

ADVANCE DIRECTIVES AND THE PROBLEM OF PERSONAL IDENTITY.¹

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Abstract

Two objections against the authority of advance directives for some incompetent persons are advanced in this paper. First, that under a psychological continuity account of personal identity, the authority of existing advance directives for now-demented persons is morally questionable because now-demented persons are different persons from their formerly competent selves responsible for creating the directive. Honoring advance directives in these cases violates contemporaneous autonomy. Second, that even if personal identity does survive dementing illness, honoring advance directives for now-demented persons is nevertheless morally problematic because it violates contemporaneous autonomy, under a certain conception of marginal autonomy of which some demented persons are still capable.

Dementing illness poses a special problem for the implementation of advance directives. Suppose a now-incompetent person potentially changes her preferences regarding treatment. Suppose further that she is not competent to create a new advance directive, nor can she clearly articulate new preferences or revoke the existing directive. Should her existing directive have authority? Two different accounts offer different responses to this problem. On the first account, existing advance directives do have authority because only competent persons have a right to autonomy and thus a right to plan for their future. Following existing advance directives is a legitimate exercise of precedent autonomy. This first view is predicated on certain assumptions regarding personal identity. Proponents of precedent autonomy, most notably Ronald Dworkin, presume personal identity survives dementing illness. According to the second view, precedent autonomy does not have authority over conscious, incompetent persons because as a result of dementing illness, the now-incompetent self and the prior, competent self are different persons. This second view is also predicated on a fact about personal identity—that personal identity does not survive dementing illness. According to this second view, contemporaneous autonomy trumps precedent autonomy because honoring precedent autonomy imposes preferences and values of a different person, the formerly competent self.

I will argue against Dworkin's view on the authority of precedent autonomy. I argue that personal identity does not survive dementing illness given a psychological continuity account of personal identity. Because demented persons suffer a loss of personal identity, their now-incompetent self is not identical to

their formerly competent self. If correct, then exercising precedent autonomy by following advance directives is not morally legitimate because doing so violates contemporaneous autonomy. Even if personal identity *does* survive dementing illness, and Dworkin is correct, respecting the authority of contemporaneous autonomy is still appropriate given an account of autonomy that differs from Dworkin's.

Dworkin's Integrity View of Autonomy: Implications for the Demented Self

In "Autonomy and the Demented Self," Dworkin (Dworkin, 1986: p. 4-16) argues that precedent autonomy should be honored in the context of health care decisions, including end-of-life decisions. Dworkin claims that persons who are presently incompetent do not have a right to autonomy, and therefore should have no legitimate role as decision makers in the context of their own health care.

Dworkin offers a view of autonomy he refers to as the integrity view. On the integrity view, the agent is treated as the subjective experiencer of a unique life. The agent's decisions constitute an integrated whole—the narrative of the agent's life. On Dworkin's integrity view, in order for a person to possess autonomy, she must recognize and appreciate her decisions as part of a greater, coherent whole—the whole that is her life. Given such a view of autonomy, one can only have the right to autonomy, in the relevant sense, if one can appreciate her decision as being concordant with her other values. According to Dworkin, a person has a right to autonomy depending on the "degree of that patient's capacity to direct his or her life in accordance with a recognized and coherent scheme of value, that is, capacity for authenticity and integrity" (Dworkin, 1986: p. 9).

Dworkin's account of autonomy as given by the integrity view excludes demented persons from being capable of such autonomy. Quite uncontroversially, given cognitive decline and memory loss, dementia patients do not appreciate their decisions within the greater framework of a continuous life. They do not, according to Dworkin, "possess the capacity for authenticity and integrity" (Dworkin, 1986: p. 9). Dworkin specifies that a demented person does not possess requisite competence to have a right to autonomy on the integrity view when her choices clearly contradict prior held preferences, or are inconsistent with the values espoused by her competent self. Because demented persons have lost the capacity for maintaining integrity amongst life values, their decisions regarding health care and end-of-life choices should not be respected for the sake of honoring autonomy, since they no longer have such autonomy to protect. The thought is that because demented persons do not have the capacity for autonomous choice and because they are not capable of autonomy on the integrity view, disregarding their preferences does not amount to a violation of autonomy. According to Dworkin, because demented persons do not have a right to autonomy on the integrity view because of their lack of competence required for complex decision-making, their current decisions regarding end-of-life treatment should not be

honored. Dworkin argues that when a person has indicated her health care preferences in advance (i.e. via an advance directive), these decisions of the prior, competent self must be respected in the interest of precedent autonomy—the autonomy of the prior, competent self. Precedent autonomy, not contemporaneous autonomy, has authority because it is only the formerly competent self that had the capacity for autonomous choice and possessed autonomy on the integrity view. Again, not honoring the choices of an incompetent person is not a violation of her contemporaneous autonomy, since she is no longer capable of autonomy. For Dworkin, respecting the precedent autonomy of the demented person does not conflict with respect for her autonomy since she is no longer an agent capable of autonomous choice, or of integrating decisions within the context of a coherent chain of values and commitments.

Dworkin's view of autonomy lends support to his position of giving authority to the end-of-life choices of the prior, competent self. Respecting prior, autonomous choices of the formerly competent self exercises precedent autonomy of this self when these earlier choices govern the future, incompetent self. If the kind of autonomy required for persons' choices to be respected is of the Dworkinian kind, then the choices of a prior, competent self are the choices that should be honored. The prior, competent self should be respected, argues Dworkin, because competent persons should be allowed to plan for their futures without interference. Not respecting the precedent autonomy of the now-incompetent person amounts to violating her life plan that she created while competent, thus violating her autonomy. Not respecting precedent autonomy of the now-incompetent person is, for Dworkin, morally illegitimate, and unjustifiably paternalistic. Dworkin concludes that, "autonomy requires enforcing one's prior decisions about one's treatment when demented" (Dworkin, 1986: p. 11). Dworkin's position is further clarified by his statement on the loss of autonomy demented persons suffer. Dworkin states: "his right to autonomy—the right of the person he has become and remains—unambiguously requires that his pleas now be denied" (Dworkin, 1986: p. 13).

Dworkin explicitly acknowledges his view on the authority of precedent autonomy depends on a certain fact about personal identity—that personal identity survives dementing illness. Dworkin's integrity view of autonomy presumes that the person who endures a dementing illness is the same person as the prior competent person. That is, dementing illness does not result in a loss of personal identity; personal identity survives dementing illness. Dworkin's commitment regarding personal identity is consistent with his views on the authority of precedent autonomy. Given Dworkin's view on the authority of precedent autonomy, Dworkin cannot consistently endorse a view of personal identity that affirms the claim that personal identity does not survive dementing illness—doing so would commit him to rejecting the authority of precedent autonomy because one person's will should not have authority over another's. This is a point I will return to.

The Different Person Argument (DPA)

Given Dworkin's position for the authority of precedent autonomy, I now proceed to my argument against Dworkin, in favor of the authority of contemporaneous autonomy. I argue that enforcement of advance directives for now-incompetent patients' amounts to imposing preferences and values of a prior competent person, a person who is a different person from the now-demented person. My argument for the different person position follows.

The Different Person Argument (DPA)

Premise 1: Personal identity is psychological continuity (over time).

Premise 2: Dementing illness is a loss of psychological continuity.

Conclusion: Demented persons lose personal identity. (1, 2)

According to the DPA, the now-demented person is a different person from her prior self, and, the enforcement of preferences and values of the former self is not always morally legitimate.

Support for premise one of the DPA comes from two early modern philosophical accounts of personal identity, those offered by David Hume and John Locke. In addition, contemporary philosophical work on personal identity will support premise one of the DPA. More specifically, Derek Parfit's work on personal identity supports premise one of the DPA.

Hume's Bundle Theory of Personal Identity

Hume's account of personal identity in the *Treatise* (Fate Norton and Norton, 2001) lends support to premise one of the DPA. According to Hume, all we can be directly aware of is the present contents of perceptual consciousness, or ideational mental content, which is exclusively derived from experientially given sensations, or impressions. For Hume, the self just is a collection of these perceptions, or, the conscious mind. Hume argues that the self is a bundle or collection of perceptions appearing to be connected to each other via some uniting principle. On Hume's account, our notion of personal identity arises from supposing there is a connection amongst our perceptions, binding them into the conceived self. Remaining consistent with his empiricism, however, Hume concludes that we cannot know there is such a connecting principle since experience gives us no firm evidence warranting such a conclusion; rather, our imagination imposes a connection onto our collective perceptions.

Despite Hume's epistemological skepticism regarding knowledge, his account clearly supports premise one of the DPA insofar as he advances a necessary condition for the enduring self—some uniting principle that grounds the self. For example, Alzheimer's patients have lost awareness of this connection due to memory loss. For persons in whom this relation of connectedness does not obtain, personal identity is disrupted.

Locke's Psychological Continuity Account of Personal Identity

In *An Essay Concerning Human Understanding* (Nidditch, 1975), Locke advances a psychological continuity account of personal identity.² For Locke, personal identity consists in consciousness, where consciousness is understood as the awareness of a continuing, enduring self. Consciousness for Locke is just the individual understanding herself to be the same thinking self over time, or a continuous, subjective participant of a life (Nidditch, 1975). Also integral to Locke's view is that personal identity consists in sameness of consciousness over time. For Locke, it is memory that makes a person's consciousness remain the same over time. And it is, to use Locke's terms in the "same consciousness" (Nidditch, 1975: p. 10) that is the self and makes the individual intimately aware of the self as a self. It is memory, then, that is the connecting principle amongst a person's psychological aspects that preserves sameness of consciousness, or the self (Nidditch, 1975).

Given Locke's view on personal identity, memory is integral to same consciousness or personal identity over time. Locke's view of personal identity is positive evidence for premise one of the DPA. Given Locke's conception of personal identity, demented persons such as Alzheimer's patients suffer from a disruption of personal identity.

Parfit on Psychological Continuity

Outside of the early modern period within a contemporary context, Derek Parfit's *Reasons and Persons* (Parfit, 1986) importantly contributes to contemporary philosophical thinking about personal identity. Unlike his early modern predecessors, however, Parfit does not agree that personal identity consists in psychological continuity, but he does argue that psychological continuity is what matters to us in terms of survival.³ Because Parfit thinks that what matters to us in terms of survival is psychological continuity, psychological continuity is integral to our conception of the self, even if, for Parfit, psychological continuity is not what constitutes personal identity.

Parfit's account of psychological continuity is similar to Locke's view of psychological continuity. On Parfit's view, psychological continuity is established by psychological connectedness, where psychological connectedness is based in memory. Psychological connectedness obtains amongst an individual's mental states when she remembers at least some of her past experiences as her own. Psychological connectedness does not, for Parfit, only have to obtain amongst memories in order for psychological continuity to be present. Parfit allows for other psychological aspects or facts such as beliefs, desires, and intentions, which,

if connected in the relevant way, or are continuously held by the person, constitute psychological continuity.

While Parfit does not share the view that personal identity consists in psychological continuity, that psychological continuity is what matters to our conception of the self and lends support to premise one of the DPA. Persons who suffer from dementing illness such as Alzheimer's Disease (AD) lose personal identity because their psychological continuity is disrupted due to impairments affecting memory.⁴

Psychological Continuity and Alzheimer's Disease (AD)

The following is a brief review of the symptoms of Alzheimer's Disease (AD) as an example of a disease that causes dementia resulting in cognitive impairments and losses. This evidence supports premise two of the DPA, that AD is a loss of psychological continuity.

AD is a progressive and irreversible neurological disease affecting the brain, leading to dementia. AD is characterized by progressive cognitive and functional decline (Hurley and Volicer, 2002). The earliest stage of AD is characterized by memory impairment and personality loss (Hurley and Volicer, 2002). As AD progresses, memory loss becomes more severe, including long-term memory loss in addition to initial short-term memory loss. What begins as memory being affected in terms of recalling recent events, progresses to long-term memory loss in which the individual does not identify or remember past events of her life. In the earliest stages of AD, however, a patient can still participate in meaningful, complex decision-making (American Academy of Neurology Ethics and Humanities Subcommittee, 1996).⁵ Being a progressive disease, the symptoms of AD increase in severity over time. Over the course of AD, the patient suffers from a substantial loss of cognitive functioning and verbal communication, preventing meaningful comprehension and capacity for complex decision-making as well as verbal communication of current preferences, interests and values. Given this description of AD, it is clear that AD is the loss of psychological continuity.

Returning to the DPA, positive evidence for both premise one and premise two have been offered, thus supporting the conclusion of the DPA. Demented persons do lose personal identity. By implication of the DPA, the formerly competent self and current, incompetent self are different persons.

The Moral Problem of Precedent Autonomy

Thus far the argument is conclusive that on a psychological continuity view of personal identity, a now-incompetent person is a different person from her formerly competent self. Because a person's identity does not survive disruption of psychological continuity, following an advance directive of a formerly competent

person is more properly understood as paternalistic and not a legitimate extension of precedent autonomy, as Dworkin argues. If this conclusion is right, then it poses a special problem for the application of advance directives that were created by a different, competent person. The moral problem is not whether the preferences of the prior self mirror the preferences and values of the current, different self. Indeed, it would be ideal if these preferences did coincide. Rather, what is at stake is the moral legitimacy of enforcing the preferences and values of one person onto a second person. According to my position against the authority of precedent autonomy, in which respect for autonomy does not entail respect for precedent autonomy (Davis, 2002), advance directives governing conscious, but incompetent persons are more properly viewed as extending the autonomy of a former, different self. Following the end-of-life instructions specified in an advance directive created by a formerly competent person amounts to imposing the preferences and values of one person onto another. (The advance directive in these cases, where personal identity has been affected from a disruption in psychological continuity, should be more properly thought of as a surrogate decision-making tool of sorts.) Enforcing the preferences and values of the surrogate is, in some cases, morally illegitimate.

To clarify my position against the authority of precedent autonomy, (as enforced when following advance directives for conscious, incompetent persons), it applies only to a certain population of incompetent persons. This position does not apply to the incompetent persons who are so severely demented so as to be substantially unresponsive to various stimuli. Neither does this view apply to unconscious persons. In these cases, provided existing advance directives, following such directives may be the only guide to end-of-life care in which the former self is the most suitable surrogate. Following advance directives in these cases, where following existing advance directives for incompetent persons still should be understood as enforcing the preferences of a former, different self, does not violate autonomy because the capacity for autonomy is absent. Enforcing the preferences of a surrogate, that is, of the formerly competent self, is appropriate in these limited cases. Since contemporaneous autonomy is not violated in these cases, respecting the authority of the advance directive is appropriate and legitimate.

There are cases, however, where following advance directives is not morally legitimate. These are cases in which an incompetent person may not have the capacity for autonomy required to create a new advance directive, or perhaps cannot verbally express the desire to revoke an existing advance directive. These persons still have preferences and values, and by virtue of possessing these values, do possess marginal autonomy. While it may not be appropriate to enforce the particular preferences (or requests) of the now-incompetent person, as doing so will not enhance (Jaworska, 1999) what contemporaneous autonomy she has, incorporating her values and preferences into the decision-making process regarding end-of-life treatment is morally required to honor contemporaneous autonomy (Jaworska, 1999). It is my view that dismissing conscious, incompetent persons from this decision process altogether is morally inappropriate as it violates what contemporaneous autonomy these persons do possess.

In sum, then, for the conscious, incompetent person who cannot articulate new end-of-life preferences, or create a new advance directive due to competency status or physical inability to express the desire for revocation (of an existing advance directive), exercising precedent autonomy is not legitimate. The instructions detailed in the advance directives may coincidentally mirror the genuine preferences and embody the values of the now-demented individual, however, following advance directives is not a legitimate exercise of precedent autonomy because doing so advances the autonomy of the formerly competent self, a self as I have argued, is a different person from the current, incompetent self.

Given my objection against the authority of advance directives for a certain population of incompetent persons, let me offer some suggestions for how the decision-making process should proceed in such cases. As I have suggested, advance directives governing care for demented persons are tools for surrogate decision-making, and are only appropriate for certain kinds of cases. Insofar as advance directives are surrogate decision-making tools, however, efforts must be made for honoring the interests and values of the current person, not the former self. Even though the incompetent person may only be capable of marginal autonomy, considering the values of the current incompetent person is morally imperative, as not doing so violates their (admittedly marginal) contemporaneous autonomy. Practically speaking, I am not advocating enforcing their decisions or preferences when they do not result from rational deliberation. Rather, I am advocating incorporating these preferences and values into the decision-making process. Respecting contemporaneous autonomy in this sense does not entail honoring particular treatment decisions or requests, especially if the patient is incapable of complex decision-making. However, in spite of this limitation, efforts should be made to incorporate contemporaneous preferences and values of the incompetent person. These values should guide end-of-life decisions.

Thus far this paper has advocated the integration of current preferences and values into the end-of-life decision process is one that is also advocated by Agnieszka Jaworska in her “Respecting the Margins of Autonomy: Alzheimer’s Patients and the Capacity to Value,” on a similar account of marginal autonomy. On Jaworska’s account, marginal autonomy is defined as the “capacity to value” (Jaworska, 1999: p. 109). My notion of marginal autonomy is similar, though different. On my account, a demented person is capable of autonomy so long as she possesses values and preferences. In this respect, then, my notion of marginal autonomy is less strict than Jaworska’s.

My suggestions entail incorporating incompetent persons into the end-of-life decision-making process more so than they currently are so included. According to Dworkin, incompetent persons should have no right to autonomy once deemed incompetent. I disagree. I suggest otherwise. Incompetent persons have a right to autonomy, the right for preferences and values to be considered, even if such preferences and values are articulated in other than written or verbal modalities, and ultimately discounted in the final decision. Given the moral problem of precedent autonomy, greater efforts should be made to incorporate incompetent

patients in the end-of-life decision-making process, despite a lack of requisite competence to create new advance directives or physical disability preventing revocation of existing directives.

Autonomy Reconsidered: Autonomy as the Capacity to Value

The DPA argument offered in support of contemporaneous autonomy over precedent autonomy crucially depends upon premise one, that personal identity consists in psychological continuity. If the account of personal identity I espouse is rejected, then the view that I advocate against the authority of precedent autonomy faces a damaging objection. My argument against the moral legitimacy of applying advance directives for now-incompetent persons rests crucially on the prior, competent self and the now-incompetent self being different persons. Even if the account of personal identity I do endorse is shown to be problematic, however, my position against Dworkin can be somewhat salvaged given a different view of autonomy. This account of autonomy should be one in which now-incompetent persons are viewed as having some role in the decision-making process in end-of-life choices, not being entirely excluded from such a role, as Dworkin advocates. Agnieszka Jaworska articulates such an account of autonomy.

In “Respecting the Margins of Agency: Alzheimer’s Patients and the Capacity to Value,” Agnieszka Jaworska redefines autonomy as the capacity to value. According to Jaworska, the capacity for autonomy can be understood in a less strict sense than Dworkin suggests. Contra Dworkin, Jaworska argues that a person is not required to have a coherent conception of the self as a whole in order to be capable of autonomy. Instead, that a demented person can convey personal value via non-traditional modalities, given assistance, is indicative of the person being a valuer, and as such, meets Jaworska’s requirement for marginal autonomy, the capacity to value. Jaworska defines the capacity to value as (marginal) autonomy because a behavior or action that is indicative of some value is “a truly self-given, authentic principle of conduct” (Jaworska, 1999: p. 131). Of the capacity to value being retained in dementia patients, Jaworska comments: “[T]he capacity to value is not completely lost in dementia, and to the extent that it is not, respect for the immediate interests of a demented person is contrary neither to his well-being nor to the respect for his autonomy” (Jaworska, 1999: p. 109).

According to Jaworska’s conception of autonomy, if a person possesses the capacity to value, this in itself is good reason to respect her contemporaneous values. Furthermore, on this account of autonomy, overriding these values by referring exclusively to prior preferences *does* constitute a violation of contemporaneous autonomy. Jaworska’s account of autonomy has implications for those proponents of precedent autonomy in the context of end-of-life decision-making. On Jaworska’s account, for conscious, incompetent persons, advance directives do not have exclusive authority at the expense of violating contemporaneous autonomy of the now-incompetent person who still remains a

valuer. Jaworska remarks:

The fact that a person is no longer competent to make decisions for herself, or that she has lost the thread of her life as a whole, does not imply that her advance directive is automatically authoritative or guiding what should happen to her. So long as the person is still a valuer, current decisions on her behalf ought to take seriously her current values (Jaworska, 1999: p. 137).

Given Jaworska's defense of the authority of contemporaneous autonomy contra Dworkin, even if the account of personal identity I advocate is rejected, the moral problem of precedent autonomy still remains, despite Dworkin's efforts. Contemporaneous autonomy has moral precedence over precedent autonomy, irrespective of the theory of personal identity one holds.

Concluding Remarks

We have a moral imperative to reconsider the moral legitimacy of allocating exclusive authority to existing advance directives for now-incompetent, conscious persons. I am not advocating for complete disregard of advance directives altogether, but only that current values and preferences of the now-incompetent, conscious person be taken into consideration, involving these persons in end-of-life and treatment decision processes more so than currently permitted and recognized.

Notes

1. I am grateful to Leslie P. Francis, Margaret P. Battin, Pepe Chang, and Dale Clark for commenting on earlier versions of this paper.
2. Psychological continuity is a psychological criterion of personal identity; psychological continuity just is connectedness amongst psychological states. Personal identity accounts that appeal to a psychological criterion of identity assert that what constitutes the identity of a person over time is psychological connectedness amongst psychological states. Such psychological states or aspects of psychology include desires, beliefs, and character traits. The precise relation that holds amongst these psychological aspects to constitute personal identity will differ depending on the particular account of personal identity. For Locke, memory is the relation that obtains amongst these psychological aspects to constitute personal identity over time.
3. The view I am attributing to Parfit is one in which what matters to us (in terms of survival) is psychological continuity from a first-person point-of-view. I am not attributing to Parfit the view that psychological continuity is what matters to us *morally* from a third-person point-of-view in which decisions we make may have some effect on future generations, thus attributing moral relevance to

psychological continuity. I am therefore not making any claims as to what Parfit would be committed to regarding the moral relevance of psychological continuity. Insofar as this is the case, even if reductionist accounts of personal identity are wrong, as Parfit claims, it is still an open question as to whether psychological continuity is of particular moral relevance.

4. To be clear, the claim that the personal identity of AD patients is disrupted because they are psychologically disconnected from their prior selves is a claim that Hume and Locke would directly endorse given their reductionist accounts of personal identity. While Parfit would not directly endorse this claim, the significance Parfit places on psychological continuity as being what matters to us most in terms of survival and our conception of the self *does* support premise one of the DPA.

5. It is not clear that at this stage of AD the AD patient meets Dworkin's standard of competency requisite for the right to autonomous choice (i.e. autonomy) on the integrity view.

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Biographical Sketch

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