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The Impact of Personal Identity on Advance Directives

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Advance directives record our voluntary choices and provide guidelines for people making decisions on our behalf when we are no longer capable of making substantiated, reasoned choices for ourselves. In some circumstances, especially when no curative treatments are available, prior wishes for a painless, quick, and dignified end of life are the last bellowing of autonomy. In other cases, however, respecting the advance directive is not the right answer. When large shifts in psychology have resulted from illness, and autonomy cannot be restored, prior wishes may become obsolete. Therefore, a new conceptual framework for adjudicating the applicability of advance directives is needed.

1 The Criteria for Personal Identity

The problem of personal identity within philosophy centers on establishing a metaphysical criterion of identity for persons across time. The issue is not immediately apparent, because the problem does not exist from a first-person perspective. It is not the case that anybody actually has a personal problem of establishing identity across time. A person could wonder, perhaps looking at her own childhood photograph, whether she is the same person she was in her youth, but she would be raising the metaphysical question of numerical identity as it applies to her. The metaphysical question of personal identity does not arise from an introspectively perceived numerical discontinuity between various person stages; instead it is a problem of explanation. For example, although most people do not

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have difficulty individuating objects in the world, it remains an epistemological problem to explain how observational beliefs are justified.

Philosophers who approach this question from a third-person perspective are faced with the task of imputing identity to a constantly changing web of properties. Let us consider the changes that occur during the lifespan of a person between childhood and old age. While looking through a family photo album, Jane sees an old, faded picture of a young girl sitting at a piano. After asking about the young musician's identity, Jane is told it is her grandmother. However, this description is misleading, because the young girl in the picture was probably about twelve years old, and not old enough to be anybody's grandmother. Since that photo was taken, her appearance has changed, as have her height, weight, and various other physical features. Jane's grandmother has also endured large shifts in her beliefs and values, and in the basic features of her psychology. At the age of twelve, she dreamt of being a musician; later on, she opted for the more practical profession of medicine. The personal identity problem is the problem of fixing the identity of Jane's grandmother across the various stages of her life, and the problem exists for any person who endures changes in properties across time.

Broadly speaking, there are two main approaches to solving this problem for philosophers. One approach uses a physical criterion to establish identity, while the other employs a psychological criterion. For both criteria, establishing personal identity requires establishing numerical identity, which means establishing that an object is one and the same object across time. Numerical identity for persons is particularly difficult given the strict requirements of Leibniz's Law, according to which, two things are identical if and only if they have all the same properties.

The traditional physical criterion establishes a relationship of identity between the person and her body, where the body excludes the brain. In a typical scenario challenging the bodily criterion, we are asked to imagine an accident where two people are injured: the body of one person remains intact while the brain of another person is all that is left. The healthy brain is transplanted into the healthy body and the question is which person survives. Given that intuitively most people would identify the survivor as the person whose brain is left, the conclusion is that the bodily criterion fails.[1]

A more contemporary version of the physical criterion, and one impervious to the above criticism, is a biological criterion.[2] On this criterion we are human animals persisting through the various stages of development of the body from birth through old age, including the various stages of brain development. Since this includes the brain, it is superior to the original physical criterion where the survival of the person depended on the survival of the body sans brain.

The psychological criterion of identity, often referred to as the Lockean criterion, relies on the continuity of a person's mental features to establish identity over time.[3]

[1] See John R. Perry, *A Dialogue on Personal Identity and Immortality* (Indianapolis: Hackett Publishing Company, 1978).

[2] See David DeGrazia, *Human Identity and Bioethics* (Cambridge, England: Cambridge University Press, 2005).

[3] Ibid., p. 16.

A person at one stage is identical to a person at another stage if and only if they have the same psychological characteristics. The psychological criterion implies that large changes in personality, including significant shifts in values, preferences and long-term life plans could signal a loss of personal identity.[4]

Rather than evaluate the merits of both approaches, we will examine the impact of the personal identity problem on the validity of advance directives, and we will assume that a metaphysical criterion of personal identity can be established. This assumption is reflected in the desire to have an advance directive, which protects the interest of the future self. The wish to write an advance directive must be based on the assumption that a person's current self and her future self are one and the same.

Advance directives convey the wishes of patients with respect to future healthcare decisions should they lose decisional capacity. It is common for patients to leave advance directives specifying their preferences regarding end of life care. A person uses an advance directive to ensure that her wishes regarding treatment options are respected when she is no longer able to make decisions for herself. The advance directive is supposed to reflect a person's core values, including her views on what constitutes an acceptable quality of life.

Assuming something like a psychological criterion of identity, advance directives are questioned when an illness alters a person's psychology. For example, a chronic illness that requires a permanent change in diet or lifestyle might cause a shift in the values of a patient. A sybarite diagnosed with diabetes may alter her priorities as a result of her illness, placing more value on health than on the pleasure she derives from eating. The changes undergone by the sybarite probably will not bring her identity into question, because they are not large enough to qualify as a break in her psychology. But if we consider the changes that occur with dementia, the question of whether an individual maintains psychological continuity becomes more pressing. Adopting the psychological criterion of personal identity would imply that significant changes in the psychology of an individual do signal shifts in identity. If the person who is demented does not remember or care about any of her previous preferences, and her personality, attitudes and demeanor change, then the individual before and after dementia would fail to be the same person. If changes in psychology signal changes in identity, what importance should be accorded to advance directives?

This question should be answered while keeping in mind a broader issue. Let us consider the commitment involved in issuing a promise.[5] When a person issues a promise, she creates a commitment that obligates her to do what she promised. But part of the concept of promising is that a person cannot bind someone else by her promise, and she cannot issue a promise that obligates others to do as she promised. When a person issues an advance directive, it creates an obligation for her physician to carry out her final wishes when she can no longer express those wishes herself. An advance directive is similar to a promise, because it requires unity of personal

[4] See Sydney Shoemaker, "Persons and Their Past," *American Philosophical Quarterly*, vol. 7 (1970), pp. 269–285; see also John Perry, "Can the self Divide?" *Journal of Philosophy*, vol. 69, no. 16 (1972), pp. 463–488; Amelie Rorty, ed., *The Identities of Persons* (Berkley, Calif.: University of California Press, 1976); Derek Parfit, *Reasons and Persons* (Oxford: Oxford university Press, 1984).

[5] See Simon Beck, "Parfit and the Russians," *Analysis*, vol. 49 (1989), p. 206.

identity over time; it presumes that the person writing the advance directive and the patient receiving the treatment are the same person. But if a person's illness transforms her into someone else, such that she no longer bears any psychological resemblance to the person she was in the past, we may well ask what happens to the validity of her advance directive.

2 Similarity and Identity

The question of how personal identity affects the status of advance directives has received some attention within the literature. Allen Buchanan and Dan Brock phrase the problem thusly: "Advance directives only have moral authority if the person who issued the directive and the person to whom the directive would be applied are the same person; but the very circumstances which would bring an advance directive into play are often those in which one of the necessary conditions for personal identity is not present."[6]

Buchanan and Brock emphasize the importance of upholding advance directives, which they argue "serve several important values," because they "preserve well-being by protecting the individual from intrusive and futile medical interventions; they can promote self-determination; and they can serve as vehicles for altruism by authorizing termination of treatment that would impose financial or emotional costs on others."[7] As they explain: "If the degree of psychological continuity necessary for preservation of personal identity is set rather low…there will be very few if any real-world cases in which we would be justified in concluding that neurological damage has destroyed one person but left a living, different person."[8] Their view implies that the only cases where we would question personal identity are cases where "the neurological damage is so catastrophic that we would be equally confident in concluding that the living being who remains *is not a person at all*."[9] However, even in such cases, an advance directive would apply, because a person's prudential concerns can survive a termination of personal identity in the same way a last will and testament can remain valid after death.

Buchanan and Brock recognize that a conflict could arise between the wishes of a demented person who is cognitively diminished, but capable of experiencing pleasure and pain, and her advance directive. They argue that such cases are easy to solve, because they do not involve conflicting rights of two distinct individuals, since the threshold for personal identity is set low. Other theorists agree with Buchanan and Brock on the importance of respecting advance directives.[10] Ronald

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[6] Allen Buchanan and Dan Brock, *Deciding for Others* (Cambridge, England: Cambridge University Press, 1989), p. 155. See also DeGrazia, op. cit., ch. 5.

[7] Buchanan and Brock, op. cit., p. 152.

[8] Ibid., 159.

[9] Ibid., 159.

[10] See Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Knopf, 1993), ch. 8; see also Norman L. Cantor, "Prospective Autonomy: On the Limits of Shaping One's Postcompetence Medical Fate," *Journal of Contemporary Health, Law and Policy*, vol. 13 (1992), pp. 34–48.

Dworkin argues that being autonomous gives a person the right to determine the narrative for her life, which includes how she is to be treated should she become incompetent in the future. According to Dworkin, "autonomy encourages and protects the capacity competent people have to direct their own lives at least generally in accordance with a scheme of value each has recognized and chosen for himself or herself."[11] Therefore, respecting autonomy requires respecting a person's preferences regarding her future, which are expressed in an advance directive.

On the other side of this debate, Rebecca Dresser has questioned whether advance directives are "the ideal mechanism for resolving decisions on life-sustaining treatment for incompetent patients."[12] Dresser has argued forcibly in favor of the rights of incompetent patients, whose subjectivity, perspective, and interests are too often misunderstood or simply disregarded. Although she acknowledges the importance of respecting autonomy and giving people control over their futures, Dresser argues that autonomy is not the only value embraced by our culture. Moral judgments reflect the importance of such values as "compassion, care and protection," and also "respect for the lives of disabled people and a moral obligation to protect them from harm when they cannot do so themselves."[13] Dresser believes that in cases where an incompetent patient will be harmed by the preferences expressed in an advance directive, the moral authority of the directive should be questioned.

In cases where there is sufficient psychological dissimilarity between the patient before and after her illness, an advance directive ought to be questioned and perhaps revoked. The criterion relevant for adjudicating the validity of advance directives is not the criterion of personal identity, however, but of psychological similarity, because finding a resolution to the philosophical question of personal identity is not necessary in order to propose a view about advance directives. As Derek Parfit explains, personal identity is not always determinate, since a person can ask whether she is about to die: "But it is not true that, in every case, this question must have an answer…In some cases this would be an empty question."[14] There may be no answer to the philosophical puzzle of numerical identity across time, but the resolution of the puzzle is not relevant to the debate about advance directives. The continuity between a person's psychological stages can be accomplished even if we do not have a determinate answer to the question of whether a person is about to die, because answering the question, "Is the entity who signed the advance directive numerically identical to the entity who is demented now?" is not a prerequisite to answer the question "Is the person who gave the advance directive psychologically continuous with the person who is demented now?" The answer to the second question can be had even if the first question remains unanswered.

[11] Ronald Dworkin, "Autonomy and the Demented Self," *The Milbank Quarterly* 64, vol. 2 (1986), p. 9.

[12] Rebecca Dresser, "Advance Directives Implications for Policy," *The Hastings Center Report*, vol. 24, no. 6 (1994), pp. S2–S5.

[13] Rebecca Dresser, "Missing Persons: Legal Perceptions of Incompetent Patients," *Rutgers Law Review*, vol. 46 (1994), p. 615.

[14] Derek Parfit, op. cit.

Therefore, the psychological criterion of personal identity should be stripped of its metaphysical connotations thus transforming it into the criterion of psychological similarity. The notion of psychological similarity will be used to challenge the authority of advance directives. The similarity criterion should not be taken to support the psychological criterion of personal identity across time, because it is not used with an aim to make any metaphysical claims about the continuity of a person. The similarity criterion is meant to be a practical criterion, which should aid the adjudication of the validity of advance directives.

The shift to the similarity criterion is motivated by Parfit's view of psychological connectedness and psychological continuity, which unite a person's past and future selves.[15] Psychological connectedness is achieved when the different stages of a person's life are connected by chains holding between past experiences and memories of the experiences, and between her intentions and the acts in which those intentions are carried out.[16] Psychological connections are also present when a person continues to hold beliefs, desires, and ideals, and she maintains a particular character or approach to life.[17] For instance, the person Sally is today bears a strong connection to the person she was yesterday, because there is a direct connection between the plans she made yesterday and the acts Sally is undertaking today. There is also a strong connection between Sally's actions yesterday and the memories she has of those experiences today.

When there are enough strong connections between a person's past and future selves in terms of memories, goals, beliefs, desires, and intentions, there is psychological continuity between the two selves. Psychological continuity is achieved through overlapping chains of psychological connections. Psychological continuity is defined by reference to connectedness, where less connectedness entails diminished continuity of the self, and the relation of similarity will share this feature. Let us consider an illustration of the relationship of psychological similarity where a person is more similar to her past self from yesterday than she is to her past self from ten years ago, and she is even less similar to her future self of a few decades from now. The similarity relation is not transitive, because Alice and Bob might be psychologically similar, and Bob and Charles might be psychologically similar, but Alice and Charles might fail to be similar. Let us consider an illustrative example: Jenny at age eighteen has several direct connections with Jenny at age twelve, since at age eighteen, Jenny still has many clear memories of herself at twelve, and she still has many of the same intentions and goals. At age thirty-five, Jenny has many vivid memories of her college years, when she was eighteen, but her attitudes and goals have changed significantly, and she barely remembers her adolescent years. Therefore, Jenny at age twelve might be similar to Jenny at age eighteen, and Jenny at age eighteen might be similar to Jenny at age thirty-five, but there will be very little if any similarity between Jenny at age twelve and age thirty-five.

[15] Ibid., p. 217.

[16] Ibid., p. 206.

[17] See Llyod Fields, "Parfit on Personal Identity and Desert," *The Philosophical Quarterly*, vol. 37 (1987), pp. 432–441.

3 The Margo Case

To test the effectiveness of the similarity criterion, let us consider an actual case.[18] Let us suppose that Margo, who has Alzheimer's disease, lives at home with the help of an attendant and enjoys reading, painting, and listening to music. Let us also suppose that she seems pleased to have visitors, and enjoys her daily activities. When Margo was young, she was fiercely independent, and signed an advance directive indicating that if she should develop Alzheimer's disease, she should not receive any life sustaining treatments. Since Margo no longer has decisional capacity, her advance directive applies. Unlike Margo, some patients who are in the early stages of Alzheimer's disease might have decisional capacity and autonomy, and their advance directives would not yet apply.

Margo is living a contented life with dementia, and she has abandoned her old views about the importance of independence. Margo has contracted pneumonia, and she needs antibiotics to recover. If her advance directive is followed, Margo must be denied this simple, painless, inexpensive treatment and allowed to succumb to her illness. However, Margo does not wish to die, and she asks her physician for medication. Should Margo's physician follow the advance directive and withhold treatment?

With their proposal, Buchanan and Brock set the threshold for maintaining identity so low that in most cases, as long as someone is still alive and conscious, the individual will have sufficient psychological continuity to maintain identity. Since Margo is clearly the same person who issued the advance directive, there is no reason to question its authority.[19] Buchanan and Brock discuss four morally significant asymmetries between the choice of an autonomous individual and the issuance of an advance directive, which might bring into question the moral authority of the advance directive.[20] However, none of the exceptions apply to Margo. First, the therapeutic options from the time the advance directive was issued may change significantly. Since there is no effective treatment for Alzheimer's, this exception is not relevant to Margo's case. Second, we might question the advance directive if its future implementation occurs "under conditions in which those interests have changed in radical and unforeseen ways."[21] Margo is in exactly the future state she predicted in her advance directive; she is living with dementia and has lost her independence. Margo's advance directive correctly predicted her future state, so this exception also cannot help Margo. The third exception involves imprudent or rash choices, but in Margo's case, the fear of being demented does not appear to be rash.

Finally, there might be a disparity between a patient's implicit assumptions about the condition of the patient when the future treatment choice must be made, and her

[18] See Andrew Firlik, "Margo's Logo," *JAMA*, vol. 265 (1991), p. 201; see also Rebecca Dresser, "Dworkin on Dementia, Elegant Theory, Questionable Policy," *The Hastings Center Report*, vol. 25 (1995), pp. 32–38; Ronald Dworkin *Life's Dominion*, ch. 8.

[19] See Dworkin, *Life's Dominion*, ch. 8.

[20] Buchannan and Brock, op. cit., p. 153.

[21] Ibid.

actual condition. Whether this exception includes Margo's case depends on how we interpret the accuracy of Margo's implicit assumptions. We could argue that Margo predicted the course of her disease accurately, and her advance directive reflected her belief that life with Alzheimer's would not be acceptable. However, we could also argue that Margo failed to realize that although her cognitive abilities would diminish, her quality of life would not. The problem with this argument is that judgments of quality of life are inherently subjective, reflecting a person's values and beliefs about what make life worth living. At the time, Margo valued her autonomy and independence, and it is not clear how Margo could have appreciated what her present demented state would be like. Furthermore, research on affective forecasting suggests that most people are not very good at predicting their future emotional states and frequently misjudge how they will react to both positive and negative future events.[22] Therefore, this exception would bring into question almost all advance directives and entirely diminish their value in medical decision-making. After discussing each of these exceptions, Buchanan and Brock conclude that "in spite of these asymmetries the law and medical practice ought to regard valid advance directives as having nearly the same force as a competent patient's contemporaneous choice, because attempts to limit the authority of advance directives would in practice lead to their being ignored by paternalistic physicians or families, thus robbing them of their value."[23]

Buchanan and Brock emphasize that preserving identity is essential for maintaining many of our social practices and institutions, including practices and institutions having to do with contracts, promises, civil and criminal liability, and the assignment of moral praise and blame.[24] On their view, raising the question of personal identity opens to the door to a whole host of pragmatic problems that go far beyond the medical realm. For example, changes in personal identity will have important legal ramifications, since whatever contracts are entered into will become null and void should a person undergo a change in identity. Changes in personal identity will also affect the validity of a person's marriage, the ownership of property, and execution of a person's will. Rather than deal with the seemingly endless legal and moral problems that changes in personal identity create, Buchanan and Brock avoid the issue altogether by denying that such changes in identity occur. As they explain, with respect to psychological continutity: "If the threshold is set high, then we will be forced to conclude that there will be many cases in which neurological damage destroys the person who issued the advance directive but leaves in his or her place a different person, over whose fate the advance directive can have no authority."[25] Their solution is to set the threshold low, and they conclude that "the moral and social costs of achieving the restructuring of our

[22] See Timothy Wilson and Daniel Gilbert, "Affective Forecasting," *Advances in Experimental Social Psychology*, vol. 35 (2003).

[23] Buchannan and Brock, op. cit., p. 154.

[24] Ibid., ch. 3.

[25] Ibid., p. 186.

practices and institutions that such a shift in the threshold would mandate would be very high, and as yet we have no good reasons to incur them."[26]

By substituting similarity for identity, the pragmatic problems raised by Buchanan and Brock can be avoided without implying that advance directives should be upheld under all circumstances. On Buchanan and Brock's view, Margo's advance directive would be upheld, and she would be denied life-saving antibiotics. The similarity criterion would enable Margo's physician to question the legal acceptability of the advance directive. If Margo's illness were severe, her mind would greatly change and there would no longer be sufficient psychological continuity between the person who issued the advance directive and the demented woman who is in need of treatment. Although Margo would still be one and the same person, she would be sufficiently dissimilar to her past self such that her directive should no longer apply.

However, there is a distinction between cases like Margo's, where patients have no hope of returning to their previous autonomous selves, and cases where people suffer from temporary psychological ailments. For patients like Margo, who have undergone significant, permanent changes in their psychology, questioning the advance directives is appropriate. However, in cases of temporary and treatable illnesses, judgments about the validity of advance directives might be different. When the ailment causing incompetence is only temporary, and it is likely that autonomy will be restored, there are important reasons for upholding the advance directives. For example, some patients with treatable mental illnesses sign Ulysses contracts, which obligate their physicians to ignore their refusal of treatment should they stop taking their medication.[27] Although patients with treatable psychiatric ailments will have periods where they are psychologically dissimilar to their past selves, once their autonomy is restored, commitment to their values is likely to return. Therefore, temporary psychological dissimilarity is not sufficient to justify overruling an advance directive. If autonomy can be restored, efforts should be made to do so, and the advance directives should be given authority. However, if restoring autonomy is no longer an option, as in Margo's case, advance directives should be judged for their applicability to the current situation, and the criterion of psychological similarity is a useful tool for making these judgments.

Margo's case is also different from cases in which patients are in a coma or a persistent vegetative state, for their advance directives should be upheld. Psychological dissimilarity occurs when there is a significant change in the important things that the individual cares about. But in cases where a person is not conscious, it is not clear that she has even the basic psychological functioning necessary to achieve personhood. Therefore, we cannot question the authority of the advance directive on the grounds of dissimilarity, because the extent of the neurological damage suggests that the living body that remains may not a person at all. If prudential concerns can survive the death of a person, however, they can remain

[26] Ibid., pp. 186–187.

[27] See Rebecca Dresser, "Bound to Treatment: The Ulysses Contract," *The Hastings Center Report*, vol. 14 (1984), pp. 13–16.

valid after a devastating loss of consciousness, but their validity would not rest on a criterion of psychological continuity.

The psychological similarity criterion might be criticized for its dependence on a number of fine-grained judgments about psychological continuity. Buchanan and Brock argue that judgments about psychological continuity require a greater number of facts and entail weighing a number of competing values, interests, and rights. In contrast, they support a criterion of personal identity that requires a certain threshold of psychological continuity as a necessary condition for personal identity, which they argue circumvents the complications. Buchanan and Brock further argue, "There is nothing incoherent about designating a certain degree of psychological continuity as necessary for the persistence of personal identity."[28] But there is, because psychological continuity relies on the relationship of similarity between the various stages of the self. Criteria that do not rely on continuity establish identity as the relationship that holds between the various stages of the self. Thus, Bob at age thirty-five and at age forty-five can either be similar or identical exclusively. Buchanan and Brock cannot maintain that psychological continuity is all there is to personal identity, because continuity supplants identity as a criterion entirely, and we must choose one or the other.

Furthermore, it is wrong to suppose that the threshold criterion advanced by Buchanan and Brock entails fewer epistemic hurdles than judgments of psychological similarity. Buchanan and Brock compare setting a minimum threshold of psychological continuity to other thresholds we employ, such as maturity. Maturity is a matter of degree, but we could set a threshold for the minimal amount of skills and capacities required for a person to qualify as mature, thereby simplifying the process of issuing judgments about maturity. The problem is that setting a minimum threshold for psychological continuity would not require less complex judgments and fewer facts than judgments of psychological similarity, as that would be akin to claiming that measuring a person's body temperature at one time would be more difficult than measuring her temperature at a different time. The factors we must consider in judging whether a person has met the minimum threshold for psychological continuity are exactly the same factors we would have to consider in making judgments of similarity, since both involve examining various aspects of a person's psychology. Buchanan and Brock set the threshold for continuity so low that as long as a person is conscious, she will maintain psychological continuity. From an epistemic standpoint, however, the factors employed in issuing judgments using both criteria are the same; the difference is their criterion delivers a judgment about whether someone has met the threshold or not, while our criterion issues a judgment of the degree of similarity.

4 Psychological Dissimilarity

How much dissimilarity is needed in order to question an advance directive? The answer to this question depends on what counts as a relevant dissimilarity. Given

[28] Buchanan and Brock, op. cit., p. 187.

that advance directives document the expressed beliefs and preferences with regard to medical treatment, they presuppose a commitment to certain core values. The advance directive is a direct reflection of the values and priorities of the autonomous patient. The core values shape the patient's beliefs about issues such as what counts as a meaningful quality of life, when someone is becoming a burden to her family, how much pain someone is willing to tolerate, and the importance of independence. The similarity criterion specifies that if there is a significant shift in the core values and preferences constitutive of the advance directive, it should be brought into question.

In Margo's case, there were large shifts in the values that inspired her advance directive. In her youth, Margo believed that dementia implied that she would have a poor quality of life. But Margo is not in pain or suffering, and she no longer remembers who she was prior to dementia. Her strong preferences have dissipated with the progression of her illness. Perhaps ten years ago, her current state might have seemed insufferable, but today, Margo is happy. She is no longer committed to the values represented by the advance directive, and it seems inappropriate to enforce her prior wishes, when she no longer supports them. Since there is sufficient dissimilarity in Margo's case, the advance directive is no longer applicable.

One source of Margo's blissful state is the absence of a frame of reference. A healthy person who compares her current state with that of a demented person will anticipate the negative impact of the illness. The valance of the event is determined in comparison to a healthy state. A demented person makes no such comparisons. Margo does not have the cognitive resources to conceptualize her current states as demented, which in part makes it possible for her to enjoy her life. There is a difference, then, between how a healthy Margo feels about dementia, and how an ill Margo does.

It is also unclear whose interest is being served by withholding treatment. As a society, we have a strong preference for providing life-sustaining treatment, and a person needs justification for withholding treatment from somebody who is requesting it. Incompetent patients are not able to make voluntary decisions, but they are capable of being harmed by past decisions that they no longer support. An autonomous person is entitled to change her mind in most ways and expect her treatment to be adjusted accordingly. Although incompetent patients are no longer capable of making voluntary decisions, it is not clear that they should be treated in accordance with what they wanted earlier in life.

Many theorists view advance directives as a way of promoting and preserving autonomy, because they provide people with some control over the dying process. But upholding advance directives in all instances is not necessary to support the principle of autonomy. As a general rule, advance directives should be respected where there is enough psychological continuity between the person issuing the advance directive and the current person in need of treatment. This default attitude preserves the comfort and assurance that the contracts provide. However, in cases where significant changes in the psychology, personality, or values of the patient have transpired, there may be reason to adjust the default attitude.

Advance directives have been criticized, because they are too broad and vague to be effective in directing care after the loss of capacity, and for many people, it can

be difficult to anticipate all future medical contingencies.[29] Given these concerns, arguing for strict adherence to advance directives might be counterproductive, and further discredit their functionality. Evaluating the applicability of advance directives on a case by case basis leaves room for reconsideration when there is significant psychological dissimilarity. A comparable model is parental surrogate decision-making. Although parents are generally permitted to refuse or accept treatment on behalf of their children, there are certain restrictions. For example, Jehovah's Witnesses are permitted to refuse blood transfusions for themselves, but not for their children. Analogously, for most lifesaving treatments, parents have less liberty to refuse treatment for their children than they would for themselves. Although, surrogate decisions are meant to represent autonomous decisions, they are not on a par with them. A person can refuse more for herself than she can for somebody under her care. Advance directives should have the same status; they stand for what the patient would have wanted, but they should not be accorded the same authority as an informed, voluntary decision made by a competent patient. In cases where there is sufficient dissimilarity between the patient's past and present selves, the directive should be brought into question.[30]

[29] Ibid., pp. 295–296.

[30] We would like to thank Thomas Magnell, Editor-in-Chief of the *Journal of Value Inquiry,* and three anonymous reviewers for their helpful suggestions.