Explorations of the Relationship Between the Right to Make Decisions and Moral Responsibility in Healthcare

Acta Philosophica Gothoburgensia 37

Explorations of the Relationship Between the Right to Make Decisions and Moral Responsibility in Healthcare

Thomas Hartvigsson

UNIVERSITY OF GOTHENBURG
ACTA UNIVERSITATIS GOTHOBURGENSIS

ISBN 978-91-7963-042-3 (printed)
ISBN 978-91-7963-043-0 (pdf)
ISSN 0283-2380

The publication is also available in full text at:
http://hdl.handle.net/2077/64918

Academic thesis in Practical Philosophy
Department of Philosophy, Linguistics and Theory of Science

Subscriptions to the series and orders for individual copies sent to:
Acta Universitatis Gothoburgensis
PO Box 222
SE-405 30 Göteborg, Sweden
acta@ub.gu.se

Cover art by Sofia Jeppsson
Print: Stema Tryck, Borås, 2020

SVANENMÄRKET
Trycksak
3041 0234

Abstract

Title: Explorations of the Relationship Between the Right to Make Decisions and Moral Responsibility in Healthcare
Author: Thomas Hartvigsson
Language: English
ISBN: 978-91-7963-042-3 (printed)
ISBN: 978-91-7963-043-0 (pdf)
ISSN: 0283-2380
Keywords: Autonomy, moral responsibility, informed consent, adolescence, family, mental disorder, ethics, criminal responsibility, bioethics, medical ethics, healthcare

People intuitively think that there is a strong connection between having a right to make decisions and to be morally responsible for those decisions. This thesis explores the relationship between these notions in the context of healthcare. The exploration particularly focuses on what I call fringe decisional agents, e.g. adolescents and people who suffer from mental disorder, who have uncertain decision-making competence and exist at the intersection of different institutions.

I argue that even though the two notions are strongly connected they can come apart. First, even though both notions are concerned with the moral status of a person there is a potential conflict between the appropriate responses to a person who has the right to decide and someone who is morally responsible. Second, even if conditions for having the right to decide and being morally responsible are very similar they can come apart. Moral responsibility requires that a person exercises a certain degree of control over their actions, a condition that has no clear equivalent for the right to decide. Furthermore, even though both have cognitive conditions, the condition for having the right to decide is directed towards information regarding oneself, whereas the condition for moral responsibility is primarily directed towards information about other people. Finally, if an agent is the concern of different institutions, these might have different conditions for assigning the relevant status and may furthermore do so at different times.

List of Papers

I. Hartvigsson, T., Munthe, C., & Forsander, G. (2018). Error-Trawling and Fringe Decision Competence: Ethical Hazards in Monitoring and Address Patient Decision Capacity in Clinical Practice. *Clinical Ethics, 13*(3), 126-136.

II. Munthe, C., El-Alti, L., Hartvigsson, T., & Nijsingh, N. (2018). Disputing with Patients in Person-Centered Care: Ethical Aspects in Standard Care, Pediatrics, Psychiatry, and Public Health. *Journal of Argumentation in Context, 7(2),* 231-244

III. Hartvigsson, T. and Munthe, C. (manuscript) Responsibilities in Change: Modelling Parental Authority and Children's Autonomy

IV. Hartvigsson, T. (submitted) Between Punishment and Care: Autonomous Offenders Who Commit Crimes Under the Influence of Mental Disorder.

Previously published papers are reprinted with permission.

Acknowledgments

When I wrote my bachelor thesis, I had Christian Munthe as my supervisor. In particular I remember one tongue-in-cheek comment, not fit for print, that he made in order to point out some rather unclear reasoning on my part. As a Ph.D. supervisor he has, with endless patience and much energy, continued to point out unclarities and misfortunes in my thinking and writing, as well giving me plenty of opportunity to develop as an ethicist engaged with real world issues and philosophical ideas.

His support given is readily matched with the support and encouragement given by my other two supervisors Susanna Radovic and Joakim Sandberg who have helped me develop and explore my own ideas with critical comments, new insights and support at every pitfall.

No research is done in a social vacuum and I am grateful to all the Ph.D. students in philosophy at the department for their company and the discussions we have had during these years, Paiman Karimi, Nina van Heeswijk, Davide Fumagalli, Jasmine Elliott, Max, Dorna Behdadi, Marco Tiozzo, Karl Persson de Fine Licht, Mohammadhadi Fazeli and Maximilian Zachrau. To Alexander Andersson for showing me the best of Borås. To Ylwa Sjölin Wirling for all the mental breaks and the reminders that after sunshine comes rain. To Alva Stråge and Ida Hallgren for sharing an office with me and not once locking the door to keep me away. To Richard Endörfer for the late nights with video games. To Leila El-Alti for making many conferences a joy to attend. Finally, to Susanna Salmijärvi with whom I started to plan my Ph.D. studies as a masters student and with whom I spent my vacation training Muay Thai between the monsoon rain showers.

My Ph.D. project also benefitted from the supportive environment in practical philosophy at the department. Bengt Brülde, Erik Malmqvist, Petra Andersson, Erik Brandstedt, Olle Blomberg, Louis Larue, Anders Herlitz, Yuliya Kanygina, Frans Svensson, Clement Fontan and not forgetting the metaethical boyband: John Eriksson, Caj Strandberg, Ragnar Francén and Gunnar Björnsson.

At the department I also got to know my moral responsibility reference group: Per-Erik Milam, Benjamin Matheson, Sofia

Jeppsson and Allison Don who have shown a lot patience with my questions regarding moral responsibility as well as engaging in discussions about speculative fiction, board games and sourdough bread. In particular I want to thank Sofia for the cover art.

My research has also benefitted from the greater community of bioethicists in Sweden. Linus Broström and Mats Johansson have been generous with their support as well as inviting me to workshops and to give presentations. The same can be said about Niklas Juth who also provided extensive comments and much constructive criticism on the thesis at my final seminar.

As a philosopher I have also benefitted from summer courses that I have taken. In particular a course in Budapest where I got to know Fay Niker, Caroline Harnacke, Kelly Tuke and Joseph Burke with whom I got to explore Istanbul. At that course I also got to know Julia Mosquera who took me to an exhibition, completely in the dark.

I would also like to thank Udo Schüklenk for inviting me as a visiting researcher to Queen's university where I spent many hours discussing criminal responsibility within Ryan McSheffrey. There I also got to know Josephine Nielsen whom I have spent many hours with, chatting about philosophy and life. Marisa Lavoratore who introduced me to amaretto and ice cream, and Taylor Yurcich who did not let me miss out on Game of Thrones.

These trips would not have been possible without the generous travel grants provided by Kungliga Vetenskaps- och Vitterhets-Samhället i Göteborg, Adlerbertska, Donationsnämnden and Hvitfeldtska siftelsen. I would also like to thank FORevidence for providing funding to complete my thesis.

There are also other people at the department outside of philosophy to whom I owe a great deal. Labov's linguistic dream team Johan Gross and Julia Forsberg are two of them. I am also happy that I have got to know Ellen Breitholtz, Jenny Myrendal, Moa Ekbom, Cajsa Ottesjö and Rasmus Blanck. Martin Kaså and Felix Larsson might never know (unless I tell them) how rare it is to find someone who appreciates certain kinds of obscure culture such as old animated movies from China. Lena Eriksson for her constant concern and care for Ph.D. students.

Some people in the administration have made paperwork a pleasure (or at least less of a burden): Jenny Larsson, Linda Aronsson, Peter Johnsen and, of course, Helena Bjärnlind who is still the best general for the party that was never meant to be.

At the University I have also met some truly amazing people and even though they may not know philosophy they have taught me plenty, not the least about myself. Gaby Mercado, Houman Sadri, Simon Skau and Ylva Byrman, who has shown me more friendship than I will ever deserve.

I would also like to thank my RPG friends Anders Gjerlöv, Andreas Eriksson Sik, André Holdfeldt, Jacob Edman and Lars-Olof Arnoldsson who have all been persistent in reminding me that some possible worlds matter more than others.

And the board gamers: Andrew Colvin, Sarah Johnstone, Jens Boberg, Celia Young, Alice, Robin and Edward. In particular I wish to express my gratitude to Andy for taking "great satisfaction in mansplaining all my linguistic errors to me".

There are others who deserve a mention as well. Suzanne Green for bringing me back to the opera. Sara Persson for making the teacher's program a joy. Linnea Jacobsson for persistent yet never demanding friendship. Dulce Gámez for sticker fights, emotional support and silliness. Sofia Costa Nordwall for endless and deep conversations about everything. Hannah Saldert for making me smile even at the most stressful times during these last few months.

My family, who have always been there for me. My father for always making sure that my most basic needs (food) are met. My mother who has always encouraged me to follow my own path. And my brother who shares my lack of entrepreneurship and therefore will never realise my business idea of post-apocalyptic algae booze.

Finally, I cannot express my gratitude to Isabelle for vacuuming, leaving our apartment a mess, cooking, eating my cooking, putting up with all my bad habits, sourdough bread, board games, dirty dishes, weightlifting, and for sharing (and sometimes tolerating) my taste in movies, music and literature. But most of all for your love, affection, understanding and support.

Thomas Hartvigsson. Gothenburg, October 2020

Contents

Introduction

This thesis explores the relationship between notions of the *right of patients to make decisions* about their own healthcare, the ethical importance of *decision-making competence* for such a right, and the allocation of *responsibility* for healthcare decisions and their outcomes. This undertaking is being done against a theoretical background of a widely embraced idea in bioethics: the moral importance of respecting patient autonomy, as well as certain standard assumptions in responsibility theory about what is required for a person to be responsible for a decision. This exploration will, moreover, focus on a type of cases concerning what I will call *fringe decisional agents* in different institutional contexts, where decision-making competence plays an important normative role both for the allocation of responsibility and for grounding individual rights.

The right for patients to make decisions regarding their own healthcare has a strong standing within medical ethics and law. This right is commonly associated with the practice of informed consent: the notion that the patient should be informed of their medical condition and medical options, and be able to make voluntary decisions on that basis. This right has traditionally focused on guaranteeing the opportunity to refuse offered interventions (such as tests or treatments). It is taken for granted, both in ethics and in law, that most adults in most situations will have this right. Certain groups, such as children, are not always considered to have this right on account of their lack of maturity. Other examples are people with mental impairment or who suffer from mental disorder.

In the bioethical literature a common suggestion is that patients have the right to make decisions by virtue of being sufficiently capable of autonomous decision-making. (Beauchamp and Childress, 2013; Faden and Beauchamp, 1986; Buchanan and Brock, 1989) This right is grounded in more general ethical notions of a duty to respect autonomy. Put simply, people are autonomous when they are, in some deeper sense, in charge of their own actions and decisions. When people are ruling themselves in this way, other people have an obligation not to intervene in their life directly and disrupt their self-rule. The autonomous person should thus be respected by other people A person's autonomy should be respected by others; they should let the person proceed with their life according to their own will (within certain limits). The standard idea is thus that if a person has a sufficient capacity for autonomous decision-making then that person should be allowed to make decisions without being subject to undue external pressure, and thus exercise their right to self-determination.

Decision-making competence refers to a person's ability to make a specific decision. This includes how well the person is able to process relevant information in an appropriate way so that a decision is made. This general notion of decision-making competence can be used in two ways. First, it can refer to how well we are equipped to make decisions: denoting the abilities that makes us better or worse decision-makers. For example, a patient and a physician might both have an understanding of an illness and its associated treatment but the depth of their respective understandings will differ. Second, decision-making competence can be used to refer to one's decision-making abilities reaching a specific threshold. This threshold determines whether a person has sufficient decision-making ability to be an autonomous decision-maker and granted the right to make decisions in a particular context.

The link between decision-making competence and moral responsibility is established through what is commonly called the epistemic condition for moral responsibility. Moral responsibility, like autonomy, is a notion with important consequences for how other people should behave towards a person. If a person is morally responsible for an act then other people, in ordinary circumstances, are justified in reacting towards that person in certain ways. Most typically this is done by expressing praise or blame, or in cases of severe wrongdoing, criminal punishment which is a specific, institutionalised variant of such a response. In order for a person to be morally responsible, certain conditions need to be met and one of these is the aforementioned epistemic condition. In order to be morally responsible for an act, a person needs to be able to understand certain aspects of this act and the circumstances around it.

It is commonly taken for granted that most adult people in most situations possess the necessary degree of decision-making competence to have the right to make decisions. It is also commonly assumed that most adult people in ordinary circumstances are capable of the understanding required to be morally responsible for their actions. Furthermore, it is taken for granted that certain groups clearly do not possess this capacity, such as young children, people undergoing acute psychotic episodes, and people with severe intellectual disability. Then there are certain groups that fall between these two. I will refer to members of these groups as *fringe decisional agents*. Among these groups are older children around mid-adolescence, people who suffer from mental disorders, and those who suffer from moderate mental impairment, including early onset dementia. These are all people who have some degree of independent agency and ability to understand or make decisions, but it is unclear to what extent they meet the requirements for moral responsibility or have a right to decision-making in different situations and circumstances.

All groups of fringe decisional agents are heterogenous and what is true of one member of one of these groups might not be true of another member of the same group. However, members of these groups more commonly instantiate features relevant for fringe decisional agency, and features of the psychological characteristics that mark these groups are also factors which may impair both decision-making competence and how well the epistemic condition for moral responsibility is met. Furthermore, a person's mental status might shift over time, and this also relates to circumstances. This means that members of one of these groups may at times and in some circumstances be well above the threshold for being granted the right to make decisions, and in other circumstances below that threshold. It also means that thinking about these groups is a good starting point for critically scrutinising how the right to decision-making and moral responsibility relate to each other. Focusing on fringe decisional agents helps us see how these central ethical notions may come apart, and how the capacity for decision-competence may differ from the kind of understanding required for moral responsibility.

Another reason for finding fringe decisional agents of particular interest is that they often exist at the intersection or overlapping of different institutions. This thesis is therefore also concerned with how standards of decision competence and understanding *á la* the epistemic condition should be expressed in different institutional contexts, such as healthcare, the family, and criminal justice. In this thesis, all the aforementioned institutions and their practices relating to the right to self-determination and moral responsibility are discussed in relation to fringe decisional agents who exist in overlapping institutional contexts. For example, adolescents who need medical attention are simultaneously subject to both the ethical framework of health-care as well as that of the family. Offenders who suffer from mental disorders may be the concern of both the criminal justice institution as well as that of psychiatric care.

Different institutions can have different ways of understanding what is required to be granted the right to make decisions or being viewed as responsible, and from this follows a variation of norms regarding how people should be treated with regards to the capacities underlying the right to make decisions and moral responsibility. This means that the fringe decisional agents can make the relevant institutions pull in different directions, which adds an additional layer to the challenge of analysing how they should be treated.

With this brief background in place we are better able to understand the initial question that this thesis set out to explore, namely: what is the relationship between the right to decision-making and moral responsibility with regards to the decision-making capacity of fringe decisional agents in differing institutional practices?

The Right to Make Decisions Regarding One's Own Healthcare

The patient's right to make decisions regarding one's own care is intimately connected to the practice of informed consent. Informed consent is the practice of informing a patient of the nature of their condition, what possible interventions are available, and what the possible consequences of these are, before seeking the consent of the patient to initiate one of these interventions. The patient's right to make decisions regarding their own care is expressed in this practice as the patient's option to consent to or refuse any offered medical intervention.

The ethical and legal function of consent is to make certain actions permissible that otherwise would not be so. If a person has a capacity to give consent and does so then certain treatments can be initiated that otherwise would have been impermissible. In order for a patient's decision to consent to or refuse care to count as valid, three conditions must typically be met. The patient needs to have been given information relevant to the decision, the patient needs to be decision-making competent, and the decision needs to be voluntary. (Eyal, 2019) What is required for a person to have a capacity to consent and what range of healthcare interventions that a person can authorise through consent differ between legislations and is a matter of controversy among ethicists. These issues are central to paper 4 and I will return to them in more detail shortly.

If a person lacks the capacity to consent then someone else, such as a legally appointed representative, will have to make the decision on behalf of the patient: to consent to or to refuse the offered intervention. This means that a patient who lacks capacity to consent can be subject to involuntary procedures and be treated against their own expressed will. However, even if the final decision rests with someone else, the patient's opinion is usually thought to matter and it might be wrong to make a decision contrary to the patient's wishes. As Hawkins and Charland (2020) point out, it may harm a patient not to have their wishes respected. Furthermore, subjecting a patient to involuntary treatment may decrease the benefits of treatment if it requires the cooperation of the patient. Involuntary treatment may also undermine the relationship between the patient and the decision-maker as well as any treating healthcare staff.

Although, in bioethics, informed consent is intimately connected to the right to make decisions regarding one's own care, the picture presented above only features in paper 4. In the other papers, the situations under discussion differ in some or more respects from the typical informed consent situation. Papers 1 and 2, focus on patient consultations within a person-centred care framework, which complicates the picture. Two key features of person-centred care are patient narrative and shared-decision making. (Munthe et al., 2012) The patient's own perception of their health status and how any medical condition affects them in their life is incorporated within the process of the patient and the health professional seeking a joint understanding of the patient's situation and agreeing on what available treatment options would best suit it. This means that the patient has a more active role during healthcare consultations than simply being on the receiving end of the healthcare professional's disclosure of information before making a decision to accept or refuse an offered intervention.

Paper 1 concerns consultations with teenage patients with diabetes. Two features of their situation are of particular interest. First, the fact that they are adolescents makes the general presumption of patient competence weaker since they are still developing their abilities for decision-making. Second, treatment of diabetes is primarily done outside of the hospital setting where the patients themselves are responsible for administering care. Thus, involuntary care for teenage diabetes patients is practically impossible barring extraordinary circumstances.

Paper 3 is also concerned with adolescents. The starting point for this paper is the stark contrast between adolescent decision-making in different situations. In calm, low-arousal situations, older adolescents, from about 16 years of age, make decisions that are qualitatively similar to adults. However, in other situations, in particular when peers are present, these adolescents tend to make much riskier decisions even though, we argue, they have their decision-making competence intact. We suggest that adolescents in these situations, because of their retained decision-making competence retain a strong claim to have their decisions respected even though they may not be responsible for some of them.

In paper 2, we examine one aspect of person-centred care in three atypical settings: paediatric care, forensic psychiatric care, and public health. In both of the first two settings the competency of the patients is once again in question as both adolescents and psychiatric patients cannot be presumed to have the necessary degree of competency. In the two final settings, the overarching goal of care is different from the standard case. Even though promotion of the individual patient's health and autonomy can be a goal for public health and forensic psychiatry, both aim at broader goals, such as the promotion of the health of the population or protecting other people from crime. Furthermore, both public health and forensic psychiatry can contain elements of coercion and limitations to the patient's freedom based on the consequences for others.

What the papers of this thesis highlight is that even though the right to make decisions regarding one's own care is intimately connected with informed consent in bioethical discourse, patient decision-making is far more complex than a patient accepting or rejecting treatment. In person-centred care, the patient can have an active role in identifying and designing treatment options. The case of teenagers with diabetes shows us that even though a patient may not have fully developed abilities for decision-making it is impossible to force some treatment regimens on an unwilling patient, since this patient will carry the main responsibility for performing their care, in spite of lacking full capacity. The wish to incorporate person-centred care and shared decision-making in forensic psychiatry and public health shows that there might be room for patient influence even in coercive settings, and even though there are strict limits to what this influence may achieve. However, we also caution that such an approach could be turned against the patient and therefore should only be used with great care and transparency.

Autonomy and Informed Consent

Even though the practice of informed consent does not provide a complete picture of how the right to make decisions is expressed in relation to healthcare, it is still a central practice and remains a background condition in much person-centred care and shared-decision making (El-Alti et al., 2019). Furthermore, even though some presumptions regarding voluntariness and decision-making competence may not always be realised in all healthcare situations, efforts might still be made to emulate at least some aspects of the informed consent situation in constrained settings, such as forensic psychiatry.

The practice of informed consent is commonly justified with reference to the importance of respecting patient autonomy (Beauchamp and Childress, 2013). The underlying idea is that if a person is autonomous, that is, is capable of directing their own life, then there is a strong ethical consideration in favour of respecting that person's decision and not interfere with it. By seeking patient consent, the patient's autonomy is respected. It should be noted that the word autonomy can be used in several different senses. Here, I am interested in autonomy in the sense that grounds the right to make decisions, that is the ability to make autonomous decisions, rather than other meanings such as what it means to lead an autonomous life (Feinberg, 1986).

One way of understanding the relationship between respecting autonomy and informed consent is to distinguish between two different senses of informed consent (Faden and Beacuhamp, 1986). The first sense is consent as *autonomous authorisation*. What that means is that a person who gives consent makes an autonomous decision to authorise "a professional …to initiate a medical plan for the patient" (Faden and Beauchamp, 1986: 278) and that, by this authorisation, this person "both assumes responsibility for what one has authorized and transfers to another's authority to implement it" (Faden and Beauchamp, 1986: 280).

The other sense of consent, what we might call *institutional consent*, is concerned with the institutional status of consent. This is the notion that if an act of consent is in accordance with an institution's rules and procedures then it is, in the eyes of the institution, permissible to initiate the action consented to.

It is possible for a person to be sufficiently autonomous to give autonomous authorisation, while the rules and procedures of a particular institution might not consider that consent to be valid. This person would then be able to consent in terms of autonomous authorisation but not in the institutional sense. Furthermore, a person can meet the requirements for giving institutional consent but lack sufficient autonomy to be able to give consent in the autonomous authorisation sense.

Faden and Beauchamp (1986) suggest that informed consent in the autonomous authorisation sense should work as a regulative ideal for informed consent in the institutional sense. In other words, informed consent in the institutional sense should strive to approximate informed consent in the autonomous authorisation sense. However, as Pugh (2020) discusses, there are several good reasons for why these two senses of informed consent might and should sometimes diverge. One reason is that the choice of conditions one uses for a person being able to give institutional consent might result in fewer or more cases of false positives as well as false negatives. That is to say fewer or more people will be deemed able to give institutional consent than are able to give autonomous authorisation. Therefore, no set of conditions for institutional consent will perfectly map those who are actually able to give autonomous authorisation and those who are not. Moreover, this fact means that when an institution decides its conditions, it needs to choose which side to err on. Different balances may then turn out to fit different institutional contexts.

One reason to expect such divergence is that the actual process of assessing capacity to consent is undertaken in a real-world institutional setting, where time, training and resources for assessment will be limited in various ways. For instance, one test that relies on a widespread conception of decision-making competence in healthcare takes around 20 minutes to complete (Appelbaum, 2007).

Another reason to expect (legitimate) variation between how institutional informed consent matches autonomous authorisation is that that informed consent as an institutional practice may legitimately discharge different institutional rationales, and aim for different ends (in different ways). For instance, Pugh suggests with reference to Manson and O'Neill (2007) that trust might be one such end and, with regards to Archard (2008), that protection of bodily integrity might be another end (Pugh, 2020). An alternative end might be ideals of fair allocation of punishment in criminal justice. For this reason, different balances regarding what side to err on may be justifiable from the standpoint of the different ends pursued by these institutions.

Voluntariness

In order for informed consent to be valid it needs to be given voluntarily. There is some controversy regarding what this means and it might also, as I will explain, differ between situations. I will here distinguish three factors that have been argued to potentially undermine voluntariness: external pressure, manipulation, and internal compulsion. I will here focus on external pressure. In the section on authenticity, I will briefly address the issue of internal compulsion. I will not address manipulation directly, since some forms fall under external pressure and others, such as withholding information, deception and lying (cf. Beauchamp and Childress, 2013) are related to the information condition rather than the voluntariness condition.

Szmukler and Appelbaum (2001) provide a hierarchal categorisation of external pressures, going from less to more forceful kinds. Such external pressures are sometimes referred to as coercion, but, following Szmukler and Appelbaum in this context, I will reserve this particular term for only certain kinds of external pressure.

Persuasion is the first category and refers to an effort to affect the patient's decision by appealing to reason. By directing the patient's attention to risks and benefits associated with certain options the healthcare professional may hope to sway the patient. Beauchamp and Childress (2013) emphasise that persuasion should not appeal to the patient's emotions even though they admit that this can be hard to avoid, and they caution that what is a rationally persuasive argument for one person may have a strong emotional impact on another person. However, Charland (1998) argues plausibly that emotions are a necessary precondition for all decision-making, and requiring a complete absence of emotion is hardly possible. Rather, the relevant distinction is between different kinds of emotional effects of the attempted persuasion that may transform the persuasion into a more severe kind of external pressure (interpersonal leverage or inducements), or undermine decision-making competence. Generally, persuasion is the least problematic kind of external pressure even though, in paper 3, we argue that this strategy for affecting patient decision-making should be used with great care with regard to fringe decisional agents, especially in a coercive setting.

The second kind of external pressure is *interpersonal leverage*. This kind of pressure is applied when someone uses emotional leverage stemming from their relationship with this person. This can for example be done when the healthcare professional expresses disappointment in the patient's decision.

The third kind of external pressure is *inducements*. Inducements are, on a principled level, hard to distinguish from *threats,* which constitute the fourth kind of external pressure. Both inducements and threats have in common the offer of something (benefits or disadvantages) that are conditional on the patient's decision. Szmukler and Appelbaum suggest that threats are often coercive (undermining voluntariness) whereas inducements are not. By drawing on Wertheimer (1987) they suggest that threats are defined so that the receiver of the threat will be worse off than they have a moral claim to be, that they fall below a moral baseline. Withholding an offer, by contrast, will not put a person into a situation in which they fall below such a baseline. Wertheimer gives the example of a man who is about to drown to clarify this distinction. A potential rescuer offers to save the drowning person in exchange for a large sum of money. If the drowning person has a right to be rescued then the proposal is a threat, whereas if the drowning man does not have such a right the proposal is an offer.[1]

---

[1] Even though no doubt threats occur it is unclear to me if they can ever be legitimately used since executing a threat on Szmukler and Appelbaum's view means putting a person in a situation in which they do not have access to goods to which they are entitled.

The fifth and final kind of external pressure is *compulsion*, whereby the patient cannot refuse treatment. Patient cooperation may still be sought but the healthcare professional has a legal mandate to pursue treatment with force, if necessary. Szmukler and Appelbaum note that compulsion is not restricted to compulsory admissions to hospital but may also include different kinds of outpatient treatment whereby the patient may be subject to a renewed hospital admission without a new process for detention, forced medication or threats thereof.

Szmukler and Appelbaum note that there are ways of affecting a person that are not part of their taxonomy, albeit they may be thought to undermine voluntariness. In some cases, deception might be involved as a patient may wrongfully be made to believe that certain consequences will follow unless they accept treatment, thus creating the impression of a threat while there is none. Similarly, a patient may perceive the prediction of a decision's consequences as being coercive. One such example is if a healthcare professional informs a patient who suffers from mental disorder that, if that patient does not manage their care properly, their condition will progressively worsen and the patient will (in all likelihood) be admitted to hospital under compulsion. Furthermore, a patient may have a different understanding of what constitutes a threat and thus perceive offers on Szmukler and Appelbaum's account as coercive. This in turn may affect the patient's decision-making, not least if strong feelings are evoked which may undermine the patient's decision-making competence.

Information

In order to give informed consent, a patient first needs to be informed. A patient cannot be expected, at least not during the initial consultation, to have the relevant information and necessary understanding of it to make an autonomous decision regarding medical interventions. If the patient is to make an autonomous decision then it is necessary for the patient to not only have the information presented to them, but also that they understand it. It is therefore necessary for the healthcare professionals to disclose and explain information to the patient. But patients differ with regard to what information they need, how easily they can understand it, and how that information needs to be presented, as well as what additional steps might be necessary for the patient's understanding. This can for example be seen in paper 1, where the video recordings of some patient consultations reveal how they need relevant information to be repeated and related to how they perform their self-care, even though they have lived with diabetes for a substantial amount of time.

The requirement that relevant information needs to be disclosed to the patient is connected to decision-making competence as a necessary condition for the right to make decisions. There is simply no point in informing a patient who lacks the ability to understand and incorporate this information into their decision-making. Furthermore, the content of the information that is to be disclosed also determines what, more precisely, is required for a patient to have decision-making competence since possession of competence requires the patient to be able to comprehend and make decisions based on the relevant information.

There is debate regarding what information healthcare professionals have a duty to disclose to patients. It is impossible to disclose all potentially relevant information to the patient, due to limits on both time and cognitive abilities. Instead healthcare professionals need to limit and adapt what information to disclose. There are three competing standards for what information that should be disclosed.

The first is the *professional practice standard* which suggests that healthcare professionals should disclose information that it is customary to do in the same medical situation. It is thus up to the community of healthcare professionals to decide which information that should be disclosed to patients. This approach is limited since such a professional standard may not exist and, if this standard was accepted at face value, then there would no standard against which one could argue that the information disclosed by healthcare professionals is lacking. The information determined relevant by the professional community may be governed by different ethical considerations than the promotion of patient autonomy (Beauchamp and Childress, 2013; Pugh, 2020).

The second standard is the *reasonable person standard* which holds that healthcare professionals should disclose information that a reasonable person considers relevant to making the decision. This suggestion shifts the focus from professional judgment to the interests of the patients. The obvious problem with this standard though is in determining what information a reasonable person would find relevant (Beauchamp and Childress, 2013), not the least in light of the fact that reasonable people will differ in what they consider relevant.

The third standard is the *subjective standard* according to which the information should be adapted to the interests of the individual patient and what this specific individual patient considers important or would consider important if they knew about it. Beauchamp and Childress (2013) considers this to be "the preferable moral standard of disclosure" (Beauchamp and Childress, 2013:127) even though they recognise that it is impossible to implement on an institutional level as patients may not know what information they might find relevant before disclosure, nor can healthcare professionals be expected to investigate all of a patients interests and needs.

What standard, or mix of standards that should be adopted may in addition to considerations of patient autonomy also depend on other institutional considerations such as time constraints, the relevance of disclosure for healthcare professionals' legal liability, and medical ideals pertaining to, for example, person-centred care and the relationship between patient and care-giver. For present purposes we should note that the more flexible and sensitive to an individual patient's situation the standard for disclosure of information is, the greater the variation of requirements for decision-making competence between individual patients will be.

Decision-Making Competence

The duty of healthcare professionals to collect informed consent and respect a patient's subsequent decision holds only if the patient is decision-making competent. That is to say, they need to be able to process the information and reach a decision in the right kind of way. There is some controversy regarding whether decision-making competence alone is sufficient for this, or if the decision also needs to be based on the right kind of preferences. However, before going into that issue we first need a firmer grasp of what decision-making competence is.

First of all, let us consider what it means to be competent in general. To be competent is to possess an ability or capacity for doing something – a particular task. This general notion of competence can moreover be used in two different ways. First, it might be used in a threshold sense: If a person is sufficiently proficient at doing something then that person is competent. Competence can also be used in a scalar sense, meaning that we can be more or less competent at doing something. Consider these two meanings of competence in relation to piano playing. I might be a good enough piano player to be able to play a certain song such as Bach's minuet in G-major. I meet the threshold level of competence necessary to play that piece. However, another piano player might be better than me at playing that same piece. He would be more competent in the scalar sense.

Decision-making competence denotes a person's ability to make (autonomous) decisions. For the purposes of determining whether a person has the right to make decisions regarding their own healthcare, we are interested in the threshold sense of competence. It is not a question of how well a person makes decisions, or how rational or wise these decisions are in the eyes of others that determines whether a person has a right to make decisions regarding their own care. It is only that they are *capable enough*.

The example of competence at the piano also hints at some further features of the concept that are also relevant to decision-making competence. First, competence is a task-relative concept. I might be competent to play one piece of music but not another (e.g. Chopin's preludes). The same goes for decision-making competence. A person might be competent to make one decision but not another, as will be demonstrated later. Furthermore, a person's competence at making a particular decision is also relative to their situation. A person might be competent to make a particular decision at one specific time but not another, just as my competence at a piano piece may vary over time. Illness or medication for example might temporarily impair my ability to perform it.

Two Models of Decision-Making Competence

There are several proposed models of decision-making competence which attempt to make explicit the ingredient abilities important to determine competence. I will here limit my discussion to two of the most wide-spread and widely discussed models: the MacArthur Competence for Treatment model and the model for decision-making competence in the Mental Capacity Act of the United Kingdom.

According to the MacArthur Competency model (Grisso and Appelbaum, 1998), decision-making competence requires four abilities in sufficient quantity: Understanding, Appreciation, Reasoning, and Ability to express choice. *Understanding* is the ability to comprehend information pertaining to the decision at hand, such as grasping the nature of the illness, the treatment options (including non-treatment) and possible consequences. *Appreciation* is the ability to apply that information to one's own person and circumstances. *Reasoning* is the ability to use that information in combination with one's preferences to form a decision. *Ability to express choice* is precisely that: the ability to communicate the decision made.

The MacArthur competence can be compared with the conditions for mental capacity in the Mental Capacity Act. According to this act

> a person is unable to make a decision for himself if he is unable
> (a) to understand the information relevant to the decision,
> (b) to retain that information,
> (c) to use or weigh that information as part of the process of making the decision, or
> (d) to communicate his decision (whether by talking, using sign language or any other means).
> (Department of Health, 2005: 2)

The two models are very similar but some differences can be noted. First, while the MacArthur model describes variables of importance for determining the presence or non-presence of decision-making competence, the Mental Capacity Act focuses on determining *in*competence, thereby more clearly expressing a threshold sense of decision-making capacity (albeit the factors determining incapacity may occur in degrees). Second, the second condition of each model differ. MacArthur competence requires a patient to be able to apply relevant information to their particular situation (Appreciation) whereas the Mental Capacity Act explicitly demands the information be “retained”. The Mental Capacity Act does not define “retention” but notes that a person should not be regarded as lacking capacity if they can only “retain” information for a short period of time. The appreciation aspect of the MacArthur competence could arguably be included in criterion (c) of the Mental Capacity Act model, while criterion (b) of the Mental Capacity Act is likely to be included in all the abilities of the MacArthur competence abilities except Ability to express choice.

Having considered these two models codifying decision-making competence, we can better make sense of the decision-relative nature of decision-making competence. Some decisions require understanding of more complex information than others. A person with diminished intellectual abilities might be competent to make a decision that only requires an understanding of simple information, but simultaneously not be competent to make a decision requiring understanding of complex information. In a similar manner, a person suffering from a mental disorder causing delusions might not be able to comprehend certain information if the delusion somehow interferes with their processing of this information. For example, a patient suffering from *anorexia nervosa* may have delusion-like beliefs regarding their own body which makes them unable to apply relevant information regarding a dangerously insufficient percentage of body fat to their own case. The same patient may however be competent to make other medical decisions, such as whether or not to have their appendix removed.

Grisso and Appelbaum argue that it is not necessary for a patient to have correct beliefs to be decision-making competent, and this regards both Understanding and Appreciation. The patient needs to understand and be able to apply the information to their own case but they need to accept the information as true. In order for a patient's wrongful beliefs to render a patient decision-making *in*competent, two additional conditions need to be met: "First, the patient's belief has to be substantially irrational, unrealistic, or a considerable distortion of reality." (Grisso and Appelbaum, 1998: 45) The belief must also "be the consequence of impaired cognition or affect". (Grisso and Appelbaum, 1998:47)

The addition of this second condition means that holding highly unrealistic views of how the world works, such believing that one can be healed through the practice of placing precious stones on one's chakras in order to realign some mystical energy, does not disqualify a person from being decision-making competent. Grisso and Appelbaum's second condition mirrors the Mental Capacity Act's demand that the lack of competence must be "because of an impairment of, or a disturbance in the functioning of, the mind or brain." (Department of Health, 2005:2)

There is some similarity between the MacArthur competence condition of reasoning and the Mental Capacity act requirement that a patient needs to be able to "use and weigh" the medically relevant information in reaching a decision. However, Pugh (2020) has suggested that the Mental Capacity Act does not require one to do so *rationally*, but that Grisso and Appelbaum require this. This, however, seems to me to be incorrect. Grisso and Appelbaum indeed suggest that ability to reason requires several sub-abilities: the patient needs to be able to keep their focus on the decision while making it, and also needs to be able to consider several options and their consequences as well as the probability of those consequences. Furthermore, the patient needs to be able to *evaluate* the possible consequences as well as to compare the different options in these regards. However, none of this implies that the patient needs to actually *use* their reasoning ability, they merely need to have it.

Preference Requirements and Authenticity

The models of decision-making competence above focus on the patient's ability to process relevant information and to reach a decision based on that information and the patient's preferences. However, some have argued that decision-making competence alone is not sufficient to hold a right to decide over one's own healthcare. They argue that, in addition, the very preferences used for decision-making need to meet certain requirements.

Such additional requirements imply that patients who fully meet the requirements for decision-making competence may still be denied a right to make decisions over one's own healthcare. Tan and colleagues (2003) studied a population of patients with anorexia nervosa. Many of the patients had delusion-like beliefs regarding their weight and bodies, meaning that they did not meet the requirements for decision-making competence. However, some of the patients scored highly when tested for MacArthur competence, while still holding a *preference* for thinness. This preference was so strong that they were willing to risk their lives in pursuit of losing even more weight (see also Tan et al., 2006). Those who find the idea of granting these latter patients a right to make decisions over their own (anorexia) care problematic cannot appeal to a lack of decision-making capacity. The problem lies not in these patients' understanding of their medical condition and how they process that information. Nor does the problem lie with the conclusion they reach in light of their values. Rather the problem lies with the values themselves. This raises the issue of whether decision-making competence, while necessary to be respected as an autonomous decision-maker, may not be sufficient. An additional condition pertaining to the preferences underlying the decision must also be met.

One way to resist such a conclusion is to claim that the apparent case for additional preference-conditions can in fact be handled by some condition for decision-making competence. For instance, the Mental Capacity Act's code of practice suggests that the problem with preferences like the ones in the anorexia nervosa case might be that they are compulsive, impossible or too strong to resist (Department of constitutional affairs, 2005 section 4.22; cf. Charland, 2002). There are two problems with this strategy. First, even if a compulsive desire undermines a patient's ability for autonomous decision-making, we need an explanation of why. For instance, one may argue that compulsive preferences (just as beliefs) somehow undermines the ability to reason. However, the second problem is that it is not at all clear that all anorexia patients who hold the preference to be thin, are in fact victims of compulsive desires that undermine their reasoning ability, even though this may be true of some.[2] The same can be said for other cases when patients meeting standards such as Grisso's and Appelbaum's Understanding and Appreciation criteria, also hold preferences seen by others as self-destructive, imprudent or merely odd.

Anorexia nervosa is not the only condition that has been argued to include preferences that undermine the ability of autonomous decision-making. Rudnick (2002) has argued that patients who suffer from depression may lack this ability as well. The problem with depression is not that patients have what seems like an unreasonable or unreasonably strong desire, but rather that their desires are not strong enough. A depressed person may desire to end their life or may not care whether it continues or not. Ahlin Marceta (2020) adds further suggestions, such as a person suffering from borderline personality disorder and who may experience rapid and dramatic shifts in their preferences, or people who have been indoctrinated to have certain preferences. The question raised by these cases is whether there is any way in which we may rule out certain preferences (or lack thereof) as non-autonomous so that any decision based on them would not merit the same respect as an autonomous decision would.

One suggestion that has been advanced is that the values and preferences that guide a person's decision need to be *authentic*; they need to, in some sense, truly belong to the person. At first sight this seems a promising strategy since, for example, the values motivating the patients with anorexia may be claimed to stem more from the

---

[2] Tännsjö (1999) suggests that even though a preference might be compulsive that does not mean that its compulsive nature undermines capacity for all decisions. He exemplifies with addiction and grants that addiction might entail compulsive desires which can render an addict's decision to use a drug non-autonomous. However, accepting or refusing treatment is another kind of decision in which the compulsive desire to take the drug is sidestepped. (This reasoning may not apply to situations in which the treatment in part consists of administering the addictive substance to the addict, cf. Charland, 2002)

disorder than from the person themselves (Hope et al., 2011). But how do we know when this is the case and when it is not? What determines when a particular value "belongs to a person" rather than some other source?

Several theories of what it means for a preference or desire to be authentic have been presented. Ahlin (2018) suggests that these theories can be organised into three categories: *Sanctionist*, *Originist* and *Coherentist* theories[3]. A sanctionst theory is a theory according to which the authenticity of a desire depends on "the desire-holder's attitude towards her desires" (Ahlin, 2018:45). One example of a theory of this kind is Frankfurt's (1971) suggestion that a first-order desire is authentic if there is a second-order desire for being motivated by that first-order desire. A desire is in turn inauthentic if there is a second-order desire for not being motivated by that first desire. In the case of a patient with anorexia this means that a patient has a first-order desire to be thin. That desire would be inauthentic if that person has a second-order desire not to act on the desire to be thin.

Originist theories seek the condition of authenticity in the causal history of the desire. As Ahlin notes, all desires have a causal history but inauthentic desires stem from a certain kind of origin. Ahlin suggests that Meyer's theory exemplifies originism. According to Ahlin, Meyer holds that "desires are authentic if and only if they originate in non-cognitivist processes of self-discovery and self-definition." (Ahlin, 2018:46)

Finally, we have Coherentist theories which requires coherence between a person's desires and some external comparison. Ahlin exemplifies this approach with Christman's (2009) theory, which requires a person's set of desires to be coherent with that person's self-narrative.

It is not possible here to go deeper into the nature of what an authentic preference is or to evaluate the merits and disadvantages of the different approaches outlined above. For now, it is sufficient

---

[3] Noggle (2005) offers a related but slightly different taxonomy: structural, historic and substantivist theories. Ahlin's taxonomy does not cover substantivist theories. I will make a brief mention of substantivist theories shortly.

to note that there are reasons for why we would want to supplement decision-making competence with an authenticity condition for autonomous decision-making, and thereby for the right to make one's own decisions regarding one's own healthcare. However, a challenge for all such theories if we want to see them implemented at an institutional level, is that it needs to be *reliably assessable in clinical practice* whether a patient's preferences are authentic or not (Ahlin, 2018; Sjöstrand and Juth, 2014). A further potential challenge to all of the above mentioned theories of authenticity is that they are procedural as opposed to substantive authenticity conditions. A procedural theory does not make a judgment about the content of a preference but is merely focused on how a preference is brought about or how it relates to other preferences and attitudes. If we agree with Tan and colleagues that the strong preference expressed by the observed patients with anorexia should not be grounds for refusing care, then no procedural theory can in principle rule out such a preference. This, in turn, raises the question of whether there are any other grounds on which we can limit a patient's right to refuse care.

Limits to the Right to Decide and the Normative Significance of Autonomous Decision-Making

In spite of the strong standing of respect for autonomy and the patient's right to decide over their own care in bioethics and medical law, there are limits, albeit contested ones, to what kind of a medical procedures a patient may refuse or consent. In paper 4, I argue that current legislation concerning involuntary psychiatric treatment of people with mental disorders is discriminatory against them and ought to change so that patients with mental disorders have the same right to refuse psychiatric treatment as they and other patients have to refuse somatic care. The discrepancy between the conditions for involuntary psychiatric care and somatic care raises the issue of where and on what grounds to draw the limit of the patient's right to decide. This is not the place to settle where such a limit goes but I will here outline some of the strategies used to determine this limit in order to help us get a better understanding of what the right to make decisions regarding one's own care entails, and further clarify what role decision-making competence plays in this.

One non-controversial reason for limiting a person's right to make decisions is harm to others. The controversy, pertaining to this ground for limiting a patient's right to decide is what risk and degree of harm to others that is necessary to justifiably limit this right, and what restrictions we can impose on a patient in order to prevent harm to others. As we note in paper 2, this reason for limiting the patient's right can be relevant in public health, for instance, when there is a risk of spreading an infectious disease. In a worst-case scenario, the government can enforce quarantine for a population of infected or potentially infected individuals, even though less coercive measures exist, such as voluntary isolation, mandatory testing, requirements of physical distancing, or to inform surrounding people about one's (possible) infection status.

Another, more controversial, reason why the right to make decisions regarding one's own care may be circumscribed concerns risks or harm to oneself. Limiting a person's right to make decisions based on concerns for that person's own well-being is commonly discussed under the heading of paternalism. For present purposes we do not need to get into a detailed discussion of the nature of paternalism and I will here roughly follow the account given by Dworkin (2020). According to Dworkin an act is paternalistic if it is an act, or omission, that interferes with the autonomy of a person that is done without that person's consent and is performed for the benefit of the person.

A distinction can be made between soft and hard paternalism. Hard paternalism are acts that interfere with the decisions made by an autonomous decision-maker whereas soft paternalism refers to interferences with decisions made by non-autonomous decision-makers (Feinberg, 1986). Soft paternalism is generally considered justifiable, as people who lack the capacity for autonomous decision-making do not have the same right to make decisions as autonomous decision-makers. Hard paternalism, by contrast, is generally not permissible and the ethical debate regarding this is concerned with whether it is justifiable at all and if so under what circumstances (see e.g. Conly, 2012).

The ethical significance attached to the distinction between hard and soft paternalism explains why it is important to determine if a patient is decision-making competent or not. Tan and colleagues (2003) report their findings of patients with anorexia who meet the legal requirements for decision-making competence in this context, and they therefore suggest that conditions for autonomous decision-making also need to encompass relevant "attitudes and values" (Tan et al., 2003:706). I suggested above that as long as we rely on procedural theories of autonomous decision-making, we cannot in principle disqualify certain decisions from meriting respect in the way suggested by Tan and colleagues.

One way of meeting this challenge could be by developing a substantive theory of autonomous decision-making that limits either the content of the preferences (cf. Noggle, 2005) going into the decision-making competent person's decision-making process, or what decisions such a person can make. The problem with this strategy is that such a requirement runs the risk of being unacceptably vague, such as a demand that the decision has to be "reasonable" (cf. Roth et al., 1977) and that any substantive account risks becoming overly paternalistic as well as open to abuse (Buchanan and Brock, 1989).

Another way in which patients' rights to make decisions can be restricted by appealing to a lack of decision-making capacity is through having a risk-relative standard of decision-making competence. In order to be able to autonomously make a decision, the patient would need to possess more of the abilities constituting decision-making competence when the patient wants to make a risky decision. Consequently, if the patient wants to make a less risky decision then the patient would need to have a lower degree these abilities. In Buchanan and Brock's (1989) words this means that

> just because a patient is competent to consent to a treatment, it does *not* follow that the patient is competent to refuse it, and vice versa. For example, consent to a low-risk life-saving procedure by an otherwise healthy individual should require only a minimal level of competence, but refusal of that same procedure by such an individual should require the highest level of competence. (Buchanan and Brock, 1989: 51-52)

What determines if a patient is autonomous to choose an option depends both on the degree to which the patient possess decision-making ability and what risks of harm that option carries.

The main argument for why autonomous decision-making is risk-relative in this way is that, according to Buchanan and Brock, it best manages to balance the duty to respect autonomy and the duty of beneficence. A higher degree of ability for decision-making increases the respect for the patient's autonomy which is needed to balance a high degree of risk. At the same time, this suggestion is dependent on the idea that the risks and benefits at stake in decisions can be evaluated on grounds independent of the patient's opinion of what is best for them. This needs to be settled for the risk-relative notion of decision-making competence to get off the ground.

The opposite view of the risk relative standard is what Buchanan and Brock calls a fixed minimum threshold view. According to this view, if a patient meets a minimum requirement of competence then that patient has a right to both refuse and consent to care. Proponents of this view have presented several objections to the risk-relative standard. For example, Culver and Gert (1990) argue that if a person is competent to make a decision, then that competence encompasses all the options available since being competent to consent to treatment requires that one can understand and appreciate what it means to consent to treatment as well as what it means to refuse care. According to them it does not make sense to say that a person is competent to make a decision if the only thing that person is competent to do is consent to treatment but not competent to refuse. Competence is a feature of a person and not dependent on external factors such as risks associated with a decision. Culver and Gert give the example of a patient who has a minor medical condition and meets the risk relative standard of refusing care. Suppose that the medical condition grows worse, as the risks associated with non-treatment increases so will the demand on the patient's competence for refusal. The patient may thus, without any change in mental abilities, go from being competent to lacking competency for refusing care.

Culver and Gert further argue that competence should not be confused with rationality. It is possible that a decision-making competent person makes a highly irrational decision. They use the case of a fully competent patient with depression to make their point. They do not question the man's competence nor do they discuss the adequacy of the patient's motivations or preference for refusing care. On their analysis the patient's refusal should be overridden because it is highly irrational and they hold that this case shows that hard paternalism is justified in some cases. They suggest that the risk-relative standard of decision-making competence masks this and instead pays lip service to the idea that a competent person's decision should never be overturned.

This debate cannot be settled here. We should however note that the discussion concerning the risk-relative standard is conducted in relation to the term 'competence' and not 'autonomous decision-making'. As noted earlier, many people hold that competence is sufficient for *capacity* for autonomous decision-making but some have argued that authentic preferences should be included as well. If one believes that authenticity should be included in what it takes for a person to have such a capacity, the degree to which a preference is authentic should be included in balancing the value of respecting patient autonomy against the value of promoting patient well-being as well. For example, if one believes in a sanctionist or coherentist theory of authenticity, then a preference can be more or less strongly endorsed by a second-order volition, or by being more or less central to a patient's web of desires and should then get more weight in the balancing of the opposing values.

Person-Centred Care

Papers 1 and 2 examine ethical aspects of certain practices in person-centred care. In paper 1, we examine ethical worries associated with a particular method of informally assessing adolescent patients' decision-making competence in relation to what is mostly self-care performed outside of a healthcare setting. In paper 2, we examine the practice of disputing with patients in three atypical care settings. Both of these analyses are made against a background of patient-centred care, a concept that has emerged over recent decades as a reaction to a perceived overly biomedical approach to medicine.

The biomedical approach focuses on the presence of disease and the search for treatments of symptoms and underlying causes, thereby restoring the patient to normal functioning, or as close thereto as possible (Mead and Bower, 2000). Person-centred care by contrast is characterised by empathy, respect and engagement by the healthcare provider. A relationship is built and communication between healthcare professionals and the patient takes place and the patient is invited to take part in the decision-making process leading up to a treatment suggestion or set thereof. These suggestions should be built upon a holistic approach to the individual patient's life, preferences and circumstances (Håkansson Eklund et al., 2019; El-Alti et al., 2019).

Ekman and colleagues (2011) suggest that three routines should be implemented to better secure person-centred care. First, healthcare professionals should actively encourage patients to share their medical history narratives and how it impacts their general situation. Rather than only focusing on biomedical indicators, healthcare professionals should also take the patient's lived experience into account. This includes how their medical condition affects and manifests itself in their life, as well as what thoughts and feelings this evokes in them. Second, healthcare professionals and patients should be engaged in shared decision-making, which includes sharing of information and joint deliberation of their health problem and in designing and deciding treatments. Third, the patient's narrative and preferences should be documented as well as the content of discussions and decisions made so as to ensure continuity in care, as well as allowing for earlier discussions and decisions to be revisited and revised.

In relation to the topic of this thesis, the second ingredient of person-centred care, shared decision-making, is of primary relevance. Charles and colleagues (1999) influentially identify three steps of shared decision-making: sharing of information, deliberation and decision-making. They contrast the shared decision model with two other models of medical decision-making: the paternalistic model and the informed model. In the paternalistic model the healthcare professional is tasked with assessing the patient's medical condition and, based on their medical expertise, recommends a treatment they deem best suited for the patient. The patient can then decide to consent to or refuse this treatment. Information is disclosed to the patient, after the professional has deliberated on what the best available treatment is. On the informed model the healthcare professional informs the patient of what the possible available treatments are, and relevant medical information pertaining to them. The patient is then left to deliberate and make a decision regarding which treatment is preferable.

By contrast, shared decision-making has both healthcare professionals and patient engaged in all three steps of decision-making. Both healthcare professionals and patients bring relevant information into the decision-making process. The healthcare professional has medical expertise and the patient brings personal knowledge about how they experience their condition, as well as preferences and feelings regarding it and to possible treatments. In the next step, deliberation, healthcare professionals and patients try to decide which treatment is suitable for this particular patient together. In order for there to be any deliberation more than one option needs to be available. Furthermore, the patient and healthcare professionals need to express their preferences regarding both their treatment but also regarding how they want to conduct the deliberation and sharing of information. Charles and colleagues note that the preferences of the involved parties may be very different and the deliberation may therefore turn into negotiation. This, they hold, requires both parties to view each other as equals, something that is challenged by the power asymmetry that in general marks clinical consultations. In a best-case scenario the healthcare professional and the patient will reach a joint decision about how to continue, but the process of negotiation might well result in an impasse in which no mutually agreeable solution can be found.

The three models of decision-making presented above should not be seen as separate categories but rather as a scale with the paternalistic model on one side, the informed model on the other, and shared decision-making in between, with intermediate steps between these models. Sandman and Munthe (2010) have identified several intermediate steps between the three models just described, and they have in other work (Sandman and Munthe, 2009) analysed how these different models of shared decision-making relate to the value of patient autonomy. They show that, depending on what value one attaches to patient autonomy, different models might be preferable to others. For example, autonomy might be valuable in that it promotes preference-satisfaction for the patient. If this is to be promoted, more emphasis during consultations should be directed towards articulating and clarifying patient preferences and relating them to possible treatments. However, if the value in autonomy lies in the patient exercising control over the decision process then features that may strengthen or weaken this aspect should be emphasised.

In papers 1 and 2, different challenges are raised for the ideal of shared decision-making. In paper 1, we examine consultations with teenage patients with diabetes. These patients are, by the very nature of their illness and the treatment, mostly left to their own devices. The patients perform care in their daily life without any contact with healthcare professionals. This pulls towards the informed model of shared decision-making, where the focus of the healthcare professional is to inform the patient so as to enable them to make the best possible decision in their circumstances. Accordingly, in our study, we found that much time and effort was spent on assessing the patient's understanding and informing them about their condition. Yet the strategy we describe in paper 1, that we term error-trawling, had paternalistic undertones, as the healthcare professionals' point of departure was that care should be performed according to a biomedical ideal. If deviations were found the healthcare professional searched for a lack of understanding to explain them. Both of these pitfalls illustrate how health professionals fail to take the situations in which these "deviations" occurred into account, and how the ensuing response may undermine rather than support decision-making capacity. We suggest that different consultation strategies are necessary for this patient group, ones that better capture and make use of the lived experience of these patients, that help them to appreciate (rather than merely understand) the medical information more successfully, and that avoid responses that threaten to undermine the patient's fragile decision-making capacities.

In paper 2, which focuses on the appropriate use of disputing with patients in person-centred care, shared decision-making is challenged in two ways. First of all, we question the extent to which children, other than older adolescents or patients suffering from mental disorders, should participate in shared decision-making to the full extent that may include open disputing. Medical information can be, and often is, complex and thus requires that the patient has the competence to handle it. Furthermore, the coercive context of forensic psychiatric care and public health leads to a situation where additional power balances need to be overcome rather than just those inherent in the relationship between healthcare professional and the patient, in order to create a decision situation in which both parts have an equal role. Disputing can be a powerful tool to use against someone in a weaker position, and can be used to exacerbate these power differences but it can also be used to further important common goals, such as herd immunity to an infectious disease through vaccination.

Moral Responsibility

If a person is morally responsible then we are permitted, or arguably even obliged, to treat that person in a certain way. Depending on the moral nature of an act performed by a person we might blame or praise that person as appropriate. If the act is seriously morally wrong, we might be justified in sanctioning the person further and, in severe cases, through the criminal justice system. To be morally responsible hence entails being an appropriate target of certain kinds behaviours from other people.

Issues of patient responsibility in healthcare have been raised mainly in two contexts. First, there is the question of whether patients should be held accountable by healthcare professionals during clinical consultations for any health-related decisions they have made. Second, there is a discussion about the allocation of healthcare resources, and if these should be distributed on the basis of previous decisions made by the patient affecting their health (Hansson, 2018; Persson de Fine Licht, 2014). I will not enter into the latter debate here, as it is large and not directly relevant for this thesis.

In addition to these two questions of responsibility in healthcare, *criminal* responsibility is also relevant when considering how to assess and handle decision-making competence in healthcare. First, a standard professional task of forensic psychiatrists is to evaluate the mental health state of alleged offenders. Such evaluations are meant to inform courts in their decision concerning liability for an unlawful action. Second, as I show in paper 4, there is a division of labour between the criminal justice system and the (mental) healthcare institution regarding people who commit crime under the influence of some mental disorder. Depending on the conditions of criminal responsibility a jurisdiction uses, this will affect which patients the healthcare institution is tasked with treating (against their will).

We generally assume people to be responsible for their actions. However, there are some clear exemptions from this general rule. We do not consider small children to be responsible, nor do we consider people with severe mental impairments such as a severe intellectual disability or severe dementia to be responsible for their actions. There are also several groups of people for whom it is an open question whether they are responsible and, if so, to what extent. Such *fringe decisional agent* groups include adolescents and people who suffer from mental disorders.

Papers 3 and 4 are directly concerned with the responsibility of the two aforementioned groups of fringe decisional agents: adolescents, and people who suffer from mental disorder. In paper 3, we argue that adolescents in some situations fail to meet what is called the control condition of moral responsibility. Drawing on recent studies, we argue that in some situations, primarily when peers are present, adolescents have greatly reduced responsibility and perhaps lack moral responsibility altogether for certain acts. Yet these features of adolescent psychology do not undermine the adolescent's claim to have their decisions respected. Our argument in this paper is, in a sense, institutionally independent, as we do not discuss any concrete institutional practices. Rather, we argue that, if our analysis of the ethical relationship between having a right to make decisions and moral responsibility is correct it is of ethical importance but it remains an open question of how institutional practices should take this relationship into consideration.

In paper 4, I discuss the specific legal institution of the insanity defence. The notion of moral responsibility forms the backbone of standard arguments in favour of this defence. It is commonly held that criminal responsibility should be modelled on moral responsibility. Some mental disorders can undermine moral responsibility and criminal law should thus emulate this within the constraints pertaining to the criminal justice institution. This exemption, together with a proposed change of legislation concerning the involuntary treatment of people who suffer from mental disorder described earlier, raises the question of how dangerous people who suffer from mental disorder should be treated by society, since they might then be neither legitimately subjected to criminal punishment nor to involuntary care. It is in the face of this challenge that I present my idea of advance criminal responsibility: that people with a potentially responsibility-undermining mental disorder can incur future criminal responsibility for acts done under the influence of mental disorder by refusing psychiatric care.

The topic of responsibility is not directly raised in paper 1 and 2 but the content of these papers relates to questions regarding responsibility nonetheless. Both papers contain examples of *practices* of holding patients responsible in healthcare. At the heart of paper 1 is the distinction between forward-looking and backward-looking responsibility (cf. Hansson, 2018). Patients with diabetes are inevitably tasked with the responsibility for performing their own care. What we observed in several examples of our video recordings of adolescent patient consultations was how perceived failure to handle this responsibility prompted healthcare professionals to search for errors in the patient's understanding of how to perform the care. This search sometimes turned into blaming and shaming the patient, which holds a patient responsible in the backward-looking sense, while in others it rather led to a forward-looking engagement to enhance the patient's readiness to handle their responsibility in the future.

The topic of paper 2 is the question when and how healthcare professionals ought to openly dispute patients' views, preferences or decisions in consultations. Such disputation calls for patients to provide reasons and to justify themselves. Sometimes this can help patients to clarify certain matters, such as what they really want, but it can also be a way of holding patients responsible for decisions that they are in the process of making since "[t]o criticize an agent morally for something is implicitly to express a demand to her to justify herself"[4] (Shoemaker, 2011:605). The same holds for epistemic criticism of factual beliefs.

Before turning to the main question of this thesis, regarding the relationship between the right of fringe decisional agents to make decisions regarding their own healthcare and moral responsibility, it is necessary to consider what conditions an agent needs to meet to be responsible for an act. I will, in the following, discuss two condi-

---

[4] Shoemaker (2011) refers to this kind of responsibility as *answerability*. Sometimes moral responsibility is conceived as consisting of three different kinds of moral responsibility: accountability, attributability and answerability. I avoid this tripartite distinction here as these terms have no established meaning and it is controversial whether these are really different kinds of responsibility or if two or all of them are identical with or reducible to another.

tions of responsibility: the epistemic condition and the control condition. They are both of interest as fringe decisional agents can be impaired with regards to both of these conditions, or at least suspected to be to some extent. This said, my aim here is modest: to explain the basic tenets of these conditions for moral responsibility and to relate them to fringe decisional agents.

The Epistemic Condition

Consider the example of the good grandson who visits his grandmother. She asks him to help her take her medicine. He goes to the medicine cabinet and brings a pill from the jar with the appropriate label. He gives the pill to his grandmother who swallows it and then dies within minutes. Unbeknownst to the grandson someone has replaced all the pills in the medicine jar with botulin, a very lethal nerve poison. Even though the grandson gave his grandmother the pill he is not responsible for killing her. The intuitive reason for why the grandson lacks responsibility is because he lacked the requisite knowledge.

In order for a person to be morally responsible, that person needs to know what they are doing. It is impossible for a person to have complete knowledge of their action so having an adequate degree of relevant knowledge is sufficient. There is, however, the question of what it means to have an adequate degree of knowledge of one’s action. Consider the example of the good grandson again. He has knowledge about some aspects of what he is doing. He knows that he is putting a pill in the hand or the mouth of his grandmother but he does not know that the pill is poisonous. The problem lurking in the background is that an act can be described in many ways (Mele, 2010). In order for the grandson to be morally responsible he needs to know the morally relevant act description of what he is doing, which in this instance is giving his grandmother a poisonous pill.

Another example which highlights the relevance of knowledge of different act descriptions is the following. Daniel has a quarrel with Robert. He brings his gun with him so that he, if he meets Robert can kill him. On his way home, he encounters a man he believes to be Robert and kills him. The victim, however, is not Robert but another man named Edward. Daniel is, in this case, responsible for killing a man, even though he has only partial knowledge of all relevant act descriptions: he knows that he intentionally kills a man even though he does not know who he is killing. Unbeknownst to Daniel, Edward was on his way to Daniel to kill him. Daniel is in this situation unaware that Edward was after his life and that he thus acted in self-defence. Arguably, Daniel cannot be excused for having acted in self-defence since he was ignorant of the threat from Edward. What this example shows is that it matters what act descriptions are appropriate, and also what act descriptions that a person has knowledge or justified belief of[5].

Even though the epistemic condition for moral responsibility is generally accepted, there are situations in which we are considered to be morally responsible for acts even though we lack the relevant knowledge. Holly Smith gives the example of a woman who is near-sighted but…

> … not legally required to wear glasses while driving. Late for work one foggy morning, and unable to find her glasses quickly, she leaves home without them. Subsequently she swerves to avoid hitting a dog on her left, and seriously injures a child walking in the street on her right. Had she worn her glasses, she would have seen the child in time not to swerve. (Smith, 1983: 544-545)

The woman is responsible for the accident even though she did not know that the child was there, because she is *culpably ignorant*: The reason the woman is responsible for the accident, even though she does not meet the epistemic condition, is that her ignorance can be *traced* back to an earlier wrongful action (not taking the time to find her glasses) for which she was responsible.

One question pertaining to the idea of tracing, concerns the degree to which one is responsible for any bad consequences that results from the ultimate (voluntary and wrongful) decision that the trace leads back to. Are we responsible only for the risk that is implied by the decision, or for the actual consequences of the ensu-

---

[5] See Meynen, 2016 for more on the relevance of knowledge about act descriptions in relation to the insanity defence

ing acts? Smith (1983) suggests the latter, and supports this claim with the example of a person out camping who goes to bed without properly extinguishing the camp fire. The person is blameworthy for the mere risk that leaving glowing embers implies, but the person would be even more blameworthy if leaving the embers overnight resulted in a forest fire. Being fully responsible through tracing thus requires moral (un)luck. (Nagel, 1979)

The use of the concept idea of tracing as an explanation for moral responsibility has been questioned (e.g. Smith, 2011; Vargas, 2005). I will here limit myself to one of Vargas' arguments and the reply to it by Fischer and Tognazzini (2009), as this exchange also sheds further light on the epistemic condition in general.

Vargas (2005) presents the case of "Jeff the Jerk", a middle-aged, middle manager who is tasked with laying off some people from the mid-size company he works for. Due to his rude and inconsiderate character he delivers the message in a concordant manner. Unlike most people, Jeff made a conscious decision in his adolescent years to develop his insolent character since he believed it would make him successful in his encounters with women. He succeeded in forming the character he sought to develop without much effort. Vargas then claims that Jeff, when deciding to adopt his unpleasant character, could not reasonably have foreseen that he, as a result, decades later would lay off his employees in such a rude way. Therefore, Vargas argues, his moral responsibility for laying off his staff in a rude way cannot be traced back to his decision to become a Jerk.

In their reply to Vargas, Fischer and Tognazzini (2009) point out that Vargas seems to have a rather unclear and narrow understanding of the culpable ignorance aspect of the epistemic condition. What precisely, they ask, is it that Jeff would have needed to be reasonably able to foresee in order for the tracing to hold? Vargas seems to assume that he must be able to foresee that, in some decades, he will have to lay off precisely these people, or that he will have to lay off some people. Either of these suggestions however seem to be overly demanding, Fischer and Tognazzini suggest, for the tracing to hold: it is enough that Jeff can reasonably foresee the fact that becoming a jerk will make him rude and insensitive towards people, without having to specify in what way or against whom he will behave in this way. Again, we see that how a wrongful act or a bad consequence is described may impact moral responsibility judgements.

The idea of tracing is central to paper 4, where I argue that people who commit crimes under the influence of mental disorder can be morally responsible for these crimes even though their mental health condition at the time of the deed means that they fail to meet the epistemic condition: if they suffer from such symptoms of mental disorder as a result of a previous voluntary decision, (to refuse care which would have alleviated their symptoms), their lack of knowledge when committing their offence can be traced back to an act for which they are morally responsible.

A standard condition for culpable ignorance is that the agent has done something wrong by putting themselves in a state in which they lack relevant knowledge. (Wieland, 2017) However, even though some refusals of care are undoubtedly morally wrong it is hardly true for every refusal of care. Therefore, I invoke the distinction between brute luck and option luck (Dworkin, 2000) in paper 4. A person who, autonomously, refuses care has made an active decision to refuse care and is morally responsible for that decision and the consequences that might follow from it (given that the conditions for moral responsibility are also met).

One important feature of cases when people commit crimes under the influence of mental disorder is that they do not necessarily lack relevant knowledge of a situation but that they lack some ability necessary for being a morally responsible agent. This is different from many cases of mere (culpable) ignorance such as when a doctor through negligence is not aware of the hazards of a particular drug and prescribes it to patients.

The closest parallel to crimes committed under the influence of mental disorder are crimes committed while intoxicated since intoxication also can undermine abilities necessary for moral responsibility. Fischer and Tognazzini (2009), in their discussion of tracing, discuss the case of a drunk driver who they argue is so drunk that he does not meet the requirements of a morally responsible agent but who is responsible for getting himself drunk. Further, some people who commit crimes under the influence of mental disorder do not do so because they lack knowledge of what they are doing but because they may lack adequate control over their actions.

Presumably, Fischer and Tognazzini do not consider getting drunk to be morally wrong. For the drunk driver to be responsible, the conditions for incurring moral responsibility must be less stringent when one puts oneself in a situation in which one lacks the abilities necessary for moral responsibility as opposed to situations of mere ignorance.

One final connection between the tracing debate and the argument made in paper 4 concerns the broader epistemic condition endorsed by Fischer and Tognazzini. According to them the bad consequences must be reasonably foreseeable, even though they hold that such a prediction can be done in general terms. It is very likely that a person who develops into a jerk will behave like a jerk to people once he is a jerk. It is much less certain, however, that a person with a mental disorder will commit crimes under its influence, a difference of some importance to the argument developed in paper 4.

Moral Knowledge

One controversial aspect of the epistemic condition concerns whether a person needs to have *moral* knowledge of the act in order to be morally responsible for it. This ability is often referred to as a key difference between what it takes to have the right to make decisions regarding one's own care, and to be morally responsible: such a right may hold even in the absence of insight into the moral qualities of the options, but without it the decision-maker will not be morally responsible for their decision (Meynen, 2011). The influence of this requirement can be seen in criminal law, as the M'Naghten rule for example requires that an offender knows that what they was doing was wrong in order for the offender to be criminally responsible.

Taking the M'Nahghten rule as a point of departure, there are four interpretations in the literature of what it means to know the (moral) status of an act. First, it could mean that the person knows the legal status of the act. Second it could mean that the person knows what moral status the act has according to a majority of the people in the community. Third, it could mean that the person knows if the moral status of the act is in line with the person's own ethical values and convictions. Fourth, it could mean that the person knows the *de facto* moral status of the act (cf. Sinnott-Armstrong and Levy, 2011).

The first two interpretations only require the person to have factual understanding of either the law or of other people's moral convictions and does not require that the person has any moral opinions of their own. In a legal context, the two first conditions make sense and might be adequate in relation to the purpose of the institution of law, but they are not of primary interest here, as they do not require any additional mental capacity, beyond understanding and appreciation of ordinary facts. The last two interpretations, however, require an ability to form specifically *moral* judgments, and the last one also requires that one has actual moral knowledge. As they stand, however, none of them seem convincing as conditions for moral responsibility.

Consider first the case of Andrea Yates. She killed her five children by drowning them in the bathtub. She did so in the belief that if she did not kill them then their souls would fall into the hands of Satan and be tormented forever. After she had drowned her children, she called the police in the hope of getting arrested and then executed for her crime, an end she sought since she believed that Satan resided within her and would die along with her.

In this case, Yates knew that what she was doing was wrong according to the law, and in fact sought to be subjected to the legal consequences of what she had done. She is thus responsible for her act according to the first interpretation. She knew that a majority of people consider murdering one's children to be wrong. It is however not certain what Yates believed about the public's opinion, nor whether public opinion is that it is wrong to murder one's children to save their souls from eternal damnation (Resnick, 2007). It is therefore unclear if she was responsible according to the second interpretation of knowing that an act is wrong, since this depends on which act description is appropriate.

Even though Yates seems to have acknowledged the *prima facie* wrongness of killing her children, her overall judgment was that she was justified in doing so if it saved their souls from being tortured in hell. She was thus not responsible by the third interpretation of what it means to know that something is wrong. Nor, by implication, was she responsible according to the fourth interpretation, since this requires that one acts counter to a moral belief that one has and that the belief in question is true. Yates did not act counter to her overall moral belief.

I believe, in line with the second jury trying Yates' case, that Yates was not responsible for her acts. Her delusions led her to believe in a false act description that rendered her decision tragic but (subjectively) defensible. Yates lacked moral knowledge; she did not know that what she did was wrong but the source of her wrongful knowledge was the factual error that was the result of her delusion and not a fault in the moral values of wanting to save her children from an eternity in hell.

Now contrast the case of Andrea Yates with the case of US slave owners. These people held their slaves in accordance with the law and in accordance with the moral views of public opinion[6]. Presumably, the slave owners did not believe that what they did was wrong. The slave owners in this case do not meet any of the four interpretations of what it means to act wrongly, yet we would still judge them morally responsible for holding slaves[7]. Even though the slave owners also lack moral knowledge the key difference between them and Andrea Yates is that their lack of moral knowledge is the result of them believing in the wrong ethical values and not in having a false factual belief.

---

[6] At least the white public opinion.

[7] Wolf (1987) suggest that slave owners are similar to the fictional case of Jojo who is the beloved son of a ruthless dictator and who is brought up to be equally ruthless and tyrannical as his father. Wolf suggests that due to the special circumstances of Jojo's upbringing Jojo is not morally responsible for the horrible acts he does. To counter this objection, we can assume that there is a small but loud minority in favour of abolishing slavery. This means that the slave owners have had an opportunity to reflect upon their values and practices pertaining to slavery and are therefore, unlike Jojo who has never had such an opportunity, morally responsible for their holding of slaves.

A wider interpretation of the moral knowledge condition would be that it is only necessary to have the *ability* to form moral judgments to be morally responsible. Two questions will be discussed here. First, is the ability to make moral judgments necessary for moral responsibility? Second, are there people who cannot form moral judgments?

The reason that the ability to form moral judgment is a necessary condition for moral responsibility is that if a person lacks this ability altogether, this person is unable to act on moral grounds and respond to moral reasons. Ethical reasons for or against an action would not enter into such a person's deliberation other than possibly indirectly when considering how other people will act or react to their actions, and taking such responses into account. A person who lacks the ability to form moral judgments is not able to navigate their decision-making from a moral point of view.

This argument has some bearing on whether the ability to form moral judgments is necessary for moral responsibility, as being morally responsible means that a person is, at least *prima facie*, an appropriate target of practices[8] of holding someone responsible. One aspect[9] of holding someone responsible is to initiate or engage in moral conversation with a person. By blaming a person, we can implicitly ask for the person to justify or rethink their behaviour. We might also try to make the person, feel guilty about what they have done by appealing to their conscience. However, if blame is directed towards a person who lacks the capacity to form moral judgment then blame as a communicative device does not seem to work as that person lacks the prerequisite for understanding the message being sent (Levy, 2007). Communicative aspects of blame have also been explored in philosophy of criminal punishment (Duff, 2007, Bennett 2008).

Talbert (2012) has suggested that blame might function not only as a conversational act, but also as a moral protest. Through blaming, a person expresses their moral rejection of an act, and in

---

[8] I am here solely concerned with practices of holding people responsible which means that I am ignoring e.g. attitude theories of blame (see e.g. Wallace, 1994).

[9] I use the word aspect here as one practice of holding responsible may have several aspects, e.g. communicative and punishing.

distancing themselves from the act the blamer shows self-respect and moral integrity. Talbert gives the example of slaves who protest against their treatment by their owners, knowing that they do so to no avail. However, a protest seems futile as a communicative act unless the action can be understood as such by the party the protest is directed against. Expressing a moral stance against someone who lacks the ability to form moral judgment would be like holding up a sign to a blind person. But even if the target of the protest lacks the ability to form moral judgment the protest may nevertheless be meaningful, as long as that person understands that other people have moral judgments.

Communication is not the only function of different practices of holding people responsible. Another such traditional function is punishment. One way of punishing a person is through blame, and thereby hoping to make the morally responsible wrongdoer suffer from guilt. This form of punishment however is futile here, as it requires the target to experience guilt. Furthermore, practices of holding a person responsible that are based on expressing bad sentiments towards them does not work, unless the target cares about how other people feel about them. For someone only concerned with self-interest, this will only work if the person has an instrumental reason to care about other people's attitudes. Alternative punishing practices of holding someone responsible are thus necessary.

It might still be argued that having the ability to form moral judgment is still a necessary condition for moral responsibility and thus for someone to be an appropriate target of punishing practices of holding a person responsible. I will return to this issue shortly.

The most obvious candidates for people who lack the ability to form moral judgments would be those that are popularly called *psychopaths*. Psychopathy is assessed using the Hare Psychopathy Checklist – Revised (PCL-R) (Hare 1991). Psychopaths are characterised by being motivated by self-interest and showing little regard or remorse for callous use of other people. These general characteristics are hardly conducive to moral behaviour but it remains an open question whether these people lack the ability to form moral judgments altogether.

One reason for the suggestion that psychopaths lack the ability to form moral judgments, is that, in general, they have problems distinguishing moral and conventional wrongdoing (Levy, 2007). This argument has been criticised on the ground that it relies on a test that fails to adequately distinguish moral and conventional wrongdoing (Shoemaker, 2011)[10]. However, this criticism, as well as other research, do suggest that the ability to form moral judgments may be comprised of several parts.

Psychopaths have an impaired ability to empathise with other people. This is in turn makes them blind to moral reasons based on considerations of others' welfare and they cannot distinguish the severity of acts based on their impact on other people's welfare. Yet, our sense of morality is not built solely on empathy for other people. Shoemaker (2011) argues that one contentious, albeit possible, interpretation of the research on psychopaths, is that they have the ability to understand rules even though they might lack the ability to understand the reasons for such rules to exist. Shoemaker then goes on to suggest that it is this ability which is necessary in order to be eligible for criminal responsibility since

> all that matters to be eligible for criminal responsibility is that one be able to arrive at … correct beliefs about what one should do, given one's awareness of the rules and penalties of the criminal law. It matters less or not all that one is sensitive to all of the various reasons that may ground the rules or penalties (Shoemaker, 2011: 119, cf. Hart 2008)

Shoemaker's argument has some force but I think that there are reasons to remain sceptical about if merely understanding rules and the consequences of breaking them are sufficient for criminal punishment. The psychopath in this instance seems to be treated as something less than a person. A person who lacks the ability to appreciate the moral reasons that ground rules is forced to dance to the tune of the moral community, a community they cannot be part of. But perhaps we do not have the same moral obligations to a

---

[10] Shoemaker (2011) goes further and argues that no distinction can be made between moral and conventional. (see also Shoemaker, 2015)

person who cannot participate as a member of the moral community.

Research done by Glover (2014) suggests additional abilities that are part of a full ability to make moral judgments. He interviewed patients with antisocial personality disorder, a closely related diagnosis, who had committed crimes and were residents at a psychiatric hospital. One feature of these patients' moral thinking included simple ideas regarding fairness and rights. One such idea was equality between the sexes, that women should have the same rights and be treated in the same way as men. They also expressed that it would be wrong to occupy parking lots designated for disabled people since people with disabilities might need the extra space provided by these parking lots to get in and out of their cars.

Even though a lack of empathy impairs the ability for moral reasoning, I am inclined to consider the ability of comparing different cases on moral grounds as sufficient for moral responsibility, and for someone to be open to communicative aspects of holding people responsible. For example, one person interviewed by Glover observed that men and women are judged differently on their sexual behaviour and considered this double standard to be wrong. Even though a person might not be able to appreciate moral dimensions pertaining to people's welfare, having the ability to understand that what goes for one person should also go for other people, all things being equal, seems sufficient for engaging in moral conversation.

The Control Condition

The control condition is ubiquitous to the moral responsibility debate and, together with the epistemic condition, it is one of the two traditional conditions of moral responsibility. In order for someone to be responsible for an act they also need, in addition to meeting the epistemic condition, to have sufficient control over what they are doing. The control condition is relevant in the context of papers 3 and 4. In paper 3, we rely on recent research into developmental psychology and argue that adolescents lack responsibility for certain actions by virtue of not having fully developed the capacity for self-control. With regards to paper 4, there are some symptoms of mental disorders, such as hearing commanding voices, that can undermine control over certain actions and hence exempt someone from criminal responsibility. I will begin with a discussion close to everyday experience before moving on to some more philosophical theories of control. I will then discuss the case of adolescent responsibility in the light of these ideas pertaining to control.

Discussing the control which a person can exert over his actions, Glover (2014) starts with an example of soldiers keeping a watch for the enemy. Even though they can control when they fall asleep to some degree, there will inevitably come a point at which they cannot stay awake any longer and thus cannot be responsible for doing so.

Glover notes that there are three features of this case that are relevant for the overall discussion of what control we have over our actions. First, the ability to resist the urge to fall asleep may differ between people and also depends upon the current state of the soldier. There is a difference in ability between a well-rested and an exhausted soldier in their ability to resist falling asleep. Second, there might be contextual features that affect the soldier's ability to stay awake. It is possible that the presence of an officer would help the soldier resist sleep. That the presence of an officer has this effect does not necessarily mean that the soldier could have stayed awake in the officer's absence. Third, it is very hard to know if a soldier falling asleep is due to a genuine inability to resist falling asleep or to a lack of effort from the soldier.

This analysis seems adequate for other cases as well. For example, using a phenomenological approach[11], Timothy Schroeder (2005) has examined whether people who suffer from Tourette's syndrome[12] are responsible for their actions. He suggests that the experience of people who suffer from Tourette's syndrome is that they often have the ability to choose whether or not to act on their tics, although not acting on it leads to an increasing pressure to do

---

[11] See Radovic and Höglund (2014) for a similar approach to people who have committed crimes under the influence of mental disorder

[12] Tourette's syndrome is a neuropsyhiatric disorder which is manifest by tics, that is repeated reflex like movements or vocal sounds. For some people the disorder takes the form of coprolali, that is non-voluntary verbal expressions of socially inappropriate content such as insults or obscene words.

so. They report that they are able to refrain from acting on their urge to tic in certain situations when giving in to such a tic would be particularly harmful.

Glover (2014) applies his analysis to addiction and suggests that several arguments used against the idea that people who suffer from addiction lack control are flawed. For example, many American soldiers became addicted to heroin[13] during the Vietnam war. When they returned, a vast majority stopped using the drug without any relapse. He suggests that even though these veterans could break their addiction on their return, they might still have been unable to refrain from using the drug had they continued their stay in Vietnam. If Glover is right then drug addiction is not a matter of an either-or condition, nor is it necessarily a scalar matter where you are more or less addicted, but rather something more uneven and dependent on contextual factors.

The control condition has a central place in contemporary discussions of moral responsibility as it is considered key to the question of whether we have free will. I will not enter into that debate here, but I wish to draw upon two theories developed within that debate that can help shed some further light on the question of interest to this thesis. In paper 3 we suggest that adolescents may have the right to make decisions that they are not responsible for. We do this on the grounds that common conditions for having a right to make decisions (i.e. decision-making competence) do not encompass a control condition, other than being able to communicate one’s decision. I will here widen that discussion by contrasting the control condition we discuss in that paper with another theory of control.

The first of these theories is Frankfurt’s theory, which was briefly presented in relation to the authenticity condition in connection with conditions for having the right to make decisions regarding one's healthcare. Here, we can see a strong connection between the debate over moral responsibility and debate concerning the requirements for the right to decide. The underlying idea behind these kinds of theories is that, in order to be responsible for an act,

---

[13] As Kennett (2013) reminds us, there is a danger to treating addiction to all drugs in the same way as the substances in question are very different from one another.

we need to act upon desires that we are the source of, or which in some deeper sense belong to us.

According to Frankfurt's theory a person is responsible for an act if that act is motivated by a desire for doing that act, and is backed up by a second-order volition for acting on that desire. That I have a desire to eat an ice cream is a first-order desire. If I have a desire to have a desire for eating ice cream then I have a second-order desire for eating that ice cream. My second-order desire becomes a second-order volition if I not only want to have a desire to eat an ice cream but if I want my desire to eat an ice cream to be a desire which I act upon. This does not mean that I have to act upon my desire, simply that I want to act upon it.

The example given by Frankfurt of someone who is not responsible for their actions, is the unwilling addict: someone who is addicted to a substance but does not want to be so and does everything in their power not to succumb to the urge to take the drug. The unwilling addict has a first-order desire to take the drug, but has a second-order volition not to have that desire and act upon it.

I will not here engage with any of the criticism (see e.g. Watson 2004) and further developments of Frankfurt's theory that have been made. It here serves to function as an example of a desire control theory for responsibility.

The problem with applying this theory to the case of the adolescents is simply that we do not know what desires they have in the kinds of situations relevant to paper 3. We do know that adolescents in general are more prone to making risky decisions than adults. In particular we know that the mere presence of peers makes adolescents more prone to risk-taking and that this is associated with an activation of the brain region associated with rewards (Chein et al., 2011). We also know that adolescents react differently from adults to peer rejection (Sebastien et al., 2011) and that the brain region associated with self-control is less developed (Albert et al., 2013).

Nonetheless, these empirical findings give us some clues as to what is going on, but until this is properly investigated it will be mere speculation. We can assume that adolescents in general have a preference for being liked by their peers, or at least not rejected by them. The activation of the reward region of the brain could mean that an existing preference is modified or that a new preference appears. That adolescent behaviour becomes more risk-prone suggests that something happens to adolescents' valuation of risk. It could mean that risk-taking becomes desirable in and of itself or that the risks are discounted.

Frankfurt's theory requires that whatever happens on the first-desire level is endorsed by the second-level. For simplicity, I will assume that the relevant first-order desire is a desire to be liked by their peers. It seems safe to assume that adolescents in general have a second-order desire to be liked by their peers, that they want a desire to be liked by their peers. It is however unclear if they have a second-order volition for the desire to be liked by their peers. That is to say it is unclear whether they want the desire to be liked by their peers to motivate their actions. It seems possible that at least some adolescents will have a general second-order desire to be liked by their peers, but might not want to be motivated by that desire in certain instances. It is thus possible that adolescents may be morally responsible for their risky decisions according to Frankfurt's theory but not necessarily so. In order to get a better understanding of what is really happening and what is motivating the adolescents, something like the phenomeno-logical research on people who suffer from Tourette's syndrome done by Schroeder (2005) is needed.

The second theory of control is Fischer and Ravizza's (1998) theory of reason-responsiveness. This is also the theory of control which we use for our argument in paper 3. According to them, a person needs to be moderately responsive to reasons in order to be responsible. Moderate reason-responsiveness is then suggested to have two components: regular reason-receptiveness and weak reason-reactivity. In order to be responsible, a person has to be receptive to reason, that is be able to recognise features of a situation as reasons to act. A moderately reason-receptive person is someone who regularly, and in an understandably patterned way, identifies reasons for action, some of which are moral. Reason-reactivity refers to the translation of these reasons into action. A weakly reason-reactive person is someone who would, in some possible world, act in accordance with a sufficient reason to act.

In order to get a better understanding of what their theory entails consider a poor person who dreams about becoming rich. This person knows that they will never, on their meagre income, be able to save enough money to become economically independent. Therefore, this person buys lottery tickets even though this person knows that the expected utility is a net loss. So far, this person is receptive to reasons in an understandable and relatable way. Let us now assume that this person does not see any reason to buy tickets when the big win is precisely 1 000 005 dollars but sees a reason to buy tickets when the prize sum is any other amount. This person fails to exhibit an understandable regularity in their receptiveness to reasons (barring the possibility that there is a recognisable reason for the person not to buy tickets for that prize sum, such as believing it to be an unlucky number).

Fischer and Ravizza only require weak reactivity to reasons. This means that they only require a person to act upon a sufficient reason in some possible world. Let us return to Glover's watchful soldiers who do their best to stay awake even though they are tired. They have sufficient reason to do so as the enemy army is close. According to the weak reason-reactivity condition they are responsible for falling asleep if there is a possible world in which they would stay awake given sufficient reason to do so. Let us assume that the soldiers would have been able to stay awake had an officer been present. This is enough for Fischer and Ravizza to consider the soldiers responsible. However, I believe that this example demonstrates the shortcomings of Fischer and Ravizza's view and that a weak reason-reactivity condition is too weak for responsibility (cf. Brink and Nelkin, 2013). I cannot here go into precisely how such a condition should be spelled out, even though, as McKenna (2005) suggests, it ought to be weaker than the condition for reason-receptivity so as to allow people to be responsible, even when they go against their own better judgment.

It might be that addiction provides the hard case for when a person should be considered to have enough control to be responsible for their actions. Addiction seems similar to risky adolescent decision-making as it changes the way that the brain processes rewards (Shroeder and Arpaly, 2013). One important difference between an addict's and adolescent's decision-making is that an addict's behaviour can often involve a long sequence of actions in order to obtain the drug, such as obtaining money for it, whereas adolescents' decisions are more commonly made in the spur of the moment. This suggests that adolescents have a stronger claim to be exempt from responsibility than people who are addicted, at least for decisions made in the presence of peers. One interesting consideration here is that drug use peaks in adolescence and young adulthood. Many people who abuse drugs quit as they mature and grow older. Yet philosophers trying to understand the phenomena of addiction have primarily focused on addiction itself, and not put it in relation to adolescent and young adult psychology.

The discussion of control has further relevance to healthcare and, in particular, to self-care. In paper 1, we examine patient consultation within adolescent diabetes care. Adolescents with diabetes as a group have problems managing their diabetes and they often do not act in accordance with the treatment plan they have agreed to during these consultations. One possible problem facing the adolescents in their self-care is that decisions to perform treatment have to be done in an everyday setting, such as school where peers are present. In these cases, if their consent to the treatment plan was sincere, later decisions not to measure blood sugar and take insulin are made in a context where the unique features of adolescent psychology are in play. The "error trawling" behaviour of health professionals we discuss in the article seems to both improperly blame these patients for the diversions, and threaten to enhance this problem. We point out how the behaviour could instead be adjusted to strengthen the young patients' future ability to resist these impulses.

The Relationship Between the Right to Decide and Moral Responsibility

There are several similarities between the conditions necessary for the right to decide over one's one health and those for being morally responsible. Most adults in most situations are considered to meet the criteria for the right to decide and to be morally responsible, and a person who is considered not to do so for either concept is usually considered to also lack capacity for the other. This, as we have seen, is due to a considerable structural and thematic similarity between the conditions for having a right to decide and those for being morally responsible. The epistemic condition is similar to decision-making competence, and the information condition of the right to decide. In both cases the question of authenticity has been raised. Finally, both concepts are concerned with the ethical status of an agent and has implications for how this person ought to be treated. Still, there are also differences, and it is therefore of interest to ask how much room there may be for a person to have the right without being responsible, and vice versa.

I will begin pondering this issue by exploring in more detail the kind of responses that are appropriate to someone who has a right to decide and is morally responsible. Then I will turn to a deeper discussion of the relationship between the conditions necessary for having the right to decide and those for being morally responsible.

The right to make decisions is most straightforwardly respected by ensuring that the person is sufficiently informed and by not interfering with the decision a person makes. Arguing with a patient, even though it has the pitfalls we highlight in papers 1 and 2, can still be a way of respecting that person as an autonomous decision-maker.

Holding people responsible is typically done through blame or praise. I will here limit my discussion to blame since the tensions between holding someone morally responsible and respecting patients' right to decide are clearest in this case. There might be some controversy over what blame essentially is, but I am going to assume that blame in the typical case is a verbal expression of moral disapproval which is commonly accompanied by some sort of negative emotion such as anger, resentment or disgust.

Blame can have many functions. One such function elaborated on above is to work as a moral protest and to express the moral stance of the blamer. However, directing blame towards a person is also a call for justification from the person being blamed. If they can provide a morally satisfactory reason for what they have done, we should (and hopefully do) withdraw our blame. Blaming someone is not only a question of asking a person why they did what they did, but also has a punitive function. It is unpleasant to be blamed for something, even if we are guilty of wrongdoing. To withdraw blame is to take back a sanction.

This punitive aspect of blame gives rise to a potential conflict between the right to make decisions and holding someone morally responsible. On the list of external pressures that may violate a patient's right to decide presented by Szmukler and Appelbaum (2001), blaming would seem to fall under the heading of interpersonal leverage. This category contains external pressure that, in general, is stronger than mere persuasion but weaker than inducements.

Blame in general cannot be expected to undermine voluntariness, but there might be other features in a situation which can increase the punitive force of the blame. Blame from a healthcare professional directed towards their patient is done within a relationship marked by a power imbalance. Some fringe decisional agent groups such as adolescents are extra compliant towards authority (Grisso et al., 2003). Furthermore, a prolonged care context usually gives rise to a close relationship between healthcare professional and patient, in which emotional sanctions from the healthcare professional have a particularly strong impact. So even if blame does not necessarily undermine the voluntariness condition of a patient's right to decide, it certainly has the potential to do so.

It might be thought that having the right to make decisions does not bear any connection to the moral responsibility of the right-holder, but rather to their *prudential* responsibility. Prudential responsibility is here understood as a responsibility for decisions that affect ourselves. There are several reasons why the distinction between moral and prudential responsibility might be questioned. First of all, decisions that primarily affect a person themselves might lead to that person being in need of healthcare and thus put a strain on the limited amount of healthcare resources. This phenomenon becomes salient when healthcare is put under extra pressure, such as during the corona pandemic, when resources are even more scarce than usual. Extra demand for medical attention then can clearly take healthcare resources away from others in need. A related concern is that, even though a person might be the main sufferer of bad consequences, people around that person may also suffer directly or indirectly as a result. A more principled reason for why this distinction is problematic is seen if we accept that we have moral duties towards ourselves (Kanygina, 2020). In that case, a prudentially bad decision is also morally bad. The last reason for why this distinction is problematic in this case is that the appropriate way of responding to prudentially bad decisions seems to be the same as our response to morally bad acts, that is to blame the person.

If we return to the clinical situation and consider the typical kind of verbal and emotionally charged blame described above, in relation to person centred care and its more expansive view of the role that patients should have in medical decision-making, we see that blame may increasingly undermine this enhanced idea of the patient's right to decide. In person centred care, the patient's right to decide is not limited to refusing or consenting to a treatment that the healthcare professionals offer the patient, but is also to be actively engaged in determining the goals and design of treatment. Blaming may thus have as an effect that the patient is discouraged from participating in the decision-making and assumes a much more passive role.

In paper 1, we examined how decision-making competence was informally assessed by healthcare professionals in adolescent patients with diabetes, that is assessing decision-making competence without the aid of a formal assessment tool. In reviewing recorded patient consultations, we found that one common strategy was what we named "error-trawling". The physician would compare the blood sugar measurements done by the patient since the last consultation and, when a deviation from the medical ideal was found, the healthcare professional would probe to see if the deviation was related to a lapse of understanding on the patient's part. This healthcare situation is in many ways set up so as to be a judgment of patient performance, which an interview study with these patients also found matches their experience of these consultations (Boman et al., 2015). This means that any detected deviation from the medical ideal is perceived as something the patient has done wrong and we also found several instances of direct blame in connection to error-trawling. There is an obvious tension between, on the one hand, blaming the patient and putting them in a morally subjugated position while, on the other, simultaneously inviting the patient to participate in a therapeutic alliance as equals.

Connecting the Right to Decide and Moral Responsibility

Despite the fact that that there is a potential conflict between respecting people's right to decide and holding people responsible, there is still a striking resemblance between what is required of a person to be morally responsible and what is required to have the right to decide over their own life. I will, in the following, outline two different ways in which the relationship between the right to decide and moral responsibility can be understood.

First, one might hold that there is a necessary connection between the two. If someone has a right to decide then that person is by implication morally responsible. The intuitive pull of this way of seeing the relationship between the concepts is very strong and underlies prominent ethical theories such as luck egalitarianism (Dworkin, 2000).

Despite the intuitive appeal of this idea we might ask what creates this implication. One possibility is that the right to make decisions regarding one's one health is somehow normatively grounded in moral responsibility. Elliot (1991) suggests that having the right to decide means that we are entitled to make not only good decisions, but also bad and irrational ones. The reason for this is that what makes a decision worthy of respect is if it truly belongs to the person and, if it does, that the person is morally responsible for the decision. Noggle (2002) makes an argument along similar lines with regards to adolescents. He argues that, as we grow up, we attain adult rights to have our decisions respected by virtue of becoming capable of moral responsibility. Noggle's argument thus suggests that respect for autonomy is grounded in or dependent on our capacity for moral responsibility.[14]

The second possible relationship between these concepts is that they are conceptually connected through similarity of content. There is, as previously mentioned, a considerable similarity between the conditions for the right to decide and for moral responsibility. By comparing these conditions more precisely we can see how closely related they are. This is the approach taken in paper 4 and I will expand on that comparison in the following.

A Conceptual Comparison

There is a structural similarity between the conditions for the right to decide and for being morally responsible. I will begin by comparing the requirement of decision-making competence with the epistemic condition for moral responsibility and then discuss authenticity and control. I have already mentioned that the capacity to form moral judgements is an important ability that is considered necessary by some scholars for moral responsibility, but to my knowledge no one has argued that it is necessary for having the right to make decisions.

Both the right to make decisions and moral responsibility require capacity for some degree of knowledge of what one is doing and the kind of consequences that might follow. According to the MacArthur model, two kinds of knowledge form part of this competency. The patient needs to be able to understand in general terms what specified risks and benefits an option entails. The patient also needs to be able to appreciate what this means with regard to themselves, that is to be able to apply the understood general information to their own case.

---

[14] By contrast, Hart (2008) seems to suggest autonomy as a basis for criminal responsibility. By committing a crime, the offender voluntarily takes on the risk of getting caught and being punished.

In their discussion of tracing, Fischer and Tognazzini (2009) defend a weak epistemic condition. In order to incur responsibility via tracing only a general understanding of reasonably foreseeable consequences is necessary. This general epistemic condition stands in stark contrast to the more specific nature of the information disclosed to a patient as part of an informed consent procedure. In order to be morally responsible, it seems sufficient to have a general understanding that someone can be harmed, whereas a patient should be informed about the specific kinds of harm that are relevant and a rough estimate of their probability as well.

The understanding and appreciation conditions of MacArthur competency focus on cognitive content. It is possible that cognitive understanding and appreciation should be supplemented by some kind of emotional understanding as well. That is to say it is not enough to understand that refusing proper diabetes care carries an increased risk of a toe or a foot needing to be amputated, but the patient also needs to have an emotional understanding of what it would feel like to live without a foot. (Buchanan and Brock, 1989) This is in contrast to merely understanding that I, the patient, would not be able to play football in such a case. From a terminological perspective this is slightly cumbersome as the term normally used for this kind of emotional understanding is appreciation, a word that Grisso and Appelbaum (1998) have given a different meaning in their model. We might therefore want to separate cognitive appreciation (applying general information to one's own case) from emotional appreciation (understanding how someone will feel in a given situation).

The term appreciation is used in connection to criminal responsibility as well. The Model Penal Code states that in order to be responsible, an offender needs to have sufficient capacity "to appreciate the criminality (wrongfulness) of his conduct" (Model Penal Code and Commentaries, 1985). Sinnott-Armstrong and Levy (2011) suggest that an emotional understanding of this term is possible in this context. It would then not be sufficient merely to have the capacity to understand that a leg might be broken, but the offender would also need the capacity to emotionally appreciate the experience of having one's leg broken. A person with a diminished ability for empathy, such as someone with psychopathy, might thus struggle to meet this condition. However, since responsibility only requires imprecise knowledge of the risks, it would be too demanding to require someone to emotionally appreciate the precise impact their behaviour will have on someone. A more plausible interpretation is that a general capacity to emotionally appreciate what consequences one's behaviour will have on other people is necessary. This requirement would be similar to the general requirement that one must be able to form moral judgments in order to be morally responsible. (cf. Haji, 2010)

One important difference between having the right to make decisions and being morally responsible is that in order to have the right to make decisions regarding one's own care, the information that the patient is expected to understand and (cognitively) appreciate relates to the patient themselves. However, medical decisions do not only affect the patient but also other people close to the patient. This can cause problems for patients who can understand the meanings and consequences a decision might have for them, but not for others. For example, people with autism may have an impaired ability for empathy but they also have the connected problem of an impaired theory of mind, that is the ability to attribute mental states to other people. These two impairments may to a certain extent be ameliorated through training and alternative strategies such as developing cognitive schemes for identifying cues such as facial expressions with feelings. Nonetheless there will still be situations in which a person with autism will be blocked from knowing what mental states other people experience (Richman and Bidshahri, 2018). This suggests that a situation is possible in which a person with autism might perform an act knowing what it means for them, but failing to understand other act descriptions of what they are doing, such as that they might be hurting other people.

It is, as noted earlier, possible for a patient to have the right to decide without making a decision that is informed. That is, a patient may decide not to receive information, but still make a decision that should be respected. This situation is very similar to the tracing cases discussed in relation to the epistemic condition for moral responsibility. Even though a patient could make a decision without having had relevant information disclosed, the patient would still be responsible for that decision as they would be culpable for their ignorance.

In both paper 3 and paper 4 the control condition is mentioned as a condition that is necessary for moral responsibility, but not for having the right to make decisions regarding one's own care. However, as described above, many scholars have argued that the requirement of decision-making competence needs to be supplemented by an authenticity condition. Among the different theories of authenticity, Frankfurt's theory of endorsing second-order volitions was mentioned. This theory then reappeared in the discussion of the control condition. If a theory such as Frankfurt's is necessary both for the right to decide and being morally responsible then this difference between the conditions for having the right to decide and moral responsibility disappears.

However, even if an authenticity condition is included in the conditions for the right to decide, the control condition might nevertheless not be met. First of all, the authenticity conditions for the right to decide and for moral responsibility might differ. Second, it is possible that the control condition for moral responsibility is not an authenticity condition but another kind of condition, such as Fischer and Ravizza's reason-reactivity condition. Even though it can be expected that two such conditions might overlap to a large extent (both Tourette's syndrome and addiction might arguably be grounds for exempting someone from responsibility) they are fundamentally different. Authenticity conditions such as Frankfurt's are concerned with motivation, whereas reason-reactivity is concerned with reasons. It is true that reasons are often accompanied by motivation but this motivation can be greater or lesser. This difference between them opens up a possibility for them to come apart.

Concluding Discussion

The question I set out to explore in this thesis was how we can understand the relationship between the right to make decisions regarding one's own healthcare and moral responsibility in relation to the decision-making competence of what I have called fringe decisional agents in different institutional practices. I suggest that the issue can be explored from two different directions: first, by exploring any tensions between the appropriate responses to someone who has a right to decide and to someone who is morally responsible. Second, by comparing what conditions a person has to meet in order to have the right to decide and to be morally responsible. In the papers of this thesis, papers 1 and 2 take the first approach and papers 3 and 4 take the second approach. I will present my conclusions with respect to both these approaches, and discuss my findings in due order. I will then discuss tensions that arise in regard to fringe decisional agents at the intersection of different institutions, and I end by making some suggestions for future research.

In this introduction I have shown that there is a potential tension between holding someone responsible and respecting that person's right to decide since certain practices of holding people responsible can undermine the voluntariness of a patient's decision. This is especially so if done within a close relationship and by someone wielding a degree of power over the other party.

In paper 1 we highlight a tension between the expanded view of what it means to have the right to make decisions that is part of person-centred care. We show how one method, *error-trawling*, is aimed at strengthening the patient's ability to make decisions regarding their own care, yet easily risks being counter-productive when it takes the harsh form of holding the patient responsible for their own care. We further suggest that this may not only inhibit the patient's active participation in shared-decision making, but also make the patient less efficient at managing their own care in the future.

In paper 2 we examine the practice of disputing patients within person-centred care. Demanding answers or justification for why a patient is making a particular decision or action is generally compatible with patient's right to make decisions and is one way of expressing respect for a patient's autonomy. It is also a way of holding a person responsible. However, asking a person for the reason behind their decisions can be done in many ways and we suggest that particular care needs to be taken when dealing with fringe decisional competent patients. Arguing can be experienced by the patient as aggressive and threatening, not least when it involves blaming and shaming. We therefore suggest that disputing has its place in person-centred care, even with fringe decisional patients, but that great(er) care is needed in how this is done.

Holding people responsible is not necessarily in opposition to respecting patients' right to decide. Drawing on her clinical experience working with people with personality disorders, Pickard (2013) has developed what she calls "responsibility without blame". Central to this is distinguishing affective and detached blame. The idea is to hold people responsible without succumbing to the temptation of blaming patients in a way that is emotionally loaded. Instead focus is on making the patients aware of the control that they have and strengthening their ability to exercise it, as well as controlling and amending their destructive behavioural patterns. For some patients this includes making them aware of their behaviour and its consequences, both for others and, by extension, for the patients themselves. The key is to do so without punishing the patient through the expression of negative emotions. Pickard's approach to responsibility is very much in line with our suggestions for improved clinical practice in paper 1. It should be noted that Pickard suggests that this way of holding someone responsible is not to hold them *morally* responsible, as she takes that to involve punitive or emotionally charged aspects of blame.

The second approach is to explore and compare the conditions for having the right to decide and for being morally responsible. In paper 3 we suggest that, although similar, these may be come apart for adolescents, and that adolescents in certain situations may have a right to decide while not being morally responsible for their decisions. We do so by highlighting that control is a standard requirement for moral responsibility, while a similar condition is lacking for the right to decide. In the introduction I elaborate this claim further. I point out that some versions of the control condition are identical to proposed authenticity conditions for having the right to decide. I suggest that, even though authenticity may be necessary for the right to decide, the conditions for this right might still differ from the conditions for moral responsibility as the latter may require another authenticity condition or another form of control, such as reason-reactivity.

In paper 4, I explore the conditions for the right to decide and criminal responsibility, rooted in basic ideas about moral responsibility, by comparing different versions of decision-making competence to different versions of the insanity defence. Even though very similar in their phrasing, it is possible that that the conditions for having a right to decide and for moral responsibility come apart. I also argue that these conditions may be even further separated if the insanity defence contains a control condition. However, the most important factor when considering why a person may lack criminal responsibility for a crime they have committed and yet still have the right to decide, is that these two concepts relate to different decisions made in different situations and at different times. This means that a person who commits a crime under the influence of a serious mental disorder and who is thereby not criminally responsible may, at a later time, have recovered sufficiently to regain the right to decide.

In the introduction I add two aspects to the discussion of the conditions in the papers. First, I raise the issue of whether the ability to form moral judgments is necessary to be morally responsible. Other scholars have shown that what we think of as one ability may in fact consist of several sub-abilities. I discuss two such sub-abilities in relation to different functions of blame. I suggest that, in order to be an appropriate target of communicative blame, it is necessary to have the ability to compare different cases from an equal treatment perspective. To be an appropriate target of punitive ways of holding one responsible however, I remain hesitant about whether it could suffice to understand that there are rules and that one might be punished for breaking them.

The second addition to the discussion in the papers concerns people who have an ability to understand the consequences a treatment will have for them, yet have an impaired ability to understand how choosing such an option will affect others. These people will have the right to make decisions, but may not be morally responsible for how their decision affects others. In this context, it should be noted that harm to others, if sufficiently grave, would in effect limit what decisions the patient has the right to make.

This thesis concerns the relationship between having the right to make decisions and responsibility in different institutional contexts. It is predominantly focused on healthcare, but also considers the family institution and the criminal justice institution. One of the reasons for this, is the idea that fringe decisional agents often exist at the intersection of multiple institutions, and that the relevant abilities of fringe decisional agents pertaining to their moral or legal status within these institutions may pull in different directions. Paper 4 provides a clear example of this: a mental disorder can exempt a person from criminal responsibility and undermine their right to make healthcare decisions, but the status of a person within one institution does not necessarily tell us what status the person has within another institution.

This probing of the relationship between different institutions is not found in my treatment of the family in paper 3, even though there is an overlap between the family and healthcare, not least in paediatric care. The adolescents with diabetes discussed in paper 1 exemplify how a lot of care takes place outside a clinical setting and within the sphere of the family. The ethical relationship between adolescents and parents that we explore in paper 3 is of central importance to understanding the division of responsibility between different family members when this care is performed in a domestic setting.

Family members may also be directly involved in clinical decision-making. This is obvious in the case of younger children where parents hold the right to make decisions regarding their child's care. As the child grows older it will have a greater say in whether care should be accepted or rejected until eventually the decision comes to rest solely with the child.

In the transitional phase before the child reaches full maturity however, there are possible tensions between the ethical norms regulating the family and the healthcare institution respectively. If we focus on decision-making competence as a condition for the right to make decisions then there is research indicating that adolescents gain the same degree of decision-making competence as adults somewhere between 14-16 years of age (Weithorn and Campbell, 1982; Grisso and Vierling, 1978; Icenogle et al., 2019) or possible even as early as 12 (Expert Panel Working Group on MAID for Mature Minors, 2018). Yet, since children per definition have not yet come of age, parents will often still be involved in decision-making concerning their medical care. If we want to treat similar cases consistently, then according to bioethical norms children should be granted the right to decide on a par with the right of adults. However, as we discuss in paper 3 there might be other ethical considerations pertaining to the family which give parents a stronger claim to be involved in such decision-making than exist within healthcare. We will not settle here precisely how the ethical norms regulating healthcare and the family should be balanced with regards to clinical decision-making during the transitional phase, when decisional power is transferred from parents to the child (see e.g. Manson, 2015).

Suggestions for Future Research

One natural extension of my research on the relationship between what it means to have the right to make such decisions and to be morally responsible, would be to examine this relationship in other contexts as well. In paper 3, we examine some aspects of this relationship even though, as we suggest towards the end of the paper, more work remains. However, if we compare the family as an institution to the institution of healthcare, we can note a number of important differences between them that are worth considering when thinking about expanding the research conducted in this thesis.

First of all, healthcare is a formal institution with standardised routines and many clearly defined rights and responsibilities for both patients and healthcare professionals. The Mental Capacity Act provides an example of legislation regulating the capacities patients in somatic care need to have the right to make decisions regarding their own care. In other countries other pieces of legislation regulate this issue. Even though the family is subject to some legal regulation, it will not provide details of how rights and responsibilities should be divided among the family's members. How ethical situations relating to the right to decide and moral responsibility is dealt with, will therefore vary between families based on, among other things, the perceived maturity of the children, parental ideals, tradition, and pragmatic considerations. There are no legal documents specifying conditions in the same way that the Mental Capacity Act does, or that criminal law does. This means that some of the methods used in this thesis will be hard to apply.

This problem is to some extent touched upon in this thesis as well. In my treatment of the control condition for moral responsibility. I have to a large extent relied on philosophical theories of moral responsibility: theories that cannot straightforwardly be used in institutional practice. Criminal law is one example of how (moral) responsibility is codified within institutional practice. This in turn can be compared to responsibility in healthcare. One of the main arguments against using responsibility as a ground for allocation of healthcare resources is that it is hard, if not impossible to know whether a person was responsible for the decision that led to a bad health outcome (Sharkey and Gillam, 2010). This problem is twofold: first we need to know what the conditions for being responsible for such a decision are, and second, we need to know if those conditions applied when the decision was made. This issue becomes even more complicated in the case of repeated decision-making as patient may be differently equipped to meet these conditions at different times (Brown and Savulescu, 2019). In order to undertake the kind of conceptual comparison above, these conditions need to have been clearly defined, either in formal documents or through actual practice.

Yet there are areas where some degree of similar work has been done. Sexual ethics is one such area. Consent is a central concept for making sexual acts permissible and sexual consent has similar conditions to consent in healthcare: consent should be voluntarily and competently given (Archard, 1998, Wertheimer, 2003). One example of how the right to decide and responsibility may diverge concerns the case of intoxication. Generally, voluntary intoxication does not absolve moral responsibility, but it can undermine one's ability to consent. This in turn can lead to a situation in which two severely intoxicated people have sex with each other, both lacking the capacity to consent but both responsible for engaging in the act (Wertheimer, 2003). Further questions may arise concerning the relationship between having the right to decide and moral responsibility if we systematically examine cases of fringe decisional agents.

Another direction in which the research of this thesis can be expanded is by further developing the idea of advance criminal responsibility that I present in paper 4. Admittedly, many issues need a fuller treatment than I was able to do within the scope of this paper. Here I would like to highlight one issue in particular which is crucial to my proposed model, but which is of more general interest as well: namely, what it means for a mental disorder to be a cause of a crime (see e.g. Anckarsäter et al., 2009). In paper 4 I suggest that people who suffer from mental disorder should have a right to refuse psychiatric care on the same conditions as they have to refuse somatic care, but that, should they refuse psychiatric care, they have to accept responsibility for future criminal acts committed under the influence of their mental disorder. I believe such an idea would be best be implemented by focusing not just on psychiatric diagnoses, but rather on symptoms or combinations thereof in conjunction with theories of causality to see if this would yield plausible results. If so, it remains to be investigated how well such a scheme would be implementable within the actual practice of assessing criminal responsibility.

The final suggestion for future research that I will make here was raised above in my introduction. It concerns adolescent decision-making in the presence of peers. One of the limitations of modern psychological research on adolescent decision-making is that it fails to adequately capture certain aspects that are philosophically relevant. The behavioural and neuroscientific research underpinning our argument in paper 3 should be complemented with research that is better suited to capturing the adolescents' experience and perception of their own decision-making. This research would combine empirical investigation with a philosophical analysis of the empirical results. We have seen how this has been made for mental disorder and addiction and there is no reason to suspect that similar explorations of adolescent decision-making would not yield interesting results and complement the existing research literature.

To achieve a broad understanding of adolescent decision-making, a range of decisions need to be examined. Adolescents in general make riskier decisions than adults, as exemplified by rates of unprotected sex and substance use. Even though these decisions are important to examine, we should not forget to include more low-stake, everyday decision-making. One example provided by Boman and colleagues (2014) is adolescents with diabetes who put off checking their blood sugar while spending time with their friend as they do not want to interrupt their fun. Situations like these may be explored further from the perspective of philosophical theories, whereby the researcher could try to understand more precisely what desires the adolescent has, how they experience them, and what effect these desires have on their eventual concrete decision.

Summary of the papers

Paper I: Error-trawling

In this paper, we explore some ethical aspects of patient-physician interactions during consultations with adolescents with diabetes. More specifically, we examine a fact-oriented patient education strategy, used by doctors to assess a patient's decision-making capacity without using a formal assessment tool. We argue that, although this method might help with detecting a patient's decision-making competence and address any deficiencies in it, it risks turning into what we call *error-trawling*, which, in turn, risks undermining patient participation in decision-making, as well as the patient's ability to adhere to the agreed upon treatment plan.

Adolescence is here used as an example of a larger group of people, characterised by what we call fringe decision-competence, that is to say patients in between the two endpoints of the spectrum of paradigmatically decision-making competent people, such as regular adults, and people who are paradigmatically not decision-making competent, such as small children and the severely cognitively impaired. The group of people with fringe decision competence is thus taken to include "patients whose capacities may be partially or gradually impaired, underdeveloped or fragile" (Hartvigsson et al., 2018:127). Such patients include adolescents, patients with progressive dementia, milder mental disorders or cognitive impairments, as well as patients suffering from moderate confusion and intoxication. The competence for this group may also change over time and vary depending on the issue at hand.

There are several reasons why it is relevant to assess a patient's decision-making competence. The first reason is the usual respect for autonomy: patients who possess a sufficient degree of autonomy have a right to have their decisions respected. Second, in a person-centred framework, one goal is to promote patient autonomy by letting the patient participate in medical decision-making and enhancing their ability to do so, for example through educating them. One final but related reason, is that in the case of diabetes as well as many other conditions, the main responsibility for delivering care rests with the patient and is performed in settings other than the hospital. In order for the patient to competently deliver care and make decisions regarding their care without the presence of a healthcare professional, the patient needs to have an understanding of nature of the illness and the treatment, as well as being emotionally prepared to handle the responsibility of self-care.

Assessment of decisional competence is commonly connected to formal assessment tools. These tools are appropriate when assessing a patient's decision-making competence in one-off high-stake decisions such as participation in research or when one isolated medical intervention is considered. In relation to chronic or long-term illnesses with continuous contact between patient and healthcare staff, the use of a formal tool would be time consuming, as well as formalistic when developing trust and long-term care relationships. However, these tools can still guide informal assessment practices by setting out what to look for. In this paper we focus on the ability called *understanding,* that is to say the patient's ability to intellectually comprehend facts about the nature of their illness and treatment, as this ability is likely to receive more attention due to the professional's training and knowledge.

In our study of twelve physician-patient consultations, we observed several instances of a destructive form of fact-focused informal assessment that we termed error-trawling. During consultations it was common for the physician and the patient to, together, review the blood sugar values during the period since the last consultation. When the physician noted a deviation from what they perceived as biomedically ideal care (taking both frequency of measurement as well as actual measures into account) they often interrogated the patient regarding this deviation and whether it could be explained by deficient understanding on behalf of the patient regarding the nature of the illness or treatment.

The paper provides four examples of how error-trawling might be a hazard. The first example is that of a patient who has high blood sugar values in the morning, prompting the healthcare professional to emphasise the importance of continuously monitoring their blood sugar levels, and making sure that the patient knows the reasons for this. However, this strategy *misses the point.*

The patient is already measuring their blood sugar levels, otherwise we would not have known that the values were too high. The interrogative style of the professional pacifies the patient instead of probing what aspect of the patient’s lifestyle causes these high values. The second example is that of a healthcare professional who finds what they perceive to be a gross misunderstanding on the part of the patient concerning ideal blood sugar levels. This professional submits the patient to a *systematic faulting* in order to teach the patient what blood sugar level is ideal, but even as the patient eventually states the right level, the professional still rejects the patient’s answer, risks undermining the patient’s self-confidence. The third example is of a healthcare professional who *promotes fear* as they forcefully rehearse all the risks associated with failing to perform adequate care. This is a patient who mismanages their care yet is forced to consider the dangers ahead under pressure from the healthcare professional. Unfortunately, this is done in a way that makes the patient very uncomfortable and undermines the therapeutic alliance between professional and patient. Furthermore, increasing negative sentiments when thinking of the illness may make the patient more inclined to put the illness out of their mind and thus mismanage their care even more. The fourth and final example is when error-trawling is used as a bridge towards outright *blaming, shaming and humiliating* the patient for not performing care adequately.

The paper does not show how prevalent the phenomenon of error-trawling is, but it does show that it exists and that there are good reasons to be wary of any negative consequences it might have. At the same time, there are good reasons for monitoring decision-making competence, especially among patients with fringe decisional capacity. In order to achieve the goals of person-centred care with this type of patient, error-trawling should probably be avoided. A better means of lessening the communicative gap between patients and healthcare professionals needs to be found.

Paper II: Disputing with Patients in Person-Centered Care

In this paper we discuss the ethical aspects of healthcare professionals debating with patients within a person-centred care (PCC) framework, and its role and limitations in three different contexts. One key component of PCC is a process of shared decision-making. This in turn can be subject to different interpretations, but has, as its goal, healthcare professionals and patients sharing information in order to formulate a treatment plan that takes into consideration the patient's preferences, values, beliefs, experiences and life circumstances.

Open disputing can - and sometimes should – be part of such collaborative process. Ideally, the outcome of shared-decision making will be a clinical partnership between the healthcare professional and the patient, wherein they reach a consensus that harmonises professional medical standards and responsibilities with the patient's aims and preferences. Disputing – in both directions - might well provide a means to this end.

The rationale usually given for endorsing PCC is that it empowers the patient in order to respect and even strengthen patient autonomy. However, in the standard PCC model two important assumptions are made: that the patient has a robust autonomy, and that respect for patient autonomy as well as their well-being are the primary considerations. Despite this PCC has been advocated as appropriate for patients who do not meet these assumptions, such as the three cases we discuss here: paediatrics, forensic psychiatry and public health.

Children in general, and adolescents in particular, are characterised by having their autonomy in development, that is to say the assumption of a robust autonomy is not yet in place. Even though the child, may have a capacity for autonomous decision-making, as is the case for those in middle to late adolescence, this capacity is fragile and could be undermined by a process of open disputing. The underlying aim of PCC to support autonomy is in line with the general aim of helping teenagers to develop into autonomous adults. However, it is advisable to take care *how* to enact PCC in practice with this patient group, since many forms of interaction that might be suitable for a person with stable autonomy run the risk of hampering the development and health of a patient lacking it.

In the case of forensic psychiatry, neither of the two assumptions hold true. Here, patients may be at or under the threshold of autonomy and subject to coercive care, not to mention incarceration. The primary aim here is not that of the patient's well-being, but to protect others and prevent the patient from committing serious crime. The aims of the treatment, in conjunction with its involuntariness, render it probable that healthcare professionals' interests and the patient's interests are in stark opposition. Furthermore, there is little to no possibility for the healthcare professionals to compromise. This means that there is little room to realise the alliance between healthcare professionals and patients that is key to the PCC ideal. Open disputing here then, becomes restricted to explaining the institutional rules to the patient, and the consequences of their transgression or compliance. This can in turn help the patient to develop in the desired direction, but it also runs the risk of teaching the patient how to navigate the system without changing. Or, since openly disputing a patient can be confrontational and thus perceived as aggressive, it can also contribute to a hostile relationship between healthcare professionals and patients.

Like forensic psychiatry, public health has goals other than an individual patient's health, the health of the general population. Furthermore, in order to achieve that end certain coercive measures might be employed, although they are generally less forceful than those in forensic psychiatric care. Though public health is dependent on the health of individuals, there is often a conflict between what promotes the health of a population at large, and the will and health of a particular individual. This conflict can, for instance, be seen in the case of vaccines and antibiotics resistance. If there is such a conflict, the aim of the patient consultation will be to steer the patient's will in a specific direction. Open disputing should then be used only in as far as it is conducive to the end of public health, but it will not promote the standard aim of PCC.

We conclude that open disputing can have a role in each of these areas, but that its use is more limited than that in standard PCC, and the suitability of openly disputing the patient is to a large extent dependent on how it is done. We furthermore note that healthcare professionals usually receive very little training in the skills necessary to better enact open disputing, or to determine when it is appropriate.

Paper III: Responsibilities in Change

In this paper, we address the issue of intra-familial rights and the responsibilities between parents and adolescent children. We argue that, given certain standard ideas concerning the right to autonomy and responsibility, adolescent psychology gives rise to an interesting situation in which these children might have a right to make decisions for which they are not responsible. This in turn gives rise to a quadrilemma regarding what this responsibility gap implies for parental authority, parental responsibility, and the right for parents to make decisions concerning their children. The problem we outline appears as an upshot of how, as children mature, they increasingly have a claim to have decisions regarding their own life respected. These claims are at odds with parental authority. However, as adolescents, their capacity for responsibility is still underdeveloped, which gives rise to the following quadrilemma on what ethical conclusion to draw:

- neither the parents nor the children are responsible for certain acts over which the parents lack authority, or
- parents are responsible for some of their children's acts even though they have no authority over them, or
- parental claims to authority have a stronger weight than the adolescent's rights to autonomy in these cases, or
- a combination of the three suggestions above that mixes differently in different situations.

A common condition for having the right to decide over one's own life is that one is decision-making competent. By this view, adolescents have stronger claims to self-determination than younger children, since they are competent to make more decisions. The abilities which give rise to decision-making develop dramatically during early adolescence and research indicates that adolescents from around 16 years of age are as capable decision-makers as adults in certain situations.

However, it is a well-known phenomenon that, in spite of having this increased capacity for decision-making, adolescents make different and more risky decisions in real-life than adults do. Recent research within adolescent psychology throws light on why adolescents behave in this way and offers several factors which can explain, at least partially, this systematic difference. Adolescents might be aware of risks to the same degree as adults, but they weigh them differently. Adolescents are also very sensitive to peers and their opinions, something that is associated with inferior impulse control and greater risk taking. Our suggestion therefore is that adolescents have diminished self-control or, to use Fischer and Ravizza's terms, that adolescents may be reason-receptive but less reason-reactive. The latter feature makes them lack responsibility for certain actions.

There might be reasons to question whether adolescents' greater claim to self-determination translates to a bona fide moral right. A strong right to self-determination may require further psychological features, which are still in development late into adolescence. Alternatively, certain grounds for parental authority may provide reasons to curb the rights of adolescents in spite of their decision-making capacity. We consider three different suggestions for what exactly grounds parental authority: its role in discharging their duties as parents, its role in reaching important familial relationship goals, and its role in facilitating children to become morally decent adults. We accept that all of these grounds have merits and should be taken seriously, but we do not see how they remove the quadrilemma we pose, as it only requires that adolescents have a right to make some decisions on their own behalf. Even though there might be reasons to curb adolescents' right to self-determination they should still, by virtue of their increasing maturity, have a right to make more decisions. Pragmatic considerations that will put them in situations in which other adults are not present reinforce this point. Providing reasons to curb adolescent rights may make the problem smaller but it will not make it go away.

We end the paper with a brief discussion of the merits and drawbacks of each of the four suggestions, and suggest that options one and three seem slightly more plausible than two and four, although we make no claims to have solved the puzzle we have uncovered.

Paper IV: Between Punishment and Care

This paper is concerned with people who commit crimes under the influence of a severe mental disorder. As psychiatric patients they fall within the scope of psychiatric care, but as offenders they fall within the scope of the criminal justice institution. Different jurisdictions have different solutions for which of these two institutions is responsible for a person belonging to this group. At the same time, both of these institutions fill important societal roles and are guided by their own sets of ethical values and norms that inform how this group of people is, and should be, treated.

Common current practice is that, if a person commits a crime under the influence of a mental disorder, that person can be exempt from criminal responsibility. But if the mental disorder continues to be present, the person will be subject to involuntary psychiatric care. Several ethicists have argued that the laws governing involuntary psychiatric treatment are discriminating against those who suffer from mental disorders, in that it allows them to be subjected to involuntary treatment on grounds which are unjustifiably different from those who do not suffer from mental disorders. If the common legislation were reformed in line with this criticism, we would face a situation in which people who suffer from mental disorders and have committed crimes under their influence would, in some instances, be exempt from responsibility but have a right to refuse care. In other words, some people who have committed violent crimes would not face any consequences and would continue to pose a threat to others. In this paper, I conclude that the ethical principles leading up to this conclusion are justifiable, but argue that an expanded notion of criminal responsibility, which I call *advance criminal responsibility*, can justify holding people who suffer from mental disorder criminally responsible if, at any previous time, they have refused care for their psychiatric condition.

The insanity defence is controversial and exists in some form in most jurisdictions. The most widespread version of the insanity defence is the M'Naghten rule, according to which a person is not responsible for having committed a criminal act if "at the time of committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind as not to know the nature and quality of the act he was doing: or, if he did know 'it', that he did not know he was doing what was wrong." (M'Naghten rules. House of Lords (1843)). This version of the insanity defence targets the epistemic condition of moral responsibility. There are other versions, such as the Model Penal Code, which also has a clause exempting people from responsibility due to lack of control.

The different versions of the insanity defence have various merits as well as drawbacks, but all major theories of criminal punishment support the existence of the insanity defence in some form or other. Theories holding that criminal responsibility should trace moral responsibility supports the insanity defence, since mental disorder can exempt a person from being morally responsible. Forward-looking theories, such as consequentialist theories, arguably support the same conclusion. The insanity defence thus enjoys broad ethical support and should not be abolished.

The second part of the problem, that people who suffer from mental disorder should have a right to refuse care, follows from well-established principles in medical ethics and law. Current legislation in most countries allow for the involuntary treatment of people with mental disorder if they pose a threat to themselves or to others, regardless of whether they have capacity to consent or not. This stands in sharp contrast to the legislation and international conventions regulating somatic care, where patients who have capacity to consent have the right to refuse care regardless of whether they pose threats to others or not. Mental disorder can undermine capacity to consent, as indeed can some somatic conditions, such as brain tumours or head trauma, but does not necessarily do so, and treating patients differently within psychiatric care from somatic care discriminates against people with mental disorder.

Since mental disorders might undermine the capacity to make specific decisions at specific times, it is possible that a person who lacks criminal responsibility for a criminal act due to their mental disorder may, at a later point be fully competent to make a decision regarding their own care, and thus have the right to refuse it. This leads to the situation in which a person who has committed an offence suffering from mental disorder might walk away without being subject to either care or punishment.

One way of dealing with this problem would be to adopt a "full responsibility" model of criminal responsibility, in which no exemptions are made for those who suffer from mental disorders. Another way would be to make an exception of the right to refuse care for people who suffer from mental disorder but pose a threat to others. Both of these suggestions go against the ethical principles underpinning the problem. A third solution could be preventive detention. This suggestion would not be discriminatory if applied to both people with and without mental disorder on the grounds of dangerousness. It does, however, come with the cost of depriving some people of their liberty who would never (again) pose a threat to others. While if the bar of dangerousness for preventive detention is set high it will with all likelihood miss dangerous people.

My solution, alone or in conjunction with preventive detention, is to make people with a mental disorder criminally responsible for future acts that they commit under the influence of that mental disorder if they have refused offers of care for their condition. For my argument to hold, this care needs to be available and affordable for this group of people, who are often in a dire financial situation. Furthermore, since the conditions for decision-making competence are more stringent than the conditions for criminal responsibility, a person who is decision-making competent, and can therefore both give informed consent and refuse care, will also meet the conditions for criminal responsibility when accepting or refusing care. My suggestion is also in line with well-established ethical and legal principles, such as the prior fault rule, in which people incur responsibility for acts they do in ordinary non-responsible states if they are responsible for being in such a state.

The major problem for this proposal is how we can know in advance if a person suffers from a mental disorder that might exempt them from responsibility at a later time. While I do not solve this problem in the paper, I do outline some possible directions for future research, such as an examination of which conditions lead to responsibility exemptions.

Svensk sammanfattning

Det finns en intuitiv koppling mellan att någon har rätt att fatta beslut och att samma person är moraliskt ansvarig för dessa beslut. I den här avhandlingen undersöker jag relationen mellan dessa båda begrepp med avseende på agenter vilkas beslutskompetens befinner på gränsen till vad som krävs för att ha en rätt att bestämma över sin egen vård, respektive att vara moraliskt ansvarig. Dessa agenter, så som tonåringar och människor som lider av psykisk sjukdom befinner sig ofta i flera olika institutionella sammanhang där deras rättigheter och ansvar kan ifrågasättas.

Jag närmar mig frågan från två olika perspektiv. Det första perspektivet innebär att jag utforskar vad det innebär för andra människors bemötande av dessa personer. Det andra perspektivet är att jämföra vilka villkor som en person måste uppfylla för att ha den status som det innebär att ha en rätt att bestämma över sig själva och att vara moraliskt ansvariga.

Jag visar att det finns en potentiell konflikt mellan att hålla en person moraliskt ansvarig och att respektera dennes rätt att bestämma över sig själv. Många sätt att hålla en person ansvarig riskerar att bli en form av otillbörlig påverkan som inte är förenligt med att respektera någons rätt att bestämma över sig själv.

I den första artikeln i avhandlingen visar vi att denna konflikt löper extra stor risk att realiseras i person-centrerad vård, på grund av att man där har en utvidgad idé om vad det innebär att en person har rätt att bestämma över sin egen vård. Denna idé innebär att patienten aktivt ska delta i ett gemensamt beslutfattande som en jämlik part med sjukvårdspersonalen. Då blir det mycket viktigt för personalen att ha en bild av patientens beslutskompetens. I artikeln visar vi med exempel från inspelade läkar-patientmöten från ungdoms-diabetesvården hur en vanlig metod som läkarna använder sig av för att skatta patienternas beslutsförmåga och förståelse för sin vårdsituation riskerar att bli kontraproduktiv. Detta fenomen kallar vi för *error-trawling* och det uppkommer när läkaren granskar hur patienten har skött sin egenvård. Om läkaren hittar någon avvikelse från ett biomedicinskt ideal så förhör sig läkaren om denna avvikelse är resultatet av ett missförstånd eller bristande kunskap från patientens sida. Denna typ av systematisk felsökning i patientens vårdutförande riskerar att ta sig ett destruktivt uttryck genom att patienten klandras. Detta klander placerar patienten i ett moraliskt underläge och riskerar därmed att passivisera patienten under patientmötet såväl som att negativt påverka patientens framtida utförande av sin egenvård.

I den andra artikeln undersöker vi etiska aspekter av att sjukvårdspersonal argumenterar med patienter inom ramen för person-centrerad vård. Att argumentera med en patient innebär att man invänder mot patientens påståenden och ber patienten rättfärdiga exempelvis ett visst beslut. Övertalning utgör generellt sätt inte en form av otillbörlig påverkan men vi menar att man bör iaktta stor försiktighet när man argumenterar med en patient, speciellt om det rör sig om någon av de atypiska sammanhang, pediatrik, rättspsykiatri och folkhälsa, som vi framförallt intresserar oss för i artikeln. Argumentation kan uppfattas aggressivt och hotande av patienter, speciellt när detta görs i samband med att man klandrar en patient.

Det andra sättet som jag närmar mig frågan om relationen mellan rätten att bestämma över sin egen vård och att vara moraliskt ansvarig är genom att undersöka de villkor som en person måste uppfylla för att ha rätten att bestämma över sig själv och att vara moraliskt ansvarig.

I den tredje artikeln diskuterar vi en följd av att dessa villkor skiljer sig åt. Ett standardvillkor för att vara moraliskt ansvarig är att man på ett tillfredställande sätt kan kontrollera sina handlingar. Men ett liknande krav saknas för standarduppfattningar om vad som krävs för att man ska ha rätt att bestämma över sig själv. Denna skillnad är central för hur man ska förstå tonåringars moraliska status då dessa, åtminstone under senare delen av tonårsdelen vanligtvis uppfyller villkoren för att ha en rätt att bestämma över sig själva, samtidigt som psykologisk forskning visar att de saknar en fullt utvecklad förmåga till självkontroll och att deras förmåga att kontrollera sina handlingar försämras i jämnårigas närvaro.

I den fjärde artikeln argumenterar jag för att nuvarande lagstiftning rörande tvångsvård av människor med psykisk sjukdom är diskriminerande och att dessa bör ges samma rättighet att neka psykiatrisk vård som man har rätt att neka somatisk vård. Detta leder emellertid till ett problem, då många länder har en lagstiftning som undantar vissa människor från straffrättsligt ansvar om en brottslig handling begås under inflytande av en allvarlig psykisk störning. Det innebär att en person i kraft av sin psykiska sjukdom kan utgöra en fara för andra människor samtidigt som denne på grund av sin sjukdom inte är straffrättsligt ansvarig för vissa handlingar.

Den lösning som jag föreslår är att en människa med psykisk sjukdom som potentiellt kan undanta personen från straffrättsligt ansvar kan ådra sig ett sådant ansvar genom att neka vård. Personen skulle i sådana fall åta sig straffrättsligt ansvar för framtida brottsliga handlingar som utförs under inflytande av den psykiska sjukdomen.

References

Ahlin, J. (2018). The Impossibility of Reliably Determining the Authenticity of Desires: Implications for Informed Consent. *Medicine, Health Care and Philosophy, 21*(1), 43-50.

Ahlin Marceta, J. (2020). Resolved and Unresolved Bioethical Authenticity Problems. *Monash Bioethics Review, 38*(1), 1-14.

Albert, D., Chein, J., & Steinberg, L. (2013). The Teenage Brain: Peer Influence on Adolescent Decision-Making. *Current Directions in Psychological Science*, 22(2), 114-120

Anckarsäter, H., Radovic, S., Svennerlind, C., Höglund, P., & Radovic, F. (2009). Mental Disorder is a Cause of Crime: The Cornerstone of Forensic Psychiatry. *International Journal of Law and Psychiatry, 32*(6), 342-347.

Appelbaum, P. (2007). Assessment of Patients' Competence to Consent to Treatment. *New England Journal Of Medicine, 357*(18), 1834-1840.

Archard, D. (2008). Informed Consent: Autonomy and Self-Ownership. *Journal of Applied Philosophy, 25*(1), 19-34.

Archard, D. (1998). *Sexual consent.* Boulder: Westview.

Beauchamp, T.L. & Childress, J.F. (2013). *Principles of Biomedical Ethics*. (7. ed.) New York: Oxford University Press.

Bennett, C. (2008). *The Apology Ritual: A Philosophical Theory of Punishment*. Cambridge: Cambridge University Press.

Boman, &., Bohlin, M., Eklöf, M., Forsander, G., & Törner, M. (2015). Conceptions of Diabetes and Diabetes Care in Young People With Minority Backgrounds. *Qualitative Health Research, 25*(1), 5-15.

Brink, D.O. & Nelkin. D. (2013). Fairness and the Architecture of Responsibility. In D. Shoemaker (ed.) *Oxford Studies in Agency and Responsibility, vol. 1* (p. 284-313) New York: Oxford University Press.

Buchanan, A.E. & Brock, D.W. (1989). *Deciding for Others: the Ethics of Surrogate Decision Making*. Cambridge: Cambridge University Press.

Charland, L. (1998). Is Mr. Spock Mentally Competent? Competence to Consent and Emotion. *Philosophy, Psychiatry, & Psychology*, 5(1), 67–81.

Charland, L. (2002). Cynthia's Dilemma: Consenting to Heroin Prescription. *The American Journal of Bioethics*, 2(2), 37–47.

Charles, C., Gafni, A., & Whelan, T. (1999). Decision-Making in the Physician–Patient Encounter: Revisiting the Shared Treatment Decision-Making Model. *Social Science & Medicine, 49*(5), 651-661.

Chein, J., Albert, D., O'Brien, L., Uckert, K., and Steinberg, L. (2011). 'Peers Increase Adolescent Risk Taking by Enhancing Activity in the Brain's Reward Circuitry', *Developmental Science* 14(2), F1-F10

Christman, J.P. (2009). *The Politics of Persons: Individual Autonomy and Socio-Historical Selves*. Cambridge: Cambridge University Press.

Clarke, S. (2001). Informed Consent in Medicine in Comparison with Consent in Other Areas of Human Activity. *Southern Journal of Philosophy, 39*(2), 169-187.

Conly, S. (2013). *Against Autonomy: Justifying Coercive Paternalism*. Cambridge: Cambridge University Press.

Culver, C. M. & Gert, B. (1990) The Inadequacy of Incompetence. *Millbank Quarterly*, 68(4), 619–643.

Department of Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*. London: The Stationery Office, 2007. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice Last accessed: 2020-10-25

Department of Health. (2005) *Mental Capacity Act*. London: Stationery Office http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf Last accessed: 2020-10-23

Duff, A. (2007) *Answering for Crime: Responsibility and Liability in the Criminal Law*. Oxford: Hart Publishing.

Dworkin, G. (2020) Paternalism. In Zalta, E. (ed.),*The Stanford Encyclopedia of Philosophy* https://plato.stanford.edu/archives/fall2020/entries/paternalism/ Last accessed 2020-10-23

Dworkin, R. (2000). *Sovereign Virtue: the Theory and Practice of Equality*. Cambridge, Mass.: Harvard University Press.

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., Carlsson, J., Dahlin-Ivanoff, S., Johansson, I-L., Kjellgren, K., Lidén, E., Öhlén, J., Olsson, L-E., Rosén, H., Rydmark, M. & Sunnerhagen, K. (2011). Person-Centered Care — Ready for Prime Time. *European Journal of Cardiovascular Nursing, 10*(4), 248-251.

El-Alti, L., Sandman, L. & Munthe, C. (2019). Person Centered Care and Personalized Medicine: Irreconcilable Opposites or Potential Companions? *Health Care Analysis, 27*(1), 45-59.

Elliot, C. (1991) Competence as Accountability. *Journal of Clinical Ethics*, 2(3), 167–171.

Expert Panel Working Group on MAID for Mature Minors (2018) *The State of Knowledge on Medical Assistance in Dying for Mature Minors.* *https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf* Last accessed: 2020-10-25

Eyal, N. (2019) Informed Consent. In Zalta, E. (ed.) *The Stanford Encyclopedia of Philosophy* https://plato.stanford.edu/archives/spr2019/entries/informed-consent Last accessed: 2020-10-30

Faden, R. & Beauchamp, T. (1986). *A History and Theory of Informed Consent*. New York: Oxford University Press.

Feinberg, J. (1986). *The Moral Limits of the Criminal Law Vol. 3 Harm to Self.* New York: Oxford University Press

Fischer, J.M. & Ravizza, M. (1998). *Responsibility and Control: a Theory of Moral Responsibility*. Cambridge: Cambridge University Press.

Fischer, J. M. & Tognazzini, N. (2009) The Truth about Tracing. *Noûs*, 43(3): 531–556. doi:10.1111/j.1468-0068.2009.00717.x

Frankfurt, H. (1971) Freedom of the Will and the Concept of a Person. *The Journal of Philosophy* 68 (1): 5–20.

Glover, J. (2014). *Alien Landscapes?: Interpreting Disordered Minds* Cambridge, Mass.: Harvard University Press.

Grisso, T. & Appelbaum, P.S. (1998). *Assessing Competence to Consent to Treatment: a Guide for Physicians and Other Health Professionals*. New York: Oxford University Press.

Grisso, T., Steinberg, L., Woolard, J., Cauffman, E., Scott, E., Graham, S., Lexcen, F., Repucci, N. & Schwartz, R. (2003).

Juveniles' Competence to Stand Trial: A Comparison of Adolescents' and Adults' Capacities as Trial Defendants. *Law and Human Behavior, 27*(4), 333-363.

Haji, I. (2010). Psychopathy, Ethical Perception, and Moral Culpability. *Neuroethics, 3*(2), 135-150.

Hansson, S-O. (2018). The Ethics of Making Patients Responsible. *Cambridge Quarterly of Healthcare Ethics 27*(1), 87-92. doi:10.1017/S0963180117000421

Hare, Robert D. (1991). *The Hare Psychopathy Checklist-Revised.* North Tonawanda, New York: Multi-Health Systems

Hart, H.L.A. (2008). *Punishment and Responsibility: Essays in the Philosophy of Law*. (2. ed.) Oxford: Oxford University Press.

Hawkins, J. & Charland, L. (2020) Decision-Making Capacity. In Zalta, E. (ed.) *The Stanford Encyclopedia of Philosophy* https://plato.stanford.edu/archives/fall2020/entries/decision-capacity/ Last accessed: 2020-10-24

Hope, T., Tan, J., Stewart, A., & Fitzpatrick, R. (2011). Anorexia Nervosa and the Language of Authenticity. *The Hastings Center Report, 41*(6), 19-29.

Håkansson Eklund, J., Holmström, I., Kumlin, T., Kaminsky, E., Skoglund, K., Höglander, J., Sundler, A., Condén, E. & Summer Meranius, M. (2019). "Same same or different?" A review of reviews of person-centered and patient-centered care. *Patient Education and Counseling, 102*(1), 3-11. doi: 10.1016/j.pec.2018.08.029

Icenogle G., Steinberg L., Duell N., Chein, J., Chang, L., Chaudhary, N., Di Giunta, L., Dodge, K., Fanti, K., Lansford, J., Oburu, P., Pastorelli, C., Skinner, A., Sorbring, E., Tapanya, S., Uribe Tirado, L., Alampay, L., Al-Hassan, S., Takash, H. & Bacchini, D. (2019). Adolescents' Cognitive Capacity Reaches Adult Levels Prior to Their Psychosocial Maturity: Evidence for a "Maturity Gap" in a Multinational, Cross-Sectional Sample. *Law and Human Behavior.* 43*(*1*),* 69–85 10.1037/lhb0000315

Kanygina, Y. (2020). Duties To Oneself and Third-Party Blame. *Public Affairs Quarterly*, 34(2), 185-203. doi:10.2307/26921126

Kennet, J. (2013) Just say no? Addiction and elements of self-control. in Levy, N. (red.) (2013). *Addiction and Self-Control:*

Perspectives from Philosophy, Psychology and Neuroscience. New York, NY: Oxford University. Press, 144-164

Levy, N. (2007). The Responsibility of the Psychopath Revisited. *Philosophy, Psychiatry & Psychology*, 14(2), 129-138.

M'Naghten, R v. (1843). 8 ER 718 10; Cl & F 200, 210 (M'Naghten's case) (House of Lords).

Manson, N. (2015). Transitional Paternalism: How Shared Normative Powers Give Rise to the Asymmetry of Adolescent Consent and Refusal. *Bioethics, 29*(2), 66-73.

Manson, N. & O´Neill, O. (2007). *Rethinking Informed Consent in Bioethics*. Cambridge: Cambridge University Press.

McKenna, M. (2008). Putting the lie on the control condition for moral responsibility. *Philosophical Studies, 139*(1), 29-37.

Mead, N. & Bower, P. (2000). Patient-Centredness: A Conceptual Framework and Review of the Empirical Literature. *Social Science & Medicine (1982), 51*(7), 1087-1110.

Mele, Alfred, 2010, "Moral Responsibility for Actions: Epistemic and Freedom Conditions", *Philosophical Explorations*, 13(2): 101–111. doi:10.1080/13869790903494556

Meynen, Gerben. (2011). Autonomy, Criminal Responsibility, and Competence. *Journal of the American Academy of Psychiatry and the Law, 39*(2), 231-236.

Meynen, G. (2016). *Legal Insanity : Explorations in Psychiatry, Law, and Ethics* Switzerland: Springer International Publishing

Model Penal Code (1985). *Official draft and explanatory notes: complete text as adopted May 24, 1962.* Philadelphia: American Law Institute.

Munthe, C., Sandman, L., & Cutas, D. (2012). Person Centred Care and Shared Decision Making: Implications for Ethics, Public Health and Research. *Health Care Analysis, 20*(3), 231-249.

Nagel, Thomas, (1979) *Mortal Questions.* New York: Cambridge University Press

Noggle, R. (2002). Special Agents: Children's Autonomy and Parental Authority. in Archard, D. & MacLeod, C. (eds.) *The Moral and Political Status of Children* Oxford: Oxford University Press): 97-117.

Noggle,R. (2005) Autonomy and the Paradox of Self-Creation: Infinite Regresses, Finite Selves, and the Limits of Authenticity. In Taylor, J. (Ed.), *Personal Autonomy: New Essays on Personal Autonomy and Its Role in Contemporary Moral Philosophy*. Cambridge: Cambridge University Press: 87–108

Persson de Fine Licht, K. (2014). *Responsibility and Health: Explanation-Based Perspectives.* Gothenburg: University of Gothenburg.

Pickard, H. (2013) Responsibility Without Blame: Philosophical Reflections on Clinical Practice. In Fulford, K. W. M., Davies, M., Gipps, R., Graham, G., Sadler, J., Stanghellini, G. & Thornton, T., (eds.) *Oxford Handbook of Philosophy and Psychiatry.* Oxford: Oxford University Press: 1134-1152

Pugh, J. (2020) *Autonomy, rationality and Contemporary Bioethics*. Oxford: Oxford University Press

Radovic, S, & Höglund, P. (2014). Explanations for Violent Behaviour - An Interview Study Among Forensic Inpatients. *International Journal of Law And Psychiatry 37(2):* 142-148. doi: 10.1016/j.ijlp.2013.11.011

Resnick, P. (2007) Andrea Yates Case: Insanity on Trial. *Cleveland State Law Review* 55(2), 147-156

Richman, K., & Bidshahri, R. (2018). Autism, Theory of Mind, and the Reactive Attitudes. *Bioethics, 32*(1), 43-49.

Roth, L., Meisel, A., Lidz, C. (1977). Tests of Competency to Consent to Treatment. *American Journal of Psychiatry 134(3):* 279-284

Rudnick, A. (2002). Depression and Competence to Refuse Psychiatric Treatment. *Journal of Medical Ethics, 28*(3), 151-155

Sandman, L. & Munthe, C. (2009). Shared Decision-Making and Patient Autonomy. *Theoretical Medicine and Bioethics, 30*(4), 289-310.

Sandman, L. & Munthe, C. (2010). Shared Decision Making, Paternalism and Patient Choice. *Health Care Analysis, 18*(1), 60-84.

Schroeder, T. (2005). Moral Responsibility and Tourette Syndrome. *Philosophy and Phenomenological Research, 71*(1), 106-123.

Schroeder, T. & Arpaly, N. (2013) Addiction and Blameworthiness. In Levy, N. (ed.) *Addiction and Self-Control: Perspectives from Philosophy, Psychology and Neuroscience*. New York, NY: Oxford Univ. Press.

Sebestian, C., Tan, G., Roiser, J., Viding, E., Dumontheil, I. & Blakemore, S. (2011). Developmental Influences on the Neural Bases of Responses to Social Rejection: Implications of Social Neuroscience for Education. *Neuroimage*, 57(3), 686-694.

Sharkey, K. & Gillam, L. (2010) Should Patients with Self-Inflicted Illness Receive Lower Priority in Access to Healthcare Resources? Mapping out the Debate. *Journal of Medical Ethics*36(11), 661–665

Shoemaker, D. (2011). Psychopathy, Responsibility, and the Moral/Conventional Distinction. *The Southern Journal of Philosophy, 49*, 99-124.

Shoemaker, D. (2015). *Responsibility from the margins*. Oxford: Oxford University Press.

Sinnott-Armstrong, W. & Levy, K. (2011) Insanity Defenses. in Deigh, J. & Dolinko, D. (eds.) *Oxford Handbook on the Philosophy of the Criminal Law*. Oxford: Oxford University Press, 299-334

Sjöstrand, M. and Juth, N. 2014. Authenticity and Psychiatric Disorder: Does Autonomy of Personal Preferences Matter? *Medicine, Health Care and Philosophy* 17(1), 115–122.

Smith, H. M. (1983) Culpable Ignorance. *Philosophical Review*, 92(4): 543–71. doi:10.2307/2184880

Smith, H. (2011). Non-Tracing Cases of Culpable Ignorance. *Criminal Law and Philosophy, 5*(2), 115-146.

Szmukler, G. and Appelbaum, P. (2001). Treatment Pressures, Coercion and Compulsion. In Thornicroft, G. & Szmukler, G. *Textbook of Community Psychiatry* Oxford: Oxford University Press, 529-543

Talbert, M. (2012) Moral Competence, Moral Blame, and Protest. *Journal of Ethics*, 16(1): 89–109. doi:10.1007/s10892-011-9112-4

Tan, J., Hope, T., & Stewart, A. (2003). Competence to Refuse Treatment in Anorexia Nervosa. *International Journal of Law and Psychiatry, 26*(6), 697-707.

Tan, D., Hope, T., Stewart, A., & Fitzpatrick, R. (2006). Competence to Make Treatment Decisions in Anorexia Nervosa: Thinking Processes and Values. *Philosophy, Psychiatry, & Psychology, 13*(4), 267-282.

Tännsjö, T. (1999) *Coercive Care: The Ethics of Choice in Health and Medicine*. London: Routledge.

Vargas, M. (2005) The Trouble with Tracing. *Midwest Studies in Philosophy*, 29: 269– 291. doi:10.1111/j.1475-4975.2005.00117.x

Wallace, R. J. (1994) *Responsibility and the Moral Sentiments*, Cambridge, MA: Harvard University Press.

Watson, G. (2004). *Agency and Answerability: Selected Essays*. Oxford: Clarendon.

Weithorn, L.A. and Campbell, S.B. (1982). The Competency of Children and Adolescents to Make Informed Treatment Decisions. *Child Development* 53(6): 1589–1598.

Wertheimer, A. (1987) *Coercion*. Princeton: Princeton University Press.

Wertheimer, A. (2003) *Consent to Sexual Relations*. Cambridge: Cambridge University Press

Wieland, J. (2017) Introduction. In Robichaud, P and Wieland, J. (eds.) *Responsibility: The Epistemic Condition*. Oxford: Oxford University Press.

Wolf, S, (1987) Sanity and the Metaphysics of Responsibility. in Schoeman, F. (ed.) *Responsibility, Character, and the Emotions: New Essays in Moral Psychology*, Cambridge: Cambridge University Press, 46–62. doi:10.1017/CBO9780511625411.003