold standard” of the substituted judgement standard of proxy decision-making appear a less plausible standard for proxy consent to aim for.

**<H2>4. 3. Challenges to the moral authority of proxies</H2>**

If the moral authority to make decisions on behalf of another is viewed as an extension of our own contemporaneous autonomous decision-making authority, then whether it is ever possible to transfer or “bequeath” moral authority to another person lies at the very heart of considering what grounds we might have for respecting the decision of the proxy, rather than the decisions of some other person or group of people. The response that it is simply because they are the ones designated to do so does not provide us with a convincing philosophical explanation.

This problem has been addressed in detail by Wrigley (2015), in which a two-horned dilemma is posed. On the one horn, if proxy decisions lack the moral authority of a contemporaneous autonomous decision, their use is undermined because we would lack the moral obligation to respect a proxy’s decisions as if they were the decisions of the still-autonomous individual. The other horn of the dilemma arises in response to a particular concern about the transfer or “bequeathing” of decision-making authority. If proxy decisions do have moral authority akin to contemporaneous autonomous decisions, this creates the possibility for the repeated application of the extension of authority process, allowing a proxy to potentially appoint their own proxy to make decisions for both themselves and the person they were acting as proxy for. This results in decisions being made by decision-makers to whom the authority had not been initially extended. Reflecting upon this dilemma tells us something about the foundations of proxy decision-making, the extent to which it offers us control over future treatment decisions, and whether this can really be said to be an extension of the original appointing individual’s autonomy. The implication is that, either way, we should view proxy decision-making as offering much less scope over how we wish future decisions to be made on our behalf than may currently be anticipated.

This is not to say that justifications for respecting the decisions of a proxy are not available to us on moral grounds other than as a bequeathed extension of our own autonomy, such as making appeal to the status of the proxy themselves as being in some way trustworthy or worthy of respect, or the way in which guardians or other decision-makers are appointed for children or people who have never been competent, often with a default to the “next of kin”.[[24]](#endnote-24) Moreover, there are plenty of cases where we grant limited decision-making authority to others to act as our agents whilst we are ourselves still competent, autonomous agents. However, the reason for addressing the transfer of authority in the way suggested by Wrigley (2015) is that it is a direct challenge to the “extension view” of our precedent autonomy. What ultimately gives someone else the authority to consent on behalf of another may have a very different foundation than it being simply an extension of an individual’s autonomous wish that they do this.

**<H1>5. Conclusion</H1>**

Although we might lack an entirely compelling account of the moral authority underpinning some of the approaches to obtaining consent, practical imperatives force us to seek some means of making decisions for others. Although legal and practical approaches provide us with sanctioned decision-makers, whether their decisions constitute consent is unlikely to be established unless we are able to provide a convincing account of how the moral authority to consent for others is established.

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**Related topics**

Ch.8 Valid consent

Ch.12 Consent and autonomy

**<NH>Notes</NH>**

1. One major exception to this is the comprehensive and compelling work by Buchanan & Brock (1990), which has grounded much of the subsequent debate in this area since its publication and remains one of the foremost works on the topic. [↑](#endnote-ref-1)
2. Although recognising the wide range of areas this may apply to, such as financial, lifestyle, and relationship choices, the focus here is on medical treatment decisions. It will also be on consenting for adults rather than for children. [↑](#endnote-ref-2)
3. There are well-recognised limitations to this, such as enforced quarantine to limit communicable diseases, requests within what is legally permissible, and that there is no right to simply receive any treatment that is demanded. [↑](#endnote-ref-3)
4. Mill (1859) famously advocated a paternalistic approach to those lacking autonomy. [↑](#endnote-ref-4)
5. Concerning the former, see Buchanan (1988); Buchanan & Brock (1990), and Wrigley (2007a). Concerning the latter, see Davis (2004, 2009), Dworkin (1988), and Wrigley (2015). [↑](#endnote-ref-5)
6. The “extension view” is a term famously used by Davis (2009: 349–74), although the underlying principle goes back earlier and is advocated by, e.g. Buchanan & Brock (1990). The term “precedent autonomy” is itself usually attributed to Dworkin (1993). [↑](#endnote-ref-6)
7. This makes it almost impossible to talk of autonomy without specifying what one takes “autonomy” to be in any given context. A significant distinction is often drawn between Kant’s conception of autonomy as the foundation of morality and Mill’s conception of autonomy as independently and intrinsically valuable. Here, it is a form of what Dworkin (1988) called “personal autonomy” (also called “individual autonomy”), more akin to Mill’s conception, that is in play. However, there are multiple variations on what that might be; for example, Feinberg (1989) identified four central meanings of “autonomy” used in moral and political philosophy alone. [↑](#endnote-ref-7)
8. As developed in Dworkin (1993). [↑](#endnote-ref-8)
9. There is sometimes a distinction drawn between “competence” and “capacity”. Little of any substance hangs on such a distinction for our purposes and they may be used interchangeably in this context. [↑](#endnote-ref-9)
10. Other major concerns may include adequate information provision or the liberty or voluntariness of the decision. These elements can often be addressed by changing the circumstances surrounding the consent. However, there may be rare cases where lack of voluntariness may require consent to be provided by another person. For example, lack of voluntariness that arises from problems such as a mental disorder which impedes free decision-making. Alternatively, a person may find themselves in such a restricted situation that one may plausibly maintain that they do not meet the requirement for voluntariness demanded by valid consent, for example, people detained in concentration camps or even prisons. [↑](#endnote-ref-10)
11. For a discussion of competence see Buchanan & Brock (1990) chapter 1. [↑](#endnote-ref-11)
12. This is broadly the account given in Anscombe (1981). [↑](#endnote-ref-12)
13. For example, Buchanan & Brock (1990) tend to favour substituted judgements whereas Harris (2003) has argued for a best-interests approach. Different jurisdictions can also require a certain approach be taken by proxies for their decisions to be considered as legally appropriate. [↑](#endnote-ref-13)
14. See Sibley et al. (2012). [↑](#endnote-ref-14)
15. See Noonan (1989). [↑](#endnote-ref-15)
16. This follows Locke’s use of the term in his (1690) *Essay*, where he takes “person” to be a “forensic” (i.e. legal and moral) term. I have, however, refrained from defining “person” in terms of the properties with which we attribute the making of moral decisions and being morally responsible for their actions, as this might be seen to beg the question against certain accounts of personhood. [↑](#endnote-ref-16)
17. Other accounts include, for example, narrative accounts of personal identity often traced back to MacIntyre (1984). See also the discussion in DeGrazia (2005). Parfit (1984) has even argued that questions of identity may not be what matters at all. [↑](#endnote-ref-17)
18. This approach has been refined numerous times to involve greater degrees of continuity and connectedness, for example, by Mackie (1976) and Parfit (1984). [↑](#endnote-ref-18)
19. Various thought experiments involving losing our bodies but having our minds preserved and the subsequent favouring of preferring to consider that our existence continues to follow our minds tend to support this view. More challenging cases involve “split brain” considerations. See Parfit (1984). [↑](#endnote-ref-19)
20. See Wrigley (2007a). [↑](#endnote-ref-20)
21. See, for example, Seckler et al. (1991), Suhl et al.(1994), and Sulmasy et al.(1998). [↑](#endnote-ref-21)
22. As advanced by Wrigley (2007b). These concerns utilise the theories of mental representation given in Davies & Stone (1995a, 1995b). [↑](#endnote-ref-22)
23. This debate has been pursued in much further detail concerning the validity of substituted judgements as based on “counterfactual wishes” models in terms of “what the other person would have decided had they been able to do so for themselves”. See Wierenga (1983), Barnbaum (1999), and Wrigley (2011). [↑](#endnote-ref-23)
24. See e.g. Aiken & LaFollette (1980). [↑](#endnote-ref-24)