Prospective Autonomy: On the Limits of Shaping One's Postcompetence Medical Fate

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A competent person may use an advance directive to achieve a measure of autonomy over a post competency dying process. By formulating instructions regarding future medical intervention, the declarant (directive-maker) seeks to shape medical handling according to his personal preferences. The advance directive may also designate an agent or representative who ultimately will be responsible for implementing the substantive instructions.

The person issuing an advance directive is obviously seeking to impose his own values and preferences on the intimate matter of a future dying process. This personal conception of self-respect and dignity in the dying process might be grounded on religious precepts, personal philosophy, or a personal vision of what constitutes degradation during the dying process. That conception might or might not coincide with what are believed to be the person's perceptible best interests at that later moment when the directive is to be implemented.

It is easy to envision instances of extreme dissonance between the perceptible interests of a now incompetent patient and the advance directive purporting to govern medical intervention for that patient. For example, a
directive might reject certain forms of life-saving medical intervention even though they could restore the patient to a healthful existence, as in the case of a Jehovah's Witness or of a believer in faith healing. The incompetent patient's contemporaneous interests apparently would be served by ignoring the directive and instituting treatment to restore the patient. On the other hand, a person's directive might seek to preserve the pristine dignity of the patient as a vital, fully-functioning human being by directing that life-sustaining medical intervention be withheld whenever the person becomes permanently mentally incompetent. That person might then become mentally impaired and incompetent but remain alert, retaining significant awareness of the environment and ostensibly enjoying this impaired existence. If that incompetent person then contracts pneumonia, contemporaneous patient interests would dictate medical intervention although the advance directive prescribes that antibiotics should be withheld and that the patient be allowed to die.

In a converse fashion, contemporaneous interests would favor allowing the patient to die while the advance directive dictates maintaining life-preserving intervention. A person who is a "vitalist," and believes that life is so sacred as to demand preservation to the last possible moment, may issue an advance directive requesting continuation of all life-preserving treatment no matter how dismal the patient's ultimate condition. Subsequently, as a mentally incapacitated patient stricken with terminal cancer, that person might experience unbearable, unremitting pain. To continue all possible medical intervention would then conflict with the incompetent patient's contemporaneous interests, which would compel withdrawal of life-preserving machinery.

These examples test the limits of future-oriented autonomy. In each, a person has issued an advance directive which defines a personal concept of dignity and self-respect, including the upholding of certain personal values. That directive now appears to conflict with the contemporaneous interests of the incompetent persona.

For a competent person exercising contemporaneous autonomy, personal choices need not coincide with material best interests. The respect accorded contemporaneous autonomy extends to personal decisions which deviate

3. While analgesics can relieve the vast majority of pain, there are still some kinds of terminal conditions which are accompanied by unrelievable pain. Alternatively, the directive itself might preclude palliatives or analgesics because either they might violate the patient's religious precept that suffering has important redemptive value, or the patient might wish to remain fully lucid.

from mainstream conceptions of wisdom or best interests. A competent patient may refuse a medical procedure that would leave her in a debilitated state (for example, an amputation) even though most reasonable people would choose otherwise. Autonomy in contemporaneous medical decision-making thus embodies a prerogative to impose personal values and preferences whether they are "sound" or not. Does a similar prerogative attach to prospective autonomy—decisions aimed at post competence medical handling?

Prospective autonomy is clearly different in some respects from contemporaneous personal choice. Future oriented decisions generally involve hypothetical facts, variable circumstances, and a limited perspective which complicates decision-making. Advance medical directives thus present problems about accurately anticipating a multitude of scenarios involving the dying process of a future incompetent being. Do these problems of projecting future medical conditions dictate limits on the scope of prospective autonomy as implemented in advance directives?

Prospective autonomy in the form of advance medical directives also poses certain moral issues. First, what are the real interests of incompetent persons? Are those interests confined to the contemporaneous benefits and burdens being experienced by the incompetent patient? Alternatively, can that patient's interests encompass elements which can no longer be sensed by the patient, such as prolonging a previously defined undignified status or the burden and suffering imposed upon surrounding loved ones? Given the real possibility that when a person becomes incompetent that person will not sense or appreciate the violation of the previously articulated personal values, what is the moral stature of future-oriented autonomy?

Assuming that a person can have interests in having previously important values and choices respected, what about the contemporaneous interests of the incompetent persona who has succeeded the formerly competent patient? The possibility of "harming" a helpless incompetent patient by withdrawing a life preserving treatment leads to an additional moral contention. The idea is that a person may lose moral authority to dictate the fate of a later, incompetent persona if the later persona is so changed as to have a different "personal identity." A continuous personal identity supposedly requires some


6. The moral significance of one's personal identity is addressed in Derek Parfit, Rea-
measure of psychological continuity, either through continued memories or beliefs. In the context of death, dying, and prior directives, a competent person might become so demented and lacking in psychological continuity as to be considered a new person for moral purposes. If so, it follows that one person, the maker of the directive, cannot morally harm or dictate the death of another person—namely the demented, new persona. In other words, "self-determination" no longer prevails because the original "self" no longer exists. From this perspective, an advance directive might lose its moral stature if, at the moment for implementation, it conflicts with the contemporaneous interests of the incompetent persona.

The above dilemmas are the focus of this Article. The central issues are whether advance directives should be determinative of post competency medical decisions and, if so, whether such instructions should govern when they conflict with the contemporaneous interests of an incompetent persona? After thorough examination of those issues, the Article will conclude that, despite the ostensible dilemmas, law and public policy ought to give expansive scope to deliberately constructed advance directives.

I. PROBLEMS IN PROJECTING FUTURE MEDICAL CHOICES

Practical difficulties confront a person formulating instructions concerning future medical handling in the event of incompetency. First, incompetency can encompass a wide spectrum of mental states ranging from total unconsciousness to acute awareness, but not including the ability to process the impressions being absorbed. A person's attitude toward future handling may vary widely across this spectrum of possible states. Further, a person might ultimately face a wide range of physical afflictions and disabilities. This range of afflictions in turn engenders a host of medical contingencies. Finally, a patient contemplating this range of mental and physical states must consider a multiplicity of factors in planning future medical intervention. Personal attitudes toward physical pain, appearance, physical incapacity, diminished mental function, helplessness, dependence, religious precepts, economic burdens, and the well-being of surrounding family and friends represent some of the elements which might influence a person's future-oriented
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medical decisions. The sheer complexity of the issue, therefore, raises concern about a person’s ability to make an informed and considered choice about dying in a future, incompetent state.\(^9\)

Despite the difficulties involved, the multiplicity of prospective medical situations should not prevent effective advance directives. Although it might not be possible to formulate a comprehensive directive which anticipates all possible situations because of the limits of one’s imagination, every competent person is capable of addressing a few precepts or guidelines regarding his future medical care.\(^{10}\) A person can articulate certain principles—whether grounded on religious scruples, personal philosophy, or personal notions of dignity—which will be relevant across a wide spectrum of medical conditions. Religiously based principles are likely to be simple, such as an aversion to blood transfusions or a belief that life should be preserved to the maximum extent possible. Principles based on dignity-based concerns may be more complex, but may also be reduced to understandable terms. First, a person may have well-developed dignity concepts only about one particular status, such as permanent unconsciousness. This preference can be expressed in a simple, clear-cut fashion. Second, even if a person is seeking to avoid a conscious, but severely debilitated existence, it may be possible to describe a few key factors, such as level of dementia, which would make life sustaining intervention unwanted regardless of the particular medical condition at hand. In short, an outcome oriented directive which describes a debilitated status that is personally intolerable may be considered in a wide variety of situations involving potential medical interventions.

Additional problems regarding future-oriented decisions\(^{11}\) flow from the lack of proximity between the competent person’s choice regarding future events and the events themselves. A person might well formulate medical instructions far in advance of the anticipated events. Indeed, this is sound policy because one cannot foresee when an unexpected accident might precipitate a permanently incompetent state. This distance sometimes necessitates predictions about remote and abstract developments.

This problem of immediacy generates several concerns. One is that the

\(^{9}\) See In re Westchester County Medical Ctr., 531 N.E.2d 607, 612-613 (N.Y. 1988).

\(^{10}\) The limited scope of a person’s predictive capacity might become an influential factor in the interpretation of advance directives. In that context, limited predictive capacity serves as a reason to afford flexibility to the agent ultimately charged with administration of an advance directive. However, limitations of predictive capacity ought not preclude enforcement of advance directives, especially if the directive is clearly expressed and the product of competent deliberation.

\(^{11}\) For a perceptive discussion of the difficulties of future-oriented decisions, see Buchanan & Brock, supra note 4, at 106-07; Donald L. Beschle, Autonomous Decisionmaking and Social Choice: Examining the "Right to Die", 77 Ky. L.J. 319, 335-45 (1988-89).
abstract nature of the initial decision-making reduces the scrutiny and consideration which otherwise would be given to deviant or morally problematic decisions.\textsuperscript{12} A patient making a contemporaneous decision to reject life-preserving medical intervention, as in the case involving religious scruples or views about post treatment indignity, will likely be subjected to counter arguments and supplications by surrounding medical staff and concerned observers. The person drafting a directive to shape prospective treatment may not receive similar input or confrontation, thereby making the advance decision less informed or considered than desirable.

Another concern relates to the fact that the directive may be based on projections about hypothetical feelings which may not materialize. Professors Dresser and Robertson argue that the difficulty of foreseeing personal interests in a remote and abstract state make an advance directive an unreliable device.\textsuperscript{13} They observe that a person's condition, feelings, and sensations as they materialize in a future, incompetent state might be radically different from those contemplated at the time of making an advance directive. For example, a debilitated status which previously appeared demeaning may have some redeeming value to the incompetent patient.

A third concern is the hypothetical nature of projected feelings in a future, incompetent status. A person shaping her future medical handling speculates about inherently unknowable feelings and sentiments experienced in an incompetent state. A person cannot precisely anticipate the feelings and experiences of an incapacitated existence—whether positive feelings of satisfaction or negative feelings of frustration and humiliation.\textsuperscript{14} If a person can only guess about the nature of personal reactions to a future debilitated state, then should society respect life and death judgments made from such a divorced perspective? In some other contexts, significance is attached to the abstract perspective of the decision-maker toward actual consequences. For example, there is great reluctance to bind a woman to prebirth decisions regarding the adoption or future custody of a prospective child.\textsuperscript{15} An inability to accurately envision the feelings of childbirth and bonding supposedly undermines the advance decision.

The difficulties of remoteness and perspective in making future oriented

\textsuperscript{12} Buchanan & Brock, supra note 4, at 107, 153.
death and dying decisions should not preclude the binding effect of advance medical directives. While a person cannot be precisely certain of what conditions will develop postcompetency, it may well be that a directive-maker correctly anticipates the suffering and debilitation associated with his or her dying process. An adult may have firm, well developed attitudes about some important issues—e.g., concern for the surrounding family's emotional and fiscal interests—which apply across a spectrum of medical conditions and are likely to remain invariable.

Of course, a person's philosophy and attitude toward death might change over time. It is therefore appropriate for the eventual administrator of an advance directive to examine whether the patient's values did vary or change after the directive was issued. Yet the potential for people to change their feelings should not be a basis to bar future-oriented directives. Certainly, law does not withhold enforcement of future-oriented disposition of property by will, irrevocable trust, or contract, even though the disposer's inclinations may change over time. In those contexts, documents are enforced as written even if it is later shown that the disposer's inclinations in fact changed but no alteration was made in the document while the actor remained competent. In the context of advance directives for medical treatment, it should at least be assumed that a directive-maker's wishes persist over time unless there is some showing to the contrary.

Additionally, the inability of a person to know prospective feelings in an incompetent state should not constitute a bar to advance directives. This factor ought to impel some serious deliberation by the directive-maker about the content of an advance directive. A person ought to ponder the range of possible feelings in various debilitated states before dictating the rejection of life-preserving intervention in those states. A person is generally capable of contemplating states of incompetency and fixing her basic parameters of personal dignity in those states. Sometimes, prospective feelings or sensations will not be particularly important, such as when the condition being contemplated is an unconscious or semiconscious state. Nonetheless, if future feelings are relevant, a person is capable of making an informed prediction about those feelings and considering the importance of such feelings in relation to other elements relevant to a terminal decision.

For some persons, an altruistic concern for the interests and well-being of surrounding loved ones will be an overriding factor even if the prospective incompetent being does not experience great suffering. For others, a personal vision of dignity—grounded on the image which the person wants to leave for posterity—will be a determinative factor even if a feared sense of embarrassment or humiliation does not materialize. In short, the problems
of remoteness and perspective associated with advance directives dictate care in formulating such instruments, but do not vitiate their utility.

Likewise, remoteness and the possible abstract nature of a determination do not necessarily mean that inadequate deliberation has gone into the advance instructions. In drafting a written document with the expectation that it will govern life and death decisions, a person would indeed be well advised to consult with someone knowledgeable and caring concerning the practical and moral implications of the advance instructions. However, documenting and signing the instructions have a cautionary impact on the signer which ought to impel reflection. A prerequisite that an advance directive be signed only after consultations with a knowledgeable person would entail costs likely to make such instruments accessible only to the upper income classes. The agent who eventually implements advance instructions may properly inquire into the nature of the incompetent's deliberations surrounding the advance directive. For instance, that agent might inquire as to whether the directive-maker was aware of the considerations making a particular instruction morally problematic. The competent's signature on an advance directive, however, ought to be presumed to reflect sufficient deliberation to make it binding. Every person knows that he or she might be disabled tomorrow, and so the specter of incapacity will prompt a certain amount of contemplation even if the maker of an advance directive is currently hale and hearty.

There is no better way to respect future-oriented self-determination than through an advance directive. A person's own projections about preferred choices are more likely to accurately reflect that person's will than the approximations suggested by other parties at a later date when the subject is incompetent.16 Thus, if society wants to uphold self-determination in the context of medical decisions for incompetent patients, advance directives must be respected.

A public policy which upholds advance directives is likely to benefit the peace of mind of both competent persons in general and persons afflicted with degenerative diseases in particular. Many persons experience anxiety in contemplating the prospect of prolonged existence in a status they regard as degrading. That anxiety can be acute for persons who perceive a protracted, severely debilitated dying process as a significant detriment to a lifetime image. Other persons may be so wary of the aggressiveness of health care prov-

iders as to forego treatment for all life threatening disorders. For all such persons, the knowledge that advance instructions will be honored may be a source of relief and reassurance. Limited studies tend to confirm both that loss of control over events prompts patients to suffer negative physical and emotional effects and that discussion of advance directives causes patients to worry less. Future-oriented control of medical intervention may also promote competent persons' sense of self-respect. Such factors as reduced anxiety and increased self-respect add a general, morale promoting value to a general public policy upholding advance directives.

Another utilitarian benefit is the saving of public resources. That is, widespread use and implementation of advance directives might well result in reduced use of expensive life-preserving medical machinery. This would be an incidental public benefit flowing from the upholding of future-oriented autonomy. While it is not suggested that these general public benefits provide a morally sufficient basis for enforcing advance directives, they do reinforce the argument for upholding a competent person's advance directive.

The decided trend in both legislative and judicial bodies is to accord binding effect to advance directives. Living will statutes rest on the assumption that a competent person should have a measure of control over postcompetence medical intervention in the dying process. Durable Power of At-

17. "Patients who feel secure that their wishes will be respected are relieved of anxiety and are more likely to seek medical advice in a timely and open manner." INTRODUCTION TO ADVANCE DIRECTIVES IN MEDICINE 1, 4 (Hackler et al. eds., 1989). See also Peters, supra note 5, at 938.

Professor Burt laments people's lack of confidence in terminal care and the "nurturant potential in our common social life" and analogizes the nurturant aspects of terminal care to positive "images of childhood and infancy." Robert A. Burt, Withholding Nutrition and Mis-trusting Nurturance: The Vocabulary of In re Conroy, 2 ISSUES L. & MED. 317, 320-21 (1987). Unfortunately, most people do not want to complete their life cycle by returning to an infant's status, even if the care process carries with it certain value.


20. Many living will statutes confine rejection of life-sustaining treatment to situations in which the incompetent patient is in a terminal condition, i.e., the patient is unavoidably going to die within a particular period. See Cantor, supra note 2 (commenting on and criticizing various living will statutes); Marni J. Lerner, State Natural Death Acts: Illusory Protection of Individuals' Life-Sustaining Treatment Decisions, 29 HARV. J. ON LEGIS. 175, 189-97 (1992). Such legislative qualifications on the scope of prospective autonomy ultimately may not constrict personal choice. Under many living will statutes, there is a provision preserving the person's existing rights as recognized by common law or the state's constitution. Judges in many jurisdictions will recognize expansive autonomy rights as a matter of either common law or state or federal constitutions. See, e.g., Corbett v. D'Alessandro, 487 So. 2d 368, 371-72 (Fla. Dist. Ct. App. 1986); NANCY KING, MAKING SENSE OF ADVANCE DIRECTIVES (1991).
torney for Health Care Acts (DPOA-HC) reach even further. These acts usually give an appointed agent the prerogative to make the same range of decisions which the patient could have made if competent. They also instruct the agent to implement the prior instructions of the now incompetent patient.

Courts have exhibited considerable sympathy toward the concept of advance directives. In deciding the fates of incompetent medical patients, many courts indicate that prior instructions of the patient are to govern whenever they are determinable.21 Moreover, judges have spoken broadly of a person’s “right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity.”22 In short, neither legislatures nor the courts have been persuaded that the practical problems associated with advance directives undermine their effectiveness.23

The question remains whether a competent person ought to have the moral prerogative to decide the medical fate of his future incompetent persona.24 The answer depends upon both the moral basis for extending the will of the competent being and the moral relationship between the competent being and the subsequent persona.

II. DEFINING THE INTERESTS OF INCOMPETENT PATIENTS

Professors Dresser and Robertson assert that it is wrong to use advance instructions as a guide to managing the medical treatment of a helpless, in-

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23. The Supreme Court’s disposition in Cruzan v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841 (1990), does not alter this assessment. Cruzan holds only that it is constitutional for a state to prevent withdrawal of life preserving care in the absence of clear and convincing evidence of instructions from the previously competent patient. Id. at 2854. See generally Yale Kamisar, When is there a Constitutional Right to Die? When is There No Constitutional Right to Live?, 25 GA. L. REV. 1203 (1991). The Court did nothing to undermine the effectiveness of clearcut advance directives. See Robertson, supra note 13, at 1178, 1179 n.148. The Court may even accord constitutionally binding effect to the decisions of an agent appointed by a previously competent individual. See Cruzan, 110 S. Ct. at 2857 (O’Connor, J., concurring). But see Robertson, supra note 13, at 1172-75 (arguing that the majority’s use of the terminology “liberty interest” presages a determination that a decision to reject life preserving medical intervention is not a fundamental aspect of personal liberty).

24. By future persona I mean the changed, incompetent version of the previously competent person who propounded an advance directive.
competent patient. Their basic premise is that the autonomy interests reflected in a person's prior choices become "meaningless" once the incompetent patient can no longer understand and appreciate the violation of those choices. That is, the patient's previously cherished ideas about dignity, religion, or altruism lose importance when their nonimplementation cannot be sensed. For Dresser and Robertson, an incompetent patient "lacks interests in privacy, dignity, and other values that presuppose some conscious appreciation of those concerns."27

Professors Dresser and Robertson go further. They not only discount the significance of autonomy interests once violation of such interests can no longer be appreciated, but they also speculate that if incompetent patients could miraculously be given momentary competence to decide their fate, those patients would focus on their current material interests and not any prior abstract, philosophical, or dignity-related concerns.28

A concomitant precept for Dresser and Robertson is that a helpless, incompetent patient's contemporaneous interests (in a debilitated status) ought to be the predominant guide to care, so long as the patient retains any significant interest in continued life, which to them includes any patient with the capacity to interact with her environment. Dresser and Robertson focus on the current welfare of the incompetent patient. For them, that focus demonstrates moral concern for the debilitated human being. By contrast, it would be morally wrong to allow "meaningless" prior values to prevail over the patient's current interests in continued life.29

The Dresser/Robertson position would certainly obviate some hard problems associated with advance directives. Unclear, ill-considered, or deviant instructions could simply be ignored. Health care providers would be following a humane course by acting according to the contemporaneous, perceptible interests of an incompetent patient. However, the Dresser/Robertson approach seems critically flawed.

The most fundamental flaw is the thesis that incompetent patients are not

25. Professor Dresser's initial analysis was presented in Rebecca Dresser, Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law, 28 ARIZ. L. REV. 373 (1986). A more developed explication of her position is presented in Rebecca Dresser, Relitigating Life and Death, supra note 7. A joint presentation with Professor Robertson is found in Dresser & Robertson, supra note 13. For Professor Robertson's individual position, see Robertson, supra note 13.

26. Dresser & Robertson, supra note 13, at 238; Dresser, supra note 7, at 430-31.

27. Dresser & Robertson, supra note 13, at 238; see Robertson, supra note 13, at 1158-59.

28. Such miraculous choice would reflect the patient's "current and future interests as incompetent individuals, not their past preferences." Dresser & Robertson, supra note 13, at 236.

29. Robertson, supra note 13, at 1143, 1162, 1167.
harm by rejections of their prior directives. This thesis certainly does not conform to common perspectives and ways of thinking. For instance, if a dying, incompetent Jehovah's Witness receives a blood transfusion in contravention of a prior instruction (in a vain attempt to prompt a remission), we tend to say that the person's religious values have been affected and that this constitutes harm to the patient. If a person dictates in a trust that funds be expended in a particular way and the trustee absconds with those funds after the person's incompetency, we tend to say that the now incompetent grantor has been injured by this breach of faith (as have the intended beneficiaries). If a person expresses a desire to receive all possible life-preserving intervention, yet a life-sustaining ventilator is subsequently withdrawn in order to save another patient, then we tend to see an impingement of the patient's self-determination even if the patient was comatose at the moment of the deed.\footnote{30}

There are other examples of societal respect for the unsensed interests of incompetent persons. Assume that a permanently unconscious patient has left no instructions about medical intervention and assume he has no surrounding family or friends. What prevents the medical staff from carving up the patient in order to harvest nonvital organs or tissue for the benefit of others? What prevents the conduct of nontherapeutic medical experiments on the insensate being? The obstacle is social respect for the intrinsic dignity interests of persons, even when violations of those interests cannot be felt by the affected individual.\footnote{31} As Professor Rhoden demonstrates, society can and does attribute dignity interests to incompetent persons despite their incapacity to sense or appreciate breaches of those interests.

The question remains whether future-oriented autonomy interests warrant recognition and implementation of advance directives in the critical context of life-preserving medical intervention. A positive response can be grounded on the notion that postcompetency respect for a person's prior, competent

\footnote{30. This is not to say that an advance instruction must prevail against all countervailing interests. For example, allocation of a scarce medical resource to another critically ill patient might necessitate overriding a patient's choice. The point is that the patient's interest in having a prior choice respected is affected in a meaningful fashion even if the plaintiff cannot sense the violation.}

\footnote{31. Professor Robertson suggests that the distaste experienced by observers, rather than the dignity interests of unsensing patients, accounts for any proscription of the practices involved. Robertson, supra note 13, at 1162 n.94. For an unusual case in which a court suggested that anencephalic neonate's non-vital organs could be harvested for the benefit of others, see Organ Donations Barred by Judge, N.Y. TIMES, Mar. 28, 1992, at A7.}

choices is an integral part of respect for the dignity and self-realization of all human beings.

The moral case for prospective autonomy over a dying process has been made by Professor Rhoden.\textsuperscript{33} Professor Rhoden argued that the advance directives of a competent person have considerable moral force, even if that person reaches an incompetent state in which failure to honor prior wishes cannot be felt or appreciated. For Rhoden, it is highly "humane" and respectful of human dignity to give force to future-oriented decisions, even at the expense of some contemporaneous interests of a now incompetent persona. She comments:

The competent person's primacy derives from his status as moral agent [autonomous individual]. Moral agency is inherently future-directed, and the future may . . . encompass one's incompetency. Prior directives are the tools for projecting one's moral and spiritual values into the future. These values seem to me worthy of respect even when they conflict with the subsequent, purely physical, interests of an incompetent.\textsuperscript{34}

Rhoden further states,

Viewing the patient only in the present divides her from her history, her values and her relationships—from all those things that made her a moral agent . . . . If a person has stated, "treat me, when incompetent, as if my competent values still hold," respect for persons demands that we do so.\textsuperscript{35}

Professor Childress adds, "The principle of respect for persons, which supports respect for the autonomous patient's choices, also supports reliance on the nonautonomous person's prior autonomous directives."\textsuperscript{36}

Is all this convincing? Or is the Dresser/Robertson position more appropriate in emphasizing the contemporaneous, material interests of the incompetent patient as reflecting a morally correct focus on the helpless patient's immediate interests? Just because people want others to treat them in postcompetency as if they had their prior sense of dignity intact does not necessarily mean that society should promote such a "delusion." In other words, the moral foundation for allowing persons to impose choices about dignity and personal values upon a future incompetent persona needs elaboration.

A starting point in understanding the moral foundation of prospective au-

\textsuperscript{33} See Rhoden, Legal Objectivity, supra note 32, at 845; Nancy Rhoden, How Should We View the Incompetent?, 17 LAW MED. & HEALTH CARE 264, 266 (1989); Rhoden, Litigating Life, supra note 32, at 375.

\textsuperscript{34} Rhoden, Legal Objectivity, supra note 32, at 858.

\textsuperscript{35} Id. at 864. See also Peters, supra note 5, at 935-36.

\textsuperscript{36} James F. Childress, Dying Patients: Who's in Control?, 17 LAW MED. & HEALTH CARE 227, 228 (1989).
tonomy over the dying process is to note the importance people commonly attach to control over the dying process. As an empirical matter, it is apparent that many people care mightily about their postcompetence medical handling, and hope (if not expect) to shape their own fates in the face of potentially fatal afflictions. The hundreds of thousands of requests for advance directive forms provide one index of public interest. The 1991 Danforth Act, federal legislation requiring health care institutions to inform patients about advance directives, provides another index of the perceived importance of advance directives. This widespread and growing public interest in advance directives reflects a common perception that wondrous medical technology poses a threat to achieving a dignified dying process. Self-determination is perceived as a possible antidote to that hazard.

A variety of motives may move people to try and direct their postcompetence medical fate. One important object is to avoid a debilitated status which the competent person regards as undignified or demeaning. "Living wills" and other prior expressions frequently focus on avoiding existence in a degraded state. For example, the cases dealing with the prior expressions of patients in a permanently vegetative state (PVS) reflect that focus. Courts hearing such cases understand and empathize with people's distaste for the utter helplessness associated with PVS, the wasted bodily status, and the devitalized personality.

Another future-oriented object of a person's advance directive is to avoid emotional and financial burdens to attending family during the dying process. In Cruzan v. Director, Missouri Department of Health, Justice Brennan commented on the understandable wish of people to prevent "a prolonged and anguished vigil" for surrounding family. Public surveys disclose that many persons wish to avoid future medical maintenance in the event of total and permanent dependence on others. Such predilections might be grounded either on a wish to avoid what is perceived as a helpless, undignified state or on a concern for the surrounding persons burdened by the future patient's care.

37. "[P]eople want to assert control over dying because they profoundly distrust contemporary medicine's capacity to respond to terminal illness or protracted, painful debilitation." Peter Steinfels, In Cold Print the Euthanasia Issue Can Take On Many Shades of Color, N.Y. TIMES, Nov. 9, 1991, at L11.


Finally, a person's advance directive may reflect religious or other philosophical values. A religious person, such as a Jehovah's Witness or a believer in faith healing, may conscientiously believe that certain forms of medical intervention must be foregone at all stages of life. Similarly, a Buddhist may seek to reject any prospective medication or analgesic which would diminish consciousness and, thus, readiness for passage to a subsequent existence.

People's expectations that future-oriented decisions will be respected upon incompetency are not grounded simply on personal preferences or aspirations. Social structures and conventions also have supplied a foundation for such expectations. Even before the development of legislative mechanisms for promoting control of post competence medical intervention, society demonstrated considerable respect for individuals' future-oriented autonomy. Irrevocable trusts and durable powers of attorney furnished legal mechanisms for persons to prospectively control the postcompetence disposition of property. Conventional wills served as a vehicle for disposition of property after death. Contract law allowed for postcompetence implementation of a person's preferences in such matters as care setting and disability insurance. Additionally, families commonly honored a person's prior requests regarding burial or other disposition of his cadaver, including a subsequent gift of anatomical parts.

In these respects, and others, society commonly upheld a person's future oriented decisions even when the person no longer had capacity to appreciate violations of those personal values or preferences. Professors Dresser and Robertson would distinguish death and dying decisions from other exercises of future-oriented autonomy on the basis of the serious, negative consequences involved, such as the death of an incompetent patient when an incompetent patient.

45. See generally James F. Childress, Ethical Criteria for Procuring and Distributing Organs for Transplantation, in ORGAN TRANSPLANTATION POLICY: ISSUES AND PROSPECTS 87 (James F. Blumstein & Frank A. Sloan eds., 1989) (describing the effect of the Uniform Anatomical Gift Act); Erik S. Jaffe, Note, "She's Got Bette Davis's Eyes": Assessing the Nonconsensual Removal of Cadaver Organs Under the Takings and Due Process Clauses, 90 COLUM. L. REV. 528 (1990) (discussing the substantive rights existing relative to the body and the family's disposition of the cadaver).
46. See Dresser & Robertson, supra note 13, at 237 (analogizing advance directives to future-oriented contracts or wills).
advance decision dictates the withdrawal of life-preserving medical intervention. A maker of an advance directive can thus be materially harmed by being allowed to die while still possessing significant interests in life. According to Dresser and Robertson, this is unlike the maker of a will who is dead and therefore cannot be affected by implementation of an ill-considered or unwise disposition of property.\textsuperscript{47} It should be noted, however, that accepted forms of future-oriented autonomy also have the capacity to "harm" a future, incompetent persona. A person can bind oneself to disadvantageous contracts or dispose of wealth through trusts and durable powers of attorney in a fashion which negatively impacts a future, incompetent persona. Thus, the potential for inflicting serious harm to one's future interests does not appear to be a sufficient basis to restrict future-oriented autonomy.

The widespread desire to control a post competency dying process is grounded on a simple object—the shaping of posthumous recollections of the person. Popular acceptance of prospective autonomy in this context is probably premised on the notion that a competent person deserves to shape recollections of her life. Desire to shape recollections is grounded, in turn, on popular recognition of the tie between human dignity and a personal image projected to others. Because of this tie between dignity and image, the self-realization value of autonomy is commonly seen as encompassing control of medical intervention in the intimate matter of dying, even at post competency stages. Not surprisingly, then, courts view implementation of the prior instructions of a now incompetent patient as the fulfillment of a "right" to self-determination.\textsuperscript{48} To ignore such instructions would relegate the patient to the status of an object whose fate is determined by others, rather than a human who has etched his own fate.\textsuperscript{49}

Self-determination in shaping medical intervention during a naturally occurring dying process honors the intrinsic value or dignity of human \textit{capacity} for autonomous choice. This is especially clear for a competent patient who directs medical intervention and, thus, receives the satisfaction of controlling bodily invasions and etching her own fate, rather than being manipulated by others.

The extension of a self-determination prerogative to a postcompetency context honors the fulfillment of human autonomous capacity as reflected in

\textsuperscript{47} Id.


\textsuperscript{49} My late stepbrother's will prescribed that a Dixieland band play at his wake and that the mourning family wear white. It was obvious to me that fulfillment of his wishes gave expression to his character and that to dishonor his instruction would have been an offense to his memory.
each person’s shaping of his own lifestyle and character. Part of a person’s self-respect lies in the image cultivated. Each competent person cultivates and nurtures a particular vision of body and soul, thereby fulfilling the potential of human autonomy. By preserving the body and developing the character associated with it, a person “earns” the moral prerogative of shaping the (postcompetency) images and recollections other persons will have of the previously competent individual.

The moral prerogative of shaping recollections is recognized in numerous situations. It underlies the disposition of property by will, contracts for postcompetency care (e.g., nursing home residency), and requests regarding disposal of a cadaver. Society conceivably could choose to intervene and direct the allocation of wealth upon a person’s death, but rather it chooses to afford people wide discretion in the distribution of their property. In part, this reflects a utilitarian concern for the encouragement of wealth accumulation. But in part it reflects a moral judgment that people have earned a right to dispose of their property. That prerogative is important to people because they seek to shape the images and memories which will survive their competency and their lives.

A competent person views control over the postcompetency dying process as part of the earned prerogative to shape the subsequent images and recollections of her life. These images include both the self-image which the person may hold while still mentally aware and the postcompetency images which surrounding people and survivors may hold. Professor Dworkin has commented, “[I]t seems essential to someone’s control of his whole life that he be able to dictate what will happen to him when he becomes incompetent.” This is so because the nature of how one is remembered is considered important to the success of one’s life and survivors’ recollections are affected by the lingering impressions of the moribund persona. These facts prompted Justice Stevens, dissenting in Cruzan, to recognize the important interests of people in not having their memories sullied by a protracted and undignified dying process. In short, it is widely acknowledged that the

50. Ronald Dworkin, Autonomy and the Demented Self, 64 MILBANK Q. 4, 11 (Supp. 2 1986). See also BUCHANAN & BROCK, supra note 4, at 100 (acknowledging the legitimacy of future-oriented interests to individuals as well as their families).

51. In our culture, we attach great importance to the “embodiment” of our beings, whether that embodiment is competent, incompetent, or even dead. “We only know of ourselves and each other in and through our bodies . . . .” Thomas H. Murray, Are We Morally Obligated to Make Gifts of Our Bodies?, 1 HEALTH MATRIX 19, 24 (1991).

52. Justice Stevens commented, “Nancy’s interest in life . . . includes an interest in how she will be thought of after her death by those whose opinions mattered to her . . . . How she dies will affect how that life is remembered.” Cruzan v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841, 2885-86 (1990) (Stevens, J., dissenting); see also id. at 2892.
incompetent persona is part of a person's life image—an image which reflects the exercise of human choice and cultivation. Respect for that person and the image which she cultivated can, therefore, morally justify respect for the person's decisions surrounding a postcompetency dying process.

The recollections a person leaves behind are shaped by more than the visual images of the deteriorated, incompetent persona. A person's altruistic nature and concern for the interests of family and others are also part of the character and recollections which the individual cultivates. That character also influences the human relationships one has with others—human relationships which form part of a person's individual image and legacy. A person who has nurtured certain relationships during competency may seek to advance those relationships even during a postcompetency period, such as an advance directive which dictates that the emotional and financial interests of surrounding family be considered in shaping the person's postcompetency medical handling. Implementation of such an instruction thus helps an individual perpetuate a relationship which he has sought to cultivate as part of a lifetime character. It honors an autonomous person's effort to build a life image and legacy.

The above depiction of the common importance attached to abstract interests, such as dignity and altruism, in a postcompetency state underlines another flaw in the Dresser/Robertson thesis. Specifically, they claim that if persons could miraculously regain momentary cognition in order to make an informed decision in their now incompetent state, they would act according to their contemporaneous interests, apparent benefits and burdens, rather than their prior values. However, it is impossible to test the premise and no reason can be seen to accept it a priori. There is no reason to assume that a person's values and priorities would change while the person is in a permanently incapacitated status. If a person previously cared about the indignity of a severely deteriorated status, or if a person cared about the emotional and financial well-being of surrounding family, those deeply rooted values would presumably persist. Those values were felt deeply enough that the individual, when competent, knowingly used them to dictate her death and dying process. Experience shows that competent persons commonly issue instructions that they not be maintained in a permanently unconscious state even though they are aware that they will not sense or experience the degradation of such a state. This can be best explained by people's acute concern about how they will be remembered and the distasteful image which may be left behind. In short, the Dresser/Robertson premise regarding noncon-

53. See Buchanan & Brock, supra note 4, at 164.
54. See Rhoden, Legal Objectivity, supra note 32, at 858-59.
III. Personal Identity and the Moral Status of an Incompetent Persona

Some commentators suggest that a person can lose "personal identity" via loss of the memory and character which distinguish an individual. From this perspective, an incompetent persona may be, in effect, a different person from the being who previously formulated an advance directive. The directive-maker, then, would have no moral right to "harm" the incompetent persona by directing the withholding of life-sustaining medical treatment. Harm would be inflicted at least so long as the incompetent persona's pain and suffering did not make life so torturous as to be considered a fate worse than death.

The notion of personal identity seems to be of limited utility. No source employing this concept defines the degree of memory loss or character change that would make an incompetent persona a "new" person. Even if an administrable standard were defined, it would probably have limited practical application. In most instances, an incompetent persona retains a significant measure of long-term memory of a prior, competent status, thereby retaining his original personal identity. If an incompetent persona is so severely demented as to have lost all or almost all memories, the resulting being (a new personal identity) may have very limited contemporaneous interests. This is true, for example, for the incompetent persona who is in a permanently vegetative or barely conscious state and lacks relational or interational capacity.

Professors Buchanan and Brock use the limited interests of a severely de-

55. Another shaky premise in the Dresser/Robertson position is that once incompetent, a person cannot experience the previously feared indignity associated with a grossly deteriorated status. It is suggested that some patients, in some phases of mental incapacity, can be aware of, and suffer from, grossly reduced functioning. That is, the frustration, embarrassment, or humiliation originally feared by the patient may in fact materialize and inflict emotional suffering on some incompetent patients. Admittedly, it is difficult to identify and measure these phenomena in severely compromised patients. But there will be some such patients whose overall distress will be apparent. And there will be some less mentally deteriorated patients whose particular distress relating to indignity can be discerned. For example, a senile incontinent patient, once proud, independent, and punctilious about personal hygiene, who now weeps each time that a diaper must be changed. In such instances as these, the patient's prior expressions, directives, or values may help observers understand the nature of the apparent distress. At stages in which the incompetent patient is still aware of the environment, loss of prior faculties can prompt real emotional consequences.

56. See Brock, supra note 14, at S5.

57. See Robertson, supra note 13, at 1157. One troublesome case regarding the personal identity matter would be the person, perhaps with advanced Alzheimer's disease, who has total or almost total loss of recall but still is aware and can interact with the environment. See infra.
mented patient to partially finesse the personal identity dilemma. They argue that a persona so severely demented as to lose basic cognitive or interactive capacity is no longer a "person" with cognizable moral interests. Thus, a competent person can dictate the fate of a future persona in a persistent vegetative state because that latter persona is not, for Buchanan and Brock, a person with equal moral status. For them, such a nonperson has radically truncated interests. However, if a profoundly demented persona is still aware, that persona does have cognizable interests. For example, if a demented persona is still subject to pain, Buchanan and Brock would question the moral status of a prior directive which would produce a painful death. Similarly, Buchanan and Brock would probably deem it morally necessary to protect a profoundly demented person with clear capacity for pleasurable sensations from a prior directive dictating termination of care.

An argument can be advanced which rejects the notion that a demented persona is a different person for purposes of implementing an advance directive, regardless of the degree of memory retained by the incompetent persona. The lifespan of each person's embodiment is a unitary event, even if the persona associated with the embodiment can be seen as now so severely demented that she retains no recollection of the prior competent persona. Along these lines, Professor Dworkin asserts that "the competent and demented stages of life are steps in a single life, . . . [and] the competent and demented selves are parts of the same person." This judgment about a single, unified life conforms to the way people see their own lives, as shown by the effort to employ advance directives. "Someone who makes a prior directive sees herself as the unified subject of a human life. She sees her concern for her body, her goals, or her family as transcending her [future] incapacity." For most persons, then, it is self-evident that they ought to be given prospective dominion over postcompetency matters such as medical intervention, property dispositions, residency locus, organ donations, autopsy, and funeral arrangements.

58. Buchanan & Brock, supra note 4, at 160.
59. Id. at 168.
60. Id. at 160, 185. Even in situations in which Buchanan and Brock consider personal identity to be unchanged, they wrestle with the conflict between a person's autonomy interests and the contemporaneous interests of the incompetent patient. To them, it would be immoral to accomplish the demise of an incompetent persona possessing clear capacity for net pleasure or satisfaction in life. See id. at 160.
61. This argument is not directed towards situations in which a person has undergone a brain transplant or has been successfully thawed after years in a cryonic state (causing the patient to lose all memory of her prior character). Judgment about such eventualities is hereby deferred.
62. Dworkin, supra note 50, at 5.
63. Rhoden, Legal Objectivity, supra note 32, at 860 (footnote omitted).
The notion of a single integrated existence which encompasses both competent and postcompetent stages also conforms to the way others view a person’s life. A person is remembered as one being, even if that being undergoes radical changes during his lifetime. The incompetent persona is viewed by surrounding persons as a reflection of the former self, still embodying the values and beliefs previously associated with the now incompetent person. Thus, we still think of the incompetent individual as a Catholic, Jew, or whatever faith she previously professed. Similarly, that person is perceived as maintaining a character—self-centered, altruistic, or whatever—even if that character is no longer discernible. In short, the concept of a unitary existence—with a competent and postcompetent being viewed as having a single personal identity—conforms both with how people see themselves and how others see them.

The moral foundation for permitting a competent person to control the fate of his later incompetent persona has already been presented. The competent person nurtured and developed the body, character, and relationships later associated with the incompetent persona. The competent person thus earned a certain prerogative to direct the fate of the succeeding incompetent persona as that fate impacts on the recollections of a person’s integrated lifetime.

At the same time, however, the incompetent persona is still a human being and possesses certain interests despite his or her demented state. The demented persona may not only have physical sensations, but might even be in an ostensibly pleasant emotional state. While it is argued here that a person’s advance instructions have substantial moral status, the incompetent person’s contemporaneous interests also have moral status. The question then becomes whether and to what extent the future-oriented autonomy interests of the individual must be circumscribed by the contemporaneous interests of the incompetent patient.

The key to response might be the boundary of humane conduct toward an incompetent being. Just as society places a limit on what a competent person can do to his competent self, there is a limit on what a person can dictate for his future, incompetent persona. In the next section, how this notion of basic humanity impacts on actual medical decision-making will be explored.

IV. CONFLICTS WITH CONTEMPORANEOUS INTERESTS

Several examples will help crystallize the potential tension between an advance directive and the contemporaneous interests of an incompetent patient. Although some commentators would resolve the tension through

64. See supra note 50 and accompanying text.
significant constraints on the implementation of an advance directive, it may
be argued that advance instructions should usually prevail despite some im-
pingement upon the immediate interests of the incompetent patient.

In the following scenarios, assume that all patients were fifty-years-old at
the time of making an advance directive and that the critical medical deci-
sions are confronted five years later. Assume also that no evidence exists
that the patient changed his mind or wavered in resolve between preparation
of the advance directive and losing competence.

Scenario (1): Person A, a Jehovah's Witness, prescribes in an advance
directive that blood transfusions should not be administered regardless of
the life-saving potential of such medical intervention. A is aware of the life
and death implications of this religiously motivated instruction. Later, A
becomes prematurely senile and incompetent. Still later, the senile patient
develops bleeding ulcers which demand blood transfusions. With a blood
transfusion, A will survive and continue to live as a "pleasantly senile" per-
son for a number of years. The senile A no longer has recollection of, or
interest in, religion; however, she remained an avid Jehovah's Witness up
until the time of incompetency. Should the attending physician administer a
life-saving blood transfusion?

Scenario (2): Person B believes both that life should be preserved to the
maximum extent possible and suffering is preordained and carries redemp-
tive value in an afterlife. B prepares an advance directive in which all possi-
ble life-extending medical intervention is requested and all pain relief is
rejected. At the time of the preparation of the directive, B has a conversa-
tion with a physician in which the physician explicitly warns B that many
terminal illnesses entail excruciating pain. Despite that admonition, B di-
rects that all means to preserve life be utilized, and that analgesics be omit-
ted. Subsequently, B suffers from cancer which both affects B's brain,
rendering B incompetent, and causes B to suffer excruciating pain. Further
medical treatment such as radiation or chemotherapy will extend B's life,
but will not itself relieve the pain or cause any remission in which compe-
tence would return. Should the attending physician sedate the patient and
cease the life-prolonging medical intervention or both?

Scenario (3): Person C is an individual with chronic heart problems. Phy-
sicians have informed C that at some stage he will need a heart transplant in
order to survive. C prepares an advance directive stating that if he becomes
incompetent and survival becomes dependent on a heart transplant, then
such a transplant should be rejected because of its expense. C prefers to
leave a substantial monetary legacy to his children. Later, C becomes pre-
maturely senile and incompetent. Still later, C's heart deteriorates and a
heart transplant becomes necessary to preserve C's life. With the transplant, C will very likely continue to live for three to five years. Without it, C will die within a few months. The transplant will cost $100,000 and is not covered by any insurance or government benefit program. C's estate totals $100,000. Should a life-extending heart transplant be performed?

Scenario (4): Person D is a health care professional sensitive to society's needs for organ and tissue donations. In her advance directive, D provides that if she should become incompetent but remain physically healthy, then she wishes to donate a kidney and bone marrow to needy recipients. Later, D is afflicted with Alzheimer's disease and reaches a point of profound dementia. Needy recipients for kidney and bone marrow transplants have been located. The prospective transplant operations will pose only a slight risk to D and entail only mild pain. At the same time, the now incompetent D has no recollection of her prior instruction and no appreciation of the altruism involved in donating an organ or tissue. She will derive no contemporaneous gain from the contemplated operations. Should the transplants be performed in accord with D's advance directive?

Scenario (5): Person E is a sociology professor known for her intellectual sharpness. E takes enormous pride in that intellectual acuity. E drafts an advance directive prescribing that if she should become mentally impaired and incompetent to the point where she can no longer read and comprehend a sociology text, then all life-preserving medical intervention should be withheld. When reminded by her spouse about the potential for happiness in an incompetent state, E replies that she deems significant mental dysfunction to be degrading and personally distasteful. For her, such a debilitated existence is a fate worse than death. Later, E suffers a serious stroke which renders her permanently incompetent and incapable of reading or performing intellectual tasks. E is also unable to swallow and is therefore dependent on artificial nutrition. At the same time, E does not appear to be in any pain and seems to derive some pleasure from listening to music. Should the life-preserving nasogastric tube be disconnected?

In each of the above situations, people have issued advance directives which effectuate their personal values and concepts of dignity. Yet implementation of those prior instructions conflict in some measure with the contemporaneous interests or well-being of the incompetent persona. Can the advance directive prevail? Does prospective autonomy encompass the prerogative to impact negatively on the incompetent persona?

The cases decided to date do not really resolve the conflict between advance instructions and contemporaneous best interests. There are decisions which speak in fairly absolute terms of a person's "right to avoid circum-
stances in which the individual himself would feel that efforts to sustain his life demean or degrade his humanity.”65 But none of these cases involve situations in which the previously competent patient’s vision of dignity clashes with that patient’s subsequent perceptible interests. A few decisions suggest that a previously competent patient’s clear directive prevails against a subsequent guardian’s appraisal of the incompetent patient’s best interests.66 Yet these judicial expressions occur in cases in which the incompetent patient had reached a permanently unconscious or stuporous state. As such, the expressions merely represent dicta because the cases do not involve any evident conflict between a prior directive and the perceptible interests of the incompetent patient.67

In addition to the above judicial expressions, DPOA-HC acts in many states purport to give a health care agent the authority to make the same range of decisions that the principal could make if competent.68 It is a truism that a competent patient would be entitled to reject life-sustaining medical intervention or to consent to nontherapeutic medical procedures even if such a decision did not conform to the apparent well-being of the patient. Thus, in theory, these statutes confer authority on an agent to implement an advance directive which conflicts with the immediate well-being of the incompetent persona. However, the theoretical scope of these statutory measures has not been tested.

As a practical matter, the moral clash between advance directives and contemporaneous patient interests will seldom require judicial resolution. Most commentators agree that when obvious harm to contemporaneous patient interests will be a consequence of literal application of an advance directive, the decision-makers69 may at least examine whether the maker of the directive anticipated and considered the consequences now confronted.70

66. See In re Browning, 568 So. 2d 4, 13 (Fla. 1990); Estate of Greenspan v. Gelman, 558 N.E.2d 1194, 1202 (Ill. 1990); In re Peter, 529 A.2d 419, 425 (N.J. 1987).
67. Implicit in this statement is the judgment that prolongation of life is not always in the best interests of a moribund patient.
68. Such measures commonly instruct a health care agent to implement the wishes of the principal as gleaned from the advance directive or elsewhere. “Best interests” of the incompetent patient must guide the agent when the patient’s wishes cannot be determined. See, e.g., CAL. CIV. CODE § 2500 (West Supp. 1990); IDAHO CODE § 39-4505 (Supp. 1991); MISS. CODE ANN. § 41-41-163 (Supp. 1991); N.Y. PUB. HEALTH LAW § 2982(2) (McKinney Supp. 1992); R.I. GEN. LAWS § 23-4.10-2 (1989).
69. The decision-maker will usually be the patient’s designated agent or another guardian acting on behalf of that patient together with the attending medical staff.
70. See President’s Comm’n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment
When obvious harm to the now incompetent patient is threatened by enforcement of the directive, the decision-makers will be tempted to say that the previously competent patient did not adequately envision the situation that has now unfolded. Sometimes, such a determination will knowingly distort the previously competent patient's (perhaps idiosyncratic) wishes expressed in the advance directive. At other times, the decision-makers will simply be making a good faith judgment that the patient did not adequately contemplate the situation at hand. In either event, an accompanying decision to uphold the perceptible, contemporaneous interests of a now incompetent patient will seldom be challenged or overturned.

Medical staff, surrounding family, and courts are likely to acquiesce in decisions to maintain an ostensibly happy patient, or allow a severely anguished patient to die, regardless of the apparent intention of the prior directive. In sum, when clear-cut contemporaneous interests of an incompetent patient compel a particular course, the tendency will be to "interpret" an advance directive in accord with those interests. Alternatively, some agents will simply ignore the advance directive without engendering significant negative reactions or consequences.

Even if implementers of an advance directive are, as a practical matter, often guided by clear-cut contemporaneous interests of an incompetent patient, a question remains regarding what should be the result. Can an agent implement an advance directive which prescribes a result inconsistent with the incompetent patient's perceptible interests? Ordinarily, a guardian is required to act according to the best interests of an incapacitated ward. Can those best interests be overridden by the prior instructions of the ward? The legal authorities cited above suggest that the answer is yes—that at least in some states a patient's clearcut advance directive can override a patient's subsequent best interests. Yet even if it is a legally tolerable course, can the implementer of an advance directive morally override the clear-cut contemporaneous interests of the incompetent patient?


72. For examples of judicial willingness to follow the perceptible best interests of a patient when the patient's prior contrary instructions were not clearcut, see In re Estate of Dorone, 534 A.2d 452, 455 (Pa. 1987); University of Cincinnati Hosp., 506 N.E.2d 299, 302 (Ohio Comm. Pleas 1986). See also MO. ANN. STAT. §§ 459.025, .045 (Vernon Supp. 1992) (authorizing health care providers to treat a patient in contravention of prior expressions if the treatment would be consistent with the best interests of the patient).

73. As noted, however, the force of this authority has yet to be tested in actual controversy.
Commentators have expressed diverse views on the subject. A few simply assert that prior choices, if specific, must prevail over contemporaneous patient interests. By contrast, Professor Dresser argues that an advance directive should not be followed if the incompetent patient has any significant interest in continued life—meaning a capacity to interact with the environment. As we know, she accords little status to prior expressions. Even commentators who generally respect advance directives tend to draw a line in situations when the directive calls for withholding life-preserving medical intervention from an apparently content, though demented, patient. Professors Rhoden, Buchanan, and Brock seem to agree that an advance directive should not be implemented if to do so would terminate a life that "clearly contains more pleasure and enjoyment than suffering and pain." This constraint on advance directive implementation appears to flow from two considerations. First, future-oriented autonomy may have somewhat less force than contemporaneous autonomy. With contemporaneous self-determination, one can be sure that an effort is made to dissuade the competent patient from a foolish choice, allowing the competent patient to continue to re-assess the competing personal interests right up to the moment of her implementation of a terminal decision. By contrast, an advance directive is based on projections and speculation about prospective interests, and it may not be clear how much the directive-maker actually considered the situational conflict now confronted by the decision-makers. In particular, it may be difficult to determine how much the directive-maker was confronted and challenged concerning any morally problematic instructions issued. Second, there seems to be a moral compunction or instinctive revulsion about allowing a helpless, ostensibly content individual to die—even when the decision is grounded on that individual's own prior direction.

This author's position would be to implement, in most instances, a considered, future-oriented determination even at the expense of an incompetent patient's contemporaneous interests. Advance directives have moral status because a person's self-determination and self-realization goals naturally include a strong interest in shaping future images and recollections. The competent individual developed a physical body and spiritual character and thus has "earned" the right to influence future recollections. Because those recol-

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75. Dresser, Relitigating Life and Death, supra note 7, at 433.

76. Buchanan & Brock, supra note 4, at 111, 188-89; see also Rhoden, Legal Objectivity, supra note 32, at 859-60.
Prospective Autonomy

Selections become embodied in, and associated with, an incompetent persona, thus affecting other people's lifetime memories of the unitary person, the person's prior autonomous decisions carry some moral force.

Moreover, there is no intrinsic bar to competent decisions which may entail future harm for the decision-maker. A person can give away one's wealth, subject to rules involving fraud against creditors, even though that act might cause substantial hardship to a future incompetent persona. It is also understood that self-determination includes a prerogative to make decisions which most people would regard as foolish or unsound. Once a person has considered the relevant factors, including the prospect of "harm" to a future, incompetent persona, even an imprudent future-oriented decision should ordinarily be respected.

It is acceptable that special steps be taken to examine the circumstances surrounding the formulation of an advance directive that appears to subordinate the perceptible contemporaneous interests of an incompetent patient. As noted, future-oriented autonomy entails projections, and a problematic decision can no longer be reconsidered by the now incompetent person. Therefore, it is sensible to require that implementation of a "problematic" life and death decision be predicated on an examination of whether the maker of the advance directive really considered and intended the problematic result ostensibly dictated. This means that the ultimate decision makers should at least inquire whether the directive-maker was aware of the problematic consequences now being faced. For example, did the vitalist declarant realize that excruciating pain might be encountered during an extended dying process? Did the future-oriented person seeking to avoid indignity realize that the incompetent persona might derive some pleasure from a debilitated existence? Such inquiries are legitimate, but when good faith examination discloses that the maker of an advance directive knowingly dictated the result in issue, then that directive ought ordinarily to be upheld.

With regard to the scenarios presented above, this author takes the position that the advance directives should be implemented in each instance. This position is explained below by addressing each of the examples individually.

Scenario (1) (the Jehovah's Witness who has prospectively rejected all blood transfusions): A person's autonomy should include the prerogative to choose religious precepts that govern the competent and postcompetent portions of a lifetime. This is so whether or not violations of those religious precepts will be sensed or felt by the person. The premise is, as already explained, that persons may be harmed by disrespect for their values and self-defined dignity even if that disrespect is not sensed or appreciated. If
prospective autonomy is a meaningful concept, as is asserted, then the injury to autonomy interests from disregarding the advance directive outweighs the harm to the incompetent persona. The result is similar to that of the competent Jehovah's Witness who rejects a life saving blood transfusion.

The fact that the critical moment comes years after the original directive should not matter so long as the directive reflects a considered awareness of its content and effect, and so long as there is no indication that the person's values changed while still competent. The situation here is different from that of parents who are legally precluded from imposing religious precepts on immature minors in a fashion that will seriously harm the incompetent minor. Here, a mature adult has adopted a religious tenet understanding that the decision may subsequently disadvantage that person's own material interests as an incompetent persona.

Scenario (2) (the vitalist patient in excruciating pain): If a person has made a considered decision that, for purposes of future medical intervention, sanctity of life principles should prevail over distaste for suffering, then that choice ought to be respected. It is certainly a heart-rending spectacle to contemplate the helpless, anguished patient being sustained in reliance on prior instructions. There will be a great temptation to find that the patient did not sufficiently anticipate or appreciate the prospective pain, and therefore ought to be spared the consequences of an "imprudent" directive. Yet, when the directive is carefully considered and unambiguous, it is not immoral to hold the patient to the bargain. Respect for autonomy justifies such a result. People may have strong philosophical or religious beliefs in both the sanctity of life and the meaning of suffering. Those beliefs can form a legitimate part of the personal character and self-image which an individual may seek to project during a lifetime, including the post competence dying process.77

There may be certain limitations to the suggested approach to this scenario. For example, countervailing interests of certain surrounding parties might come into play. B's unpalliated suffering might provoke conduct, such as groans or screams, which are disruptive of the well-being of other

77. Professors Dresser and Robertson adopt a somewhat puzzling posture with regard to a "vitalist" who has dictated all possible life extending medical intervention. They suggest that such a position should be "left to individual discretion." Dresser & Robertson, supra note 13, at 244 n.55. If this refers to the discretion of the patient as expressed in an advance directive, then they are violating their precept that prior preferences are irrelevant. If the reference is to the discretion of the incompetent patient's guardian, then they are ignoring their precept that the current interests of the patient should govern. Perhaps to them, life extension is always of some benefit, so that the current interests of the incompetent patient are ambiguous. However, if this is their assessment, their current interests focus would dictate extension of life-saving intervention, rather than "discretion."
patients. If there is no practical way to insulate fellow patients against such impact or to transfer B to a more isolated setting, then the interests of the fellow patients would presumably justify overriding the patient’s prior instructions rejecting palliation. Further, medical personnel may have personal scruples about cooperating with the patient’s chosen course. The objecting personnel ought not be compelled to violate their consciences by implementing the advance directive. However, this clash of interests does not mean that the wishes expressed in the advance directive should be sacrificed. Objecting personnel should be permitted to withdraw from attending to the anguished patient, but there should be an obligation on such persons to secure medical personnel who would be willing in good conscience to cooperate with the patient’s advance choices.

Another practical constraint is the availability of resources to finance B’s protracted medical struggle. It is increasingly clear that there is no constitutional or social obligation to finance all beneficial medical services. The impetus to finance medical services is even less for care which is torturous to the incompetent patient and inappropriate from the perspective of some medical staff. Health care providers may be unwilling to provide this latter type of care to the impecunious “vitalist” patient.

Another wrinkle might be added to the scenario if the incompetent patient is not only groaning in distress, but is also verbally demanding to have the life-preserving medical intervention withdrawn (contrary to her prior instructions). When the incompetent patient is capable of articulating a preference, there is temptation to treat the new expression as a revocation of the advance directive. Indeed, “living will” statutes in many jurisdictions provide that a living will can be revoked by any instruction from the patient regardless of the patient’s mental condition.

Declarations by a currently incompetent patient can be accorded only limited force. That force depends on the degree of dementia involved. Incompetency can cover a wide range of mental incapacity. While some patients may be barely conscious and totally unable to comprehend, others may have some degree of understanding of their condition, including the prospect of death. For this latter group, a previously vitalist patient’s contemporaneous requests to be allowed to die may reinforce the determination of decision-makers to override the advance directive that prescribes prolongation of the torturous existence. The decision-makers tend to see the patient’s utterances as confirmation of their choice to act according to that patient’s contemporaneous interests. Of course, the patient is incompetent, so the expressions cannot be regarded as acts of genuine, considered self-determination. None-

theless, an aware (though legally incompetent) patient may be able to give assent to a proposed course of medical handling and that assent is entitled to some recognition. By contrast, the utterances of a gravely demented patient can reflect neither self-determination nor assent. Such deranged utterances certainly cannot be permitted to override a clear advance directive. If the patient is severely demented, then reliance on the verbal “revocation” of a vitalist advance directive is inappropriate.

An alternative rationale for nonimplementation of an advance directive might arise where an incompetent patient has reached such a degraded and undignified status that it is simply inhumane to allow a patient’s prior directive to dictate prolongation of that status. For example, B—who left an advance directive dictating all possible intervention—may not only be groaning in agony, but also thrashing to the point at which continuous physical restraint is necessary to keep the life-preserving medical intervention in place. Is not the specter of this helpless, agonized, and tethered human being enough to conclude that basic humanity demands some relief despite the patient’s carefully considered advance directive? Have we not reached the moral boundary of autonomy? Just as a self-determination prerogative cannot morally encompass self-mutilation or consent to slavery, can we not say that the prospective imposition of an utterly degrading status on an incompetent patient is simply beyond tolerable bounds?

The answer is yes. There are limits to what can be stomached under the rubric of autonomy. However, a few caveats should be imposed on a boundary to future-oriented autonomy governed by intrinsic human dignity. First, the criterion ought to be intrinsic human dignity as understood by a clear majority of the population. The fact that a guardian’s subjective version of human dignity will be offended by adherence to advance instructions ought

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79. See Bruce J. Winick, Competency to Consent to Treatment: The Distinction Between Assent and Objection, 28 Hous. L. Rev. 15 (1991). Even when the incompetent persona is aware and has some comprehension, ascribing binding force to contemporaneous utterances is problematic. Suppose the patient had been a devout Catholic who always believed in receipt of last rites but who now is an incompetent persona with some, but limited, understanding of the issue and is declining last rites. Should we follow the incompetent’s current wishes, or should we adhere to the advance directive? Unambiguous, competently made instructions should prevail so long as the treatment dictated for the incompetent persona is not fundamentally inhumane. Receipt of the last rites would not be widely perceived as inhumane. For discussion of an incompetent patient’s expressions seeking continuation of life sustaining medical intervention, see Cantor, supra note 2.

80. If the vitalist patient’s advance directive is overridden, it must be based on some other rationale, such as the moral impropriety of extending the suffering of a helpless, incompetent person on the basis of prior instructions. Such a sweeping rationale that an unambiguous advance directive must always yield to a patient’s contemporaneous interests is difficult to accept.
not be determinative. This caveat has application to B's case in Scenario 2. Many people would not be offended by continued administration of life-preserving treatment, in accord with the patient's prior instructions, despite the incompetent patient's significant suffering. Many people would acquiesce in a person's prerogative to design a dying process consistent with personal views about the nature and value of suffering. Only when actual suffering reaches the level most people would label intrinsically inhumane should the patient's directive be overridden.

Second, the directive should be breached only to the minimum extent necessary to avoid inhumane handling. In Scenario 2, for example, B ought to be given analgesics (in contravention of the directive), but the life-sustaining intervention should be continued in accord with the directive. In this way, the patient's intrinsic human dignity is preserved as consistently as possible with the patient's advance instructions.

A final obstacle to the implementation of B's advance directive may arise from attending physicians or other health care providers contending that continued medical intervention would be "futile." The contention may be that the torturous existence being sustained is so dismal that further medical intervention would be useless or futile. Implicit in that contention is the proposition that health care providers are not required to furnish care which is futile. Indeed, commentators frequently assert that physicians may decline to provide treatment that is useless and carries not even a modicum of benefit to the patient. However this principle cannot usually be permitted to prevail in a situation in which an advance directive prescribes continued life support. The proper resolution is to uphold the patient's competently expressed preference despite the tension with the physicians' view of sound medical practice. This is not to say that individual physicians will be compelled to furnish care they deem ethically inappropriate. When health care providers' conscientious scruples clash with patient preferences the solu-


82. Cf. In re Wanglie, PX-91-283 (Minn. Dist. Ct. Hennepin County 1991) (presenting a case which deals with a hospital's effort to secure withdrawal of life support from a permanently vegetative patient on the basis that the medical intervention was "inappropriate"); Lisa Belkin, As Family Protests, Hospital Seeks an End to Woman's Life Support, N.Y. TIMES, Jan. 10, 1991, at A1.

83. In some instances, professional scruples might be reinforced by a determination that the patient's previously prescribed course is so inhumane as to be beyond the bounds of acceptable professional behavior. In such instances, the patient's prescribed course might offend not only the attending physicians' ethical standards but also the profession's general ethical stan-
tion is to secure transfer of the patient's care to another professional who is willing to cooperate with the patient's chosen course. This recourse is particularly appropriate when preservation of life is the patient's chosen course.

Scenario (3) (the expensive heart transplant): If C were still competent, there would be little question that the patient would be entitled to reject a heart transplant for the sake of preserving a fiscal stake for his or her descendants. The patient would then be permitted to die despite the possibility of preserving a clearly meaningful existence for a number of years. Should C's altruistic nature and impulses be denied merely because the critical personal decision was made years before the moment for its implementation? Should the contemporaneous interests of the now incompetent persona dictate life preservation? For the same reasons future-oriented autonomy permits a person to impose her religious precepts on a subsequent incompetent persona, a person's articulated, altruistic principles should prevail. A person should be able to shape the collective memory of that person's lifetime, including recollections of the person's character and principles. Continued respect for those principles are part of the contemporaneous interests of the now incompetent patient.

Scenario (4) (harvesting an organ and tissue): Like the advance directive in Scenario (3), D's advance directive to donate a kidney and bone marrow upon death is grounded in altruism. In this case, solicitude is directed toward some future unknown organ recipients rather than known family members. Also, the altruistic gesture takes the form of authorizing removal of an organ or tissue rather than mere rejection of life-sustaining medical intervention.

Use of a prospective organ donation to fulfill an altruistic impulse is consistent with the previously expressed notion that a person's body is associated with a single, unitary existence. That is, the competent declarant tends
dards. Professionals who are willing to implement the disputed directive in that situation may be difficult or impossible to find.


85. Buchanan & Brock sympathize with this position. See BUCHANAN & BROCK, supra note 4, at 98. It is not clear, however, how this can be reconciled with their position that advance directives might not be permitted to dictate withdrawal of life-preserving care for an ostensibly happy incompetent. Id. at 188-89. Perhaps they are suggesting that a person should be able to dictate postcompetency medical care in accord with the interests of survivors but not to the point of terminating the life of an incompetent patient who is clearly enjoying her incompetent existence.

86. See Rhoden, Legal Objectivity, supra note 32, at 859.
to see the kidney (or bone marrow) as his own. The credit for altruism is registered in recollections about the unitary person even though the incompetent persona may not sense satisfaction from the altruism involved or from the approbation engendered. D will be remembered as the generous donor of the life-saving organ and tissue. Thus, the advance directive ought to be implemented even though the operation involved will have no therapeutic value for the now incompetent patient.

In the hypothetical case as presented, the harvesting operations would pose slight risk and create only mild pain for the incompetent persona. Suppose, though, that the incompetent patient is debilitated to the point at which the operation would pose a significant mortal risk for that patient. One reaction is that the prescribed course resembles suicide more than the rejection of life-sustaining medical intervention in the face of a naturally occurring dying process. This person is initiating a course of conduct involving a bodily invasion which will place her life in jeopardy. It may well be that health care professionals would refuse to cooperate with such a venture even if the patient were competent. If that is the case—the patient's prescribed course would not be followed even if the patient were competent—*a fortiori* that course need not be followed for the now incompetent patient.

Assume again that D's risk is slight and the pain modest. Suppose now the incompetent persona does not assent to the operations, so that she will have to be restrained and forced to undergo the procedures. In other words, implementation of the course prescribed in the advance directive will subject the incompetent persona to a measure of indignity. How does this element get factored in?

If good faith investigation discloses that the declarant never considered the possible degradation of the incompetent persona, that fact might provide a rationale for deviation from the prescribed course. Perhaps the declarant would have wavered in his resolve if the prospective indignity had been appreciated. But if good faith investigation discloses that the declarant did want the transplant performed—regardless of the implications for the incompetent persona—then the advance directive should be implemented. Just as an advance directive can prescribe the withdrawal of life support and arguably "harm" an incompetent persona, a directive should be able to dictate a course which subjects the incompetent persona to a modicum of indignity. The limit to this principle has been discussed above in the context of Scenario (2). At some point the course prescribed by the advance directive becomes so intrinsically inhumane that decision-makers may justly refuse to fulfill the directive. But that point would not be reached in the present sce-
nario so long as the restraint of the incompetent persona would only be temporary.87

**Scenario (5) (the demented professor):** For E, maintaining a dignified image was crucial. Similar to her, some people wish to preserve for posterity their images as vital, active, and acute individuals. Part of the self-respect and dignity which they value is grounded on avoiding a deteriorated status which they regard as degrading. This concern about deterioration may reflect apprehensions of frustration, embarrassment, or humiliation of being viewed in an incompetent state. If that is the rationale for the original instructions, and if the feared emotions don't materialize (as best the decision makers can tell), then there might be a legitimate basis to override the advance directive. But such apprehensions might not be the core of the patient's concern. Previously active and vital people may seek to avoid an undignified status, such as permanent unconsciousness or extreme dementia, even if they understand that there will be no emotional suffering in the debilitated state. In part, their concern may be to avoid mental anguish or burdens for surviving relatives who must cope with the debilitated individual. Or, the person may simply view a life image (and the personal investment in cultivating that image) as being debased by a gravely deteriorated existence.

In principle, this aspiration to maintain dignity deserves as much respect as the religious or altruistic motivations discussed in previous scenarios. Indeed, religious precepts, concern for survivors' interests, and concern about a dignified image are all part of the self-respect, values, and personality which an individual seeks to cultivate in a lifetime.

As a result of strokes, brain trauma, or degenerative neural diseases, many persons reach a point of grave physical and mental debilitation. The names Conroy, Clark, Dinnerstein, Foody, and O'Connor each represent a court case in which the saga of such a person is recounted. The formerly vigorous person has become a helpless patient, confined to bed, unable to feed himself, and usually incontinent. The patient is conscious, but barely so. It is difficult to determine if the patient is in physical or emotional pain. The patient may occasionally groan, sigh, or smile. The patient may be aware of surrounding people but cannot recognize or communicate with friends or loved ones. The patient has no hope of recovery. The patient is indefinitely sustained by artificial nutrition, by kidney dialysis, or by mechanical ventilation.

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87. Restraints are often used to prevent institutionalized patients from harming themselves or others. Such restraints are not per se inhumane, though they may become inhumane, depending on their nature and duration.
In such a situation—when the contemporaneous benefits and burdens of the incompetent patient can no longer be measured with any confidence—the patient's previously articulated, dignity based instructions ought unquestionably to prevail. The incompetent patient has reached a level of incapacitation which many previously vital persons would view as demeaning. If a person has indicated in an advance directive that such a status is personally distasteful, then that judgment ought to be respected. This is so even if the uncomprehending, deteriorated patient is not perceptibly suffering and has some remaining capacity for pleasure.

Some commentators would draw the line at an incompetent patient whose potential for pleasure and satisfaction seems to clearly outweigh any material detriments, such as perceptible pain and suffering. An illustrative case is the “pleasantly senile” person. This incompetent individual may have lost all short-term memory, and may be incapable of functioning intellectually at anything resembling the person’s previous level. Nonetheless the person seems “happy” and capable of deriving certain simple pleasures from life (such as E’s listening to music). The commentators’ thesis seems to be that it is inhumane or immoral to withhold or withdraw life preserving medical intervention from such a person, even in reliance on an explicit advance directive.

Perhaps not. One the premise accepted above (in Scenario #2) is that certain handling of an incompetent patient might be so intrinsically degrading or undignified as to be immoral (according to widely shared societal standards). That principle has some relevance to the present context. For example, if the withholding of medical intervention would prompt an agonizing dying process for the ostensibly content, yet incompetent patient, that result might be labelled inhumane and impermissible. In many situations, though, the withholding of life-preserving medical intervention could be accompanied by palliatives to provide a painless dying process.

The further question, then, is whether it is intrinsically immoral to implement an advance directive which calls for withholding life-preserving medical intervention from a gravely deteriorated, previously vital individual when the incompetent persona still has clear capacity for net pleasure or satisfaction from continued existence. From a perspective that values prospective autonomy, it is not immoral for E to seek to preserve an image of vitality—a certain version of self-respect—by dictating the withholding of further medical intervention from her severely deteriorated persona. This is so even if E’s

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88. If the advance directive were grounded on unrealized apprehensions of embarrassment and humiliation, there might be a basis for maintaining medical intervention despite the advance directive. This is a matter for good faith interpretation of the directive.
incompetent persona is still capable of deriving some pleasure from existence, such as by listening to music. As long as withholding medical intervention will not impose cruel suffering on the incompetent patient, an unambiguous and considered directive should be upheld.

The issue is not likely to arise very often. Most people would not want to prompt the demise of their ostensibly happy future persona. Yet it is not intrinsically immoral for a person to shape future medical intervention in a way which will minimize any period of substantially deteriorated existence. Avoidance of a personally demeaning dying process is, ordinarily, part of the self-realization and self-respect furthered by future-oriented autonomy.

Of course, my moral perspective on E's case may be perverted by an excessive-compulsive preoccupation with notions of autonomy. If my perspective is indeed aberrational as tested by prevalent social standards, it perhaps ought to be ignored. I concede that if allowing E to die is widely deemed immoral, then that judgment ought to instruct the legal norm governing those responsible for the medical fates of incompetent patients. However, the intrinsic moral nature of withholding life-preserving medical treatment from a contented but severely demented patient is still an open issue. It is a subject for continued public debate informed by medical, legal, and philosophical inputs. It has been argued here that giving expansive scope to advance directives, even to the detriment of the ostensible immediate interests of an incompetent persona, is both morally and legally sustainable.