Social Philosophy and Policy (2024), **41**: 2, 546–564
doi:10.1017/S0265052524000244

Social Philosophy & Policy

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

RESEARCH ARTICLE

Informed Consent, Autonomy, False Beliefs, and Ignorance

James Stacey Taylor

Department of Philosophy, Religion, and Classical Studies, The College of New Jersey
Email: jtaylor@tcnj.edu

Abstract

It is widely believed that health policy should take care to ensure that persons are informed about the expected risks as well as the anticipated advantages of medical procedures. This is often justified by a concern for the moral value of personal autonomy, as it is widely believed that to the extent that a person makes decisions on the basis of false beliefs or ignorance her autonomy with respect to them is compromised. This essay argues against this widespread claim. A person's autonomy with respect to her decisions will not be compromised by either ignorance or false beliefs. However, it does not follow that there is no reason to provide persons with the opportunity to have access to the available information relevant to their decisions concerning their medical treatment. The epistemic requirements for a person to give her consent to her treatment are more stringent than those that must be met for her to be autonomous with respect to her consent. Consent, not autonomy, can be undermined by ignorance or false belief. It is a concern for consent, not a concern for autonomy, that justifies providing people with information about their prospective medical procedures.

Keywords: autonomy; consent; plasma markets; kidney markets; belief

Introduction

It is widely believed in the West that in crafting health policy care should be taken to ensure that persons are informed about the expected risks as well as the anticipated advantages of the procedures or treatments that they are considering undergoing or receiving. It is, for example, widely accepted that it should be a matter of health policy that persons give their informed consent to their medical treatment if they are competent to do so.[1] It is similarly widely held that the prospective subjects of medical research should be informed of any health risks

[1] See, for example, Thomas Ploug and Søren Holm, "Informed Consent and Routinisation," *Journal of Medical Ethics* 39, no. 4 (2013): 214.

© 2025 Social Philosophy and Policy Foundation. Printed in the USA. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (http://creativecommons.org/licenses/by/4.0), which permits unrestricted re-use, distribution and reproduction, provided the original article is properly cited.

that it might involve.[2] It is also generally accepted that persons who are considering donating body parts to others (for example, plasma or a kidney) should be allowed to do so only after they have demonstrated that they understand the medical risks involved.[3]

Just as it is widely believed that health policy should be crafted so that persons are able to give their informed consent to their medical treatment, so too is it widely believed that this requirement is justified by a concern for the moral value of autonomy. Understood broadly, a person is autonomous with respect to her decisions or actions if she directs herself to make or to perform them. This account of autonomy is broad enough to be acceptable to all autonomy theorists.[4] The reasoning that supports this belief is simple. It begins with the claim that "[t]o the extent that a person's understanding is based on false beliefs about that which would otherwise be relevant to an understanding of the action, performance of that action is less than fully autonomous."[5] This claim is often then supplemented with a second: "[W]hen I choose to remain ignorant of relevant information, I am choosing to leave whatever happens to chance. I am following a path without autonomy."[6] A person who acts on the basis of false beliefs or out of ignorance of information that is relevant to her decision has her autonomy compromised with respect to the decisions that she thereby makes and the actions that she consequently performs.[7] Autonomy is of

[2] Søren Holm, "Informed Consent: Ethical and Legal Issues," *Encyclopedia of Life Sciences* (Chichester: John Wiley & Sons, Ltd., 2015), 10.1002/9780470015902.a0005198.pub3.

[3] Janet Radcliffe Richards, "Nephrarious Goings On: Kidney Sales and Moral Arguments," *Journal of Medicine & Philosophy* 21, no. 4 (1996): 379.

[4] While all autonomy theorists will agree that autonomy is understood as self-direction, they will disagree on how "self-direction" is to be understood. Some will understand it as contrasting with being directed by others; others will deny that this is the correct contrast. See note 11. They disagree about how to characterize the "self" that is doing the directing. Many will also argue that false beliefs or ignorance will compromise a person's ability to direct herself, and hence compromise her autonomy—the claim that I oppose in this essay.

[5] Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986), 253.

[6] Rosamond Rhodes, "Genetic Links, Family Ties, and Social Bonds: Rights and Responsibilities in the Face of Genetic Knowledge," *The Journal of Medicine & Philosophy* 23, no. 1 (1998): 18. Rhodes is not committed to the claim that a person who decides not to access this information would have her autonomy with respect to this decision compromised. To endorse this claim "would imply that one can never voluntarily choose not to inform oneself." Jason Hanna, *In Our Best Interest: A Defense of Paternalism* (New York: Oxford University Press, 2018), 158. I thank an anonymous referee for bringing my attention to Hanna's work.

[7] Having a false belief about something (e.g., that burning sage is an effective way to sterilize an operating theater) is a different epistemic condition from being ignorant of it (e.g., an eighteenth-century surgeon would be ignorant of how to sterilize an operating theater). There are also different ways in which one could be ignorant. One could be ignorant of facts related to knowledge that one has, such as knowing that sterilization is a good thing prior to operating but not knowing how to accomplish this. One could be ignorant of facts as they pertain to concepts that lie outside one's conceptual repertoire, such as an eighteenth-century surgeon not knowing how to sterilize his theater, as he has no concept of sterilization. I thank Søren Holm for interesting discussion of these points. Arnon Keren and Ori Lev argue that while false beliefs compromise a person's autonomy, ignorance does not. The Revisionary View outlined here is stronger: neither false beliefs nor ignorance compromise a person's autonomy with respect to her decisions or her actions. See Arnon Keren and Ori Lev, "Informed Consent, Error, and Suspending Ignorance: Providing Knowledge or Preventing Error?" *Ethical Theory and Moral Practice* 25 (2022): 357–59.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

great moral value. To protect it, persons must have the opportunity to acquire all of the available information necessary for them to be autonomous (or, at least, sufficiently autonomous) with respect to their health-care decisions.[8] Hence, health policy should be crafted to ensure that this occurs.[9]

This argument is simple, elegant, persuasive, and widespread. It is also unsound. As I will argue in this essay it is not true that a person's autonomy with respect to her decisions (or her consequent actions) will be compromised if she makes them on the basis of false beliefs or out of ignorance. It does not follow, though, from the failure of the above argument that there is no reason to provide persons with at least the opportunity to have access to the available information relevant to their decisions concerning their medical treatment. This is because the epistemic requirements for a person *to give her consent* to her treatment are more stringent than those that must be met for her *to be autonomous with respect to* her consent. For a person to consent to her prospective treatment she will (typically) need to be provided with information about it. However, this move away from autonomy and toward consent to justify the requirement that health policy ensures that persons are able to give their informed consent to their treatment is not merely to offer a different theoretical justification for a standard practice. Recognizing that the moral concern for autonomy cannot justify the ethical requirement of informed consent raises a fundamental question for health policy: If concern for autonomy cannot be the guiding principle that undergirds the requirement of informed consent, then what is?

The standard view is plausible

I term the view that a person's autonomy with respect to her decisions and consequent actions will be compromised if she acts on false beliefs or out of ignorance of information she would deem relevant to her decision the "Standard View." The Standard View is both intuitive and theoretically plausible. A patient makes it clear to his physician that he will only consent to take medications that will have no adverse sexual side effects. Believing that it is critical that his hypertension is treated, his physician prescribes him medication that she knows has a common side effect of causing erectile dysfunction. Knowing that he would be unwilling to take this medication if he were to realize this, she falsely informs him that it will have no adverse sexual side effects. As a result of this deception, he takes the medication. Because he was deceived into doing so, he was not autonomous with respect to this action.[10]

[8] Faden and Beauchamp, *A History and Theory of Informed Consent*, 240–41, focus on the need for persons to be "substantially" autonomous rather than "fully" autonomous.

[9] A version of this argument is outlined in Ploug and Holm, "Informed Consent and Routinisation," 214.

[10] The view that successfully deceiving a person into making a decision to perform a particular action is widespread in both the bioethics literature (especially on the use of placebos) and the literature on autonomy theory. See, e.g., Mark Alfano, "Placebo Effects and Informed Consent," *The American Journal of Bioethics* 15, no. 10 (2015): 9; and James Stacey Taylor, "Introduction," in *Personal Autonomy: New Essays on Personal Autonomy and Its Role in Contemporary Moral Philosophy*, ed. James Stacey Taylor (Cambridge: Cambridge University Press, 2005), 6.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

How does successfully subjecting a person to deception compromise her autonomy? One explanation will begin by noting that in this case it was the physician, not the patient, who was the font of the decision that the patient should take the prescribed medication to address his hypertension. She took steps to ensure that his beliefs were such that he would make the decisions and perform the actions that she desired him to make and to perform. To the extent that this was so, he was under her control. He was thus not self-directed, autonomous, with respect to these decisions and actions.[11]

This is not the only possible explanation of why this patient's autonomy with respect both to his decision to take the medication and to his consequent act of taking it was compromised. One might hold that it was compromised owing to his false beliefs about the medication's side effects. Support for this can be drawn from an example developed by Tom Dougherty.[12] Dougherty outlines two cases in which one person, Candace, asks another, Courtney, to store her antique skis for her. The skis were once owned by Josef Stalin. Courtney is unwilling to store items that were previously owned by dictators. In the first case, Candace knows both that the skis were owned by Stalin and that Courtney is unwilling to store the former property of dictators. To secure Courtney's consent to store the skis she withholds information about their history from her. As in the case of the patient with hypertension, Courtney's autonomy with respect to her consent to store the skis was compromised by Candace's successful deception.

In the second case, neither Candace nor Courtney is aware of the skis' history. Dougherty notes that, in this case, we would hold Candace blameless for thwarting Courtney's interest in not storing the property of former dictators, as she did not deceive her into storing the skis. Candace was "justifiably ignorant" that the skis were owned by Stalin.[13] Candace's blamelessness here is thus the result of features of *Candace*, not Courtney. However, because this is so, we cannot infer from Candace's blamelessness that Courtney was autonomous with respect to

[11] I develop this account of how successfully deceiving a person will compromise her autonomy with respect to the decisions that she makes in consequence in my *Practical Autonomy and Bioethics* (New York: Routledge, 2009), chap. 1. Distinguishing between the acts that a person directs herself to perform and those that she performs at the behest of another also undergirds my account of how threats can compromise a person's autonomy with respect to her actions; see my "Autonomy, Duress, and Coercion," *Social Philosophy & Policy* 20, no. 2 (2003): 127–55. This account of the relationship between autonomy and coercion contrasts with that of Harry Frankfurt, who holds an internalist account of what it is for a person to act "freely ... of his own free will." Harry Frankfurt, "Freedom of the Will and the Concept of a Person," *The Journal of Philosophy* 68, no. 1 (1971): 19; this article is widely taken to offer an account of autonomy. Frankfurt holds that the adverse effects that successful coercion has on a person's autonomy "is not essentially due to the fact that he is subjected to the will of another." Harry Frankfurt, "Coercion and Moral Responsibility," in Harry G. Frankfurt, *The Importance of What We Care About* (Cambridge: Cambridge University Press, 1988), 45. I discuss Frankfurt's view in my "Autonomy, Duress, and Coercion," 129–44.

[12] Tom Dougherty, "Sex, Lies, and Consent," *Ethics* 123, no. 4 (2013): 737–38. Dougherty developed this example in an attempt to meet a challenge to his view that a person's false beliefs about or ignorance of a deal-breaker could vitiate her consent to an event; he was not addressing the relationship between a person's epistemic limitations and her autonomy.

[13] Dougherty, "Sex, Lies, and Consent," 737. I added the claim concerning the thwarting of Courtney's interests.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

her (putative) consent to store the skis. After all, Courtney's mental states are no different in this case than in the first, where (owing to Candace's deception) she was not autonomous with respect to her consent to store them. It is thus plausible to hold that the question of whether Courtney is autonomous with respect to her consent "depends on facts about Courtney—it depends on the nature of her mental attitudes or utterances."[14] In both cases, Courtney's mental attitudes and utterances were the same. Hence, because Courtney was not autonomous with respect to her consent to store the skis when Candace deceived her into doing so, she was not autonomous with respect to her consent to store them when Candace was blameless. It is thus Courtney's ignorance of the history of the skis that renders her nonautonomous with respect to her consent to store them. Hence, when a person is successfully deceived into making a decision and consequently performing an action, her autonomy with respect to them is compromised owing to their being made and performed on the basis of her ignorance of "deal-breakers"—that is, facts about a situation that would make a decisive difference to someone's decision to perform an action.

It is plausible that neither the deceived patient nor Courtney (in either case) was autonomous with respect to their relevant decisions or actions. The claim that false beliefs about (or ignorance of) deal-breakers compromise a person's autonomy with respect to it is thus intuitively plausible.[15] But the Standard View is not only intuitively plausible; it also has theoretical support.[16] In writing of how ignorance could be "a threat to self-government" (that is, autonomy), Sarah Buss states:

> If doing Y is constitutive of doing Z, then if I authorize myself to be moved by the desire to do Y because I mistakenly believe that doing Y is a way of not doing Z, then there is an obvious sense in which I have not authorized myself to do what I am now doing when I am moved by the desire to do Y.[17]

Gerald Dworkin holds that Buss's account of how a person's ignorance could compromise her autonomy with respect to the actions that she subsequently performs "seems to me the strongest reason for saying that ... being deceived ... [is] incompatible with a decision being one's own."[18] He also notes that Buss's account provides reason to hold that a person who acts on a false belief that has not been brought about through the deception of another has diminished autonomy with respect to her actions.[19] If a person authorizes herself to perform a certain action because she mistakenly believes that that action will achieve a particular end, then

[14] Dougherty, "Sex, Lies, and Consent," 738.

[15] Dougherty, "Sex, Lies, and Consent," 731.

[16] In addition to being endorsed by the authors I mention both above and below, the Standard View is also endorsed by (among others) Alfred Mele, *Autonomous Agents: From Self-Control to Autonomy* (New York: Oxford University Press, 1995), 179–81; and Suzy Killmister, "Autonomy and False Beliefs," *Philosophical Studies* 164, no. 2 (2013): 513–31.

[17] Sarah Buss, "Personal Autonomy," *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta (February 15, 2018), https://plato.stanford.edu/entries/personal-autonomy/; quoted by Gerald Dworkin, "Lying and Autonomy," in *The Routledge Handbook of Autonomy*, ed. Ben Colburn (New York: Routledge, 2023), 241.

[18] Dworkin, "Lying and Autonomy," 241.

[19] Dworkin, "Lying and Autonomy," 241.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

"there is an obvious sense in which" she has not authorized herself to do what she is doing. On this analysis, the patient who took the medication prescribed to him because he believed that this was a way of treating his hypertension without affecting his sexual performance did not authorize himself to take it when he was moved to do so by the desire to treat his hypertension. He was thus not fully self-directed with respect to this action, and so his autonomy with respect to it was compromised.

This analysis of why a person's ignorance of relevant deal-breakers would compromise her autonomy with respect to her consequent decisions and actions also accounts for why persons who are not subject to deception could still have their autonomy with respect to their decisions and actions compromised owing to their ignorance. Courtney's storing of the skis constituted storing the former property of a dictator. She authorized herself to be moved by the desire to store the skis as she mistakenly believed that this would be an act that did not involve storing the former property of a dictator. Since this is so, "there is an obvious sense in which" she did not authorize herself to store the skis when she was moved by the desire to agree to do so.[20] Courtney's mistaken belief that the skis were the sort of thing that she was willing to store thus compromised her autonomy with respect to her agreement to store them. She attempted to direct herself to consent to store skis that had *no* connection to a dictator. She did *not* direct herself to consent to store skis that were formerly owned by a dictator. Because she did not direct herself to do what she actually did, her autonomy, her self-direction, was compromised with respect to her relevant decisions and consequent actions. It was thus her false belief about a deal-breaker that compromised her autonomy with respect to her consent to store the skis and her consequent storage of them. How she came to have this belief—for example, as a result of being deceived into having it or a result of making an unwarranted assumption about the history of the skis—is irrelevant.

The revisionary view is also plausible

The Standard View is both intuitively plausible and has theoretical support, but the same claims can be made about what I will call the Revisionary View. According to the latter, that a person has false beliefs about deal-breakers or makes decisions in ignorance of their presence does not in itself compromise her autonomy with respect to the decisions that she makes (or the acts that she consequently performs) on the basis of these false beliefs or in ignorance of these deal-breakers.

The Revisionary View is intuitively plausible. Consider the Canadian Health Coalition's (CHC) opposition to the legalization of offering financial compensation to prospective blood or plasma donors in Canada.[21] Some (perhaps all) members of the CHC believe that allowing donor compensation will compromise

[20] Buss, "Personal Autonomy."

[21] The Canadian Health Coalition is "a national organization made up of health care workers, unions, seniors, academics, community organizations and faith-based organizations, as well as affiliated coalitions in the provinces and one territory." Canadian Health Coalition, *Submission to the Standing Senate Committee on Social Affairs, Science, and Technology on Bill S-252, Voluntary Blood Donations Act* (February 22, 2019), 1, https://www.healthcoalition.ca/wp-content/uploads/2019/04/CHC-SENATE-SUBMISSION-S-252.pdf.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

Canada's ability to be "self-sufficient in blood and blood products," that it will compromise Canada's ability to provide "free and universal" access to blood and blood products, and that it will compromise the safety of the Canadian blood supply system.[22] These beliefs motivated some of the members of the CHC to advocate the legal prohibition of donor compensation. They also led them to lobby Health Canada to revoke the licenses of for-profit plasma collection agencies operating in Canada as well as to lobby Health Canada and Canadian Blood Services to work together to increase uncompensated plasma donation within Canada.[23] To achieve these ends the members of CHC engaged in a series of activities, including lobbying the Canadian Government, campaigning to educate the public about their views, and soliciting donations to fund their political efforts.[24]

However, the beliefs held by these members of the CHC about the effects that donor compensation will have on the Canadian supply of plasma are all false. If Canada were to offer sufficient financial compensation to current and prospective plasma donors, the amount of plasma that it would secure would be greater than that which it can secure absent such compensation.[25] Allowing donors to be compensated would facilitate rather than compromise Canada's ability to be self-sufficient in plasma. Similarly, compensating plasma donors would not compromise Canada's ability to provide "free and universal" access to plasma-derived medical products (PDMPs) to those patients within its borders who need them. Offering donor compensation would no more compromise Canada's ability to provide "free and universal" access to PDMPs than would the offer of compensation to health-care professionals to entice them to work in Canada's health-care system compromise its ability to offer "free and universal" health care. Finally, compensating plasma donors would not compromise the safety of the Canadian plasma supply.[26]

Yet despite the falsity of their beliefs concerning the effects that allowing donor compensation would have on the Canadian plasma supply, the members of the CHC who act on them still appear to be fully autonomous with respect to their decisions to oppose donor compensation and their consequent actions in support

[22] Canadian Health Coalition, *Submission to the Standing Senate Committee.*

[23] See Canadian Health Coalition, "Unpaid Plasma and Blood Donations," https://archive.healthcoalition.ca/unpaid-plasma-and-blood-donations/.

[24] Canadian Health Coalition, "Unpaid Plasma and Blood Donations."

[25] For evidence in support of this, see James Stacey Taylor, *Bloody Bioethics: Why Prohibiting Plasma Compensation Harms Patients and Wrongs Donors* (New York: Routledge, 2022), 22–25.

[26] In support of the claim that blood and plasma donors should be uncompensated to ensure the safety of the Canadian blood system, the CHC cites Horace Krever, *Final Report: Commission of Inquiry on the Blood System in Canada* (Ottawa: Commission of Inquiry on the Blood System in Canada, 1997). The Krever Report was commissioned in the wake of the transmission of HIV through blood donation in the 1970s and 1980s. It thus addressed the flaws of a collection system for blood and blood products that operated over forty years ago, when many of the current techniques for testing for blood-borne pathogens were unavailable and when the blood collection system was under a very different regulatory regime. To object to donor compensation on the basis of the events addressed by the Krever Report is thus akin to objecting to buying a new Ford on the grounds that the Ford Pinto (produced from 1971 to 1980) tended to explode when rear-ended. For an extensive discussion of the safety of plasma from compensated donors, see Taylor, *Bloody Bioethics*, 15–21.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

of this.[27] They identify the goals that they wish to achieve, determine the steps that they need to take to realize them, plan accordingly, and then put their plans into action. That the beliefs on which they act are false does not appear to compromise their autonomy, their self-direction, at all.

The intuitive plausibility of the Revisionary View gains further support from the observation that persons with religious convictions often make medical decisions based on their faith, but many of these religious convictions conflict. Jehovah's Witnesses, for example, believe that the Bible prohibits accepting blood transfusions.[28] This belief motivates them to decline them. Catholics, however, do not believe that the Bible prohibits blood transfusions, and so they accept them. At least one of these beliefs is false.[29] However, both Jehovah's Witnesses and Catholics can, intuitively, be fully autonomous with respect to their respective decisions to decline or accept transfusions. The Revisionary View is thus intuitively plausible.

The Revisionary view also has theoretical support. It is possible that a member of the CHC who opposes compensating plasma donors volitionally endorses, for example, her first-order desire to write to the Canadian Health Minister to oppose compensating plasma donors; she both wanted to possess the desire and wanted it to be that desire that moved her to act. She could thus meet the conditions that Harry Frankfurt outlines in his seminal article "Freedom of the Will and the Concept of a Person" for her to be autonomous with respect to the desire that moves her to act.[30] Similarly, it is possible that the decisions she makes concerning her efforts to oppose donor compensation were not the result of "manipulation, deception, the withholding of relevant information, and so on" and that she had not previously renounced her "independence of thought or action" prior to developing them. She could thus be fully autonomous with respect to them, on Gerald Dworkin's account of autonomy.[31] She could also qualify as autonomous with respect to the desires that she acted on that led her to work against donor compensation, on John Christman's analysis of autonomy. She did not resist (and would not have resisted) the development of the desire to oppose compensating plasma donors had she attended to the process by which she formed it. This lack of resistance did not occur under the influence of factors that would inhibit self-reflection. Her self-reflection involved no self-deception

[27] The (plausible) assumption here is that the members of the CHC who oppose compensating plasma donors are acting in good faith, with their opposition being motivated by a combination of these false beliefs and a desire to serve the medical needs of Canadian patients who have a medical need for plasma-derived medical products. This assumption is not, alas, always borne out in the debate over donor compensation in Canada. See James Stacey Taylor, "The Ethics and Politics of Blood Plasma Donation: The Case in Canada," *International Journal of Applied Philosophy* 34, no. 1 (2020): 89–103.

[28] I thank Sarah Raskoff for suggesting this example to me.

[29] Unless, of course, God both exists and issues different commands for different groups. It is possible that He just dislikes Jehovah's Witnesses.

[30] Frankfurt, "Freedom of the Will and the Concept of a Person," 5-20. See note 11. Killmister mischaracterizes Frankfurt's view, asserting that he holds that a person identifies with a first-order desire if he endorses his possession of it with a second-order desire. Killmister, "Autonomy and False Beliefs," 521–22.

[31] Gerald Dworkin, "Autonomy and Behavior Control," *Hastings Center Report* 6, no. 1 (1976): 25.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

and was minimally rational. She had no conflicting beliefs or desires that would significantly alter her behavior.[32] She could also qualify as autonomous with respect to her relevant preferences, on Laura Waddell Ekstrom's analysis of autonomy. A preference, Ekstrom explains, is a desire "(i) for a certain first-order desire to be effective in action ... and (ii) that is formed in the search for what is good."[33] For Ekstrom, a person will be autonomous with respect to those of her preferences that cohere with her "other preferences and acceptances."[34] When a person (such as a member of the CHC) acts on such preferences, she will be acting in a way that is characteristic of her—for example, she is acting in a way that manifests her compassion toward her fellow Canadians—and she will be able to provide reasons for her action, such as donor compensation will adversely affect the Canadian supply of plasma.[35] On Ekstrom's account, she will thus be autonomous with respect both to her preferences and her consequent actions.

Objections to the standard view

We are now at an impasse. Both proponents of the Standard View and proponents of the Revisionary View can provide equally intuitively plausible—but contrary—accounts of the relationship between false beliefs, ignorance of deal-breakers, and autonomy. Furthermore, the proponents of both accounts can provide theoretical support for their respective views.

The above discussion has served a useful purpose, though, for it has identified the core disagreement between proponents of the Standard View and proponents of the Revisionary View. Proponents of the Standard View assert that the question of whether or not a person is autonomous with respect to her decisions and consequent actions can be settled solely by appeal to facts about her. This is the lesson to be drawn from the discussion of Candace and Courtney. Proponents of the Revisionary View, however, deny this. This is the lesson to be drawn from the example of the deceived patient.

Seamus and the monstrous raccoons

Identifying this core disagreement enables us to see why the Standard View is mistaken. On the Standard View, a person's autonomy with respect to a decision

[32] John Christman, "Defending Historical Autonomy: A Reply to Professor Mele," *Canadian Journal of Philosophy* 23, no. 2 (1993): 288. Christman explicitly states that, on his view, the requirement that a person be only minimally rational when she reflects on the process by which she formed her desires precludes the requirement that "the beliefs upon which ... [her] conditional desires rest are based on an (objectively speaking) adequate degree of evidence." On his view, then, it is possible that an agent could be autonomous with respect to her desires even if she only possesses them as a result of having false beliefs owing to her using an objectively inadequate evidentiary standard in their formation. See John Christman, "Autonomy and Personal History," *Canadian Journal of Philosophy* 21, no. 1 (1991): 14. I thank an anonymous referee for pressing me to clarify this.

[33] Laura Waddell Ekstrom, "A Coherence Theory of Autonomy," *Philosophy and Phenomenological Research* 53, no. 3 (1993): 603.

[34] Ekstrom, "A Coherence Theory of Autonomy," 608.

[35] Ekstrom, "A Coherence Theory of Autonomy," 615.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

(and a consequent action) will be diminished if she makes that decision (and hence performs the action) on the basis of a false belief about a "deal-breaker." It does not matter how she came to have that false belief, for example, whether she was deceived into having it or not. The question of whether or not she is autonomous with respect to her decisions (and consequent actions) depends solely on facts about her. In this discussion the pertinent fact about her is whether or not she has a false belief about a deal-breaker. But whether a person has a false belief about something external to her would *not* depend merely on facts about her, *but on facts about the external world.* The falsity of a CHC member's belief about the safety of PDMPs produced from plasma sourced from compensated donors depends on facts about PDMPs, not on facts about the CHC member who holds this belief. The (possible) falsity of a Jehovah's Witness's beliefs about the will of God depends on facts about the will of God, not on facts about the Jehovah's Witness. It is thus possible on the Standard View for two persons with identical mental states to differ in the degree to which they are autonomous with respect to a decision that they make. Consider a revised version of the example of the deceived patient. This time, the medication is just as his physician presents it to him: an effective treatment for hypertension with no adverse sexual side effects. Because this patient is now not ignorant of facts about the medication that would be deal-breakers for him, he could (on the Standard View) be fully autonomous with respect to his decision to take the medication. This is not because of facts about him, though, but because of facts about the medication.

The simple observation that the truth or falsity of a person's beliefs will depend not only on facts about her but also on facts about the external world should lead us to reject the Standard View. To see this, consider the (true-ish) example of Seamus and the Monstrous Raccoons.[36]

Growing up in Scotland, Seamus's only exposure to North American fauna was through Disney cartoons. As a result, he came to believe that raccoons and chipmunks were roughly the same size—about 3–5 inches long, weighing about 3–5 ounces. The first time he encountered (regular-sized) raccoons in America, he thought they were far, *far* larger than they should be—over 100 times as large as they should be, in fact. Deeply concerned (and not a little frightened) he called the police to report the presence of monstrous raccoons.

Seamus's decision to call the police and his consequent actions were motivated by his false beliefs about raccoons. On the Standard View, then, his autonomy with respect to them was compromised. On its face, this claim is plausible. That the raccoons he saw were normal-sized was a deal-breaker for Seamus. Had he been aware of this, he would not have called the police. Seamus's ignorance of the presence of this deal-breaker ensured that he failed to perform the act that he appeared to have authorized himself to perform: to alert the police to the presence of monstrous raccoons. Because there "is an obvious sense" in which he failed to authorize himself to perform the act that he actually performed—that is, alerting the police to the presence of *regular-sized* raccoons, when he did not desire to do this—Seamus did not do what he directed himself to

[36] This example is based on a series of real events that occurred in Rudolph, Ohio, in 2000. I thank David Schmidtz and Fred Miller, Jr., for encouraging me to note this!

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

do; he did not alert the police to the presence of monstrous raccoons. Because he did not direct himself to alert the police to the presence of regular-sized raccoons, his autonomy with respect to his actions was compromised.

So far, the Standard View's account of why Seamus's autonomy was compromised with respect to his decision and consequent action is plausible. But the veneer of plausibility that the Standard View enjoys with respect to this example should not lead us to lose sight of the fact that the question of whether a person is autonomous with respect to a decision that she makes or an action that she performs is a question about whether she directs herself to make or perform it. It is a question about whether she is *self*-directed with respect to it. To answer this question, then, *we must make essential reference to facts about her*. We need to know whether she was self-directed with respect to this decision or this action—that is, whether she directed herself to make it or perform it—or not. This question *cannot* be settled solely by reference to facts about the world that are *external* to her that make no essential reference to her.

Consider Seamus and the raccoons again. On the Standard View, Seamus's autonomy with respect to his decisions and actions was compromised because he had false beliefs about the size of raccoons. This is a fact about Seamus; it is a fact about his mental states. So far, so good. This approach to answering the question of whether Seamus was autonomous with respect to his decisions and actions appears to be addressing the question by essentially referring to facts about Seamus. However, on the Standard View, it is the *falsity* of Seamus's beliefs that compromises his autonomy with respect to the actions that he performed as a result of his having them. This is where things go awry. The falsity of Seamus's beliefs was determined *not* by facts about Seamus, but by facts about raccoons, just as, in the example, above, the falsity of the patient's belief about his medication was determined by facts about its side effects. Proponents of the Standard View are thus committed to claiming that the answer to the question of whether Seamus is autonomous, self-directed, with respect to his act of informing the police about the presence of what he believed to be monstrous raccoons *is determined by facts about raccoons.* But the question of whether Seamus was self-directed, autonomous, with respect to his decisions and actions *cannot* be settled by reference to facts about raccoons. It can only be settled by reference to facts about Seamus. Similarly, the question of whether a patient is autonomous, self-directed, with respect to her taking a medication that she has been prescribed cannot be settled by reference to facts about that medication. The Standard View must thus be wrong. It locates in the wrong place the answer to the question of whether a person is autonomous, self-directed, with respect to her decisions and actions.

Rejecting internalist accounts of autonomy

In rejecting the Standard View in this way, I am not claiming that the question of whether a person is autonomous with respect to a decision or an action can be settled solely by reference to her motivational state. I am not endorsing an internalist approach to autonomy on which the question of whether or not a person is autonomous with respect to, for example, a desire, decision, or action

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

can be settled by reference only to the structural features of her motivational set.[37]

Consider again the example of the physician who deceived her patient into taking medication for his hypertension by deliberately falsely informing him that he would have no adverse sexual side effects. Let us call this example A. The patient's autonomy with respect to his decision to take the medication was compromised, as it was his physician, not he, who was the font of the decision that he should take it. It was she, not he, who directed his decision-making. To the extent that this was so his self-direction, his autonomy, with respect to his decisions and consequent actions was compromised.

Now consider an alternative version of this example in which the physician believes that the medication will have no adverse sexual side effects. Let us call this example B. The external behavior of this second physician and her initial counterpart are identical, as is that of their patients. However, in this case the physician does not deceive her patient into taking the medication; she simply provides him with the facts about it as she understands them. In taking the medication he, and not she, is the font of his decision to do so. His autonomy is not usurped; he remains self-directed with respect to his decisions. The difference in the degree to which these patients are autonomous with respect to their decisions and consequent actions is determined in part by the mental states of their respective physicians. The degree to which a person is autonomous with respect to their decisions and consequent actions thus appears to be determined in part by the mental states of others.[38]

While examples A and B provide us with reason to believe that (to put it crudely) *my* autonomy can depend on *your* mental states, they do not tell the whole story of how this could be so. The physicians in examples A and B differed in their beliefs about the effects of the medication. A realized that it had adverse sexual side effects while B did not. That A knew that the medication had these adverse side effects and failed to disclose these to her patient does not, however, establish that she thereby usurped his autonomy with respect to his decision to take the medication.

Consider a third example, C. In this example the physician provides her patient with a list of the side effects of the medication that has been compiled by a third party. This list inadvertently fails to mention its adverse sexual side effects. Like the physician in example A, the physician in example C knows that these side effects are a possibility. She also resembles the physician in example A in that she fails to disclose these side effects to her patient. But *unlike* the physician in example A, her failure to disclose is not motivated by a desire that the patient take the medication. She is completely indifferent as to

[37] For a discussion of the difficulties faced by internalist ("structural") views of autonomy, see Christman, "Autonomy and Personal History," 5–10.

[38] This example can be developed to lend support to a view of autonomy on which a person is autonomous with respect to her decision and actions to the degree that it is she, and not someone else, who directs her to make or perform them. This political account of autonomy is not accepted by everyone; see notes 4 and 11.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

whether or not he takes it. Her failure to disclose is simply the result of laziness.[39]

Unlike the physician in example A, the physician in example C has not decided to make it the case that her patient will take the medication that she has prescribed; she has merely recommended that he do so. By refraining from deciding what he will do, she does not usurp his autonomy with respect to the decision as to whether or not he should take the medication. To see this, consider the different responses of the physicians in examples A and C if their patients were to question them directly about the possibility of adverse sexual side effects. In A, the physician would lie, reassuring her patient that they would not occur. In C, however, the physician would tell the truth. The physician in example A would deceive her patient so that he will make the decisions that she has decided that he will make, while the physician in example C would not. The physician in example A is thus attempting to usurp her patient's autonomy, his self-direction—and if, as a result of this deception, his patient acts as he desires, he will succeed in this usurpation—while the physician in example C is not. A person's (true) belief that another person has a false belief that the first person believes that she will rely on to make a decision is thus not sufficient for the first person to have usurped the second person's autonomy with respect to that decision. For this usurpation to occur the first person must also *intend to control the decision* that the second person makes, for example, through deceiving him into making the decision that she desires that he makes. For this intended usurpation of his autonomy to be successful the decisions that he made must have been made as a result of the actions that she performed to fulfill her intent to control him.

It is important to note that in the above examples the facts about the external world—that is, the mental states of the physicians—that are relevant to assessing whether the patient is autonomous with respect to his decisions and consequent actions still involve *his* (that is, the patient's) mental states in that they make essential reference to them. The facts about the external world that are relevant to assessing whether or not this patient's autonomy was compromised with respect to his decision to take the medication were *some* of the mental states of his physician: those which had as their intentional objects the relevant mental states of the patient, such as his beliefs concerning the effects of the medication. Facts about the external world can thus be relevant to determining whether or not a person is autonomous with respect to his actions or decisions, but those facts must make essential reference to his mental states. To return to the crude characterization I offered above, my autonomy can depend on your mental states, provided that your mental states are about mine. An account of autonomy on which the question of whether or not a person is autonomous with respect to her decisions or actions can be settled without reference to her mental states is just as mistaken as internalist accounts that refer only to the structural relationships that hold between a person's mental states.

[39] I thank an anonymous referee for pressing me on this example.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

Facts about nonintrinsic properties can be deal-breakers

Proponents of the Standard View mislocating the answer to the question of whether Seamus was autonomous with respect to his decisions and actions is not, however, the only problem that their view of the relationship between autonomy, false beliefs, and ignorance faces. The Standard View faces a further problem that stems from its acknowledgment that deal-breakers are not limited to the intrinsic properties of the things that feature in a person's decision-making—for example, that this medication has an ingredient that causes erectile dysfunction—but can also include their nonintrinsic properties, for example, that these skis were once owned by Stalin.

Because they are not limited to the intrinsic properties of persons or objects, a deal-breaker could be the fact that an option that I consider preferable to that which I am considering is available to me. For example, if I would prefer to date Jack rather than Jill in a situation where I would be willing only to date one person, Jack's willingness to date me would be a deal-breaker for my willingness to date Jill. On the Standard View, then, if I were ignorant of the fact that Jack is willing to date me or if I were falsely to believe that he would not date me, then my autonomy with respect to my agreeing to date Jill would be compromised.

Proponents of the Standard View are thus committed to holding that unless a person consents to an event that is ideal for her given her available options, she will not be autonomous with respect to her consent.[40] This implies that many of the choices that a person makes when she is presented with a range of options—for example, dating partners, diet, or medical care—would be ones with respect to which her autonomy is compromised. This is implausible; it treats autonomy as a success concept. But autonomy is not a success concept.[41] Persons can be fully autonomous with respect to their decisions—for example, to pay for name-brand medication—even if they would not have done so had they been aware of other options—for example, for their insurance to pay for generic medication that was chemically identical to the name brand. This implausible implication of the Standard View provides us with a second reason to reject it.[42]

[40] There is a complication here. Persons might consent to events (e.g., surgery) that they realize have only a certain chance of leading to the outcomes that they desire. Proponents of the Standard View are not committed to the claim that in a such a situation a person is autonomous with respect to her decision to embark on a course of action that she realizes has only a probabilistic chance of success only if the result that she desires transpires. Instead, they are committed to the weaker (but still implausibly over-strong) view that persons in such situations are autonomous with respect to their decisions if they are informed by a correct understanding of the probabilities involved. In such situations, proponents of the Standard View treat autonomy as a success concept with respect to the agent's understanding of the probabilities rather than with respect to outcomes.

[41] As Steven Weimer puts it, to treat it as though it was, is to confuse whether a person is autonomous with the separate question of whether her exercise of her autonomy provides her with success. Steven Weimer, "Beyond History: The Ongoing Aspects of Autonomy," *Journal of Ethics & Social Philosophy* 4, no. 1 (2009): 30.

[42] This line of argument should also lead us to reject the account of consent that Dougherty develops in his "Sex, Lies, and Consent," esp. 737–38. Note that for reasons independent of this line of argument, Dougherty no longer endorses his earlier account of consent that treated it as a purely

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

Autonomy and consent

The Standard View is thus mistaken. A person acting out of ignorance or on the basis of false beliefs is no bar to her being fully autonomous with respect to her actions, even if she is ignorant of or has false beliefs about deal-breakers.

This conclusion might appear to have rather alarming implications for health policy. As noted at the start of this essay, persons who work on health policy often claim that health-care professionals should secure their patients' informed consent to their treatment to protect their ability autonomously to choose for themselves.[43] On the Revisionary View of the epistemic conditions required for autonomy, securing a person's informed consent is no longer necessary for this. Others who work on health policy express ethical qualms about certain forms of medical research involving human subjects where their risks are unknown, and so the subjects must agree to participate in ignorance of what they are letting themselves in for.[44] On the Revisionary View, though, a valuer of autonomy should hold that such qualms are misplaced. Such ignorance would not compromise the ability of potential research subjects to be fully autonomous with respect to their consent to participate. Many persons object to the buying and selling of human body parts (such as plasma or kidneys) on the grounds that the prospective sellers will typically be ignorant of the risks they will incur through such sales, and so concern for their autonomy should lead us to preclude them from entering into such contracts. In response, defenders of such markets note that prospective participants in them should be educated about the risks that they might run.[45] On the Revisionary View, though, such ignorance is no bar to one's selling a kidney.

The Revisionary View, then, seems to have startling and implausible implications for health policy. However, accepting this view's account of the epistemic conditions that a person must meet to be autonomous with respect to her decisions and consequent actions does not have the startling implications for health policy that it might appear to have. This is because the epistemic conditions that must be met for a person to be autonomous with respect to her decision to perform an action and her consequent attempted performance of that action might differ from those that are required for her successfully to perform that action. (The implications that this has for health policy will become clear below.) Consider marriage. In many traditions, in order to marry, a person has to utter a certain form of words. Someone who fails to do so does not become married. A person who utters the wrong form of words due to not knowing the correct form would fail to marry; she would fail to perform the act that she authorized herself to perform. The possession of false beliefs can thus preclude a person from performing an action that she autonomously attempted to perform.

mental phenomenon. Instead, because "consent is a public phenomenon, we must engage in outward behaviour to give consent. Once we take on board that point, we lose the motivation to hold that our intentions all by themselves fix the scope of our consent." See Tom Dougherty, *The Scope of Consent* (Oxford: Oxford University Press, 2021), 6.

[43] See, e.g., Ploug and Holm, "Informed Consent and Routinisation."

[44] See, e.g., Holm, "Informed Consent: Ethical and Legal Issues."

[45] Richards, "Nephrarious Goings On," 379.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

Strictly speaking, then, persons will be autonomous with respect to their decisions to perform actions and autonomous with respect to their consequent *attempts* to perform those actions. Her false beliefs would not compromise her autonomy with respect to her *attempt* to marry, but they would preclude her from succeeding in doing what she attempted to do, that is, marry.

The same point can be made with respect to consent. Although one might assume that the epistemic conditions that must be met for a person to be *autonomous with respect to her (attempt to) consent* are the same as those that must be met for her *to consent*, this assumption is unwarranted.[46] Consider a person who has a religious conviction that human skin should never be broken intentionally. She does not realize that a biopsy on a growth on her lungs involves an incision, believing instead that it involves the placing of a tube down her throat.[47] Her attending physician explains the advantages and disadvantages of performing a biopsy on the growth. He is unaware of her misconception concerning the nature of a biopsy and so does not correct it. She considers the information that she has been given and appears to consent to the procedure. Because she directed herself to make the decisions and perform the actions related to this event, she was autonomous with respect to them. However, when she wakes from the anesthesia and realizes what occurred, she would rightly deny that she had consented to being cut open. While her ignorance of this deal-breaker did not preclude her from being autonomous, self-directed, with respect to her (attempt to) give her consent to the procedure, it did preclude her from consenting to the procedure. The epistemic conditions that must be met for a person to be autonomous with respect to a decision and her attempt to perform the actions consequent to it are thus weaker than those that must be met for her to consent.

What are the epistemic conditions that must be met for a person to consent to an event (for example, a biopsy or the donation of her plasma)? Loosely put, a person will have an idea in mind of to what she intends to consent. To the degree that the events that transpire as a result of her (attempted) consent differ from what she had in mind, the less likely it is that she consented to what occurred.[48] At first blush, then, a person whose attempted consent to the occurrence of an event was based on a false belief about a deal-breaker related to that event would

[46] Tom L. Beauchamp, e.g., defines informed consent as "an individual's autonomous authorization of a medical intervention or of participation in research," in his "Autonomy and Consent," in *The Ethics of Consent: Theory and Practice*, ed. Franklin G. Miller and Alan Wertheimer (Oxford: Oxford University Press, 2010), 57. I am *very* grateful to Stephen Kershnar, Philip Held, David Hershenov, and Greg Bognar for helping me to realize that the epistemic conditions for autonomy and consent differ, thereby aiding my escape from the fly-bottle in which I was trapped.

[47] This example is adapted from Dougherty, *The Scope of Consent*, 3, 86. Dougherty would hold that even though this woman did not know what a biopsy was, she would still have consented to the biopsy. On my view of consent, this is mistaken. It conflates the question of whether a person consented to the occurrence of an event with the question of whether the person who brought about the event was blameworthy for so doing. For a similar conflation, see Dougherty's discussion of Candace and Courtney, in his "Sex, Lies, and Consent," 737.

[48] This does not imply that the events that transpire are ones to which she would not have consented had she known what they would be; she might be pleasantly surprised by what occurred.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

not have successfully consented to its occurrence. This is so in the biopsy case. Owing to her ignorance of what a biopsy was, the patient did not consent to the procedure that she underwent. But it is not only facts about an event's intrinsic properties that could be deal-breakers. Facts about relational properties could be, too. This is shown in Dougherty's example of Candace, Courtney, and Stalin's skis. The history of the skis was a deal-breaker for Courtney, and so she did not consent to their storage.[49] However, not every deal-breaker will defeat a person's attempt to consent to an event. Consider again the observation that on the Standard View autonomy is treated as a success concept. On the Standard View, owing to my ignorance of Jack's romantic availability to me, I was not autonomous with respect to my decision to date Jill. This implication of the Standard View is implausible. It is similarly implausible to hold that I did not consent to date Jill, owing to my ignorance of Jack's romantic availability. A person's ignorance of alternatives to an event to which she is considering consenting when the availability of those alternatives would be a deal-breaker for her is thus not relevant to determining whether she consented to the occurrence of the event in question.[50]

A person will be precluded from consenting to the occurrence of an event if she is ignorant of facts about the intrinsic properties of that event that are deal-breakers for her. She will also be precluded from consenting to the occurrence of an event if she is ignorant of facts about the relational properties of that event that are deal-breakers for her, for example, that these skis were owned by Stalin. The epistemic conditions that must be met for a person to consent to an event are thus more stringent than those that must be met for her to be autonomous with respect to her attempt to consent to that event. Certain facts about the external world can preclude a person from consenting to an event when she attempts to do so, even though they do not similarly preclude a person from autonomously attempting to perform an action. Careful attention to the scope of the concepts of consent and autonomy reveals that this is not surprising. When I consent to the occurrence of an event, my consent is conditional on the world being a certain way. If the world transpires not to be that way, then my attempt to consent is unsuccessful. By contrast, when I autonomously make a decision or perform an action, I am directing myself to *attempt* to make the world a certain way. If my attempt fails and the world does not become the way I attempted to make it, this will not retroactively render my attempt any less an exercise in self-direction.

It might be tempting to conclude that the concern for autonomy in discussions of health policy should be replaced by a concern with securing consent, but this temptation should be resisted. A person who is deceived or manipulated into giving her consent could still meet the conditions for her consent to be valid if the deception or manipulation did not engender within her any false views concerning either the intrinsic or relational properties of the event in question. My consent to date Jill could still be genuine, even if it was the result of Jenny's deceiving me into thinking that Jack was not romantically available to me. If I

[49] If unpersuaded by this example, consider whether a person who buys a forged Van Gogh drawing, believing it to be genuine, consented to his purchase.

[50] See note 42.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

were later to discover Jenny's deception, I would likely say that I *would not have* consented to date Jill had I known that Jack was available; I would not say that I now realize that *I did not consent* to date Jill at all. But owing to its deceptive origins, we would not say that such consent was authoritative. We also would not say that it was authoritative, because the person concerned was not *autonomous*, self-directed, with respect to her consent. Remember, successfully subjecting a person to manipulation or deception will compromise her autonomy with respect to the decisions or the actions that she was manipulated or deceived into making and performing. Rather than jettisoning our moral concern with autonomy and replacing it with a moral concern for consent, then, we should instead be concerned with both autonomy *and* consent. We should be concerned with ensuring that persons do not merely consent to their treatment, but that they are *autonomous* with respect to their consent, that is, that they give their *autonomous consent.*

Conclusion

This has been a long essay and some readers might now feel rather cheated. Such a thicket of words to arrive at the apparently anodyne conclusion that health policy should be crafted to ensure that persons can give their informed consent to their treatments! But this conclusion is not as anodyne as it might appear. First, it is often claimed that persons should give their "autonomous consent" to their treatment (medical or otherwise).[51] However, until now there has been little or no recognition of the fact that this is a portmanteau requirement, with the epistemic conditions that must be met for a person to consent to her treatment differing from those that must be met for her to give her autonomous consent. Second, the above discussion has established that the common justification for requiring that persons give their informed consent to their treatment—that is, that this is required to protect their autonomy—cannot be correct. The epistemic conditions that must be met for a person to be autonomous with respect to her decisions and actions are *weaker* than those that must be met for her to give her autonomous consent. A person could thus be autonomous with respect to her (attempt to) consent, even if she has sufficient information to be able to give her autonomous consent. The more robust epistemic requirements that are required for a person to give her autonomous consent to her treatment are thus not required (as they are too stringent) for the protection of autonomy. The justification for these robust epistemic requirements thus cannot be grounded on a concern for autonomy.

This last observation leads to the third reason why the conclusion of this essay is not as anodyne as it might appear. It raises a fundamental question for health policy. If a concern for the moral value of autonomy cannot justify requiring

[51] See, e.g., Elizabeth Reis, "Did Bioethics Matter? A History of Autonomy, Consent, and Intersex Genital Surgery," *Medical Law Review* 27, no. 4 (2019): 658; Keren and Lev, "Informed Consent, Error, and Suspending Ignorance," 357, 360; Robert K. Martin, "Trustworthiness as Information: Satisfying the Understanding Condition of Valid Consent," *Bioethics* 37, no. 5 (2023): 487.

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press

persons to be able to give their autonomous consent to their treatment, what can? Two possibilities suggest themselves. Such consent could be justified out of a concern to protect and promote well-being. This view is based on the defeasible empirical claim that securing a person's autonomous consent to their treatment would be (in rule-utilitarian fashion) the best way to protect and promote their well-being.[52] Alternatively, one might eschew such empirical claims to argue that the need to secure a person's autonomous consent to their treatment is required by respect for personhood.[53] Which of these two approaches is correct (if, indeed, either is) is the subject for another day.

Acknowledgments. This essay's great-grandfather was presented at a Bioethics Workshop organized by Samuel Director in January 2023; its grandmother was then presented at the Romanell Bioethics Workshop at the University of Buffalo in March 2023. Its father was then discussed by other contributors to this volume in May 2023. (Unlike ships, academic essays in English are gender-fluid.) I thank the discussants on all three occasions for their very helpful comments and criticisms. I also thank an anonymous referee for their *very* constructive suggestions on how to improve the father of this essay.

Competing interests. The author declares none.

[52] I consider this view in my *Practical Autonomy and Bioethics*, chap. 10.

[53] I thank Frances Kamm for pressing me on this possibility.

Cite this article: Taylor, James Stacey. 2024. "Informed Consent, Autonomy, False Beliefs, and Ignorance." *Social Philosophy and Policy* 41, no. 2: 546–564. https://doi.org/10.1017/S0265052524000244

https://doi.org/10.1017/S0265052524000244 Published online by Cambridge University Press