Respect for Other Selves

ABSTRACT. Philosophers have mostly advocated that advance directives should bear the same authority, with regard to refusal of life-extending treatment, as a patient's contemporaneous consent or refusal. Such authors typically support this position through a theory of persistent personal identity. I agree that the loss of mental competence does not render someone a moral stranger to their prior goal but argue that equating advance direction with consent is to ignore the capacity of nonpersons to attribute and withhold moral value. A distinction should be drawn between advance directives that seek to pursue deeply held goals and those that express contempt for the mentally incompetent.

ADVANCE DIRECTIVES AND THE OTHER SELF DEBATE

How ought we respond to advance directives that appear to fly in the face of a severely mentally impaired patient's quality of life? An advance directive is a legal instrument wherein a person records instructions regarding the medical treatment that she is to receive in the event that she becomes persistently incapable of refusing or giving informed consent to treatment. Where these instructions are legally binding, they enable a person to exercise control over her future medical treatment. This has been welcomed by some on the grounds that it increases patient autonomy, but there has also been concern that in cases in which a patient is left conscious but severely mentally impaired, the person's advance instructions may be at odds with her future interests.

Two sources of this concern are discussed in the philosophical and bioethical literature. One is misinformation or false expectations by the advance directive's author regarding her future experience of illness and the treatments available (e.g., Dresser 1995). The other, which is the subject of this paper, is the sacrifice of such interests as the promotion of future happiness or the prevention of suffering by the advance directive's author in the pursuit of nonexperiential goals and values. The most obvious example of this is the use of an advance directive to refuse life-extending treatment.
irrespective of whether the patient is happy and content following the onset of advanced dementia. In making the advance directive, the person is not seeking to safeguard her future happiness but rather her current goals such as (her conception of) dignity or independence. The apparent tension between the advance directive and the patient’s interests, then, is twofold: not only is the advance directive at odds with the promotion of the patient’s ongoing happiness, but it is motivated by goals and values of a kind that the patient, in her severely impaired state, can no longer evaluate and no longer cares for.

For philosophers, advance directives exemplify a kind of concern where practical questions of practice and policy meet long-standing conflicts of philosophical principle. The authority of patient instructions in medicine is usually determined by the doctrine of informed consent, in which the patient’s instructions are judged not by their reasonableness but by the patient’s mental competence and access to information (Kirby 1983; Kihlbom 2008). However, advance directives take effect at a time when the patient is no longer capable of giving informed consent. The doctrine of informed consent is the high watermark of philosophical and ethical liberalism, in which personal autonomy is given an overriding authority that is increasingly rare in other parts of life. Conflict between advance directives and patients’ interests invites a consideration of how the loss of personhood affects the claim to personal autonomy and integrity on which philosophical liberalism (and hence the informed consent doctrine) rests.

Ronald Dworkin discusses the problem in *Life’s Dominion* (1993, pp. 220–30), where he recounts the experience of a medical student who repeatedly visited “Margo,” who was then suffering the advanced stages of Alzheimer’s disease. Margo’s mental capacities are impaired to the point that she is only capable of a daily routine of simple activities, but she appears to obtain substantial pleasure from those activities. The student describes her as possibly one of the happiest people he has ever met. Dworkin then asks, counterfactually, what our appropriate response should be if Margo had (while mentally competent) executed an advance directive requesting that any life-extending treatment be withheld once she reached her current advanced stage of dementia.

We can describe Margo as having reached a “post-personhood” stage in her life. “Personhood” is often used loosely to refer to the mental capacities that we associate with the typical adult human. We can also use the term in a stricter sense, to refer to the property of holding the capacity for personal autonomy and moral responsibility. Personhood, in this latter
sense, can be decision-specific: in an earlier stage of dementia, Margo may have been capable of personal autonomy in relation to medical procedures while lacking that capacity with regard to the distribution of her estate. However, now Margo has lost personhood in a broader sense. Advanced dementia has eroded the “self” on which Margo’s personal autonomy and moral responsibility depends. That is, it has deprived her of the capacity for long-term memory, forethought, planning and reflection that could enable a sense of persistent identity and a conception of the kind of life she wants to lead. Margo’s state is one of “post-personhood” in that she no longer comprises a sophisticated self to which qualities like personal autonomy or moral responsibility can apply.

Margo’s case is troubling because it reveals a conflict between two sets of interests arising from different periods in Margo’s life, both of which we would normally view as obliging our respect. The practice of advance directives is grounded in our moral claims to autonomy and the pursuit of our deeply held goals and values, these being interests that arise from our existence as persons. By directing that her death be hastened in the event of severe mental impairment, Margo brings these autonomy interests into conflict with the persistence of her own post-personhood life. However, Margo’s post-personhood life is characterized by happiness and contentment—experiences that imbue her life with value. The interests underlying the moral authority of Margo’s advance directive—namely, her interests in autonomy and the pursuit of her preimpairment goals and values—are in conflict with her interest in continuing to live a severely mentally impaired but happy life.

There is a sense in which this is a conflict between different stages of Margo’s life. When making her advance directive, Margo (assuming she was well-informed and instrumentally reasonable) placed greater worth on the goals and principles motivating her refusal of treatment than she did on the prospect of a happy post-personhood life. After the onset of advanced dementia, however, Margo is no longer capable of having concern for complex goals and principles but nevertheless remains capable of experiencing happiness and contentment. This is troubling for those of us who believe that Margo’s “own” wishes should be applied; we would need to ascertain whether to prioritize the way of living that Margo currently values or to impose the instructions she gave prior to losing the capacity for personhood.

This conflict has encouraged philosophers to view Margo’s different stages as different “selves.” Under this view, “Margo, the person,” who
gives rise to Margo’s interests in autonomy and the pursuit of goals and values, forms one relevant self, whilst “Margo, the severely mentally impaired human,” who has ongoing experiential interests, is another such self. This terminology does not necessarily imply that the selves are numerically distinct individuals but rather simply marks a disunity in Margo’s character (i.e., in the conative states—goals, values, attitudes, and principles—that characterize Margo’s life). Dworkin reasons that we should consider Margo’s current state to be an extension of “Margo, the person,” and that respect for both Margo’s autonomy and her best interests should lead us to implement the advance directive (1993, p. 231). Other authors have thought differently. Rebecca Dresser (1994; 1995), Jeff McMahan (2002) and John Robertson (1991) claim that when an individual loses personhood (in the broad sense experienced by Margo), they no longer have a substantial prudential or moral commitment to the goals and values that characterized them as persons:

An individual’s good may change along with his nature, character, values and preferences. And this is the basis for claiming that it would be better for the Demented Patient now to continue to live. The dementia has caused a profound alteration in her nature. She was once devoted to creative intellectual endeavours. For a person like that, the plunge into dementia could be deeply degrading. Yet now that the dementia has already occurred, the elements of her nature that opposed or were hostile to a state of contented dementia have been eradicated. Now that she is demented, the good that seems appropriate to her present nature is contentment. (McMahan 2002, p. 500)

When our situations change drastically, our interests and preferences also change. The difference between competent and incompetent interests is so great that if we are to respect incompetent persons, we should focus on their needs and interests as they now exist and not view them as retaining interests and values that, because of their incompetency, no longer apply (Robertson 1991, p. 7).

From this they conclude that, where a post-personhood patient’s experiences and preferences are mostly positive, we should not impose any earlier directive that would deprive her of those experiences and preferences, as the interests that motivated her to make the advance directive are no longer relevant. For ease of reference, I refer to these arguments as the “other self thesis”: they emphasise the change that has occurred since the advance directive was made, such that the patient’s current experiential interests ought to constrain our implementation of the choices made by the person she once was.
Many people find the other self thesis intuitively compelling, as is suggested by the fact that Dworkin keeps open the possibility that moral considerations external to the patient’s interests may justify limitations on the use of advance directives (1993, pp. 228–29). Nonetheless, the other self thesis has found very little philosophical acceptance, particularly in the field of bioethics. Numerous authors have disputed the claim that loss of the capacities that comprise personhood divests the patient of the moral interests arising from personhood (e.g., Blustein 1999; Kuczewski 1999; Ott 2009; DeGrazia 2005). These arguments vary in the ways that they conceive of personal identity, character, and the interests that motivate the advance directive, but they all lead to the principle that we ought to consider the patient’s life as a whole, wherein the claims of the person that she was outweigh those of the human that she is.

I suspect that these arguments are correct in their common claim about personal identity: that we ought to consider Margo’s life “as a whole.” Whether we characterize them as separate but closely related identities or as different stages of the one identity, “Margo, the person,” and “Margo, the post-personhood human,” are not moral strangers. However, they are mistaken in interpreting the “other self thesis” as purely a problem of personal identity. We can acknowledge the continuing relevance of the interests arising from Margo’s personhood, such as the goals and values that informed her advance directive, without accepting that those interests are the sole determinant of Margo’s moral worth. If we are to care for her life “as a whole,” we ought to recognize that Margo is not just an extension of the person she once was. Moreover, the liberal multifaceted conception of the good that underlies the moral authority of advance directives also obliges us to recognize that Margo’s way of life can have value regardless of the rejection of that way of life implicit in her advance directive. Moral worth is not restricted to personhood, and so we are obliged to respect not only “Margo, the person,” but also those interests arising from Margo’s post-personhood life.

In endeavoring to rehabilitate the other self thesis, I do not intend to make out a case against the advance direction of euthanasia in general. To the contrary, I hope to provide an account that allows for the advance refusal of life-extending treatment such that failure to apply an advance directive would catastrophically undermine a patient’s preimpairment life projects. My aim is to show that our obligation to apply a patient’s advance directive is constrained by that patient’s ongoing moral worth. If such advance directives are to be of use, we must reenvisage the form that

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advance directives should take and the process by which they operate. We must look beyond the face of the patient’s bare instructions to consider the values and goals that the advance directive promotes and the role that those values and goals play in the patient’s overall life. Rather than holding authority by virtue of being a properly executed document, then, advance directives refusing treatment should be subject to the discretion of a substituted decision maker—preferably one appointed by the patient when making the advance directive—tasked with weighing the patient’s preimpairment instructions against the value of her current way of life.

PATIENT CONTROL OF MEDICAL DECISIONS AND THE APPEAL TO PERSONAL INTEGRITY

It is worth distinguishing two contexts in which we might analyze the moral significance of advance directives. Dan Brock states:

Executing an advance directive is more than simply expressing a preference regarding future treatment. Advance directives, like wills governing property, make use of a rule-governed social practice in order to create and secure from others obligations and commitments about one’s medical treatment in the case of future incompetence. They constitute what philosophers have called performative utterances that call on background social practices in order to create obligations and responsibilities. (1988a, pp. 251–52)

Brock is correct on this point: the very existence of social norms alters our moral obligations, and if a particular social norm is relied on enough, it may well become self-justifying. When asking whether an individual advance directive should be implemented, then, we need to take into account the legal and social commitments that were secured by executing it. However, in many countries, advance directives are a relatively recent practice (Bogdanoski 2009), and formal policy can be expected to guide social expectations. My aim here is to analyze advance directives as a practice, asking what obligations and commitments should be created by recording one’s instructions regarding future treatment.

In the context of its background social practices, including the informed consent doctrine, an advance directive is a means of giving or withholding informed consent for future treatment. However, in evaluating the moral authority of advance directives as a practice, we ought to ask what moral claims underlie the authority that medical ethics attributes to a patient’s informed decision to give or refuse consent, and then ask whether those moral claims are still served when we give informed consent by means of an advance directive. Of these moral claims, some can be characterized as
relating to the general value of personal well-being. In a medical context, “well-being” suggests physical health, but I do not want to limit its scope to physical health; rather I want to use to refer to all of a person’s experiential self-oriented interests. Through the informed consent doctrine and the practice of advance directives, we can promote patients’ well-being by promoting their happiness, improving patient-doctor relationships, and facilitating the effective provision of future medical treatment. But there are some occasions when we have good reason to believe that we can improve the well-being of an informed and mentally competent patient by imposing treatment against her will; such as where a patient refuses life-saving medical treatment on moral or ideological grounds. Nonetheless, the informed consent doctrine serves to prevent unwanted treatment in such cases, on the understanding that the person has nonexperiential interests in personal integrity that warrant protection from paternalism.¹

The liberal advocates of advance directives claim that this appeal to personal integrity gives rise to an interest in having one’s advance directive implemented that is similarly independent of well-being.

The appeal to personal integrity has its roots in John Stuart Mill and was adopted into modern theories of ethics as the starting point of liberal arguments against paternalism (Arneson 1980; Feinberg 1984; Kleinig 1983; Mill 1977). This statement by Ronald Dworkin is representative:

Recognizing an individual right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives according to our own coherent or incoherent—but, in any case, distinctive—personality. It allows us to lead our own lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves. (1993, p. 242)

The central claim is that the “good life” for a person is (among other things) one that is consistent with the person’s deeply held goals, values, and convictions—that is, a life of personal integrity (Arneson 1980; Feinberg 1984, pp. 52–97; VanDeVeer 1986, pp. 124–27; Kleinig 1983, pp. 27–30; Brock 1988b; Scoccia 1990). Dworkin actually makes two arguments toward this claim, one grounded in autonomy (1993, p. 224), and the other in beneficence (1993, p. 231), but both lead to the same moral prioritization of deeply held goals and values ahead of well-being. In broader moral philosophy this “central claim” requires defending, but in the subfield of bioethics (and especially in discussion of medical paternalism and informed consent) it has become part of the accepted
theoretical background (e.g., Buchanan 1988; DeGrazia 2005; Harvey 2006; Kuczewski 1994, 1999; Kuhse 1999; Post 1995). I compromise by omitting the lengthy reasoning required to justify the appeal to personal integrity while explaining its implications for medical decision making.

Personal integrity is not simply a matter of pursuing one's immediate preferences. As Dworkin's passage indicates, personal integrity is a matter of design, a shaping of one's life, that stands quite at odds with an impulsive focus on transitory desires. That is why I preface my reference to the conative states (goals, values, convictions, etc.) relevant to personal integrity by describing them as “deeply held.” What I mean by this is that they accurately reflect the person's own attribution of value: the way that a person values things and experiences within her life, thus imbuing with value both the thing itself and her life insofar as it contains that thing. For example, by deeply valuing the practice of playing the piano, I give that practice value within my life and also imbue my own life with value—my life has greater worth (to me) than it would without such attribution of value.

The term “deeply held” is deliberately vague, because it refers to a concept that is easily understood at a loose level but that invites interminable difficulties when analyzed with greater precision. We all understand what it means to say that certain of our values matter greatly to us, that those values are what define our character, and that other preferences are less important to us. However, when trying to state what it is that makes a particular value more “central” or “deeper” than others, philosophers struggle to agree on seemingly basic notions such as the relevance that a value's stability, longevity, content, and formation process has over that value's importance (Frankfurt 1988, pp. 11–25; Frankfurt 1999, pp. 129–41; Christman 2004, 2005; Dworkin 1989; Meyers 2005; Taylor 2003; Valerius 2006; Young 1989). We can say with less controversy that the more important values are those that we identify with most strongly, whereas we do not identify with the preferences that we temporarily succumb to when our will is weak (Frankfurt 1988, pp. 11–25; Frankfurt 1999, pp. 129–41; Dworkin 1989; Christman 2005). However, while that may help relate the idea of “deeply holding” a value to our concepts of character and identity, it doesn't render the attribution of value itself any less opaque. For the current discussion we can use the loose notion of “deeply holding” goals and values while putting aside how the question of how that notion should be filled in.

Severe mental impairment can threaten our personal integrity by rendering us unable to effectively pursue our goals and implement our values.
Our most deeply held goals and values are often those that characterise our conception of how we ought to live. Our commitment to some of these goals and values, such as our moral codes, extends to circumstances where we lack the capacity to experience or understand the effects of breaching them. For example, many of us would be horrified at the idea of being kept alive by means of an organ transplant using an organ that was stolen from a child who was killed for that purpose. The knowledge that our faltering mental state may prevent us from understanding how the organ was procured would not lessen our disgust. Some such commitments may be more esoteric—for example, a Jehovah’s Witness’s refusal of blood transfusions or a musician’s repugnance at the idea of living without the capacity to perform Beethoven. In such cases, the person holds the goal or value to be more important than the extension of her life, even if that life is characterized by happiness or contentment.

In some cases, the patient’s commitment to her deeply held goals and values can only be met by withholding life-extending medical treatment. Ordinarily, in the event of the patient’s mental incompetence, a paternalistic substitution of the patient’s consent would allow that treatment. Given such a scenario, then meaningful pursuit of the patient’s goals and values in the face of mental incompetence requires some means of making medical decisions in advance, before she suffers mental impairment. If such measures are not in place prior to the patient losing mental competence in relation to her treatment choices, she risks becoming subject to a substituted decision-making procedure that is unmotivated to prioritize her goals and values ahead of her experiential interests.

So, while individual advance directives may be made for any number of reasons, the social and legal practice of advance directives primarily serves to protect personal integrity, with a secondary role of promoting well-being. Where a patient has been deprived of consciousness or temporarily rendered mentally incompetent, the appeal to personal integrity explains why the patient’s former instructions through her advance directive remain morally authoritative. The other self thesis, however, questions whether the appeal to personal integrity has the same relevance when applied to a patient who is conscious but has permanently lost the capacity for personhood. The notion that this drastically changes the patient’s interests appears compelling because, ordinarily, personal integrity concerns the goals and values that we currently deeply hold and identify with. There is something extraordinarily inauthentic about allowing your life to be governed according to a set of goals and values that you no longer identify with. This places the onus on
opponents of the other self thesis to explain why the appeal to personal integrity continues to have relevance in such circumstances.

SURVIVING INTERESTS

The accounts that I discuss in this section vary considerably in their conceptions of personal identity and character, but they converge through their shared proposition that whatever experiential interests Margo (I’ll continue to use her as a representative case) has qua her existence as “Margo, the post-personhood human,” she is also the biological extension of “Margo, the person,” and therefore the beneficiary of that person’s interests. My interest is not so much in the intricacies of their varying models of personal identity as in the implications of their claim that the erosion of an individual’s goals and values caused by advanced dementia does not sever her interest in pursuing those former goals and values. In the later sections of this paper, I acknowledge that this claim is compelling and argue that the other self thesis can be reconstructed in a form that is consistent with that position. I refer to these accounts collectively as the “surviving interest thesis,” after their shared conclusion that the interests arising from personhood survive the loss of the capacity for personhood.

The surviving interests thesis begins with Dworkin: “When we consider how the fate of a demented person can affect the character of his life, we consider the patient’s whole life, not just its sad final stages, and we consider his future in terms of how it affects the character of the whole” (1993, p. 230). Dworkin’s view invites the response that he is asking us to consider the interests of a person who no longer exists. Philosophers supporting the surviving interests thesis have sought to elaborate on Dworkin’s reasoning or provide alternative justifications for why we ought to consider the patient as an extension of the prior person. Andrea Ott (2009) reasons that even if we identify with our psychological existence, we are nonetheless constituted by our bodies, that is, our human organism. Choices made by “Margo, the person,” are also, derivatively, the choices of “Margo, the human.” This leads to Ott to claim that what “Dworkin is getting at is the intuition that the person and her organism are connected in a close enough way to generate such concern and respect for the life as a whole” (2009, p. 41).

There is something compelling about this, even if one doesn’t accept Ott’s account of personal identity. Even if we identify primarily with our mind in thought experiments about extraordinary scenarios such as mind swaps, our body remains important to our self-conception (DeGrazia 2005;...
Schechtman 1996). There is something intuitively problematic about treating “Margo, the person,” and “Margo, the severely mentally impaired human” as moral strangers, as though Margo had always been severely mentally impaired rather than spending most of her life as a person with complex goals and values.

David DeGrazia (2005, pp. 79–84) and Mark Kuczewski (1999; 1994) describe surviving interests in terms of personal narratives. They adopt closely related versions of Marya Schechtman’s (1996) account of personal identity, wherein our identity (not numerical identity, but identity in the sense of character) consists of our self-told life stories. Even though severe mental impairment may deprive Margo of her ability to continue developing her self-told narrative, the narrative that characterized “Margo, the person,” involves Margo’s life post-personhood. DeGrazia’s point is that there is a strongly subjective component to whether our lives have gone well and that this is informed by the goals and values that matter most to us. Depending on Margo’s goals, the factual events of her life might be construed as the life of a person who successfully secures what is most important to her or as a life characterized by efforts that are wasted in failed pursuits. Even though the capacity to tell this narrative requires personhood, the narrative is affected by the whole of Margo’s life, including her post-personhood existence. As Kuczewski notes,

People are their stories, not just their psychological states or their biological sensations. One’s death forms an important part of the story. . . . The surviving interests of a person are interests in seeing the story carried out in a way that is meaningfully related to how it has proceeded up to the loss of decision-making capacity. (1999, p. 33)

For DeGrazia this narrative is constructed by the person herself (2005, pp. 84–87), but for Kuczewski (1997, pp. 135–38) it is a communal project between the person, her community and their personal and institutional memories. Rather than taking moral authority as an act of independent self-creation, on Kuczewski’s communitarian model, the advance directive serves to preserve the person’s decision in the community’s institutional memory: “The body that belongs to the incompetent patient at t₂ is in some sense ‘mine’ because other persons will call it by my name and make what happens to it a chapter of the story they tell about ‘me’” (1997, p. 13). As such, Kuczewski’s is concerned for the advance directive as a means to the more important end of continuing the person’s self-conceived narrative: “The continuing of the person’s self-conception of their narrative
self-construction is what makes the person the same person, not some act of will that is encoded in an instructional directive” (1999, p. 35).

Similarly, Dworkin is concerned for autonomy rights as a means of securing the opportunity to develop and meaningfully pursue “critical” interests—the nonexperiential but deeply held, goals and values that give our lives purpose (1993, pp. 196–206). As with Kuczewski’s communal conception of narrative, this suggests the possibility of a divergence between the patient’s personal integrity and the precise terms of her advance directive. Nonetheless, an advance directive has relevance beyond being evidence of the person’s state of mind at a fixed point in time. Advance directives are made within a legal and social context wherein they may function as a means of deliberate self-authorship, and the mere existence of the directive could serve to define one’s critical interests or shape one’s narrative in the communal mindset.

It is worth noting that the progressive nature of dementia itself complicates the stance taken by many proponents of the surviving interests thesis. Some who advocate a surviving interests stance regarding the advanced stages of dementia may nonetheless alter their position once the patient’s mental deterioration is so profound that even the marginal continuity created by minor familiarities, familial relationships or shared fragments of memories is completely extinguished. Allen Buchanan and Dan Brock (1989, pp. 154–57; see also Buchanan 1988, pp. 282–92) limit their account of surviving interests in such a manner (requiring a minimal psychological continuity for personal persistence), and Kuczewski’s communal understanding of narrative suggests that surviving interests may become marginal if the patient’s former social relations are extinguished completely. By contrast, the emphasis that Dworkin (1993, p. 230) and Ott (2009, p. 41) place on the need to consider the patient’s life “as a whole” appears to warn against limiting her critical interests, even under such extreme loss of psychological continuity.

THE EXPERIENTIAL CLAIM

Rearticulating the Other Self Thesis

The accounts that warrant the “surviving interests” label posit a variety of conceptions of personal identity and of the relationship between “Margo, the person,” and the human that survives her. Rather than disassembling each of these accounts and analyzing them piecemeal, I accept them because of the artificiality of judging “Margo, the post-personhood
human,” as though she were morally unrelated to “Margo, the person.” Philosophical accounts of personal identity are drawn largely by observing the circumstances in which we feel prudential concern. Many people are prudentially concerned for their post-personhood existence, even when they are aware of the psychological change that will occur, and the surviving interests accounts explain why that concern may be rational. Whether we view “Margo, the post-personhood human,” and “Margo, the person,” as two individuals or one, they are closely morally related, such that they have a legitimate moral interest in each other. This can work in either direction. Not only does personal integrity remain relevant to “Margo, the post-personhood human”; it is also part of the prudential interests of “Margo, the person,” to ensure that her future post-personhood self is well provided for.

So where does that leave us? “Margo, the post-personhood human” is not a moral stranger to “Margo, the person,” and so whatever the intuitive repugnance of killing her, it can’t arise from that. Nonetheless, the intuitive repugnance of killing Margo is difficult to dismiss as groundless prejudice, and the intuition isn’t limited to those who downplay the relation between the preimpairment and impaired selves (e.g., Dworkin 1993, pp. 228–29). Similarly, it doesn’t seem quite adequate to rearticulate our intuitive concern as arising from some moral rule that is external to Margo, such as a general moral principle against passive euthanasia of a contented human—our concern is for Margo, not merely triggered by her. Insofar as this concern has a rational basis, it lies in the implication that Margo’s current interests should be wholly subjugated by the pursuit of her former goals and values. On this interpretation, the concern that motivates the other self thesis is that Margo’s life has moral worth of a kind that is not extinguished by the antipathy that she previously held toward such an existence. That is, Margo, in her post-personhood state, attributes value to her life in such a manner that she has serious moral worth that is independent of “Margo, the person.”

A hypothetical case example may assist in more precisely defining my concern. What if a patient, “Bill,” had for his entire adult life kept an unwavering belief in the moral and spiritual value of flagellation, wherein he would arrange to be savagely whipped as a means of suppressing his material desires and building his character? In order to ensure that his valued practice is not disrupted by the onset of dementia, Bill makes an advance directive demanding that his future mentally impaired self be savagely whipped each week, and he finds someone willing to carry the whipping
out. The example is absurd, but that is the point: its purpose is to show that the absurdity of the request matters. For simplicity, let’s assume that there is no self-deception going on, and that Bill deeply values this practice far more than the experiential suffering it causes. The advance directive isn’t demanding anything that goes beyond what we would allow Bill to do if he was choosing contemporaneously and in a mentally competent state of mind. That is not to suggest that the surviving interests thesis would treat Bill’s well-being as a triviality. But, as Dworkin (1993, pp. 201–6) argues well, a life in which one successfully pursues one’s central nonexperiential goals is a better life than one in which one sacrifices those goals for experiential contentment. Say that Bill’s commitment to flagellation is as central as Margo’s hostility to extended advanced dementia and presumably of comparable importance to his personal integrity. It seems beyond absurd that we would view the advance directive as legitimately authorizing what is, essentially, torture carried out on a vulnerable and mentally impaired patient. We could create similar, admittedly far-fetched, examples by replacing the advance directive with one that contains instructions that are degrading or exploitative; say where the person requests that her future impaired self be spat on or (to fulfill her preimpairment commitment to protesting the global inequalities in availability of health-care) be denied all pain relief. The point is not that these are realistic risks that require protecting against but that the pursuit of personal integrity through our future, severely mentally impaired, selves is subject to limits that do not apply when making the same decisions contemporaneously. Of course, these all involve the infliction of positive abuse. That in itself might be a significant moral distinction from the withholding of life-saving treatment under heavy pain relief. But that simply emphasizes that the patient’s post-personhood interests matter and that they matter in a way that is not predetermined by the relevance placed on them by the person she once was. The impaired patient has moral worth that is independent of her preimpairment goals and values and that limits the authority of her preimpairment instructions.

I will now try to rearticulate the concern that underlies the other self thesis. Whatever the value of the patient’s commitments prior to her loss of personhood, it is not the only value that matters. The patient has moral worth independently of the person she was. The concern at the heart of the other self thesis is that by sacrificing a patient’s experiential interests to implement her advance directive, we are not respecting her independent moral worth but rather are treating her as a mere vessel for the interests of
the person she once was. If we are to respect the patient’s interests both in her own current moral worth and in the person she once was, we need to look beyond the face of her advance directive. We must inquire whether the importance of the advance directive’s contribution to the patient’s personal integrity outweighs that of the experiential interests that would be sacrificed through withholding treatment.

In making this comment, I feel obliged to address a passage from the proclamation that has become known as “The Philosophers’ Brief”:

A person’s interest in following his own convictions at the end of life is so central a part of the more general right to make “intimate and personal choices” for himself that a failure to protect that particular interest would undermine the general right altogether. Death is, for each of us, among the most significant events of life. (Dworkin, Nagel, Nozick, et al. 2007, p. 492)

I agree strongly with this declaration. My concern is not that too much importance is being placed on a person’s interest in “in following his own convictions of the end of life” but rather that we are misconstruing that interest. In the context of the other self thesis, withholding life-extending treatment would not promote the patient’s own convictions but rather her previous convictions. By sacrificing the things that the patient now cares about for those that she once cared about, we risk foisting onto her an inauthenticity that runs contrary to the interest that Dworkin and his coauthors urge us to protect.

If we are to accept that our interest in personal integrity continues past our loss of personhood, we must also accept the implication that we are not just persons. Underlying the importance that “The Philosophers’ Brief” gives to convictions is an interest in living in accordance with one’s own attribution of value. For those with the capacity for personhood, their “attribution of value” is reflected in their deeply held goals and values. They attribute value not only to particular experiences and objects but to ways of life. The claim to personal integrity requires that we respect this attribution of value, allowing those with the capacity for personhood to shape their lives in a manner consistent with their deeply held goals and values (Feinberg 1984, pp. 52–97; VanDeVeer 1986, pp. 124–27; Kleinig 1983, pp. 27–30; Brock 1988b; Scoccia 1990). Those who lack the capacity for personhood are incapable of evaluating complex goals and values and of “shaping” their lives in the manner required for personal integrity. However, they can attribute value to their experiential interests, such as happiness or contentment, independently of their preimpairment.
views. This attribution of value cannot, strictly speaking, be the basis for an interest in “personal integrity.”

Nonetheless, the ability to imbue one’s life with value is not an “all-or-nothing” capacity, and nor is it the sole domain of persons, or even of humans (Singer 1993; Taylor 1989, pp. 27–30). Similarly, nonpersons are entirely capable of withholding value from complex goals and values. It would be absurd to suggest that simply because a duck is not mentally capable of evaluating the great English hunting tradition, we can’t be confident that the duck values its experiential interests more than it values that tradition. From the duck’s incapacity to evaluate the tradition we may safely infer that the duck does not value it—we have no need to look for some earlier miraculous display of avian mental competence in order to ascertain the duck’s attribution of value. It is at least as absurd to refuse to credit mentally impaired humans with substantial capacity for attributing and withholding value.

Respect for personhood is just one aspect of the broader principle of respect for the independent moral worth of other sentient beings. Insofar as a mentally impaired patient is capable of imbuing her life with value, we are obliged to respect that value. While this is not a claim to personal integrity per se, it is respect for integrity nonetheless—a demand that we determine the patient’s good by reference to her own attribution of value. As such, respect for the patient’s “life as a whole” requires that we not only consider the goals and values that informed her advance directive but that we also observe how her attribution of value has changed since that time and respect her interest in living and dying in a manner consistent with that value.

**Self and Surviving Interests**

In seeking to reconcile the “surviving interests” and “other self” accounts, I have made the following two claims: that the post-personhood patient has serious moral worth that is independent of the person that she once was and that the post-personhood patient is part of the life of the person she once was, such that her way of living, as well as the manner of her death, influences the integrity and value of that person’s life as a whole.

These two claims are not conceptually contradictory; to the contrary, taken together they mirror some common attributions of moral worth. For example, I have moral worth that is independent of my status as a member of a family, while at the same time, I am a member of a family, such that my way of living is relevant to the well-being and value of that
family. My claim to independent moral worth does not preclude me from having obligations to my family, and the severely mentally impaired patient’s independent moral worth does not preclude the person she once was from having good moral claims over her way of life.

Nonetheless, the notion of holding moral worth independently of one’s own former self requires some explanation. In accepting the general thrust of the surviving interests account, I have sought to avoid the Parfitian claim that we are numerically different individuals from our future selves. Rather than describing a moral conflict between different individuals, the claim that the severely mentally impaired patient has independent moral worth should be understood as a claim about “the good life” for an individual, as matter of viewing her life as a whole. In particular, it is a claim about the extent to which personal integrity determines “the good life” for an individual.

I outlined the appeal to personal integrity in the second section of this paper. Ordinarily, so the appeal goes, the good life for us is one lived consistently with our own deeply held goals, values, and convictions, that is, it is a life that is consistent with our own attribution of value. Following this line of reasoning, a patient’s informed choices are the ultimate indicator of “the good life” for that patient: the patient’s own attribution of value is the authoritative arbiter of her life’s independent moral worth. In any conflict between autonomy and well-being, autonomy must always win out, as the patient’s well-being only matters to the extent that she values it (insofar as we are talking only of the patient’s self-oriented concerns). Under my account, the patient’s preimpairment attribution of value is not her life’s only source of value, independently of other persons. In saying that a post-personhood patient has moral worth independently of the person she once was, we assert that her current (post-personhood) experiences can, if positive, imbue her life with value regardless of her preimpairment attribution of value. That is, in settling a conflict between the patient’s preimpairment autonomy and her well-being, we ought to take into account two competing attributions of value: the patient’s preimpairment goals and values and the patient’s post-personhood appreciation of positive and negative experiences. Where the patient’s directive is only of moderate importance to her preimpairment attribution of value but would be catastrophic with regard to her post-personhood attribution of value, we have good reason to subjugate the patient’s autonomy in protection of her well-being.

The “surviving interests” account cannot by itself adequately explain why moral limits should apply to the fulfillment of goals that deeply
characterize a patient’s preimpairment personhood where that fulfillment would be permissible were the patient still competent—that is, it cannot explain why flagellation or painful but safe electric shocks could be delivered to a competent and consenting individual but not to a severely mentally impaired human under their instructions by advance directive. Extrinsic explanations, such as potential harm to the reputation of the medical profession, misconstrue the target of our moral horror by making it seem as though the patient is only incidental to the grounds for her own protection. My account explains these limitations as a feature of the patient’s own interests and thus provides an initial basis for doubting the blanket moral authority of advance directives—not by denying the appeal to personal integrity but by constraining it with a consideration of the patient’s ongoing attribution of value. The patient is not just an extension of the person she once was but imbues her life with value and moral worth through her experiences of happiness and contentment.

RESOLVING THE CONFLICTING CLAIMS

I have argued that the moral authority of an advance directive ought to be constrained by an obligation to respect the independent moral worth of the patient in her severely mentally impaired state. This obligation becomes the fundamental question to be asked when determining whether an advance directive refusing treatment should be implemented: is the advance directive compatible with respect for that patient’s worth or does withholding treatment here instead implicitly reduce the patient to a mere extension of the person she once was?

Some possible instructions could be so horrific that they could never be carried out while respecting the patient as the bearer of serious moral worth—for example, it would be out of the question to impose significant and unnecessary suffering or deliberate degradation. To carry out such instructions with respect to a severely mentally impaired patient would entail such abject cruelty that they could only appear warranted by viewing the patient entirely as an extension of the person that the patient once was rather than as a being with serious moral value in her own right. The patient is capable of experiencing suffering but incapable of understanding the reasons for which we impose it, leaving her tortured and confused. The patient’s ignorance and resulting fear magnify the harm imposed by such suffering beyond any plausible benefit. The withholding of life-extending treatment, if done with negligible suffering, is not inherently such a case. The compatibility of passive euthanasia with respect for the patient’s worth
depends on our resolving the conflicting claims of the values protected
by the advance directive (as per the surviving interests account) and the
patient’s ongoing experiential interests.

In resolving these claims, we can begin by noting the obvious: that
many patients aren’t as happy as Margo and aren’t capable of such vivid
experiential interests and that not all advance directives are equally vital
to personal integrity. While such cases are less philosophically interesting,
it is worth noting that there are “easy” cases as well as moral dilemmas
such as Margo’s. For example, there are cases in which the patient’s un-
happiness leaves us with no reason to override her advance directive and
in which a patient’s advance directive is grounded entirely in an ultimately
misplaced fear that her post-personhood life will characterized by suffering.
Elsewhere, a patient may be the subject of concern simultaneously
under both the “surviving interest” and “other self” accounts. We face the
dilemma of choosing between two moral concerns that would otherwise
be morally essential: a person’s interest in imbuing her life as a whole
with meaning and her moral worth as a sentient being in pursuing a life
of positive experiential interests. There is no need, as we have seen, to
construe this as a contest between two separate moral beings, nor is the
dilemma adequately characterized as a trade-off between personal integ-
rity and well-being. Rather, we are concerned with how to interpret an
individual’s interest in living a life that embodies her attribution of value,
under circumstances where her present and ongoing attribution of value
consistently differs from that which characterized her as a person. Dworkin
directly addresses this conflict: “There is a conflict between Margo’s prec-
edent autonomy and her contemporary experiential interests if she is still
enjoying her life, but there is no conflict with her critical interests as she
herself conceived them when she was competent to do so” (1993, p. 230).

That is, there are two attributions of value by Margo that warrant our
moral concern, but only that attribution associated with “Margo, the
person,” is consistent with Margo’s efforts to give her life, as a whole,
meaning through the pursuit of her critical interests. Nonetheless, leading
a meaningful life is not an all-or-nothing matter. Most people do not get
the opportunity even to make an informed and relevant decision about the
final stages of their life, let alone have those plans implemented. They die
through accident or unexpected illness, or before they have given thought
to their mortality, or under circumstances in which they feel deeply alien-
ated by all possible choices. Many people consider deaths of this kind to be
particularly tragic, despite their frequency. A large part of this extra tragedy
comes from the loss of the opportunity to follow one’s goals and values in death. Yet we often have little difficulty in reconciling this tragedy with the view that the person’s life had great meaning when taken as a whole.

What the surviving interests thesis makes clear is that there is a certain type of person for whom control over the final stages of her life is utterly crucial to the meaning and value she finds both in her death and in her life as a whole. The kind of cases I have in mind here are those where a person’s life is characterized largely by self-sacrifice and self-deprivation that only become valuable to that person through their contribution to some greater goal or project that spans to the end of the person’s life. Religious and ideological projects provide some of the clearest examples. The Jehovah’s Witness’s refusal of blood transfusions is nonsensical, even to the person herself, without the context of that person’s larger project of living in accordance with a particular religious code. More importantly, the same can be said for the rest of the efforts and sacrifices that go toward “following her religious code.” By forcing a blood transfusion upon the Jehovah’s Witness, we deprive all of those efforts and sacrifices of that necessary context. Insofar as the person’s life is characterized by the pursuit of the life project of “following her religious code,” we trivialize her life by overriding her refusal of treatment.

This quality is not unique to moral and religious commitments. Rather, it arises because such prescriptions go beyond directing individual choices to set out a conception of the kind of person one wants to be and the kind of life one wants to live. These are commitments concerning the whole of one’s life, drawing one’s past and future choices together into a unified project. We could replace the example of the Jehovah’s Witness with that of a quintessentially independent person who views her self-sufficiency as part of a broader goal of living an independent life in which she is not to be reliant on others financially or for day-to-day personal care. By the “quintessentially independent person,” I mean someone for whom independence is a project that is embodied in her broader way of life: self-sufficient independence is a project that she has strived for and that shapes her choices and her self-conception. That is, she attributes value to the overall project of independence itself, as something distinct from the choices that comprise it and the satisfaction she experiences through being self-sufficient. As with the Jehovah’s Witness’s religious practice, this means that the meaning and worth of her prior efforts are contingent on the success of the overall project. The quality of the person’s final years can reshape the worth of her life, as measured against her own attribution of value.
These are extraordinary projects, representing one extreme with regard to differing views of what makes a life meaningful. The “quintessentially independent person” is not just someone who deeply values independence—in fact, it is not strictly necessary that such a person enjoy the minutia of such independence at all (though it would be a truly bizarre goal were that the case). The defining feature of such life projects is that the person attributes value to the “greater goal” of the life project as a whole rather than to the goals and values that comprise that greater goal. Certainly, the concept of a life where one commits oneself to the accomplishment of life projects, making sacrifices if necessary, forms one common concept of the good, and one that is strongly conducive to enabling the overriding emphasis that the surviving interest places on the fulfillment of a person’s prior goals and values. But we may contrast it with another concept of the good life, one in which we find nonexperiential value in things enjoyed for their own sake. This has become a cliché with regard to the arts, as in the concept of the musician who is dedicated to music “for its own sake” or the playwright who writes plays “for the sake of good theater.” To the person who has such a conception of what constitutes a meaningful life, the idea of attributing value not to her immediate commitment to art but to the greater goal of “living a life characterized by artistic achievement” may seem hollow, perhaps even self-defeating. A person who holds this concept of a meaningful life may ask what possible benefit there might be to being “a quintessentially independent person,” above the value one finds in one’s immediate commitment to independence. Similarly, we can distinguish between the life project of the Jehovah’s Witness who follows a religious code and that of the person who finds value in the minutia of religious commitment, such that her religious practices have meaning to her regardless of whether they are steps toward the accomplishment of a greater goal.

The latter type of “meaningful life” is not so malleable in its final stages as would be presumed by an overriding emphasis on the person’s surviving interests. This is because the person has already taken value from her commitments in a way that cannot be undermined through later incapacity. If there is value in my immediate commitment to composing music, and I spend a time doing that, I do not lose that value if I cease composing music. I would, all else being equal, have a better life were I able to compose music for fifty years rather than compose music for thirty years and then lose the capacity to do so owing to advancing dementia, but the same would apply were my loss of capacity caused by death, pursuant to an advance directive, rather than dementia. Nonetheless, it is conceivable
that I might take composing music to be so central to what I find good about life that I cannot imagine myself living a worthwhile life without it (from Kadish 1992, pp. 871–88). My motivation, in this case, is not the completion of a life project but the prevention of a way of life that I do not value. Implicit in this is the denial that my future satisfaction has moral legitimacy—that is, it implies that such a life lacks serious moral worth because I do not presently value it, regardless of my attribution of value at that future time.

Where this type of motivation comprises the sole reason for the advance directive and at the same time euthanasia will deprive the patient of a happy life, I cannot reconcile euthanasia with respect for the patient’s independent moral worth. My concern is that euthanasia in this context seems to involve a kind of contempt for the moral worth of the impaired patient; that rather than being grounded in the pursuit of some vision of the good life, it is primarily concerned with the denial that value could be found in a severely mentally impaired life. Here, euthanasia seeks to promote the patient’s overall interests by preventing a way of life rather than promoting one. Euthanasia cannot restore or extend the patient’s ability to lead a life that is independent of others or to write fine literature or do any of the myriad things that are unavailable to the severely mentally impaired. Instead, it is grounded in the notion that the patient’s overall life is richer if we prevent her from living those ways of life that are open to the severely mentally impaired. That is, being unable to live the way of life that was important to her prior to advanced dementia, the patient cannot go on to discover a different way of life that has serious moral value. Where the patient has gone on to imbue her postimpairment life with great value through her ongoing happiness, this assertion—that the good life for the patient can only be pursued through her preimpaired goals and values—is akin to a statement of contempt for the mentally impaired patient’s attribution of value.

These are moral extremes rather than being representative of actual people making advance directives. The very act of making an advance directive may amount to a declaration of a life project directly concerning the final stages of one’s life. But it may also be motivated by fear an inability to imagine oneself with different views, prejudice against the mentally impaired, concern for one’s close relationships, or the myriad of emotions and motivations that our mortality provokes. Most people, as Dworkin states, “want their deaths, if possible, to express and in that way vividly to confirm the values they believe most important to their
lives” (1993, p. 211). But the amount that they invest in the final shape of their life, as well as what they stand to lose if we override their advance directive, varies between individuals. This human diversity demands that we look beyond the face of the advance directive to determine the role it plays in that individual’s life.

I cannot hope to provide a comprehensive stipulation of the factors that would render an advance directive refusing treatment morally just or unjust. Moreover, such a stipulation may not be advantageous. Even when providing a loose distinction of the kind I have given, there is a risk of encouraging others to see the relevant principles in terms of a set of rules governing when medical staff should be bound by an advance directive. This is misleading, as it makes out the constraint to be a far more legalistic matter than it is. The moral authority of the advance directive is constrained by nothing more than an obligation to respect the moral worth of the patient to whom it is applied. My concern so far has been to argue that such advance directives can, on occasion, lead to moral hazard and that we ought to look beyond the face of the advance directive. The actual means taken to safeguard the patient’s interests do not need to take the form of a universal and comprehensive policy stipulating the circumstances in which advance directives should be implemented. Moreover, I fear that such a universal policy would risk an unwarranted extension of paternalism, leading to the patient’s own attribution of value being replaced with that which underlies the policy. In the next section I suggest that our obligation to respect the patient’s independent moral worth may be most appropriately safeguarded through the participation and oversight of a substitute decision maker appointed by the patient herself. I make this suggestion without consideration of the practical matters of politics and law, such as the effect on overlitigation and the feasibility of enforcement. For this reason, and given the limited space available, my comments in the next section should not be taken as anything more than a preliminary suggestion. Nonetheless, having argued for a constrained use of advance directives to request passive euthanasia, I feel obliged to give some indication of how this constraint might be relevant to the practical implementation of such advance directives.

IMPLICATIONS AND SHORTCOMINGS

On this articulation, the other self thesis does not imply that we should never implement an advance directive refusing life-extending treatment in the event of severe mental impairment. In that manner it is narrower
than at least the versions put by Dresser (1994; 1995) and Robertson (1991). Nonetheless, it implies that we cannot know whether an advance directive is just without considering both the reasons the person had in making the advance directive and the extent of her current enjoyment of life. This is problematic for the practice of advance directives in the United States and as envisaged by Brock (1988a) in his description of advance directives as “performative utterances.” Under that practice, the means by which advance directives carry out their function of protecting personal integrity is that once properly executed, the advance directive is legally binding (Bogdanoski 2009; Cantor 1993; Samanta and Samanta 2006). By describing advance directives as “performative utterances,” Brock is noting that they are not simply requests regarding future treatment. They are rather instructions that are to be evaluated with regard to whether they fall within the social and statutory authority invested in that practice and not in relation to the adequacy of the person’s reasons in that particular case. If the concerns I have raised in this paper are warranted, this existing version of the advance directive is poorly suited as a means of determining whether a patient’s death should be hastened. A process whereby we implement the letter of a properly executed advance directive is well suited to a scenario where one’s moral authority is unfettered by a need to consider values other than one’s immediate goals and values. Our moral authority over our future, post-personhood, treatment decisions is constrained by the independent moral worth of our future post-personhood life. This suggests a need for a kind of supervisory discretion that is at odds with treating the advance direction of passive euthanasia as a performative utterance.

Nonetheless, such decisions are not well suited to judicial oversight either. The moral authority of an advance directive refusing life-extending treatment turns on a great deal of information that is extraneous to the person’s instructions. In particular, it involves the goals and projects that motivated the person to create the advance directive and the role that these goals and projects play in the person’s life, as well as how overriding the advance directive will affect the meaning and value of the person’s prior efforts. A judicial body would face insurmountable evidentiary difficulties if it were charged with assessing the justifiability of an advance directive refusing life-extending treatment in terms of the considerations that I and others have raised, if such an advance directive was to retain the same form as that of advance directives in general.
Having said that, I believe that decisions regarding euthanasia require us to reenvision what an advance directive should be and how it should operate. An advance directive refusing life-extending treatment should combine the patient’s instructions with what is effectively an application to have those instructions carried out. The advance directive should serve as a source of information that others can use to situate those instructions in the context of the person’s life and projects. The advance directive should make out the person’s case for withholding treatment, explaining how her commitments or convictions would be undermined by an extended life of severe mental impairment. For example, where refusal of treatment is vital to a patient’s moral code, the advance directive should record not only the patient’s moral objections but should also detail the manner in which this moral code has permeated the patient’s overall life, the self-sacrifice the patient has made in pursuing those ideals, and the loss that the patient will endure if treatment is imposed. This notion of an extensive advance directive, giving context for the instructions contained within, is certainly not new to bioethics (see, e.g., Emanuel, Danis, Pearlman, et al. 1995), though it has greater urgency in a context where another party is tasked with looking beyond the face of the patient’s bare instructions. Such advance directives are typically envisaged as being produced through a process of consultation with the patient’s doctor and, if necessary, others who through training will know what considerations the patient ought to take into account.

Even with such information being supplied within the body of the advance directive itself, the presence of a supervisory body introduces another layer of paternalistic intervention. Where this body is called on to assess the moral worth of the projects protected by the advance directive and of the patient’s ongoing experiential happiness, there is a potential for the supervisory body to unjustly substitute their own values for those of the person for whom it decides. This risk is present with any supervisory body, but some are more prone than others. While a judicial body may be most reliably bona fide in its attempt to avoid such substitution (if that is demanded of it in the law), it is poorly placed to adopt and apply the patient’s own values. This by itself may provide good reason to favor a system whereby the maker of the advance directive appoints a limited guardian with power of attorney regarding the advance directive over a system of direct judicial supervision. Such guardians have been discussed as alternatives to advance directives, on some occasions for similar reasons to those I have cited as constraints on euthanasia (Gedge 2004; Lynn,
Teno, Dresser, et al. (1999). Elizabeth Gedge (2004) argues that advance directives fail to capture the *process* of agency and self-governance; we make decisions and form our identities in large part through interaction and dialogue with those close to us, and by appointing such people as our substituted decision makers we may better approximate the choices we would have made. I would add to this the observation that agency and autonomy are not ordinarily pursued through choices that are fixed in time; we reconsider our choices as our goals and values change. To adopt the language of narrative theorists, advance directives reflect our story as it was at that particular point in time, whereas our narrative is more accurately something that progresses and adapts to changing capacities and circumstances. A substitute decision maker may be better placed to assess one’s choice in light of one’s life story as ongoing, especially in light of changes to one’s capacities and values.

An advance directive in this reenvisaged form serves as the primary tool available to assist the substitute decision maker by revealing the patient’s goals and projects prior to advanced dementia and by providing a context for those goals and projects. My hope is that a substitute decision maker who is properly informed by the advance directive and who is sufficiently close to the patient to have concern for both her preimpairment goals and her current happiness may better approximate the process of agency while ensuring that the patient’s moral worth is respected. Jeffrey Blustein (1999) recommends a similar method of substitute decision making informed by an advance directive, though he sees its merits more as a means of securing the continuance of the person’s narrative than as a means of adjudicating between competing interests: “Proxy decision-makers are to act as continuers of the life stories of those who have lost narrative capacity, and it provides a defense of the moral authority of advance directives that is immune to the loss of personal identity objection” (1999, p. 20).

Blustein (1999, pp. 30–31) recognizes the independent worth of the post-personhood patient through her experiential interests but appears to view this as a counterweight to the authority of the substitute decision maker. My hope is that the substitute decision maker may be charged with concern for the patient’s interests as a whole, that is, both the person’s surviving interests and the post-personhood patient’s continuing happiness. Like Dworkin and Kuczewski, Blustein’s account seems to envisage a particular kind of person—one whose life is characterized by life projects that are capable of being meaningfully continued through an advance directive. Even if we allow that some advance directives may represent
the creation of exactly such a life project, this is too narrow a concept of substitute decision making to address the full range of motivations that may underlie a person’s plans for her post-personhood future.

In this final section I have sought to give a brief practical context for the concerns I raise earlier in the paper. My main thesis, however, concerns ethics rather than legal theory. While philosophers have largely supported the use of advance directives to demand that treatment be withheld, I am advocating a more cautious approach. Our implementation of a patient’s advance directive ought to be constrained by our respect for the patient in her current state. This respect obliges us to consider the value of the patient’s life by reference to her current capacities and attribution of value. Thus, I have sought to rehabilitate the “other self thesis” by restating it as a claim about the patient’s interests rather than as about her identity as possibly different and unrelated (or marginally related) individual now from the she was before. I have not sought to rebut the works that I have grouped together as the “surviving interests thesis,” but have opposed the absolutist conclusion often drawn from this account: that the patient’s most important interests are always those that occupied a central role in the life narrative of the person she once was. Finally, I state once more that I agree with the major message of “The Philosophers’ Brief”—namely, the urgency of the moral claim to have one’s convictions followed at the end of one’s life. The supporters of an unconstrained right to have one’s advance instructions implemented do not have a monopoly over those principles. My concern is that the interests underlying that statement of principles should be extended to the patient’s post-personhood life. As Dworkin (1993) puts it, we ought to respect the patient’s life “as a whole.” This requires that we acknowledge that the patient is not just the meandering extension of a person’s life, but that she is capable of serious moral worth that is completely independent of that prior person.

NOTES

1. This is often referred to as “personal autonomy”—I prefer “personal integrity,” because while both terms have multiple meanings, the philosophical over-use of “personal autonomy” invites confusion between the numerous different but related conceptions that it can refer to (Dworkin 1988, pp. 5–10).

2. The boundaries of what constitutes “negligible suffering” may prove to be a critical moral concern.
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