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Epistemic Burdens, Moral Intimacy, and Surrogate Decision-making

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Berger (Forthcoming) argues that morally intimate rather than relational surrogates (*per se*) hold the moral authority to apply the best interests standard as surrogate decision-makers. We agree that a kind of intimacy rather than any kind of relation is the appropriate criterion by which to evaluate applications of the best interests standard. But, we argue that it is ultimately *epistemic* intimacy that distinguishes morally appropriate from morally dubious applications of the best interests standard in cases of surrogate decision-making.

We have argued elsewhere that whether surrogates can meet an obligation to act on a patient's best interests depends first and foremost on whether they can surmount their epistemic burdens with respect to this goal (Crutchfield and Scheall, 2019). A person's epistemic burden with respect to some goal is simply everything that the person does not know, which they must know, in order to realize the goal *deliberately*, i.e., without recourse to the assistance of luck, fortune, or any other spontaneous forces (Scheall, 2019). A surrogate decision-maker's epistemic burden with respect to the goal of applying the best interests standard in a morally appropriate manner in some particular case is thus the knowledge required to deliberately realize this goal that the surrogate lacks in decision-relevant circumstances. Typically, a surrogate's epistemic burden consists of some combination of ignorance concerning the incapacitated patient's best interests or ignorance of treatment options in keeping with these interests. Put another way, a surrogate might be ignorant of either *ends* associated with morally appropriate applications of the best interests standard or of *means* adequate to deliberately realize these ends.

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We have also argued that epistemic burdens play an essential role in all human decision-making. The epistemic burdens of competing courses of action determine what counts as an option and where options are ranked in a person's initial incentive structure or preference ranking. Courses of action that bear impossibly heavy epistemic burdens rarely, if ever, figure as options in a person's incentive structure. More generally, the heavier the epistemic burden of an option relative to other options, the lower it tends to appear in a person's preference ranking (Scheall and Crutchfield, Manuscript). A decision-maker's options are, in effect, pre-consciously filtered and ranked according to their comparative epistemic burdens in the given decision context. Epistemic burdens are thus unique – and, we argue, logically prior – among considerations that figure in human decision-making.

It is the pre-conscious filtering and ranking of courses of action according to their comparative epistemic burdens that makes cases of surrogate decision-making far more complex than cases of individual decision-making, in which a person decides for herself. In single-person cases, the menu of options from the person chooses has been filtered and ranked for the relative epistemic burdens of relevant courses of action. In surrogate cases, however, there is no guarantee that the menu of options from which the surrogate chooses mirrors the menu of options from which the incapacitated patient would choose, if she were able to decide for herself. Nothing ensures that a surrogate knows *of* or knows *how to realize* the options in the patients' best interests. In short, epistemic burdens can prevent (even the most morally inclined) surrogates from meeting their obligation to act on patients' best interests.

Berger's morally intimate surrogate has, among other things, overcome her epistemic burdens with respect to the goal of applying the best interests standard in a particular case. In other words, a morally intimate surrogate is epistemically intimate with the patient *and* exhibits other features, which Berger names as having a shared personal history, demonstrating

trustworthiness in action, and exhibiting enduring concern. Thus, where a particular patient-surrogate relationship fails to be morally intimate, either epistemic intimacy or at least one of these latter relational properties is lacking. We argue below, however, that epistemic intimacy is more fundamental than these relational considerations (in isolation or collectively). Indeed, the ultimate significance of these other relational properties may be merely that they tend to engender epistemic intimacy. Sharing a personal history with, demonstrating trustworthiness to, and exhibiting enduring concern for a patient may be only means to the end of overcoming one's epistemic burdens with regard to the patient's best interests.

Berger also explains the moral authority of applying the best interests standard by appealing to moral intimacy: a person has moral authority to apply the standard *because* they are morally intimate with the incapacitated patient. We argue that the notions of epistemic intimacy and epistemic burdens not only help to explain the notion of moral intimacy, but also better explain the moral authority to apply the best interests standard. Bioethicists and physicians should consider a surrogate's epistemic standing relative to the patient's best interests before pronouncing on the former's ethical probity.

Who is typically epistemically intimate?

Life partners are often the most epistemically intimate of potential surrogates. Unacquainted individuals have no epistemic intimacy. All other surrogates, including physicians, are somewhere in between. In fact, physicians are often significantly epistemically intimate with patients, even with patients they have never met. This is because physicians have at least overcome the heavy epistemic burdens associated with knowledge of medical treatments appropriate to realize a given end, even if they may not know the ends associated with a

particular patient's best interests. As Berger mentions, distant family members tend to have little epistemic intimacy, usually less than that of a physician, if only for the latter's more extensive medical knowledge. For the same reason, court-appointed public guardians tend to have very little epistemic intimacy with incapacitated patients.

Epistemic intimacy and moral intimacy

When a surrogate fails to meet the condition of moral intimacy with respect to an incapacitated patient, it is either because they are not epistemically intimate with or fail to bear one or more of the aforementioned relational properties to the patient. However, a surrogate can make decisions in keeping with the best interests standard even where the relational requirements of moral intimacy fail to obtain, provided that the surrogate is epistemically intimate with the incapacitated patient. Consider, for example, a surrogate who professes to not have any enduring concern for the patient, but who is highly epistemically intimate with them, such as a former spouse with whom the incapacitated patient had an acrimonious divorce due to mutual infidelities. Or consider a toy example: a patient incapacitated upon being struck by a vehicle after exiting a cab shared with a stranger with whom the soon-to-be-incapacitated person had an intimate conversation about her personal values. Such surrogates are likely to be relatively well positioned with respect to the patient's best interests. But, notice that the converse is not true: even if all of the relational conditions obtain between a surrogate and a patient, the surrogate cannot speak to the patient's best interests, if she is not epistemically intimate with the patient. Moral intimacy might help in applying the best-interests standard, but it is epistemic intimacy that does the heavy lifting.

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Epistemic intimacy and best interests standard

Berger claims that the moral authority to apply the best interests standard is because of the surrogate's moral intimacy. A better explanation is that the surrogate is epistemically intimate with the patient.

There are several common criteria for evaluating explanations, such as predictive and explanatory power, coherence, and simplicity. Epistemic intimacy is a better explanation because it explains at least as much as moral intimacy and is much simpler. Moral intimacy is just epistemic intimacy plus other things, and therefore requires more conceptual machinery to explain why a person is in a position to apply the best interests standard.

Overcoming the epistemic burdens associated with knowing a person's interests and how to realize ends associated with them places a surrogate in a position of moral authority to make decisions on behalf of that person according to the best interests standard (and, not to mention, according to the substituted judgment standard). When a physician or nurse is evaluating whether a person is a suitable surrogate, often the focus is on their relation to the patient. But, apart from the fact that close relations tend to engender epistemic intimacy, the relation itself is irrelevant. What is most important is that the potential surrogate has overcome relevant epistemic burdens, that she is epistemically intimate with the patient's best interests. For marginally represented or unrepresented patients, the most epistemically intimate surrogate is often the attending physician. Distant relatives or court-appointed public guardians are less epistemically intimate and so in a worse position to make appropriate judgments according to the best interests standard. Involving multiple stakeholders, such as members of an ethics committee, in a decision may be no better (though more costly) than relying on the attending physician alone, because such measures only distribute remaining epistemic burdens over a group of people equally ignorant of the patient's

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interests and less knowledgeable of how to achieve medical goals. The notions of epistemic burdens and epistemic intimacy can therefore contribute to mitigating the problems associated with marginally represented or unrepresented patients in a way that moral intimacy cannot.

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