The Limits of Legal Objectivity

Nancy K. Rhoden

THE LIMITS OF LEGAL OBJECTIVITY

NANCY K. RHODEN†

Professor Nancy Rhoden completed this Article in March 1989, three months before the United States Supreme Court granted certiorari to Cruzan, by Cruzan v. Harmon.* *The* Cruzan *case, however it is decided, will force the Justices to wrestle with a moral and philosophical dilemma that intrigued Professor Rhoden throughout her professional career.*

Nancy Cruzan was injured in a single-car accident in 1983. Since that time, she has been in a persistent vegetative state, responding only to pain and perhaps to sound. Ms. Cruzan did not execute a living will, but some time before her accident she did state that she would not want to live unless her life could be "halfway normal." Now her parents seek to have removed the tube that provides her life-sustaining nutrition and fluids. The Missouri Supreme Court has denied that request, and the nation's highest court now is considering what standards should govern and who should make a decision to terminate treatment for an incompetent patient.

Professor Rhoden surveys the philosophical approaches courts could apply to this gut-wrenching choice. In this Article, she advocates giving primacy to the directives, such as living wills, that incompetent patients made while competent. In cases such as Nancy Cruzan's, in which the prior directive is even more ambiguous than the often-ambiguous living will, Professor Rhoden still would consider relevant the formerly competent patient's probable desires. She makes a compelling justification for this moral position. To give the patient's prior choices no weight at all, in her view, would undermine the right of present choice for us all. Professor Rhoden's advice to the Supreme Court would be: Heed Ms. Cruzan's expressed wish to have a "halfway normal" life or no life at all.

I. INTRODUCTION

Ever since the well-known tragedy of Karen Quinlan, courts have held that certain incompetent patients can be allowed to die. What courts *do* in these cases is perfectly reasonable, because the patients in question typically are unconscious, or barely conscious, or unlikely to benefit from treatment. The hard

† Nancy K. Rhoden was a professor of law at the University of North Carolina at Chapel Hill at the time of her death in October 1989. She previously had served on the law faculty at Ohio State University College of Law and as a visiting assistant professor of pediatrics at Albert Einstein College of Medicine. She was a post-doctoral fellow at The Hastings Center in 1979-80. Professor Rhoden earned her B.A. degree from Oberlin College and her J.D. degree from New York University School of Law.

* 760 S.W.2d 408 (Mo. 1988), *cert. granted sub nom.* Cruzan by Cruzan v. Director, 109 S. Ct. 3240 (1989).

part is *justifying* what they do. The most common justification is that could the patient speak, she would reject treatment. If the patient has stated her preferences in advance, this subjective test works quite well. Unfortunately, most patients have not done this, so the test becomes somewhat speculative. For example, in deciding what Karen Quinlan would want, the New Jersey Supreme Court relied on a belief that most people would not want to survive in her condition.[1] Even if that is right, it does not mean Karen would feel this way. Courts typically adopt a presumption in favor of treatment and make families prove the patient would reject it.[2] In cases such as *In re Quinlan*,[3] this burden of proof seldom truly is met.

The limitations of the subjective test have led some courts to seek a more objective standard. For example, the seminal case of *In re Conroy*[4] holds that if definitive evidence of the patient's desires is unavailable, treatment still can be stopped if the family proves that the burdens of the patient's life, in terms of pain and suffering, clearly and markedly outweigh the benefits.[5] "Objective" is being used here to mean focusing upon the patient's condition now—not her prior values—and relying upon facts about persons in general. Although such objectivity is tempting, I will argue that it is ultimately misguided. The first problem is that the legal standard, as phrased, can almost never be met: a patient will seldom suffer the degree of pain cases such as *Conroy* require. Second, and far more important, the search for a standard that applies to *all* persons inclines its adherents to focus far too heavily upon pain. This focus is understandable: persons are far less likely unanimously to agree about such things as dignity and quality of life, because these reflect highly individual, subjective, and complex values. But how can we make moral choices about life and death without looking to such values, especially when the patient formerly held relevant, albeit perhaps inconclusive, views?

Another problem with an objective standard is that taken seriously, it undermines prior directives. This is because in telling us to view the patient just as she is now, bereft of her prior beliefs, it does not seem to matter whether her beliefs were strongly or weakly held, firmly expressed or never fully articulated. So why honor a living will,[6] if it clashes with the incompetent patient's current interests? Proponents of an objective test agree that it conflicts with the idea that there's a duty to honor prior choices,[7] but they do not see this as a problem.

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1. *In re* Quinlan, 70 N.J. 10, 41-42, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 922 (1976).

2. *See* D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING § 11:4, at 268, § 11:21, at 314 (1981).

3. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

4. 98 N.J. 321, 486 A.2d 1209 (1985).

5. *Id.* at 365, 486 A.2d at 1232.

6. A living will is the means by which a competent adult authorizes or requires the withholding of specified medical treatment in the event of a catastrophic illness or condition that renders the declarant incompetent to make such a decision personally. Thirty-eight states and the District of Columbia have enacted statutes authorizing living wills. *See generally* Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737 (comparing and evaluating existing living will statutes).

7. *See* Dresser, *Relitigating Life and Death*, 51 OHIO ST. L.J. 425 (1990); Dresser & Robertson, *Quality of Life and Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 LAW, MED. & HEALTH CARE 234, 236-37 (1989).

Honoring a prior choice that harms an incompetent person shows, they suggest, inadequate respect for incompetents. I will argue that giving primacy to the moral values of the formerly competent person over her later, incompetent self is indeed justifiable, because in exercising, in Ronald Dworkin's term, "precedent autonomy,"[8] a person sees her present values as relevant to future medical decisions. A reasonable precept of moral decisionmaking is to view the person as she saw herself at the time she contemplated the potential moral dilemma.

This justification for the moral primacy of competent choice retains some relevance even in the absence of a prior directive, though of course it plays a far weaker role. Only prior choices yield an actual duty to obey them, but a formerly competent person's values are relevant to a treatment decision because when competent she probably would have believed this. If people typically were indifferent to their post-incompetency fate, my conclusion might well change. Because they are not, the person's beliefs when competent are relevant, though they may carry far less weight than an actual prior choice.

Finally, I briefly will address a potential objection to the claim that we have a duty to honor prior directives. This objection is that after unconsciousness, as after death, there is no subject to whom a duty can be owed. I agree that, like testamentary wills, living wills raise the "problem of the subject."[9] Although failure to honor prior wishes cannot harm a dead or unconscious person, posthumous or post-consciousness betrayals can count as wrongs to the person, viewed as she was when the promise was made, because the living have assumed a duty to view her as she was when alive or conscious, and not as a mere corpse or insentient body.

II. THE FAILURE OF THE OBJECTIVE TEST

Claire Conroy, a nursing home patient in end-stage senile dementia, was bedridden, incontinent, and unable to speak, interact with others, move from a semifetal position, or even swallow. She was not unconscious, being able to move her head, arms, and hands to some minor extent, and to scratch and on occasion to smile;[10] rather, she would be classified as "barely conscious." Her nephew sought removal of the nasogastric feeding tube that sustained her life. The problem was that although there was some evidence that Ms. Conroy would not want to live like this—she had avoided doctors, refused to sign herself into an emergency room, and said she would hate to be in a nursing home—she had never specifically stated she would reject such treatment.[11]

This evidence, the *Conroy* court found, did not meet the subjective test.[12] Rather than stopping there, the court went on to hold that treatment can be withdrawn if either of two objective tests are met. Under the first, the "limited-objective" test, there must be: (1) some trustworthy evidence that the patient

8. Dworkin, *Autonomy and the Demented Self*, 64 MILBANK Q. 4, 11 (Supp. 2 1986).
9. *See infra* note 61 and accompanying text.
10. *In re* Conroy, 98 N.J. 321, 337, 486 A.2d 1209, 1217 (1985).
11. *Id.* at 385-87, 486 A.2d at 1241-43.
12. *Id.* at 387, 486 A.2d at 1243.

would have rejected treatment; and (2) the burdens of her life, in terms of unavoidable pain, must clearly and markedly outweigh any physical, emotional or intellectual benefits.[13] Under the second, the "pure objective" test, treatment can be withdrawn even if there is no evidence of the patient's desires, if the burdens of her life clearly and markedly outweigh its benefits, and if she is in such severe, intractable pain that "the effect of administering life-sustaining treatment would be inhumane."[14] I will discuss the two tests here in tandem, because even though the subjective prong of the limited-objective test looks to the patient's individual values, the objective prong, the proof that burdens outweigh benefits, still must be met.[15]

In critiquing the objective test, I will begin by considering its application to persistently vegetative patients. This is perhaps unfair: Ms. Conroy was not unconscious and the *Conroy* court did not claim that the objective standard would resolve cases involving the persistently vegetative. Indeed, the New Jersey Supreme Court since has recognized that an objective benefits/burdens analysis is impossible with persistently vegetative patients, who "[b]y definition . . . do not experience . . . benefits or burdens."[16] Nonetheless, the case of the vegetative patient highlights the objective test's limitations so dramatically that it sets the stage for showing that even if the patient is not unconscious, some of the problems with the test remain.

The objective stance is not concerned with the patient's prior values; it simply looks to the present benefits or burdens of the vegetative patient's life. Persistently vegetative patients are, of course, completely unaware of anything in their environment.[17] Hence it is reasonable to conclude that they reap no benefits from living, unless life, in and of itself, counts. It is very odd, however, to view life as a benefit to someone who is wholly unaware of being alive. This would mean that plants are benefited by their life and have an interest in its continuation.[18] A far more plausible view is that to have an interest in, or to benefit from, life, an entity must have, or be expected to acquire, that minimal level of consciousness needed to experience pleasure and pain.[19] Since the vegetative lack this, the benefits column in our equation is zero.

The problem is, the burdens column is also zero. When the *Quinlan* court said that Karen should not be forced to submit to the invasion of the respirator

13. *Id.* at 366, 486 A.2d at 1232.

14. *Id.*

15. In Ms. Conroy's case the court held that the subjective prong of the limited-objective test was met, based on Ms. Conroy's prior attitudes toward doctors and institutional care. *Id.* at 385-87, 486 A.2d at 1241-43. However, termination still required that the benefits/burden ratio be proved. *Id.*

16. *In re* Peter, 108 N.J. 365, 376, 529 A.2d 419, 425 (1987); *see also In re* Jobes, 108 N.J. 394, 413, 529 A.2d 434, 443 (1987) (companion case).

17. *See generally* Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 HASTINGS CENTER REP. 27 (Feb./Mar. 1988) (describing the neurological functioning of a persistently vegetative patient).

18. *See* Buchanan, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. REV. 386, 402 (1986).

19. *See* Buchanan, *supra* note 18, at 402-04; Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 383-84 (1986).

and "endure the unendurable,"[20] it sounded as if these were Karen's interests at stake. But, as Rebecca Dresser has put it:

> [T]he court imputed to the patient interests she was incapable of possessing in her comatose condition. Privacy, bodily integrity, pain, and suffering could no longer matter to this patient. The concerns that the court imputed to Quinlan were instead concerns of her family and of the significant portion of our society that opposes aggressive medical treatment for permanently comatose patients.[21]

If one is intent upon vanquishing the values the patient held while conscious, then extreme dependency, lack of privacy, and bodily invasion cannot be counted as burdens, because they currently cannot be experienced as such. Looking to the present interests of vegetative patients thus yields no reason either to treat them or to stop. If one counts the exceedingly remote possibility that the diagnosis is wrong and the patient will regain consciousness, then the scale tips slightly toward treatment.[22] Discounting this possibility leaves decision makers back with no answer at all, because a vegetative patient viewed solely in the present enjoys no benefits and suffers no burdens.

Unlike the persistently vegetative, other patients, even quite debilitated ones, can experience some benefits and burdens from their lives. Someone with, for example, Down's syndrome, has mental deficits but is able to enjoy many of life's pleasures. Hence decision makers can feel quite confident that her life's benefits outweigh its burdens. One can call this decision "objective," in that it does not rely on values specific to the individual patient. Because the assessment is neither measurable nor predictably unanimous, a better term might be "reasonable intersubjectivity." Whatever we call it, when the interest in living is strong and readily apparent, most people can agree that treatment should be provided.

While it is comforting to recognize that in certain cases a person-neutral assessment does work, this is less useful than one might think, because doctors and families are seldom debating letting someone die who can walk, run, laugh, sing, and love. When the patient in question is conscious, she is much more likely to be, like Claire Conroy, "barely conscious." Although Ms. Conroy did smile on occasion, her life was bereft of what most people consider life's pleasures. It was also unclear what, if any, burdens she experienced. Someone still mentally aware might well experience the nasogastric tubing, the lack of privacy, the physical limitations, and the total dependency as burdensome. But Ms. Conroy undoubtedly had lost the capacity to experience such complex emotions. Indeed, even assessing burdens in terms of physical pain was inconclusive, because doctors could not tell whether Ms. Conroy still could feel pain.[23]

Given the *Conroy* court's almost exclusive focus on pain, it is not surprising that the court found that neither objective test had been met, and that more

20. *In re* Quinlan, 70 N.J. 10, 39, 355 A.2d 647, 663, *cert. denied*, 429 U.S. 922 (1976).
21. Dresser, *supra* note 19, at 385.
22. Buchanan, *supra* note 18, at 402; Dresser, *supra* note 19, at 384.
23. *In re* Conroy, 98 N.J. 321, 337, 386 A.2d 1209, 1217 (1985).

evidence would be needed before treatment could be terminated.[24] The court found the evidence about Ms. Conroy's capacity to perceive pain insufficient, noting that none of the doctors "testified *conclusively* as to whether she was in pain or was capable of experiencing pain or thirst."[25] The court likewise found the evidence concerning Ms. Conroy's ability to feel pleasure insufficient.[26] One might begin to suspect that if even Ms. Conroy must be treated, an objective test almost never will justify termination of treatment for a barely conscious patient, much as it fails to justify termination for the unconscious. (This suspicion grows when we note that fully conscious terminally ill patients seldom experience pain that is not controllable by drugs,[27] making it even less likely that barely conscious patients do so.[28]) Some might argue that this suspicion can be allayed once better neurological tests are devised and implemented. After all, the *Conroy* court's conclusion was purely evidentiary—that the burdens, in terms of pain, had not been demonstrated conclusively enough to overcome the presumption for treatment. The court, in other words, wanted more sophisticated neurological evidence. Rebecca Dresser likewise claims that the challenge for courts and guardians is "to develop and refine a behavioral 'language' of pain that can be legitimately applied to incompetent patients."[29] Such a language would be based on observation of behaviors such as rubbing, bracing, grimacing, and sighing.

This project is, at the least, challenging. Pain is a subjective experience: a condition (such as being severely burned) that we know to be painful is painful only if the patient is aware of it. Hence behavioral evidence is being used to make suppositions about an internal state of awareness. External signs, however, can be unreliable indicators of internal states—for example, persistently vegetative patients, who are unquestionably incapable of feeling pain,[30] nonetheless may move and grimace in a way that suggests they are suffering.[31] But let

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24. *Id.* at 386, 486 A.2d 1243. Ms. Conroy died while the appeal was pending, with the nasogastric tube intact. *Id.* at 340, 486 A.2d at 1219.

25. *Id.* at 386, 486 A.2d at 1243 (emphasis added).

26. The court stated: "Although Ms. Conroy had some ability to smile and scratch, the relationship of these activities to external stimuli apparently was quite variable." *Id.* at 387, 486 A.2d at 1243.

27. *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 19 (1983) [hereinafter PRESIDENT'S COMMISSION].

28. *Cf.* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT 37 (1987) (available information suggests that greatly debilitated patients or those near death suffer little pain from termination of artificial feeding and hydration).

29. Dresser, *supra* note 19, at 391. Dresser's position is that courts should: (1) apply a *present* best interests test, *i.e.*, one that focuses only on the interests a patient can have now, in her condition; and (2) supplement this with a forthright analysis of when a patient's interests are so minimal that the interests of others should count, and how much others' interests, and economic concerns, should count. *Id.* at 390-400.

30. *See* PRESIDENT'S COMMISSION, *supra* note 27, at 181; Cranford, *supra* note 17, at 31.

31. Karen Quinlan's family believed she experienced considerable pain, because of her groans and grimaces, and the increased muscular tension she experienced in response to stimuli such as being pinched. *See* R. BURT, TAKING CARE OF STRANGERS 147-48 (1979).

Internal states can be mediated by values as well. For example, similar pains may be experienced quite differently if they are seen as meaningless torture than if they are seen as valuable (*e.g.*,

us assume, for the sake of argument, that a behavioral language or neurological tests could be developed that would allow observers to classify and quantify the pain being experienced by patients who are nonverbal and only marginally conscious.

If such tests and indicators are used on a set of patients in Claire Conroy's mental and physical state, they presumably will distinguish those patients in little or no pain from those in moderate or severe pain. If the benefits of each such patient's life are nonexistent or quite minimal, assessing the extent and quantity of pain will tell decision makers what to do. If a patient's pain is severe enough to make her life a net burden, decision makers can grant the family's request for termination of treatment. If the tests show that the patient's pain is not so substantial, under *Conroy* the family's wishes must be overridden and treatment must continue. Thus these mortal choices hinge on pain and pain alone.

One response to this conclusion is that it is fine; that now we can make these decisions objectively. Indeed, on one level, this narrowing of focus to the present is perfectly understandable: Ms. Conroy's former beliefs are not clear, and at present her capacities *are* limited to experiencing physical sensations. Although subjective responses to pain may vary, aversion to pain is the closest we can get to a statement that holds across persons. This is why it is no coincidence that the *Conroy* quest for objectivity leads to a primary focus on pain. Pain is the best—indeed the only—candidate for unanimity, inasmuch as views about privacy, dignity, and the like may vary enormously among persons.

On another level, it seems that something has gone seriously wrong here. Many people, prior to losing their faculties, would be horrified at the thought of being assessed merely as a repository or locus of physical sensations.[32] They would think that while persons *can* be viewed in isolation from their former values, doing so loses sight of those elements normally thought most relevant to moral decisionmaking. The original dilemma, as Ms. Conroy's nephew saw it, was about a specific human being—Aunt Claire. The court's question is about anybody and nobody. As Thomas Nagel writes:

> The . . . problem . . . of insoluble subjective-objective conflict[] arises when we succeed in constructing an objective conception of something and then don't know what to do with it because it can't be harmoniously combined with the subjective conception we still have of the same thing.[33]

Something like this has happened here. Viewed objectively and in the present, Ms. Conroy's only interests are physical; her former beliefs simply do not count. Yet no one who loved her or even knew her will view her like that. They will see her as the now tragically debilitated "shadow of her former self" and hence

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labor pains, physical therapy, etc.). The patient in a condition such as Claire Conroy's presumably will not, however, have such higher values or goals mediating her perception of pain.

32. *See* Buchanan, *supra* note 18, at 396.

33. T. NAGEL, THE VIEW FROM NOWHERE 87 (1986).

likely will see her current interests as inextricably linked to her former values about life and death.

Because a person-neutral, present-oriented test excludes so much we intuitively find relevant, there is an almost irresistible urge somehow to incorporate more complex values into the equation. Hence Justice Handler, in his moving partial dissent in *Conroy*, argued that pain should not be the sole criterion, but that privacy, dignity, and bodily integrity should count, too.[34] Dresser likewise suggests that these concerns can be incorporated into a test that is still objective, but is better, more thoughtful, and more thorough.[35] In easy cases, such as Down's Syndrome, we may have a high enough level of intersubjective agreement that the mandate to treat looks "objective enough." In harder cases, where some people would choose death, majority views about quality of life may well tell us that the case is within the gray area where one reasonably could choose either life or death. But it is hard to expect that these varying values will tell us which to choose. This is because either one set of values or another must be invoked to reach the further conclusion that of the two permissible choices—continuing treatment or stopping—one is best.

The recognition that majority values can yield a range of reasonable choices, but that individual values are necessary to go further, is illustrated, I think, if we imagine for a moment that Claire Conroy had long been a committed vitalist, who believed life, in any condition, must be preserved. This would, it seems, be relevant to a moral decision about her. If relevant, it would probably restrict the choices to one: continuation of treatment. But the objective test cannot encompass Ms. Conroy's hypothetical vitalism, because she lacks the mental structure to be a vitalist *now*. Thus the more one tries to incorporate complex moral values, the more one returns to a reliance on *someone's* values, and the harder it is to justify invoking a stranger's, or even the majority's values, if we have any sense of what the patient herself might want. If the patient was never competent, majority views are the best we can do. But if she was, imagining that her prior values differed from those of the majority highlights the difficulties in adhering even to the most moderate of objective tests that looks to majority values, because the truly relevant values would seem to be Aunt Claire's.

III. Prior Directives and the Objective Enterprise

The objective standard as articulated in *Conroy* was, of course, intended only for those situations in which the patient's prior beliefs were not determinative. If taken to its logical extension, however, the quest for a person-neutral standard may come to clash with the widespread acceptance of clear-cut prior

34. *In re* Conroy, 98 N.J. 321, 396, 486 A.2d 1209, 1248 (1985) (Handler, J., concurring in part and dissenting in part). Perhaps the more recent New Jersey Supreme Court cases augur a rethinking of this focus on pain. In *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987), the New Jersey court noted that "[b]ecause the *Conroy* balancing tests are not applicable in this case, we do not reconsider today whether 'unavoidable and severe' physical pain should be an essential burden under those tests." *Id.* at 376 n.5, 529 A.2d at 425 n.5.

35. Dresser, *supra* note 7, at 427.

directives as controlling. This conflict arises because if we focus solely on the incompetent's present interests, we so radically distinguish her from the author of the prior directive that it's hard to see why the prior choice should govern.

To illustrate how a completely present-oriented test can undermine the justification for honoring living wills, imagine for a moment that after the court evaluated Ms. Conroy objectively, her nephew discovered a valid and clearly applicable living will rejecting all medical treatment if "barely conscious." Given its preference for a subjective test, the *Conroy* court almost certainly would want to reconsider and let the document control. But this hypothetical discovery creates a "past-present" conflict, in which Ms. Conroy's present interests support treatment, while her prior choice is to forgo it. Although the court could simply hold that an applicable living will trumps current interests, this decision procedure seems rather arbitrary in light of the just-completed assessment of current interests. Why, one might ask, should a prior directive control if it thwarts a patient's present interests?

One answer to this is that it should not. Dresser, as the most logical and consistent advocate of a present best interests test, essentially rejects living wills, except to the extent they provide useful reassurance in cases in which the objective choice would be to terminate treatment, so that they are largely redundant.[36] Hence my first task is to analyze her arguments and rebut them by setting forth a rights-based justification for honoring prior directives.

A. The Personal Identity Conundrum

One of Dresser's arguments against following prior directives lures us into the quagmire of debates about personal identity. She suggests that a competent person's prior choice should not control an incompetent's fate because, in essence, two different people are involved.[37] She relies on the theory of the self articulated by Derek Parfit, who argues that there is no one, unified "self" that exists as the precondition or grounding for one's desires, experiences, and sensations. Rather, the "self" is what we call that constellation of interests, beliefs, memories, and values in a particular segment of time.[38] Parfit would recognize continuous personal identity if there were, over a period of time, some reasonable degree of "psychological continuity," overlapping chains of specific memories, desires, and values.[39] Under Parfit's view, a fully competent person in his prime could readily be found to be a different person than he was ten years ago.

Parfit gives the example of a young socialist who, in anticipation of later inheriting great wealth, tries to bind himself to give it away by making his wife promise to prevent him from reneging on this commitment. Later, of course, he wishes to keep his fortune. Parfit suggests that the young socialist and the older, bourgeois landowner may be different persons.[40] Applying this theory to the

36. Dresser, *supra* note 19, at 379-82, 394-95; Dresser, *supra* note 7, at 433.
37. Dresser, *supra* note 19, at 380-81.
38. D. PARFIT, REASONS AND PERSONS 204-06, 223-28 (1984).
39. *Id.* at 206-08. He calls this "psychological connectedness."
40. *Id.* at 327. Postulating different selves does not, of course, answer the question of which

incompetent patient who, when competent, had made a living will, Dresser states: "If little or no psychological connectedness and continuity exist between the individual at the two points in time, then there is no particular reason why the past person, as opposed to any other person, should determine the present person's fate."[41]

Analysis of Parfit's theory is far beyond the scope of this Article. It does seem legitimate to suggest that he should bear the burden of proof, because his view runs so counter to the way ordinary people think of themselves. Being embodied, we think of ourselves as our bodies (at least until presented with puzzles such as memory transfers). We have memories that mix the mental and physical; we identify with our pasts, feeling shame or embarrassment about stupid things we did (even long ago); and we have traits, such as intensity, that persist over time and that are independent of our substantive beliefs or desires. Parfit's bourgeois landowner may not differ so radically from the young socialist. Although his politics have altered, his fervent, intense nature may have remained unchanged. Whatever the correct metaphysical view of personal identity, there is excellent reason to reject Parfit's view for purposes of legal and moral decisionmaking. The principle "one body, one person" is a virtual necessity for the criminal justice system, for duties to honor one's contracts, or to pay for one's torts. Without unified personal identity, "new persons" could spring fully formed into existence and legitimately could deny all family and financial obligations.[42] Of course, a belief's practical utility does not make it true; we grant corporations legal personhood without thinking of them as real people. My point is merely that accepting Parfit's view would wreak societal havoc, and if we do not accept it in general, why should we apply it to living wills, where a person specifically claims an identity with his future incompetent self and seeks to control its fate? Indeed, applying it here might be peculiarly inappropriate, because in most cases, rather than "changing his mind," the patient has become too incapacitated to have a mind to change. A more appropriate question might be not whether the incompetent is the *same* person, but whether, in moral terms, he is a person at all.[43]

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one should win. Although Parfit suggests that the wife plausibly could feel that her present husband cannot authorize her to break her promise to the now-nonexistent young man, *id.* at 328-29, Dresser, who is arguing for the primacy of present interests of incompetents, counters: "One might also ask, however, whether the wife should be bound by her promise to a person who no longer exists, when her present husband has a strong interest that will be thwarted by the earlier agreement." Dresser, *supra* note 19, at 380 n.40.

41. Dresser, *supra* note 19, at 380-81.

42. *See* Buchanan, *Advance Directives and the Personal Identity Problem*, 17 PHIL. & PUB. AFF. 277, 293-94 (1988).

43. Buchanan accepts Parfit's theory of personal identity, at least for the sake of argument, and then suggests that the threshold for finding that there is psychological continuity is itself a matter of choice and can be affected by policy considerations. He argues for setting a very low threshold, so that virtually any time someone confidently can be said to have lost continuity with his former self, he will at the same time have lost those features that make him, morally speaking, a person. *Id.* at 283.

B. The Impairment of the Incompetent's Interests

Fortunately, we need not resolve the personal identity conundrum, because while Parfit's theory helps Dresser justify viewing persons in isolation from their pasts, Dresser need not invoke Parfit. Instead, she simply can argue that honoring a living will can compromise unacceptably the interests of an incompetent person. One cannot be sure that what the person chose then is what he would choose now, because views about what constitutes an acceptable level of functioning may change radically as function declines.[44] Active, healthy persons often say they would never want to live if wheelchair-bound, on dialysis, or whatever, and then later embrace life despite their disabilities. Likewise, once one's capacity for complex intellectual pleasures is gone, simpler things take on greater importance. As Dresser and Robertson put it:

> If we truly could determine the choice that these patients would make if suddenly able to speak—if they could tell us what their interests in their compromised states are—such choices would be most likely to reflect their current and future interests as incompetent individuals, not their past preferences.[45]

Thus prior directives reflect competent persons' former interests, but the better, more caring way to make choices for incompetents is to focus on their current interests. The law should not allow someone to make a binding future choice for death, because to do so gives an unacceptable degree of primacy to the interests of competent persons over incompetent ones.[46]

The strength of this argument is reinforced by a very troubling sort of example. Suppose a highly intellectual person makes a prior directive stating that if he becomes even somewhat mentally impaired, he wants no medical treatment. He then suffers a mild stroke and is in a nursing home. While he cannot comprehend his prior directive, and hence can neither affirm nor rescind it, he appears to enjoy his simple existence, watching television and sharing meals with other patients. Then he gets pneumonia. His directive clearly rejects antibiotics. If it is controlling, the staff must simply watch him die. But, Dresser quite reasonably argues, he has substantial present interests in life, and they must prevail. This sort of case may well incline us toward a Parfit-type view—that this happy incompetent person *is* someone different from the intellectual who made the document—or, at least, should make us question the wisdom of necessarily subordinating present interests to prior choices, no matter how explicit and strongly held.

All this makes a strong case against prior directives. It suggests that the reason living wills have been so widely accepted is not that we have an abiding faith in future-oriented choices, but that the substantive choice in most living

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44. *See, e.g.*, Cantor, Conroy, *Best Interests, and the Handling of Dying Patients*, 37 RUTGERS L. REV. 543, 559-60 (1985). For example, persons who have never experienced a particular illness or disability rank it as significantly worse than persons who have experienced it. *See* McNeil & Pauker, *Incorporation of Patient Values in Medical Decision Making*, in CRITICAL ISSUES IN MEDICAL TECHNOLOGY 113, 121 (B. McNeil & E. Cravalho eds. 1982).

45. Dresser & Robertson, *supra* note 7, at 236.

46. Dresser, *supra* note 7, at 426.

wills is an objectively reasonable one (to avoid prolongation of the dying process, or treatment when persistently vegetative). Hence a prior directive may well help bolster a decision to stop treatment for a patient who lacks present interests in living, but it should not justify termination when the patient has such interests. I will later deal with the case in which the incompetent patient has clear-cut and substantial interests in living and will suggest that the right to make binding future choices should be less absolute than the right to make present ones. But first I must resurrect prior directives in general as reflecting a moral preference for individual choice rather than merely reinforcing objective decisions. To do so, I will show that rejecting future-oriented choices threatens present ones.

C. The Continuum with Contemporaneous Choices

Assume that George is a Christian Scientist who rejects all surgical interventions. He makes a prior directive refusing surgery at any time for any condition. He subsequently develops a brain tumor which impairs his cognitive processes so that he is incapable of either affirming or rejecting his prior directive. He is happily watching television, and the brain tumor could be removed, extending his life (though not restoring his competency). Dresser undoubtedly would say that decision makers should authorize surgery, on the grounds that the prior religious faith is no longer relevant and that his present interests in his happy, albeit limited, life, should control.

George's case seems very similar to the intellectual's, except of course that his prior beliefs are religious rather than "merely" secular. A truly "hard-core" believer in prior directives may feel that in even these cases, the directive should prevail. Some proponents of precedent autonomy may feel otherwise, because the incompetent patients: (1) have such clear-cut interests in life; and (2) are so unlikely to retain beliefs in the primacy of the intellect or the tenets of the Christian Science faith. Hence some supporters of prior directives may wish to disavow them in one or both of these cases. To show, however, that this should not lead to a wholesale rejection of precedent autonomy, we merely need alter one of two variables. The first is the time frame; the second is the patient's mental status at the time of initial diagnosis and decisionmaking.

First, the time frame. Assume our intellectual is also psychic—or at least aware that his blood pressure is 210 over 190. He anticipates his stroke and one day before it makes his prior directive. Although the stroke affects only his brain, one week later he contracts pneumonia. Despite his recent choice, made in anticipation of disability, a proponent of current interests undoubtedly still would protect the incompetent's present interests. After all, interests can change gradually over twenty years, or in one fell swoop when one's neocortex is damaged.

If this feels somewhat less comfortable to the proponent of patient autonomy, it is because the rapidity of the developments has blurred the distinction between present- and future-oriented choice. We can blur this distinction even further if, returning to George, the brain tumor is diagnosed while he is still

competent. As a Christian Scientist, he refuses surgery. Because he knows incompetency may soon ensue, he makes a prior directive. One week later, he is incompetent. Rethinking his choice now seems to me like a wrong to George—the George who competently chose, based on considered religious beliefs, to reject treatment. Yet from the present-oriented perspective, I cannot see why this is any different from the other cases. *Now* George is an incompetent whose life could be prolonged by medical intervention. And *now* he lacks the mental structure to hold his former beliefs. Under a present-oriented view, we would respect choice as long as the person was competent, but then, once his powers dimmed, we would rethink it if treatment was still potentially efficacious. In other words, a competent choice will lose its force once the person is incapable of realizing it has been made, because now—whether this occurs gradually or suddenly—the incompetent is the only player in town.

If we accept this present focus, then the competent patient's "right" to refuse treatment will be upheld only for the few months, weeks, days, or hours she remains competent. After that, the treatment decision will be made on the basis of the objectively assessed present interests of the incompetent. Taken to an extreme, this could mean that a Jehovah's Witness could refuse a blood transfusion until he "bled out" and became incompetent, after which he could be transfused.[47]

However an objective test would decide cases of intermittent incompetency such as the typical Jehovah's Witness scenario, it seems to commit us to a wholesale reassessment of contemporaneous treatment refusals upon subsequent incompetency. Not all refusals will impair the interests of the now-incompetent: if he is terminally ill, he may be better off dying more quickly. But many treatment refusals will, especially those based upon minority views about religion or modern medicine. Minority beliefs are usually considered to be precisely those for which protection of autonomy is most crucial. Once we recognize that present autonomy and precedent autonomy are simply two ends of a continuum, along which are choices initially made when competent, reaffirmed repeatedly, but subject to reexamination after the person becomes incompetent, we see that rejecting precedent autonomy threatens a fairly broad spectrum of present, prior, and mixed present/prior choices.

D. Viewing the Incompetent

This returns us to the dilemma of how to view incompetent patients. They can, of course, be viewed just in the present, with only their current, highly

47. Jehovah's Witness cases perhaps could be treated differently, since they will, if transfused, return to full competency and their former beliefs, which will now include that they cannot achieve everlasting life. So a complicating factor in assessing an incompetent Jehovah's Witness' present interests is whether they include his probable future beliefs. Even the proponent of present interests could opt for harming the incompetent by upholding his prior refusal rather than wronging the future competent person by overriding his religious beliefs. Of course, if the accident causes both physical injuries and brain damage, the proponent of present interests would opt for treatment, because the patient will never regain his capacity to affirm his beliefs. So a primarily present-oriented perspective could lead to the paradox that we would uphold a refusal if, with a transfusion, the person would be fine, but override it if he would be physically sound but mentally impaired.

truncated interests taken into account. As so viewed, the prior directive clearly impairs the incompetent's interests. Back when the directive was made, however, the person was acting as a moral agent, and it is harder to take a completely present-oriented view toward moral agents and their interests. As Christine Korsgaard, who criticizes Parfit for viewing persons in a peculiarly passive sense as essentially the experiencers of various sensations, puts it:

> Perhaps it is natural to think of the present self as necessarily concerned with present satisfaction. But it is mistaken. In order to make deliberative choices, your present self must identify with something from which you will derive your reasons, but not necessarily with something present. The sort of thing you identify yourself with may carry you automatically into the future; and I have been suggesting that this will very likely be the case. Indeed, the choice of any action, no matter how trivial, takes you some way into the future. And to the extent that you regulate your choices by identifying yourself as the one who is implementing something like a particular plan of life, you need to identify with your future in order to be *what you are even now.* When the person is viewed as an agent, no clear content can be given to the idea of a merely present self.[48]

Dresser criticizes prior directives as giving moral and legal primacy to competent persons over incompetent ones.[49] While incompetent persons of course warrant respect, I think it is nonetheless perfectly appropriate to give primacy to competent persons—at least if the incompetent person inhabits the formerly competent person's body. The competent person's primacy derives from his status as moral agent. Moral agency is inherently future-directed, and the future may, unfortunately, 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. (I must admit here, though, that there may be an irreconcilable clash of instincts about whether the incompetent should be viewed as the moral agent he was or the more passive experiencer of physical sensations he is now.)

Another problem with the purely present perspective is that prior directives reflect concern for others. Many people make living wills because they do not want their family's resources to be consumed in sustaining a barely sentient existence. Consider another example of other-directed values. Suppose a pregnant woman is stricken with cancer. Her prognosis is better if she aborts, but she refuses, because having this baby is the most important thing to her. She makes out a document specifying this, and then lapses into incompetency. An abortion still could be performed. Someone who rejects prior directives would, it seems, have to reopen the issue of the abortion and endorse it if it promoted the now-incompetent woman's physical interests. Yet just as it is difficult to view moral agents only in the present, it is difficult to view them in total isola-

48. Korsgaard, *Personal Identity and the Unity of Agency: A Kantian Response to Parfit*, 18 PHIL. & PUB. AFF. 101, 113-14 (1989) (footnotes omitted).

49. Dresser, *supra* note 7, at 426.

tion. Surely it is misleading to view *this* woman in complete isolation. Her most cherished goal—to leave the legacy of a child—is attainable only via a prior directive that harms the incompetent. It reflects the values of the competent person she was, and these values warrant a degree of moral primacy.

All this suggests that while it may be true that the incompetent person, if suddenly able to speak, would choose based on her current interests, this should not be determinative, because her former values, though no longer consciously held, have not lost their moral force. Among other reasons, such values are still important because the formerly competent person made a choice—an exercise of her autonomy. Her living will should not be seen simply as evidence of what she (as an incompetent) might now want. Seen as mere evidence, a prior directive inevitably will fail, because even the most devastatingly impaired patient could now, at least hypothetically, want something else.[50] Viewed as an actual choice, a living will can function fairly well.[51] It of course has limitations, as do other prior choices such as testamentary wills. Much as one cannot know one's precise medical plight in advance, one cannot anticipate the changes in conduct, lifestyle or fortune of one's heirs. A regular will clearly is not evidence of most recent desires, but is an actual choice, and a change in circumstances is simply the risk one runs in making future choices. The alternative is not to make such choices (or to designate a proxy rather than make a substantive choice). But if we believe in the right to make future choices, we should not complain about their inherent and inescapable limitations.

The analogy with testamentary wills, however, returns us to the troubling example of the intellectual's idiosyncratic directive, because a living will, unlike a testamentary will, can severely compromise a person's present interests. Are there no limits to the harmful future choices a person can make? It does not seem inconsistent with accepting precedent autonomy to place some limits on it. In a few cases, competent contemporaneous choices are overruled, because, for example, they place medical professionals in such an untenable position. This was the impetus for denying Elizabeth Bouvia the relief sought in her first lawsuit—the right to refuse food and water by mouth while receiving hygienic care in the psychiatric ward of a hospital.[52] The court held, essentially, that individual autonomy could not transform medical professionals into attendants at a suicide parlor.[53] Prior directives are made with far less knowledge of the medical situation and the patient's future interests than are current choices.[54] Hence

50. Actually, it is more accurate to say that some incompetent patients, *e.g.*, those who are able to form, but not express, preferences, could want something else, while ones who are unconscious or barely conscious could not have different preferences, but could have interests that, assessed objectively, argue for a different course of action.

51. Allen E. Buchanan and Dan W. Brock conclude that because a person's self-determination can be exercised by making future-oriented decisions (even decisions that he might subsequently be tempted to change), advance directives should be seen as genuine exercises of self-determination and not merely as evidence about what the patient might want now. A. BUCHANAN & D. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 115-16 (1989).

52. Bouvia v. County of Riverside, No. 159780, tr. at 1238-50 (Cal. Super. Ct. Dec. 16, 1983).

53. *Id.* For criticism of this case, see Annas, *When Suicide Prevention Becomes Brutality: The Case of Elizabeth Bouvia*, 14 HASTINGS CENTER REP. 20 (Apr. 1984).

54. *See* Buchanan, *supra* note 42, at 278-79.

some restrictions could be placed on them (as the law currently does),[55] so that the former intellectual could not demand that nursing home staff let a happy, otherwise healthy, but "pleasantly senile" person die. We can thus concede that such an unusual prior directive need not control—because other concerns can override our prima facie duty to honor it—without rejecting the basic principle of prior control.[56] After all, challenging as this philosophical puzzle is, no one (at least at present) makes such directives. People make prior directives to avoid being tethered to medical technology when unconscious or in a state such as Claire Conroy's. When they start saying, "If I can't do higher mathematics, kill me," we will have to worry in earnest about the limits of precedent autonomy.[57]

Finally, I do not deny that we can, when pressed, make quality-of-life assessments from a present-oriented perspective.[58] Decision makers must do this for infants and for the never-competent. Something is wrong, however, when we treat formerly competent patients as if they were never competent. Someone who makes a prior directive sees herself as the unified subject of a human life.[59] She sees her concern for her body, her goals, or her family as transcending her incapacity. It is at least one, if not an overriding, component of treating persons with respect that we view them as they view themselves. If we are to do this, we must not ignore their prior choices and values.

Actual prior choices are an exercise of autonomy and hence deserve far more weight than informally expressed preferences. This is not only because of evidentiary concerns, but because a person who makes a living will has exercised her right to decide—a right that imposes upon others a prima facie duty to honor her choice. We have, however, no similar right that informally expressed preferences be honored. Yet many of the same reasons that make prior directives morally relevant also make prior preferences relevant. Primary among

55. Living will statutes typically grant authority to prior directives only if the person is terminally ill. *See* SOCIETY FOR THE RIGHT TO DIE, THE PHYSICIAN AND THE HOPELESSLY ILL PATIENT 24-25, 40 (1985). Hence, no living will statute in existence would require compliance with a directive refusing treatment if the patient is mildly or moderately mentally impaired.

56. Buchanan reaches a similar conclusion. *See* Buchanan, *supra* note 42, at 279, 301-02. Whether we would treat George, the Christian Scientist, like the intellectual, or would honor his prior directive is, in my view, a hard case. Logically there should be no difference between an unusual secular view and an unusual religious one. Nor should it matter how many persons share someone's beliefs, so long as they are firmly and competently held. Yet I must admit that I feel less comfortable rethinking George's refusal. The undoubted difficulties in where to draw the line for respecting or overriding truly harmful and unusual prior directives do not, however, invalidate the general principle of respect for prior choices that are more or less "in the ball park."

57. We may have to worry in the opposite direction, if vitalists start making prior directives calling for continuation of life even if persistently vegetative. If they or their estate cannot pay for such care, and if society eventually determines that indefinitely sustaining vegetative lives is an unwise use of scarce medical resources, we may have to override the vitalists' prima facie right to have their precedent autonomy respected.

58. As I have argued elsewhere, a serious problem is that courts begin with a strong presumption for treatment and then, whatever standard they use, require (at least verbally) too high a level of proof, holding that families must prove that termination is *the right* thing to do, rather than simply within a range of reasonable options. *See* Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 390-91, 429-36 (1988). Because of the diversity of individual views about the meaning and quality of life, I argue that the best we can hope for is the conclusion that termination of treatment is a reasonable choice, in the sense of being one many people would make.

59. *See* Dworkin, *supra* note 8, at 5.

them is the sense that most persons, when competent, see their preferences, goals, and values as relevant to future choices about them, because they see themselves as unified subjects of their lives. Were we all Parfitians, this conclusion would change. But, I hazard to say, we are not. Hence, when making moral choices for formerly competent persons who left no explicit directives we should still consider their probable desires, although we should avoid succumbing to the illusion that such desires will necessarily be unambiguous or determinative.[60]

IV. THE ANALOGY TO WILLS AND THE PROBLEM OF THE SUBJECT

Someone might object that all this boils down to the claim that because many people feel that if they become incompetent they would want others to think of them as they were in their prime, the law should accept and reinforce this delusion. In other words, if there is no competent person there who will notice the dishonoring of his prior wishes, then thinking we must honor them is just as silly as thinking of the dead as they were when alive and imagining we have duties to them. The "problem of the subject"—the question of just who is harmed by posthumous betrayals—has received substantial philosophical consideration.[61] I cannot treat it adequately here, but can offer some suggestions that relate back to the unconscious or barely conscious. One solution that is easy—perhaps too easy—is just to emphasize that competent people care about their future, and if word gets out that choices will be reassessed upon incompetency, everyone will be anxious and uneasy. This rule-utilitarian approach does yield a duty to honor prior directives,[62] albeit one that does not run to anyone in particular. It clearly would be acceptable to someone whose general moral theory is a rule-utilitarian one. It is less satisfactory to a rights-based theorist, because it means that while failure to honor a present choice wrongs the chooser, failure to honor a prior choice is, in Joel Feinberg's words, merely a "diffuse public harm."[63]

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60. [This aspect of Professor Rhoden's argument holds particular relevance to the pending *Cruzan* case. About a year before her accident, Nancy Cruzan told a friend that she would not want to continue living if she could not be at least "halfway normal." Cruzan, by Cruzan v. Harmon, 760 S.W.2d 408, 432 (Mo. 1988) (Higgins, J., dissenting), *cert. granted sub nom* Cruzan, by Cruzan v. Director, 109 S. Ct. 3240 (1989). Ms. Cruzan's parents also point to her lifestyle and other statements to family and friends as suggesting that their daughter would not wish to continue her present, hopeless existence. *Id.* (Higgins, J., dissenting). The Missouri Supreme Court deemed these statements to be too casual, general, and spontaneous to be reliable expressions of Ms. Cruzan's own choice regarding future treatment decisions. *Id.* at 424. Professor Rhoden clearly believed that such statements were relevant and entitled to some weight. Eds.]

61. Of the "problem of the subject," Joel Feinberg writes:

> Like a rock withstanding the lashings of a storm it stands resistant to all counterarguments, maintaining and reiterating that there cannot be a harm without a subject to be harmed. . . . [D]eath is not *any kind of evil* to the one who dies, and therefore nothing to be feared or regretted, a conclusion generally thought to be paradoxical.

J. FEINBERG, HARM TO OTHERS 80 (1984). The paradox troubled even the ancients. *See* Epicurus, *Letter to Menoeceus*, in EPICURUS: THE EXTANT REMAINS 77 (C. Bailey ed. 1926).

62. For this type of argument, see Partridge, *Posthumous Interests and Posthumous Respect*, 91 ETHICS 243, 254-61 (1981).

63. J. FEINBERG, *supra* note 61, at 95.

Because Feinberg believes that the dead can be wronged (and, indeed, harmed), he tackles this problem of who is harmed by a posthumous betrayal. Feinberg distinguishes two ways of conceptualizing the dead: as dead bodies ("postmortem persons") and as the persons they were when alive ("antemortem persons"). Postmortem persons cannot be harmed; they are mere corpses. But, Feinberg argues, antemortem persons can be harmed, because they can have "surviving interests" that can be invaded.[64] Hence posthumous betrayals can count as harms to antemortem persons. Holding that the subject of the harm is the antemortem person is an attempt, and probably a successful one, to solve the problem of the subject.

Joan Callahan argues that although in postulating antemortem persons, Feinberg has devised a proper subject of harm, he faces another problem—that of "backward causation," or the implication that an event after a person's death can harm him prior to his death.[65] Feinberg seeks to avoid this implication by holding that the antemortem subject of posthumous harm was harmed all along, or at least at the point when he acquired the interest that would subsequently be defeated. It is just that until the harmful event actually occurs, no one could know of his harmed condition. As Feinberg puts it:

> [T]he financial collapse of the life-insurance company through which I have protected my loved dependents, occurring, let us imagine, five minutes after my death, several years in the future, makes it true that my present interest in my children's security is harmed, and therefore, that *I* am harmed too, though I know it not. When that time comes, my friends might feel sorry not only for my children but for me too, though I am dead.[66]

According to Feinberg, believing that the antemortem person is harmed before the event is no different from believing that a father whose son has just been killed is immediately harmed, even though he has not yet received the bad news.

Several closely related and, it seems, telling criticisms have been made of this notion that a person whose interests will be defeated after his death is in a harmed state from the time he acquires such interests. W.J. Waluchow notes that we do not think this way about future harms to existing persons; we do not consider ourselves already harmed by events that will happen in the future.[67] It seems he is correct that future harms should have the same logical structure whether the victim will be dead or alive when the harmful event occurs. As Callahan points out, Feinberg's theory implies that a person who will later perform a harmful action is, long before doing so, responsible for placing the victim in a harmed (though as-of-yet unrecognizably so) position.[68] Sympathetic as I find Feinberg's overall approach, this particular aspect does seem to smack of predestination. If before a decedent's demise his future betrayer had not even

64. *Id.* at 90.

65. *See* Callahan, *On Harming the Dead*, 97 ETHICS 341, 345 (1987).

66. J. FEINBERG, *supra* note 61, at 91.

67. Waluchow, *Feinberg's Theory of "Preposthumous" Harm*, 25 DIALOGUE 727, 732-33 (1986).

68. Callahan, *supra* note 65, at 345.

formed his evil intent, it seems very strange to maintain that the decedent while alive was in a harmed state. Despite Feinberg's attempt to equate this with a father's lack of awareness of his son's recent death, there does seem to be a crucial asymmetry between being unaware of an event that has occurred, and being unaware of a future event that, unless we are fatalists, may not happen after all.

Even if Feinberg's attempted solution to the problem of backward causation fails, I believe that the basic moral intuition that we wrong the promisee when we breach a promise, even posthumously, remains firm, as Callahan's discussion itself illustrates. Callahan first tries to defend this duty by claiming that testamentary bequests generally merit respect in their own right; that we feel obligated to honor them because they usually coincide with other values we hold important, such as the good of individual heirs.[69] To support this, she notes that we would feel less obligation to carry out an iniquitous or wasteful request (that all the paintings of a great artist be burned). But surely we don't feel that giving an estate to the decedent's spoiled, self-indulgent son (to whom it was bequeathed) is objectively preferable to giving it to his hard-working, saintly (but disinherited) daughter. If honoring his will is morally obligatory, this is because we believe the deceased had a right to distribute his estate as he saw fit, even if we abhor the end result. If truly heinous requests are not binding upon us, it is simply because other moral principles can sometimes override prima facie rights.

Callahan does admit that the independent moral value of bequests cannot fully account for what she recognizes as the genuine moral conviction that persons have a right to dispose of their property as they see fit. However, she claims that right yields a duty not to the decedent, but only to his heirs.[70] That sounds initially plausible, but how would it apply to other promises made to a decedent? Suppose I leave my friend ten thousand dollars in my will in return for his promise to care for my cat. If, as soon as I die, he has my cat euthanized, it is hard not to think that he has breached a duty to me, rather than to my cat. It becomes even harder if the promise was to nurture my stamp collection. Moreover, when we turn to living wills, holding that the duty runs to the relatives is clearly unworkable, because surely the absence of family would not negate the duty to respect the prior directive. (And suggesting that duties run to persistently vegetative patients, viewed just in the present, is no more plausible than saying they run to corpses.) Thus Callahan is left recognizing the moral force of the duty to honor wills, but failing either to ground or direct such a duty.

The perplexities about harm predating the harmful event, and the opposite problem of being unable to justify the belief that there are duties to the dead, can each be avoided if we simply extrapolate from the observation that a right-holder need not have either the capacity or potential to discover a breach of duty. Clearly, if a person who has contracted for a statue to be erected in her honor moves to Australia, failure of the promisor to erect the statue is a breach

69. *Id.* at 350.
70. *Id.* at 351.

of duty to the person in Australia, even if she never finds out. Why should the analysis change if the promisor procrastinates and breaches the contract after the emigrant has died? It is still a breach of duty, and of a duty that ran to the person who, while alive, held the right to performance. In other words, rights and duties, although correlative, need not be temporally coextensive.

This analysis relates back to the various ways persons can view themselves. Someone seeking a future-oriented promise sees herself as caring how her body, or property, or heirs, are treated. The promisor in turn incurs a duty of performance that entails an obligation to see the promisee as she envisioned herself. Thus the promisor cannot legitimately focus only upon the consequences of a breach (reasoning "she's a corpse now, she cannot care"), but instead must think of the promisee as she was in the past, and as she projected her goals and interests into the future. This duty in some sense runs backward: the object of its fulfillment or breach is most appropriately viewed as the person as she was when alive (Feinberg's "antemortem person"). But recognizing duties to antemortem persons does not mean we have to agree that dead persons can be harmed or that future victims of harms are harmed from the moment they acquire interests that will be defeated. All we need affirm is that living persons can have rights of future performance, and that breaches of duties to perform after death count as wrongs to the right-holder, thought of as she was when alive.

Although duties to persons who previously held the correlative right but who no longer exist are admittedly an unusual case, we might think of this as similar to other future-oriented promises made in anticipation of incapacity. Suppose Joe, a manic-depressive given to extravagant and disastrous business deals in his manic phase, makes a contract (during a lucid period) with a friend whereby the friend promises not to let him make any business deals while manic. Then Joe becomes manic. In adhering to the contract, the friend is upholding his duty to view Joe (and Joe's interests) as Joe saw things when lucid. This case differs from wills or living wills, because Joe himself will benefit in the future from having his present desires thwarted. But the cases are not so completely different, because each involves a duty to act upon wishes of a person that are no longer held and indeed to view the person, for moral purposes, as he viewed himself at a previous time, and as he projected the values held then into the future. The solution of saying a duty exists *now*, and breach of it is a breach of duty, and thus a wrong, to the person as he was *then*, is not unproblematic. If one accepts a rights-based justification for present and precedent autonomy, however, the backward-looking solution seems preferable to holding that upon death or incapacity, a formerly grounded duty suddenly runs in no direction at all.

V. CONCLUSION

Thus we must reject the premise of the present-oriented objective test—that if a subjective analysis does not yield a definitive answer, a fully objective approach must be used. 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. It likewise undermines living wills. Living wills are not as unproblematic as often assumed: they are subject to the criticism that they subjugate the interests of incompetent persons to the values of competent ones. But as we have seen, many or most autonomous choices take the chooser some way into the future. Denying the right of future choice thus threatens the right of present choice. Hence the mirror image of the asserted problem with living wills is giving so much primacy to incompetents that one acts as if they never were competent. If a person has stated, "Treat me, when incompetent, as if my competent values still hold," respect for persons demands that we do so. This does give primacy to the competent person, but it is, after all, competent persons who have the considered moral values, life plans, and treatment preferences that underlie our respect. Finally, this analysis can apply, albeit less strongly, to formerly competent patients who did not make prior directives, because they too most likely held relevant views. If we believe that a competent person is more likely than not to see her values as still being relevant during incapacity, then respect for persons suggests that we consider those values in making treatment decisions, even while recognizing that they may be more difficult to assess, and hence far less determinative, than actual prior choices.