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Making Decisions for Other People: The Problem of Judging Acceptable Levels of Risk

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Abstract: People often make judgements about the risk preferences of others. Doctors do so for patients, lawyers for clients, finance managers for investors, parents for children, carers for dependants. How are these judgements made? How do they relate to people's judgements about their own risk preferences? Research in other areas of social judgement has revealed that people are egocentric: they judge others in the same way that they judge themselves. In the domain of financial risk-taking, HSEE and WEBER (1997) found egocentrism when the judges could empathise with the other people. When they could not, judges assessed others' preferences to be much closer to risk neutrality. Our results for four non-financial domains (recreation, drug-taking, modes of transport, occupations) replicate HSEE and WEBER only for activities for which people show risk aversion. We discuss reasons for this and identify various factors that influence the size of self-other differences in judgements of risk acceptability.

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1. Introduction

If someone needs to make a decision, there are broadly five ways in which that can be accomplished. They can make the decision themselves using unaided judgement. They can use some formal method of decision analysis which may or may not be computer-based. They can take advice from some source but then still make the decision themselves. They can jointly make the decision with one or more other individuals. Finally, someone else can make the decision for them. There is research into each of these different approaches and into ways in which they can be combined (e.g. HARVEY 2005). However, the literature on making decisions for other people is not large. It is this issue that we shall deal with here. We shall discuss different situations in which it is required, consider its policy context, briefly review relevant theories, and then focus on experimental work by ourselves and others concerned with people's ability to judge the acceptability of risks for other people. [1]

Situations in which people make decisions for others can be grouped into three types: those in which someone *requests* that the decision is made for them; those in which the decision is *imposed* on them; and those in which their condition *requires* that the decision is made for them. I shall refer to these three situations as proxy decision-making, executive decision-making, and surrogate decision-making, respectively. They are distinguished in terms of who wants the decision to be made. Is it the person who will primarily experience its effects (proxy decision-making)? Is it the person who makes the decision (executive decision-making)? Or is the decision better characterised as one that nobody especially wants to make but rather as one that needs to be made, given the situation that someone unable to make the decision is in (surrogate decision-making)? To put it in another way, in proxy decision-making and executive decision-making, the person for whom the decision is made *could make a decision* but either chooses not to do so or is prevented from doing so. In contrast, in surrogate decision-making the person for whom the decision is made *is unable to make the decision* because they do not have the capacity to do so. We shall briefly consider each of these situations in turn. [2]

In proxy decision-making, the person who will benefit or suffer from the outcome of the decision typically considers that they do not have sufficient knowledge or experience to ensure that they will make that decision well. This is the reason that they ask someone to make it for them. Usually, they consider that person to be more expert than they are in the domain in which the decision falls. For example, patients may ask doctors to make decisions about their treatment, clients may ask lawyers to determine how they should proceed on legal cases, investors may ask their finance managers to allocate their funds wisely, and so on. [3]

In executive decision-making, an authority figure unilaterally determines that they are better able to make a decision than the person who will experience its effects. The executive may consult but is not bound by the results of the consultation. Parents make decisions for children in this way. In the past, the way that industrialists made decisions for employees and the way that plantation owners made decisions for their slaves could also be characterised in these terms. [4]

Surrogate decision-making is necessary when somebody has been rendered incapable of making a decision through the effects of disease, accident or crime. Such people may be able to ask for help, in which case the decision-making is of the proxy type that we considered above. In many cases, however, they will not be able to make such requests, either because they cannot do so or because they are not aware that they need help or that there is a decision to be made. The surrogate decision-making that they require is of the type typically provided by carers to their dependants. [5]

2. Decision Criteria Depend on the Type of Situation

Aims of decision makers tend to be different in the three types of situation that we have discussed. In proxy decision-making, they need to ascertain what the other person's goals are and what levels of risk that person is willing to accept in attempts to reach those goals. Of course, determining goals is itself a type of decision-making and may involve some discussion. Once these have been established, however, the decision maker's job is to make the decision that is most likely to attain the other person's goals within the agreed bounds of risk acceptability. [6]

When one person imposes a decision on another, they can use whatever criterion they wish. If they adopt an empathetic approach, their aim will be to reach the goals that they consider the other person to have within the bounds of risk that they judge the other person would view as acceptable. Results of this approach to executive decision-making should be similar to those of proxy decision-making. However, this is not guaranteed if they do not consult and they have little ability to empathise. Alternatively, the executive may take a paternalistic approach. In this case, their aim is to make the decision that is most likely to produce the outcome that they consider would be objectively the best for the other person. Finally, they may adopt a more selfish or egoistic approach, which would benefit them more than the person for whom the decision is primarily being made. This approach is possible only when the decision has also some implications for the decision maker. [7]

To illustrate these three types of executive decision-making, consider parents selecting a school for one of their children. If they took an empathetic approach, they would send their child to the school they think he or she would prefer to go to (perhaps because that is where the child's friends are headed). If they took a paternalistic approach, they would select the school that they consider to be the best one. If they took an egoistic approach, they would send their child to the school nearest to their home because that would be the most convenient for them. [8]

In surrogate decision-making, decision makers face a dilemma. To what extent should they act paternalistically in the best interests of the dependent person and to what extent should they act empathetically by making the decisions that their dependent would make if they could? In practical terms, adopting a paternalistic approach is likely to be easier. It can often rely on publicly available information about the expected costs and benefits of different decisions and on adopting socially acceptable levels of risk. In contrast, taking account of a dependant's own idiosyncratic fears and desires and acting according to levels of risk that they personally find acceptable is likely to be much more difficult. [9]

Consider, for example, someone who smoked tobacco before an accident removed their capacity to make most day-to-day decisions. A paternalistic decision-maker may decide that they should not be allowed to smoke because it is bad for them and their close associates: the small transient but certain

pleasures associated with smoking are more than outweighed by the expected costs associated with less healthy and shortened lives for them and those close to them. Would an empathetic decision maker allow the person to smoke? If there is no evidence that the person wanted to stop smoking and if no additional risks have been associated with smoking since the accident occurred, they presumably would. If, on the other hand, relatives report that the person planned to stop smoking but found it difficult to do so, should the empathetic decision maker empathise with the far-sighted "planner" or the myopic "doer" (THALER & SHEFRIN 1981). And if tobacco risks are now assessed as higher than they were before the person's accident, how is the empathetic decision maker to know whether they have breached the level of risk that the person found acceptable? [10]

Given the additional difficulties associated with adopting an empathetic rather than paternalistic approach to surrogate decision-making, it is interesting to consider policy makers' recent proposals in this area. [11]

3. Policies for Dealing with Lack of Capacity

For some years, there has been mounting concern within the United Kingdom that the absence of a legal definition of a lack of capacity to make decisions results in people who need support being inadequately protected by the law. For example, the Making Decisions Alliance, a pressure group supported by many charities (e.g. by those representing people suffering from Alzheimer's disease, stroke, autism, head injury, and schizophrenia), have argued that a test of mental capacity is needed. This would replace current informal practices, such as assuming that people can make all their decisions for themselves if they know who the Queen and the prime minister are (HOLMSTRÖM 2003). [12]

As a result of these concerns, the UK government instigated a consultation process in 1989. A green paper, "Who decides", was published in 1997 and was followed by a policy statement, "Making decisions", in 1999. The Mental Capacity Act has now completed its passage through parliament and is expected to become law by 2007. The provisions made by the Act should bring practice into line with the Convention on the International Protection of Adults signed at The Hague in January 2000. [13]

The Act does not propose a psychometric test to determine someone's capacity to make all types of decision. Instead, there is a presumption that people can make decisions. Specific tests are then used to determine whether they are not able to make particular decisions. The tests are two-stage. In the first stage, it is necessary to ascertain that "there is an impairment of or disturbance in the functioning of the person's mind or brain". The second stage involves determining whether this has made the person unable to make a particular decision. People are deemed unable to make a decision when they cannot understand or retain information relevant to it, when they cannot use or weigh that information as part of the process of making the decision, or when they cannot communicate the results of this process. [14]

If tests indicate that people cannot make decisions by themselves, it is then necessary to determine whether they can make them with help. If they can, then the required assistance should be given. If they cannot, surrogate decision making is necessary. The individual may or may not be able to decide who the surrogate decision maker should be. For example, if they expect to lose capacity to make a particular type of decision (e.g. financial, medical), they may decide in advance of that to give someone else Lasting Power of Attorney. [15]

The Act specifies the criteria that surrogate decision makers should use. The first is that the decision should be the one that is least restrictive of the person's rights and freedom of action. (The decision could be that there is no need to make a choice at the present time.) The second criterion is that the decision should be made in the person's best interests. (This might suggest that a paternalistic approach is being endorsed but, as we shall see below, this is not so.) The Act specifies that these two criteria (least restriction and best interests) must be applied each time a surrogate decision is made. Clearly, there could be a conflict between the decisions determined by each of these two criteria when applied alone. The Act does not specify how they should be weighted when applied together (as they must be). [16]

From what we have said, it might be assumed that the person's own desires, fears, and risk preferences should be excluded from the surrogate's consideration. In fact, in the draft code of practice associated with the Act, paragraph 4.6 states that:

> "People with capacity are able to decide for themselves what is best, and may even choose an option which others consider to be unwise or not in their best interests. That is their prerogative as competent and autonomous adults. However, once capacity is lost, it is the best interest's [sic] of the person who may lack capacity which govern how decisions or actions may be taken on his/her behalf." [17]

However, in determining the person's best interests, the decision maker "must consider, so far as is reasonably ascertainable—(i) The person's past and present wishes and feelings, (ii) The beliefs and values that would be likely to influence his decision if he had capacity, and (iii) The other factors that he would be likely to consider if he were able to do so". All the same,

> "it is important to recognize that the person's wishes and feelings will not automatically control the outcome. The 'best interests' principle is the fundamental principle, requiring what is best for the person … While neither past nor present wishes can determine the decision which is now to be made, both are important and must be weighted against each other and considered alongside other factors." [18]

Thus the term "best interests" is to be taken to include not just what is objectively best for the person's health, wealth and material well-being. It is also taken to include their desires, fears, risk preferences, and other values. The Act is not as paternalistic as it first appears. However, the task for decision makers turns out to be a highly complex one. They must weigh up the need for preserving the

person's rights and freedom of action, what is objectively good for the person, and what the person wants. In addition, they are expected to take account of the chances that the person might regain capacity and of the views of other interested parties. Given it is not possible to provide any general specifications of the relative weightings of these various factors, there is clearly scope for the choice made by the surrogate decision maker to be challenged by others involved in the person's life. The Act therefore specifies various ways in which disagreements can be resolved. These include formal mediation (with the use of independent advocates if necessary), use of established complaints procedures, and, if other avenues fail, access to a new Court of Protection empowered to make decisions in relation to all areas for adults who lack capacity. In future, it will be very interesting to see how this court weighs the different decision criteria specified in the Act. [19]

4. Making Judgements About Other People's Opinions, Abilities, and Future Behaviour

In proxy decision-making, the decision maker can ask the other person about what their goals and risk preferences are. In executive decision-making, they may not feel the need to do this (if taking a paternalistic or egoistic approach). In surrogate decision-making, the person for whom the decision is to be made may be unable to express their desires, fears and risk preferences. If an empathetic element is to be included in such decision-making (as the Mental Capacity Act specifies), decision makers must use their own judgement to determine what the other person's aims are. How good are people at making such judgements? How empathetic are they? [20]

Research on social comparison processes suggests that we are not particularly good at assessing other people's opinions, abilities, or future behaviour. The dominant view is that we tend to be egocentric (CLEMENT & KRUEGER 2000; DUNNING & HAYES 1996; KRUEGER 1998a). To make judgements about other people, we tend to retrieve knowledge about ourselves and use it to make assessments about others. The large body of research on the false consensus effect (MULLEN et al. 1985) provides evidence for this. An early study demonstrates the relevance of this effect to judgements of risk acceptability in others. KATZ and ALLPORT (1931) asked students whether they had cheated in exams (a risky activity) and whether they thought other students did. Those admitting cheating were more likely to consider others to have cheated. [21]

KRUEGER (1998b) has argued that the mental processes underlying this effect occur automatically outside our control. However, he argues that, overlaid on this, there are other effects that are under our control. Prominent among these is our tendency to increase how favourably we assess ourselves on desirable traits relative to how we judge other people on those traits (BROWN 1986). We are assumed to do this for purposes of self-enhancement (JOHN & ROBINS 1994). [22]

MUSSWEILER (2003a) has pointed out that we may use reference points other than those provided by ourselves to assess other people. A standard may be

suggested by instructions given to somebody or by normative considerations. The most obvious normative standard for judgements related to risk is the point of risk neutrality. Indeed, some work on differences in judgements of risk acceptability for self and others does appear to implicate use of risk neutrality as a standard. We discuss it in the next section. [23]

5. Judgements of Risk Acceptability for Self and Others

How well are people able to make judgements about the risk preferences of others? It is important that they should be able to do this task reasonably well if they are to act as surrogate decision makers. Consider, for example, the following medical treatment dilemma. A dependant has a disease that can be treated in one of two ways. The first type of treatment alleviates the more severe symptoms, and has a very low risk of mortality. However, some problems will remain and there is some chance that symptoms will return in the future. The second type of treatment would provide a permanent and complete cure but the risk of mortality is considerably higher than it is for the first treatment. In this case, the carer who acts as a surrogate decision maker can be fairly certain of their dependant's outcome preferences. Most of all they would like to regain full health. Their next preference would be to be alive even if not completely healthy. Their least preferred option would be to be dead. Thus the primary problem for the surrogate decision maker is not to ascertain the dependant's outcome preferences. It is instead to determine their risk preference: the level of risk that person would be willing to accept in order to achieve their most preferred outcome. Specifically, would they accept the higher level of risk associated with the second type of treatment? [24]

How well are people able to judge whether risks are acceptable to other people? HSEE and WEBER (1997) reported three experiments on financial risk taking. Their participants made a series of choices between various sure options (e.g. $400, $600, $800 … $1600) and a particular risky option (e.g. $2000 or $0 determined by the toss of a coin). They made the choices both for themselves and for someone else. The highest-value sure option chosen over the risky option provided their measure of risk acceptability. [25]

They tested various hypotheses. If people are egocentric, they will judge others to have the same risk preferences as they have themselves. If, on the other hand, they make selections in ways designed to enhance their own image, there will be a difference between how they assess risk acceptability for themselves and for others. Following SHAPIRA (1995), HSEE and WEBER (1997) assume that people view risk-taking as a desirable trait. This would lead them to view acceptable levels of risk to be lower in other people than in themselves. Another hypothesis considered by HSEE and WEBER (1997) was that people use risk neutrality as a standard for judgements. Unless additional information is available, everyone would be judged to be risk-neutral. Additional information is available for the judges themselves and for other people with whom they can empathise. Risk preferences for others should therefore vary between those chosen for themselves and risk neutrality. [26]

HSEE and WEBER (1997) found that students assessed others who were "like most college students in the United States" or were "like most other students on this campus" as less risk-averse than they judged themselves to be. This eliminates the first two hypotheses that they were considering. However, they also found that the difference between their judgements for self and for other people disappeared when they were asked to regard the other individual as the person sitting next to them in the testing session. On the assumption that it was easier for their participants to empathise with a real person sitting next to them than with an abstraction who is not, HSEE and WEBER (1997) take their pattern of findings as a whole as support for the last hypothesis mentioned above: people assume others are risk-neutral unless they can empathise with them (in which case, they assess their risk preferences as closer to their own). [27]

Do HSEE and WEBER's (1997) conclusions extend to non-financial risks as well as financial ones? LOEWENSTEIN, WEBER, HSEE and WELCH (2001) asked students to imagine that they were riding in a taxi and that they had ascertained that the driver was drunk. Would they stay in the taxi (assumed to be relatively risky) or get out and walk five miles to their destination (assumed to be less risky)? They rated themselves as more likely to leave the taxi than they rated the average student to leave it. Thus, again, they considered others to be less risk-averse than they were themselves. (It is worth noting that the assumed standard of risk neutrality is somewhat different in HSEE & WEBER's [1997] and LOEWENSTEIN et al.'s [2001] experiments.) [28]

Our experiments (HARVEY, TWYMAN & HARRIES in preparation) were designed with three primary goals in mind. Our first was to determine whether HSEE and WEBER's (1997) findings extend to non-financial risks other than the rather limited one studied by LOEWENSTEIN et al. (2001). Our second goal was to find out whether HSEE and WEBER's (1997) identification of the variable that determines whether people can empathise with others as the concreteness or specificity of the other people is correct. The reason we queried their proposal was that work on social comparison outside the domain of risk acceptability indicates that differences between judgements for self and others decrease as the similarity between self and others increases (e.g. MUSSWEILER 2003b). HSEE and WEBER's (1997) findings can be interpreted in these terms if people view others who are physically closer to them (e.g. in the same testing room) as, on average, more similar to them than people further away (e.g. on the same campus, in the same country). Furthermore, STONE, YATES and CARRUTHERS (2002) have reported no differences between judgements for self and others in a financial risk-taking task in which the other people were absent but named similar friends. [29]

Our third goal was to test a prediction made by HSEE and WEBER's (1997) model. According to them, judgements of risk acceptability for others with whom it is difficult to empathise should lie between judgements for the self and the point of risk neutrality. They demonstrated this for a task in which people were risk-averse. Their model predicts that it should also be true for tasks in which people tend to be risk-seeking. Judgements of risk acceptability for others with whom it is

difficult to empathise should lie between the level of risk-seeking adopted for the self and the point of risk neutrality. [30]

We studied risk judgements for two categories of activity in which pilot work had shown that people from our population of participants tended to be risk-averse (drug-taking, various hazardous occupations) and for two categories of activity in which pilot work had shown that they tend to be more willing to accept risk (recreations, modes of transport). Our 80 participants received advice from two sources about the level of risk associated with each activity, used it to make their own risk estimate for that activity, and then judged the likelihoods that they and that one of their friends would engage in it. The advice was frequency-based but frequencies were perturbed by random noise to a greater or lesser extent, thereby providing a poor and a good advisor, respectively. Before the experimental session, there was a training session with feedback to allow people to learn about the relative quality of advice from the two sources. [31]

Half our participants judged risk acceptability for an absent but named friend who had values similar to their own and the other half judged it for an absent but named friend with values different from their own. Thus if empathizing is difficult when others are absent (HSEE & WEBER 1997), self–other differences should have occurred in both conditions. If empathizing is difficult when the other person is defined in an abstract way but easy when they are specified as a named person—an alternative interpretation of HSEE and WEBER's (1997) argument—then self–other differences should have occurred in neither condition. However, if similarity between self and others is what makes empathizing easy, as social comparison theorists (e.g. MUSSWEILER 2003b) suggest, self–other differences should have occurred only when the friend had different values. [32]

Our results with the activities associated with risk aversion showed no significant differences between judgements of risk acceptability for self and others when the named other people had similar values to those of the judges. This extends STONE et al.'s (2002) findings to non-financial risks. When the other people had different values from those of the judges, we found that judgements for the judges themselves showed significantly greater risk aversion than the judgements for the other people. This suggests that similarity rather than concreteness or specificity determines the ease with which it is possible to empathise with other people. [33]

Our results for the activities associated with risk-seeking showed no differences between judgements of risk acceptability for self and others, either when others had similar values to the judges or when they had different values from them. It is unlikely that this lack of difference arose because the other people for whom the judgements were made were not physically present because same–other differences occurred for the activities associated with risk aversion when the other people were not present. The difference in results between activities associated with risk-seeking and those associated with risk aversion is not easy to explain within HSEE and WEBER's (1997) model. It predicts that, with other factors held constant, whatever self–other differences are found with risk

aversion should also be found with risk-seeking. If judgements for others are closer to the point of risk neutrality in the former case, they should be in the latter case as well. This did not happen. [34]

We interpret both our results and those of HSEE and WEBER (1997) in terms of self-enhancement. Financial risk taking may have been seen as desirable by the managers studied by SHAPIRA (1995) but it is likely to have been viewed as undesirable by the students studied by HSEE and WEBER (1997). Hence, for self-enhancement purposes, they would have made judgements signalling that they were more rather than less risk averse than other people. Analogously, our students are likely to have viewed risk aversion as desirable in the context of drug use and hazardous occupations but not in the context of recreational activities and use of transport. Hence, self–other differences occurred only in the former case. In summary, we do not consider that people regard risk aversion or risk seeking *per se* as desirable or undesirable. Instead, risk aversion and risk seeking are considered desirable or undesirable in the context of particular activities. We are currently carrying out a questionnaire study to investigate this hazard-specific self-enhancement explanation of self–other differences in judgements of risk acceptability. [35]

6. Implications

One interesting implication of this self-enhancement account is that it suggests that it is risk assessment for the self rather than risk assessment for other people that is subject to error. At first glance, this may be taken as good news for surrogate decision making because it seems to imply that people are better at making risk judgements for other people than they are for themselves. However, self-enhancement is usually seen as a contrived overlay imposed on true underlying judgements for the purposes of impressing other people. If so, we can perhaps assume that this overlay, though present when people inform investigators of their propensity to take risks, is removed when they actually decide whether to take them. However, it is difficult to determine how reasonable this assumption is: curiously, we appear to know little about whether people are as likely to take risks as they say they are. [36]

In fact, whether or not self-enhancement affects actual risk taking as well as reports of judgements about intentions to take risks, it is important to remember that it is viewed as a conscious effect that is added to a more automatic egocentric bias (KRUEGER 1998b). Given this egocentrism, we cannot consider judgements for others to be more accurate than judgements for the self. Even though we would hope that it is reasonable to assume that, without self-enhancement, judgements for the self would be accurate, the presence of egocentrism means that we cannot assume that risk judgements for others are accurate. More research is needed before we can say just how accurate or inaccurate surrogate decision makers are when assessing what are acceptable risks for those for whom they are required to make decisions. Yet, as we have seen, legislation that has passed through the UK parliament requires them to take factors such as this into account. [37]

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