

# Advance Refusals and the Personal Identity Objection

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## I. Introduction

Imagine Anna who contemplates requiring future medical treatment or care, and wishes to make a decision to be applied when she is no longer competent. She wishes to ensure that, if specified circumstances occur, she will not be given life-sustaining treatment and will therefore be allowed to die. The moral and legal authority of such an *advance refusal* can clearly be no greater than the authority of a contemporaneous refusal.<sup>1</sup> It could, however, be less. In English law, an adult has an almost unlimited right to contemporaneously refuse treatment, even if life-sustaining.<sup>2</sup> And, under s 26(1) of the Mental Capacity Act 2005 (the 2005 Act), a ‘valid’ and ‘applicable’ advance refusal of treatment has the same legal force as a valid contemporaneous refusal. Thus, in theory at least, an advance refusal complying with certain procedural conditions is binding in English law.

Advance refusals—indeed any attempt to give effect to a patient’s prior views and values—present two challenges. The *first challenge* is ensuring that an advance refusal sufficiently represents Anna’s will on what should happen in the situation in which she later finds herself. The application of Anna’s previous refusal presents practical difficulties beyond those presented by a contemporaneous refusal by a competent individual. The issue is that the scope and meaning of her wishes needs to be interpreted in a context with potentially unanticipated features without the ability to return to Anna for further discussion and consideration. The *second challenge* builds on Parfit’s musings on personal identity<sup>3</sup> and will be referred to as the *personal identity objection*. According to this objection,

the very process that renders the individual incompetent and brings the advance directive into play can—and indeed often does—destroy the conditions necessary for her personal identity and thereby undercuts entirely the moral authority of the directive.<sup>4</sup>

That is to say, some contend that the loss of ability to make contemporaneous treatment decisions will (at least sometimes) change Anna’s identity, so that the

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<sup>1</sup> I have considered contemporaneous and advance requests elsewhere: SD Pattinson, ‘Contemporaneous and Advance Requests: The Fight for Rights at the End of Life’ in J Herring and J Wall (eds), *Landmark Cases in Medical Law* (Hart Publishing, 2015) 255–69.

<sup>2</sup> eg *Re T* [1993] Fam 95 and *Re B (Consent to Treatment: Capacity)* [2002] EWHC 429. In contrast, the courts have denied that there is a right to requested treatment, whether the request is contemporaneous or made in advance: see Pattinson, n 1.

<sup>3</sup> D Parfit, *Reason and Persons* (Clarendon Press, 1984) esp 204–17.

<sup>4</sup> A Buchanan, ‘Advance Directives and the Personal Identity Problem’ (1988) 17 *Philosophy and Public Affairs* 277, 280. See also A Buchanan and D Brock, *Deciding for Others* (CUP, 1989) 155.

individual to whom the advance refusal is to apply is no longer Anna.

This chapter will evaluate the response of English law to these two challenges by reference to the ethical rationalism of Gewirth, as expanded and applied by Beyleveld.<sup>5</sup> The focus will be on the second challenge, namely, the personal identity objection. Support will be offered for the implicit rejection of this objection by English law. It will be argued that the plausibility of the personal identity objection derives from the principle that life-sustaining treatment should not be removed at the whim of a third party, but (contrary to appearances) the objection does not fully engage this principle. It will also be argued that while at first sight it appears that the approach of English law to the first challenge suggests some normative inconsistency with its response to the second, in practice, this normative inconsistency is more apparent than real. That is, the response of English law to the challenge of ensuring that the advance refusal represents Anna's will is evolving and thereby becoming easier to reconcile with its rejection of the personal identity objection.

A preliminary terminological issue arises with regard to the use of 'competence' and 'capacity' in this chapter.<sup>6</sup> An individual will be described as *competent* when judged to possess sufficient cognitive-functional faculties to be able to make a decision with respect to a given situation. An individual will be said to have *capacity* when possessing the decision-making authority required for a legally valid decision. This distinction is useful because capacity need not track competence. In English law, for example, a child who is considered cognitively able to make a particular treatment decision (that is, competent) may be denied the legal authority (that is, capacity) to validly refuse treatment in the face of judicial or parental consent.<sup>7</sup> An attribution of competence (so defined) requires that the patient be considered to have the cognitive ability to understand and able to exercise that ability in the context under consideration. Since competence is task specific, patients who apparently have the cognitive abilities to make a decision must be considered to lack competence if they apparently cannot exercise those abilities in relation to a specific task or decision. For example, a patient who is completely overcome with emotion every time she thinks about her cancer is (unless and until this is addressed) incompetent to make decisions concerning her cancer, even if considered cognitively able to make other decisions at an equivalent level of complexity.

## II. The Personal Identity Objection

The personal identity objection has its origins in the view that psychological continuity with one's past self is a necessary condition for personal identity.<sup>8</sup>

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<sup>5</sup> See eg A Gewirth, *Reason and Morality* (University of Chicago Press, 1978); D Beyleveld, *The Dialectical Necessity of Morality: An Analysis and Defence of Alan Gewirth's Argument to the Principle of Generic Consistency* (University of Chicago Press, 1991); D Beyleveld and SD Pattinson, 'Precautionary Reasoning as a Link to Moral Action' in M Boylan (ed), *Medical Ethics* (Prentice-Hall, 2000) 39.

<sup>6</sup> See further SD Pattinson, *Medical Law and Ethics* 4th edn (Sweet & Maxwell, 2014) ch 5.

<sup>7</sup> eg *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, esp [84] and [86] and *An NHS Foundation Hospital v P* [2014] EWHC 1650, esp [12].

<sup>8</sup> J Locke, *An Essay Concerning Human Understanding* (R Wooldhouse ed, Penguin Classics, 1997) 302; Parfit, n 3, 204–09.

According to this view, continuity with previous memories, states and dispositions varies in degree and a sufficient degree of continuity is required for the retention of personal identity.<sup>9</sup> An individual who falls below the relevant threshold of continuity is severed from his or her past identity and, if alive, acquires a different identity.<sup>10</sup> Such is said to have occurred when an individual's memory retention and personality is considered to have changed profoundly. In such circumstances, it is supposed, giving effect to an advance refusal involves illegitimately applying one individual's will to a different individual.

There are two important points about the personal identity objection to which I will return below. *First*, to regard Anna in the past (Anna Then) as a different individual to Anna in the present (Anna Now) is to deprive Anna Then of various rights and responsibilities over her body in the future. *Secondly*, it requires a particular type of metaphysical story to be told about the two Annas. Anna Then must be considered to have either a continued existence disconnected from her physical body or to have ceased to exist. Similarly, the living body of Anna Now must be considered to be either connected to a different mind or an empty shell without a mind.<sup>11</sup>

Supporters of the personal identity objection differ with regard to its ambit. This chapter will examine and respond to the use of this objection by Dresser and Buchanan. Dresser rejects the authority of advance refusals in favour of treating incompetent patients according to their 'present best interests' and invokes the personal identity objection as one of her reasons.<sup>12</sup> She cites Parfit to support her view that where Anna has 'undergone substantial psychological alteration', Anna Then's views lack moral authority with regard to the treatment of Anna Now.<sup>13</sup> In contrast, Buchanan holds that Anna Then's past views only become irrelevant if Anna Now, though incompetent, is a *person*.<sup>14</sup> He argues that imposing advance decisions on another *person* involves their subjugation (and is thereby analogous to slavery), whereas non-persons can legitimately be subject to the 'surviving interests' of the past person they used to be.<sup>15</sup> Buchanan's conditions for personhood are sufficiently similar to Gewirth's conditions for agency to enable them to be considered equivalent for the purposes of this chapter.<sup>16</sup> That is to say that, in this chapter, a person/agent is a being that is capable of acting for voluntarily chosen purposes.

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<sup>9</sup> See esp Buchanan, n 4, 280.

<sup>10</sup> See eg R Dresser, 'Dworkin on Dementia: Elegant Theory, Questionable Policy' (1995) 25 *Hastings Center Report* 32, 35 and Buchanan, n 4.

<sup>11</sup> This latter option is only consistent with the personal identify objection where a mind is not required for moral status, because otherwise there can be no objection to imposing Anna Then's views on Anna Now.

<sup>12</sup> eg R Dresser, 'Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law' (1986) 28 *Arizona Law Review* 373, 374.

<sup>13</sup> R Dresser, 'Missing Persons: Legal Perceptions of Incompetent Patients' (1994) 46 *Rutgers Law Review* 609, 628 (n 49); Dresser, 'Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law', n 12, 380–81; Dresser, 'Dworkin on Dementia: Elegant Theory, Questionable Policy', n 10, 35.

<sup>14</sup> Buchanan, n 4, 284.

<sup>15</sup> See Buchanan, n 4, esp 281–82 and 287.

<sup>16</sup> Buchanan, n 4, 284 lists a number of popular criteria for personhood: (a) conceiving oneself as conscious over time, (b) the ability to appreciate reasons for or against acting and (c) the ability to engage in purposive sequences of actions.

### *Three Hypothetical Patients*

To facilitate discussion of the personal identity objection, as invoked by Dresser and Buchanan, consider three hypothetical patients with key differences with regard to their current abilities: Bob, Cuc and Eve. All have made advance refusals of life-sustaining treatment to be applied in specified future circumstances, which now arise. At the time of making those refusals, all were adults considered to have acted both voluntarily and competently, and to have understood their medical prognosis and future medical situation. All three appear to have suffered significant (in some cases total) memory loss. Doctors consider administration of the care or treatment refused in the advance refusals to be necessary to keep the patients alive.

#### *Bob: Antibiotics Refused in Advance of a Vegetative State*

Following a stroke, Bob is judged to be in a vegetative state. His heart continues to beat, his brain-stem continues to function, he turns, he sleeps and he wakes, but is considered irreversibly unconscious due to damage to his higher brain.<sup>17</sup> He had made an advance refusal of antibiotics to be applied if he enters a vegetative state. Bob now has an infection, which can be treated with antibiotics.

Dresser and Buchanan differ over Bob. Both would consider Bob Then and Bob Now to be different individuals. Buchanan cites a permanent vegetative state as an example of a condition that severs psychological continuity and therefore causes a loss of personal identity.<sup>18</sup> Dresser and Buchanan differ, however, because Buchanan's view is that Bob Now is a 'nonperson' and Bob Then has surviving interests that 'override whatever extremely limited obligations we may have to sustain the life of the surviving individual'.<sup>19</sup> Dresser is likely to agree that not providing antibiotics to Bob is defensible, but this would not be because Bob Then's advance refusal applies; rather it would be because antibiotics are simply not in Bob Now's interests. In short, Buchanan would apply Bob's advance refusal, whereas Dresser would consider it to lack authority on the basis of the personal identity objection.

#### *Cuc: Antibiotics Refused in Advance of Severe Dementia*

Cuc<sup>20</sup> is suffering from Alzheimer's disease. During the very early stages, she made an advance refusal of antibiotics and any other life-saving treatment. Her condition has deteriorated significantly and she now lives at home with the help of carers. She has apparent problems making new memories and those around her consider her old memories to be fading rapidly. Cuc talks to those around her and is considered able to make some simple day-to-day decisions. She regularly reads, though her place in the book seems to jump randomly from one day to the next, and paints, though she paints

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<sup>17</sup> See B Jennett, 'The Vegetative State' (2002) 73 *Journal of Neurology Neurosurgery and Psychiatry* 355.

<sup>18</sup> Buchanan, n 4, 280–81.

<sup>19</sup> Buchanan, n 4, 287.

<sup>20</sup> Cuc is loosely based on Margo: see AD Firlik, 'Margo's Logo' (1991) 265 *Journal of the American Medical Association* 201 and R Dworkin, *Life Dominion: An Argument about Abortion and Euthanasia* (Harper Collins, 1993) ch 8.

the same picture every day. Her carers consider her to be extremely happy and gaining great pleasure from her activities. Cuc now has a chest infection and requires antibiotics. Her doctors consider her to lack the competence required to make this decision.

Cuc is the type of patient for whom the personal identity objection is typically raised. Dresser and Buchanan consider apparently permanent memory loss capable of depriving a dementia patient of her past identity.<sup>21</sup> Their writings suggest that both would consider Cuc Now to lack sufficient psychological continuity with Cuc Then to be considered the same individual. Both would conclude that her advance refusal now lacks moral authority on account of the personal identity objection and would want her to be treated with antibiotics.

Buchanan only accepts the validity of the personal identity objection while Cuc remains a 'person' (that is, an agent). It seems that he would consider Cuc Now to be a person on the basis of her apparent ability to act for *some* voluntarily chosen purposes. Cuc's condition is, however, degenerative. Buchanan opines that there

will be cases like that of a profoundly and permanently damaged demented individual with Alzheimer's dementia, where neurological damage has destroyed a person, and all that survives is a terminally ill nonperson with what we may call radically truncated interests.<sup>22</sup>

Thus, at some point in the future, Buchanan would hold that Cuc Then's advance refusal will gain authority on the basis that she will have neurologically deteriorated to the point of being a 'nonperson' to whom it would be legitimate to apply Cuc Then's 'surviving interests'.

#### *Eve: Animal Heart Valve Refused in Advance of Memory Loss*

Since her brain injury, Eve identifies as a woman, eats meat and exercises extensively. Before her brain injury, she was a sedentary man known as Evan. Evan had been diagnosed with a heart condition that would, at some future date, require a replacement heart valve. As a life-long vegan, he made an advance refusal of use of an animal valve in his treatment. The brain injury has caused apparently permanent memory loss. Eve's family say that she is now a different person to Evan. When informed that she needs a replacement heart valve, she opts for an animal valve because a mechanical valve would limit her physical activity and ability to exercise. Her doctors consider her competent to make this decision.

Irrespective of the personal identity objection, Evan's advance refusal lacks authority over Eve, because of her ability to make a contemporaneous decision. It does not matter whether Eve and Evan are the same or different individuals. Eve's will takes priority over her earlier will and, *a fortiori*, over the will of a different person who once inhabited her body. What is, however, interesting about this hypothetical patient is that Evan and Eve do not seem to share a personality or personality-related memories. It therefore seems to me that Dresser and Buchanan would consider Eve to lack sufficient psychological continuity with Evan to be regarded as the same individual.

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<sup>21</sup> Consider eg Buchanan, n 4, 281.  
<sup>22</sup> Buchanan, n 4, 285.

The relationship between Evan and Eve is of relevance to matters outside the context of advance refusals. Yet, English law does not remove an individual's debts or property solely on account of a subsequent radical personality change or loss of competence. Evan is not, for any legal purposes, considered to be dead and replaced by another individual inhabiting or being his body. Eve is not, for example, freed from responsibility for Evan's crimes on account of her loss of memory or personality change. Evan is not regarded as having died, but is the same legal person as Eve.

### **III. The Mental Capacity Act and Court of Protection**

This section will examine the response of English law to the three hypothetical patients outlined above. Our starting point must be the Mental Capacity Act 2005. The 2005 Act only applies where the patient is reasonably believed to lack capacity to make a particular decision. That is, where an impairment or disturbance in the functioning of the mind or brain (s 2(1)) has rendered the patient unable to understand the relevant information, retain it, use or weigh it, or communicate the resulting decision (s 3(1)). On this test, Eve will be regarded as able to make a legally valid contemporaneous decision. 'Evan's' advance refusal is therefore legally irrelevant. The law makes no inquiry as to whether or not Evan and Eve are the same person.

In contrast, Bob and Cuc now lack legal capacity. If their advance refusals lack legal validity, then they are to be treated in accordance with their 'best interests' under the 2005 Act. The decision-maker is to weigh all factors about which he or she is aware and 'it would be reasonable to regard as relevant' (s 4(2)/(11)). This includes the patient's 'past and present wishes and feelings' and their relevant 'beliefs and values' (s 4(6)). Thus, whereas a 'valid' and 'applicable' advance refusal is binding, other past views and values are merely factors to be weighed by the decision-maker. The Act gives no guidance as to the weight to be given to any of these factors. Let us consider the application of the best interests test to Bob and Cuc, on the assumption that their advance refusals are not valid and applicable. Bob seems to have no experiences at all and English law would not regard his continued treatment to be in his best interests, but would, in practice, require referral to the Court of Protection to confirm his diagnosis and prognosis as one of a 'permanent vegetative state'.<sup>23</sup> Cuc has apparently positive experiences (such as reading and painting), so the best interest test operating (as it does) in accordance with a presumption in favour of life<sup>24</sup> would favour the administration of life-sustaining treatment, unless significant weight is given to her past views and values. Thus, a binding advance refusal would support a quicker rejection of life-sustaining treatment for Bob and would support removal of otherwise required life-sustaining treatment with regard to Cuc.

To be valid, an advance refusal must not have been directly or indirectly withdrawn. More specifically, it is rendered invalid where the patient has:

- (a) withdrawn it when he/she has capacity to do so;
- (b) subsequently conferred the authority to make the relevant decision on an

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<sup>23</sup> See eg *Airedale NHS Trust v Bland* [1993] AC 789 and *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [36] and [47].

<sup>24</sup> eg *Re T* [1993] Fam 95, 112 and *Aintree* [2013] UKSC 67, [35].

attorney; or

(c) ‘done anything else clearly inconsistent with the advance decision remaining his fixed decision’ (s 25(2)).

Neither (a) nor (b) apply to Bob or Cuc. In my view (c), withdrawal by inconsistent conduct, should be interpreted as requiring that the inconsistent act take place while the patient has capacity.<sup>25</sup> That is because an alternative interpretation would render (a) superfluous and the restriction of (c) to the inconsistent behaviour of a patient *with capacity* is supported by the example given in the Code of Practice.<sup>26</sup> There is, however, a common law presumption in favour of prolonging life, which the European Court of Human Rights has opined (in a case concerning an advance request) ‘accords with the spirit of the Convention’.<sup>27</sup> It is possible, though I believe unlikely, that this presumption could be used to support an interpretation of (c) that permits effect to be given to the desire of a patient lacking capacity for clinically indicated life-prolonging treatment refused in advance. Bob and Cuc cannot, however, be properly said to have ‘done’ anything ‘clearly inconsistent’ with the terms of their advance refusals. Losing the ability to interact or communicate (Bob) or being in a very happy demented state (Cuc) are not relevant actions.

To be applicable, the advance refusal must apply to the treatment and circumstances now faced by the patient (s 25(4)) and, in the case of life-sustaining treatment, must be explicit, in writing, signed and witnessed (s 25(5)/(6)). Section 25(4)(c) declares an advance refusal to be inapplicable where there are ‘reasonable grounds for believing that circumstances exist which [the patient] ... did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them’ (s 25(4)(c)). This cannot be said to be the case with regard to Bob, whose advance refusal anticipates the very circumstances in which he now finds himself. Cuc clearly anticipated becoming more demented, but did she anticipate being in a very happy demented state and, if not, would that have changed her view? The sketch of her situation above does not specify why she made the advance refusal (there might, of course, be means of acquiring that information from others). But her blanket refusal of future treatment does not attempt to distinguish between situations where non-treatment would cause distress to her future self. This suggests that her concern was not to avoid any future suffering but being kept alive in a demented state.

Notice that neither validity nor applicability deny legal authority to an advance refusal on account of their drafter being a different person to the current patient. Rather, both are concerned with the first challenge identified in relation to Anna, namely, the challenge of ensuring that the advance refusal sufficiently represents her will on what should happen in the situation in which she now finds herself. On the face of it, the law’s response to this first challenge makes it easy to disregard an advance refusal. Indeed, many commentators have pointed to the ease by which an advance refusal—previously under the common law and now under the Act—can be deprived of legal

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<sup>25</sup> See SD Pattinson, *Medical Law and Ethics* 1st edn (Sweet & Maxwell, 2006) 483 and 4th edn (Sweet & Maxwell, 2014) 494.

<sup>26</sup> See Department for Constitutional Affairs, *Mental Capacity Act: Code of Practice* (The Stationery Office, 2007) para 9.40.

<sup>27</sup> *Burke v UK* (No 19807/06, 7 July 2006).

authority.<sup>28</sup>

The potential liability of doctors is, for example, loaded in favour of their disregarding an advance refusal, rather than following it. Under s 26(2), the doctor avoids liability for disregarding an advance refusal, unless ‘he is satisfied’ that it exists, is valid and is applicable. Under s 26(3), a doctor avoids liability when giving effect to an advance refusal where ‘he reasonably believes’ that it exists, is valid and is applicable. Thus, it appears to be harder to sue or convict a doctor for disregarding an advance refusal (it must be shown that he was satisfied that it had legal authority) than it is to sue/convict him for giving effect to it (it must be shown that either he did not believe it to have legal authority or any belief that it had legal authority was not reasonable).

Recent case law has, however, gone some way towards interpreting the provisions of the Act so as to ensure that effect is given to the will of the individual who made the advance refusal.

In *X Primary Care Trust v XB*, an advance refusal was interpreted so as to give effect to a patient’s prior will, determined from oral evidence, despite the written document itself referring to his invasive ventilation device as ‘non-invasive ventilation’ and including the words ‘valid until’ followed by a date that had expired by the time of the hearing.<sup>29</sup> Thus, the terms of a written advance refusal are viewed as no more than evidence of the patient’s previous will and thereby subject to interpretation in the light of other evidence.

In *Newcastle upon Tyne Hospitals Foundation Trust v LM*, the Court of Protection gave effect to the patient’s prior wish not to be given a blood transfusion, despite her advance refusal apparently not having been written, signed and witnessed, as required for an advance refusal of life-sustaining treatment to be applicable under the 2005 Act.<sup>30</sup> Peter Jackson J held that in consequence of the refusal being clear and capacitated ‘the doctors rightly considered [that it] must be respected’ and ‘in the alternative’, giving ‘determinate weight’ to her long-standing beliefs and values when applying s 4(6), the blood transfusion was not in her best interests.<sup>31</sup> Thus, a refusal that technically does not satisfy the strict provisions of the 2005 Act for a binding advance refusal could still be given effect. In my view, his Lordship’s ‘alternative’ is best understood as being no more than an alternative expression of the same point, rather than an alternative ground for the decision. This avoids his Lordship being interpreted as rejecting the clear words of the legislation.<sup>32</sup>

Giving considerable weight to the patient’s previous views when applying the best interest test is the approach required by the Supreme Court in a case decided in the

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<sup>28</sup> See eg S Michalowski, ‘Advance Refusals of Life-Sustaining Medical Treatment: The Relativity of the Absolute Right’ (2005) 68 *Modern Law Review* 958 and AR MacLean, ‘Advance Directives and the Rocky Waters of Anticipatory Decision-Making’ (2008) 16 *Medical Law Review* 1. For a comparative consideration see S Halliday, ‘Legislating to Give Effect to Precedent Autonomy: Comparative Reflections on Legislative Incompetence’ (2011) 11 *Medical Law International* 127.

<sup>29</sup> [2012] EWHC 1390, esp at [10] and [15].

<sup>30</sup> [2014] EWHC 454 (COP).

<sup>31</sup> [2014] EWHC 454, [22] and [23].

<sup>32</sup> This would involve the replacement of the decision of a democratically elected body with those of a non-democratically elected judge without any weighty justification. See further below.



year before *LM*. In *Aintree University Hospitals NHS Foundation Trust v James*, Lady Hale (with whom the other Justices agreed) declared:

insofar as Sir Alan Ward and Arden LJ were suggesting [in the court below] that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail.<sup>33</sup>

This is a very significant judgment. As indicated earlier, on its face the 2005 Act appears to relegate previous views and values not satisfying the procedural requirements for a binding advance refusal to mere factors to be weighed against other potentially equally important factors. Indeed, operating in the context of a presumption in favour of life, the application of the best interests test seemed to give relatively little weight to the patient's prior views and values.<sup>34</sup> It is difficult to reconcile apparently binding force being given to advance refusals satisfying certain procedural requirements when advance refusals falling just short of satisfying those requirements are dealt with as mere factors in the application of the best interests test. The *best interests* test asks the decision-maker to determine what is in the patient's 'objective' interests, whereas a *substituted judgement* test seeks to ask the decision-maker to attempt to make the decision that the patient would have made by applying the patient's views and values.<sup>35</sup> Giving effect to advance refusals would seem, as a matter of normative consistency, to support adoption of the substituted judgement test over the best interests test in those cases where the patient had previous views and values that fall just short of the procedural clarity required for a binding advance refusal. *Aintree* and *LM*, however, go a long way towards removing any such normative inconsistency. They seem to take us as close to a 'substituted judgement' test as is possible without expressly adopting it over the 'best interests' test, which the courts cannot do within the terms of the 2005 Act.

Lady Hale added, with regard to the patient in a minimally conscious state with whom she was concerned in *Aintree*, '[e]ven if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament'.<sup>36</sup> Notice that her concerns remain focused on the first challenge (that is, understanding what the patient would have actually wanted in the situation in which he now finds himself), rather than the second challenge (that is, the personal identity objection).

Hayden J in *Sheffield Teaching Hospitals NHS Foundation Trust v TH* has, however, interpreted Lady Hale's view on the best interests test to be further away from the substituted judgement test than I have suggested. His Lordship interprets Lady Hale as holding that best interests are to be considered 'in an holistic way'<sup>37</sup> and cautions that:

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<sup>33</sup> [2013] UKSC 67, [45].

<sup>34</sup> See eg *Re T* [1993] Fam 95 and *HE v Hospital NHS Trust* [2003] EWHC 1017. See also the discussion in Michalowski, n 27.

<sup>35</sup> See further Pattinson, n 6, 148–50.

<sup>36</sup> [2013] UKSC 67, [45].

<sup>37</sup> [2014] EWCOP 4, [36].

‘Wishes’ and ‘best interests’ should never be conflated, they are entirely separate matters which may ultimately weigh on different sides of the balance sheet.<sup>38</sup>

It may be that this is less of a retreat from the substituted judgement test than it first appears to be. In the sentences immediately before, Hayden J emphasised the importance of ‘rigorous and scrupulous’ attempts to seek out past views on the basis that ‘the clarity, cogency and force that they are found to have will have a direct impact on the weight they are to be given’.<sup>39</sup> It is therefore possible to view Hayden J as emphasising caution when attributing determinate previous views to the patient. Indeed, as we shall see, moral precaution may legitimately require us to consider any ambiguities in the patient’s past views in a way that is protective of their current positive experiences.

In summary, English law does not consider apparent memory loss or personality change as a basis for concluding that there has been a change of identity. Anna, Bob, Cuc and Eve would be considered to have retained their identities over time. An advance refusal may lack legal authority on the basis that it lacks sufficient compliance with procedural safeguards to be considered determinate of the patient’s previous wishes, but those safeguards do not turn on a judgement concerned with loss of, or diminution in, psychological continuity.

#### **IV. Advance Refusals and a Good Faith Attempt to Give Effect to the PGC**

This section will first outline the moral theory under discussion in this book and then apply that moral theory to the personal identity objection to the authority of advance refusals.

##### *The Principle of Generic Consistency*

In their book *Law as a Moral Judgment*, Beyleveld and Brownsword argue that legal validity consists in the exercise of morally legitimate power.<sup>40</sup> Their starting point for analysis is ‘the enterprise of subjecting human conduct to the governance of rules’.<sup>41</sup> This enterprise, they argue, can only be understood in terms of the reasons that individuals have for complying with those rules, which is to say that the law must be viewed as an affair of practical reason. If practical reason can be shown to presuppose moral reason, it would follow that the legal enterprise is necessarily a moral enterprise. Gewirth’s argument for the Principle of Generic Consistency (the PGC) seeks to show that practical reason does indeed presuppose moral reason. It uses a ‘dialectically necessary’ method, whereby the argument proceeds *dialectically* within the first-person perspective of an agent with all the steps of the argument following logically (that is, *necessarily*) from premises that cannot be coherently denied within this perspective (that is, *necessary* premises). In essence, Gewirth seeks to show that I (an agent) deny that I am an agent if I deny that all agents have rights to the generic

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<sup>38</sup> [2014] EWCOP 4, [56].

<sup>39</sup> [2014] EWCOP 4, [56].

<sup>40</sup> D Beyleveld and R Brownsword, *Law as a Moral Judgment* (Sheffield Academic Press, 1994).

<sup>41</sup> See eg *ibid*, 120, citing L Fuller, *The Morality of Law* (Yale University Press, 1969).

conditions of agency (that is, the generic rights). This chapter will assume the soundness of Gewirth's dialectically necessary argument to the PGC. A summary of that argument can be found in the first and final chapters of this book.<sup>42</sup>

Gewirth distinguishes between the 'direct' and 'indirect' application of the PGC.<sup>43</sup> Direct applications involve substantive determinations as to whether or not actions are compatible with the generic rights of agents. For those matters that cannot be dealt with directly, the PGC requires certain procedural mechanisms in its application, which indirectly apply the PGC.

The generic rights established by Gewirth's dialectically necessary argument are claims-rights according to the will conception of rights.<sup>44</sup> That is to say, that they are to be understood as justifiable claims imposing correlative duties, the benefits of which are waivable by the rights-holder. Rights according to the will conception (will-rights) are to be contrasted with rights according to the interest conception (interest-rights), the benefits of which are not automatically waivable by the rights-holder.<sup>45</sup>

The generic rights are both negative (that is, rights of non-interference) and positive (that is, rights to assistance). They are rights to retain and obtain whatever an agent needs to act or act successfully, regardless of his specific purpose. These generic needs vary in degree. The generic needs and the corresponding generic rights can therefore be ranked according to the 'criterion of degrees of needfulness for action'.<sup>46</sup> Death may be an agent's purpose, or a consequence of it, but death itself is not a generic need. An agent who refuses life-sustaining treatment is therefore to be understood as exercising his or her generic rights, rather than claiming a generic right to die.

In addition to granting generic rights to agents, Gewirth considers the PGC to apply to non-agents who 'approach' being agents, and cites children and 'mentally deficient persons' as examples of beings with partial generic rights.<sup>47</sup> Unfortunately, Gewirth's argument to the PGC cannot establish that non-agents have any generic rights at all, no matter how close they approach being agents.<sup>48</sup> Gewirth has inferred that those others who act like agents (such as Cuc and Eve) are agents and those who display some but not all of the characteristics and behaviour expected of agents (such as Bob or a more demented Cuc) are non-agents who merely approach being agents. This inference is intuitive and seems perfectly reasonable, but it is not epistemologically

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<sup>42</sup> See P Capps and SD Pattinson, 'The Past, Present and Future of Ethical Rationalism' and D Beyleveld, 'What Is Gewirth and What is Beyleveld? A Retrospect with Comments on the Contributions'.

<sup>43</sup> See Gewirth, n 5, chs 4 and 5 respectively.

<sup>44</sup> On claim-rights see the seminal work of WN Hohfeld, *Fundamental Legal Conceptions: As Applied in Judicial Reasoning and Other Legal Essays* (WW Cook ed, Yale University Press, 1923).

<sup>45</sup> Compare eg HLA Hart, 'Are There Any Natural Rights?' (1955) 64 *Philosophical Review* 175 with N McCormick, 'Rights in Legislation' in PMS Hacker and J Raz (eds), *Law, Morality and Society: Essays in Honour of HLA Hart* (Clarendon Press, 1977) 189.

<sup>46</sup> See A Gewirth, *The Community of Rights* (Chicago University Press, 1996) 45–46. See also Gewirth, n 5, esp 53–58.

<sup>47</sup> See Gewirth, n 5, 120–24. The substance of the following argument, for the dialectical necessity of moral precaution, was seminally published in Beyleveld and Pattinson, n 5.

<sup>48</sup> See Beyleveld and Pattinson, n 5 and SD Pattinson, *Influencing Traits Before Birth* (Ashgate, 2002) ch 2.

secure. Agency involves a special kind of self-awareness (that is, reflective purposivity), which means that while I can know directly that I am an agent, I cannot know this directly of anyone other than myself. The inferences made by Gewirth about ‘normal adults’, children or ‘mentally deficient persons’—which we all make on a day-to-day basis—depend on unverifiable metaphysical assumptions. I cannot eliminate the possibility that those others who behave like agents are very cleverly programmed robots without minds and that those others who do not behave like agents are actually locked-in agents unable to fully display their agency to me. Those possibilities are relevant to the application of the *categorical* requirement that I (any agent) act in accordance with the generic rights of agents.

I cannot strictly know whether or not Eve or Cuc are agents, but I can treat them as agents because they behave like agents. To mistakenly treat them as agents would involve unnecessarily restricting my freedom of action, but to mistakenly treat them as non-agents would be to fail to respect their generic rights, despite being able to do so. The PGC therefore requires me to treat Eva and Cuc (and anyone else who acts like an agent) as agents and act in accordance with their (presumed) generic rights. It follows that agency-like characteristics and behaviour must, under moral precaution, be considered evidence of agency.

Since Bob or a more demented Cuc do not behave like agents, I cannot coherently treat them as if they are able to exercise the generic rights. It is, however, possible and meaningful for me to guard against mistakenly treating them as non-agents by acting towards them in ways that would respect their generic rights should they (unknowably) happen to be agents. It is therefore dialectically necessary for me to grant Bob or any other being that displays some agency-like characteristics ‘duties of protection’ tracking their (presumed) generic interests. Thus, Eve and Cuc Now are to be treated as having will-rights to their presumed generic interests, whereas Bob and a more demented Cuc are to be treated as having interest-rights to their presumed generic interests.

What if I am faced with a *single-variable conflict* between respecting one of Eve’s will-rights and respecting Bob’s equivalent interest-right? *If no other variables arise*, my duties to Eve take precedence over my duties to Bob. This is an application of the ‘criterion of avoidance of more probable harm’.<sup>49</sup> Moral precaution requires me to consider agency-like characteristics and behaviour to be evidence of agency, and Eve can be treated as an agent and therefore displays more of those characteristics than Bob, who cannot be treated as an agent. Thus, in a single-variable conflict of the type under consideration, an agent’s duties to those others who can meaningfully be treated as having (presumed) generic interests will be proportionate to the degree to which those others approach being analogically agents. In single variable disputes, Eve and Cuc count for more than very demented future Cuc, who in turn counts for more than Bob. There can, however, be differences not only between the agency-like behaviour displayed, but also the importance of the generic conditions affected<sup>50</sup> and the probability of any given action having effects on the generic conditions. Where, as here, the PGC-relevant values have not been rendered commensurable within an algorithm directly supported by the PGC, the best that we can do is rely on a procedural turn, operating to protect the unequivocally most important values of the

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<sup>49</sup> Beyleveld and Pattinson, n 5, 44.

<sup>50</sup> Measured by the criterion of degrees of needfulness for action.

PGC. The procedure must be one seeking, in good faith, to give effect to the PGC.

Beyleveld and Brownsword have considered the need for PGC-compliant procedures elsewhere.<sup>51</sup> Ultimately, they argue, the justification for proceduralism also requires that we avoid ‘an infinite regress of one layer of proceduralism on another’.<sup>52</sup> In this light, they consider what a Gewirthian should make of the processes of representative government adopted by large modern democracies. It may well be the case that any given individual has not consented to the process by which delegated authority happens to be exercised by the State in which he or she lives and might not have voted for those who are elected at any given time. They argue that human agents, in recognising that their own judgement is not infallible, must consider a free, fair and transparent democratic process as simply the ‘optimal compromise’ by which committed Gewirthians can mutually co-exist in a complex society governed by the PGC.<sup>53</sup> Gewirth refers to this as the ‘method of consent’.<sup>54</sup> As an indirect application of the PGC, the democratic method only operates where there is ‘rational and not unreasonable disagreement’ over the direct application of the PGC for which there is no more optimal response.<sup>55</sup>

### *Applying the PGC to the Personal Identity Objection*

The PGC only requires the personal identity objection to be dealt with indirectly where it cannot be dealt with directly. For the reasons below, any application of the PGC will place significant (and in some cases conclusive) restrictions on the permissibility of treating my past, present and future selves as distinct individuals and the past, present and future (presumed) selves of others as distinct individuals.

In *Human Dignity in Bioethics and Biolaw*, Beyleveld and Brownsword consider whether the PGC can be applied to give effect to the notion of duties to oneself by reference to a distinction between ‘my future selves’ and ‘my present self’.<sup>56</sup> They argue that ‘my future self’ develops from, and is an extension of, ‘my present self’, and this makes the relationship between ‘my present self’ and ‘future selves’ different to my relations to others. It is for this reason, they argue, that ‘my future selves’ cannot call ‘my present self’ to account for harming them.

If I could hold my ‘past selves’ to account, this would imply that I could never be held responsible in the future for my actions in the present. Therefore, in relation to a crucial aspect of rights-claims, I cannot properly be said to have past, present, and future selves. All there is, is me at different times.<sup>57</sup>

I agree. The PGC places significant limitations on how we must consider the relationship between a living body and a particular agent over time. To regard a person who has just awoken as a different person to the one who went to sleep last night is both to free the present person from responsibility for the actions of the

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<sup>51</sup> See eg D Beyleveld and R Brownsword, ‘Principle, Proceduralism and Precaution in a Community of Rights’ (2006) 19 *Ratio Juris* 141.

<sup>52</sup> *ibid.*, 150.

<sup>53</sup> *ibid.*, 152.

<sup>54</sup> See Gewirth, n 5, 304–12.

<sup>55</sup> Beyleveld and Brownsword, n 51, 147.

<sup>56</sup> D Beyleveld and R Brownsword, *Human Dignity in Bioethics and Biolaw* (OUP, 2001) 107.

<sup>57</sup> *ibid.*, 107.

person who went to sleep and to deprive the present person of the achievements, relationships and claims of the person who went to sleep. It deprives them of responsibility for infringing the rights of others and denies their claim to many specific rights for themselves. It follows that there are significant limits on the moral permissibility of treating a living human body as housing or being different agents over time. Continuity of identity over time cannot require an apparently unbroken continuity of consciousness.

But what does this mean in the context of an advance refusal made by Anna? The personal identity objection requires action contrary to any presumption of continuity of identity, as it requires a distinction between Anna Then and Anna Now. Anna's situation is not one where the costs of erring are all one way. We either mistakenly deny Anna's authority to exercise her will over her body in the future or mistakenly fail to attempt to extend the now incompetent Anna's biological life. But the conclusion that either is a morally significant risk is subject to a prior procedural assessment.

Before concluding that following an advance refusal presents a morally significant risk of failing to extend the patient's biological life, we must first conclude that, in the absence of the advance refusal, there is a duty to extend the patient's life. The PGC does not impose an absolute duty to provide life-sustaining treatment. For a start, positive generic rights are more limited than negative generic rights<sup>58</sup> and, when dealing with limited resources, relative moral status will be relevant (compare, for example, the status under moral precaution of Bob Now and Cuc Now). Determining whether there would otherwise be a duty to provide life-sustaining treatment involves a multiple variable calculation of the type requiring a PGC-compliant procedure.

Before concluding that failing to follow an advance refusal presents a morally significant risk of denying an agent's will over her body in the future, we must first conclude that the advance refusal captures what she would have wanted in the current situation. The PGC will again require a PGC-compliant response to this challenge. That response will need to take account of any procedural response to the question of whether there would otherwise be a duty to provide life-sustaining treatment to Anna. If it has been legitimately concluded that there would otherwise be such a duty, then moral precaution will need to be exercised when interpreting any ambiguities in her previously expressed views. Without examining this issue in depth, it is worth noting that the 2005 Act's requirements of 'validity' and 'applicability' are a response to this challenge by an elected body.

In short, the personal identity objection only arises for consideration as a challenge to the authority of Anna's advance refusal if we have already legitimately concluded that the refusal covers the current situation and there would otherwise be a duty to provide the life-sustaining treatment. Cuc's situation is one in which it is plausible that PGC-compatible procedures would support reaching these two conclusions. The demented Cuc currently behaves like an (incompetent) agent and administering the antibiotics poses no undue burden, she therefore has a very strong claim to a positive right to the antibiotics expected to save her life. If we assume that her refusal is witnessed, in

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<sup>58</sup> See Gewirth, n 5, 217–30. See also the discussion of positive duties in SD Pattinson, 'Consent and Informational Responsibility' (2009) 35 *Journal of Medical Ethics* 176, 177, and the first chapter in this collection.

writing, and expressly states that it applies even if she is in a happy demented state, it is difficult to see how it may be legitimately concluded that it did not represent her will with regard to the current situation. In these circumstances, is the case for accepting the personal identity objection as plausible as the case for rejecting the objection? Two factors suggest not.

First, the criteria for identity and their application to Cuc must be compatible with the PGC, and this is questionable in relation to the personal identity objection. It vests identity in the retention of memories and personality traits above a certain threshold. But, it is not at all clear why an agent's identity must be defined and determined in this way. When Cuc makes an advance refusal that she intends to take effect even when her memory retention and personality traits fall below that threshold, why must she nonetheless accept that her future body will then house or be another agent? Why must others identify Cuc not in terms of her apparent retention of agency-like characteristics and behaviour over time, but in terms of a specific level of apparent retention of memory and personality traits?

Even if the PGC could support the Lockean-Parfitian theory of identity, it is not at all clear how we would identify the threshold point for apparent retention of memory and personality traits. At what point is it legitimate to conclude that Cuc's memories and personality traits are such that her body has ceased to be (or house) one presumed agent and is now (or now houses) another presumed agent? Wherever that point is, since Eve and Evan's memories and personality traits seem to be no more closely connected than those of Cuc Then and Cuc Now, they must also be regarded as having crossed that point. Any threshold of identity requiring Cuc Then to be regarded as a different agent to Cuc Now would have significant implications for when an individual is regarded as having ceased to exist. The psychological continuity criterion of identity implies that where an individual apparently loses and later regains their memories and personality traits, as in the case of some forms of mental illness, they are to be regarded as having lost one identity and then regained it; which seems to require that they be considered to have died and come back to life.

Secondly, the personal identity objection requires us to make more assumptions to accept it than it does to reject it. *To reject the personal identity objection*, I need to accept or assume that *either* Cuc has remained the same agent *or* consider Cuc Then's views on the treatment of Cuc Now to take priority over the views of other third parties. This second move is plausible because the two Cucs share a more intimate relationship than anyone else has with Cuc Now. *To accept the personal identity objection*, I need to accept or assume the converse of both of these points. Thus, I need to consider Cuc's body to be connected to, or be, a different agent to that to which it was connected when the advance refusal was made *and* consider her treatment decisions to be better made by someone other than Cuc Then.

If those factors do not, as I suggest, support rejection of the personal identity objection, they do at least justify the conclusion that a PGC-compliant procedure could in good faith reject the personal identity objection. That is to say that if the UK's democratic process is compatible with the PGC's requirements, then the approach of English law to the personal identity objection may at least be regarded as an indirect application of the PGC.

## V. Conclusion

Assessing English law in terms of the requirements of an indirect application of the PGC, it need not be shown that the approach taken by English law is the only one capable of being supported by the PGC. Rather, it needs only be shown that English law takes an approach compatible with a good faith attempt to give effect to the PGC. This I have done. I have argued that the personal identity objection requires more than the claim that life-sustaining treatment should not be removed at the whim of a third party. It requires the moral defensibility of three additional claims:

- (1) personal identity is to be determined according to ‘psychological continuity’, assessed by apparent retention of interpersonal memories and personality traits,
- (2) the threshold of psychological continuity is such that Anna Then is to be regarded as having a different identity to Anna Now, and
- (3) Anna Then has a weaker right to make decisions for Anna Now than another third party.

Since a good faith application of the PGC may legitimately reject these claims and assumptions, it is morally defensible for English law to reject the personal identity objection in relation to Anna, Bob and Cuc. These claims will similarly pose significant justificatory problems for other moral theories and their acceptance would require a radical reconsideration of when an individual is regarded as having died or otherwise freed from existing entitlements, obligations and relationships.

This chapter has examined the views of Dresser and Buchanan to demonstrate that the personal identity objection is no ‘straw man’ and there are, indeed, other supporters of this objection.<sup>59</sup> The position advanced by these theorists requires us to consider both Bob Now and Cuc Now to be different individuals to those who made the advance refusals. Dresser would seem to consider the personal identity objection to apply to Bob and Cuc, and Buchanan would consider it to apply to Cuc. It is morally and legally defensible for the Mental Capacity Act 2005 and the English Courts to reject these views.

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<sup>59</sup> See eg N Gligorov and C Vitano, ‘The Impact of Personal Identity on Advance Directives’ (2011) 45 *Journal of Value Inquiry* 147, esp 157–58.