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RESEARCH ARTICLE

When Suicide is not a *Self*-Killing: Advance Decisions and Psychological Discontinuity—Part II

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Abstract

Derek Parfit's view of personal identity raises questions about whether advance decisions refusing life-saving treatment should be honored in cases where a patient loses psychological continuity; it implies that these advance decisions would not be *self*-determining at all. However, rather than accepting that an unknown metaphysical 'further fact' underpins agential unity, one can accept Parfit's view but offer a different account of what it implies morally. Part II of this article argues that contractual obligations provide a moral basis for honoring advance decisions refusing life-saving and/or life-sustaining medical treatment; advance decisions have similarities to contracts, such as life insurance policies and will-contracts, that come into effect when the psychological discontinuity is through death.

Keywords: advance decisions; consent; contracts; Parfit; psychological continuity

Introduction to Part II

In Part I of this article, I argued that rather than attributing an unknown metaphysical 'further fact' of agential unity, we could accept Derek Parfit's metaphysical claim of personal identity as psychological continuity but offer a different account of what it implies morally, that we nevertheless have moral grounds for rejecting the notion that we must treat one's future incapacitated self differently from how we may be morally required to treat someone else in similar circumstances. I argue that we have social reasons for thinking that a dead human body has the same persisting identity as the psychologically distinct entity that once inhabited it and that the body is morally relevant. For instance, a wife mourns her husband even after death, though he no longer has psychological personhood.

Michael Hardimon and others argue that normative roles, such as spousal roles, are contractual.[1] Likewise, here in Part II I argue that healthcare professionals have a contractual relationship with patients. Such contractual obligations provide a moral basis for honoring advance decisions to refuse life-saving medical treatment, even though metaphysically the distinction between killing oneself and killing another person or a future self may break down. Accordingly, in the section "My proposal for honoring advance decisions" I show how advance decisions, as with other medical consent decisions, have similarities to contracts, such as life insurance policies and will-contracts, that come into effect when the psychological discontinuity is through death. I then address possible objections to my position and make concluding remarks.

My proposal for honoring advance decisions

Introduction to my proposal

If we accept Parfit's view of personal identity, it is not clear that any death could be considered a suicide (a *self*-killing) since most deaths involve a prior self that is, at some point, not psychologically continuous

with a later self. (This may even be true of all deaths on Parfit's view if one considers that the dead body is not a self or person at all.) Death involves a stage whereby the agent's psychological states are permanently disrupted. As discussed in Part I of this article, Parfit's view of personal identity undermines the notion of suicide since one would not kill oneself; if one shoots oneself, he kills, but not the self who dies—in Parfit's sense, it is not clear that we can even kill a person. The body that remains cannot be said to be the same person who dies. Therefore, I maintain that Parfit's view of psychological continuity as it stands is implausible as it relates to death.

Yet, we need not reject the view that personhood relies upon psychological continuity. According to Marya Schechtman, "Parfit's argument is that although we may prereflectively assume that there is such a thing as a deeply unified consciousness, on closer inspection this certainty dissolves and what we assumed is revealed to be incoherent."[2] Rather than relying on a mysterious 'further fact' of personal identity, we could still endorse Parfit's metaphysical view but offer a different account of the moral implications. Schechtman suggests that we have social and pragmatic reasons to think of personal identity or agential unity as persisting over time.[3] She claims that Parfit's work shows "that identity itself is not what is really important; the practical significance we attribute to identity inheres instead in the psychological relations in terms of which identity is defined."[4] Schechtman argues that personal identity persists in terms of living a "person-life," even in cases where someone lacks personhood; since people are inherently social, "living the life of a person involves occupying a space within a social or cultural infrastructure of the sort that beings like us naturally develop."[5]

I argue that the social and legal bases for ascribing a persisting personal identity gives and maintains moral relevance to the distinction between homicide and suicide. We have social reasons for thinking that a dead human body has the same persisting identity as the psychologically distinct entity that once inhabited it and that the body is morally relevant. In suicide the agent who kills must be the same agent who dies and this requires that we ascribe personal identity for pragmatic purposes even when psychological continuity is absent. In what follows, I argue that contractual obligations provide a moral basis for honoring advance decisions to refuse life-saving medical treatment, even though metaphysically the distinction between killing oneself and killing another person or a future self may break down. Accordingly, advance decisions should maintain their full moral and (where jurisdictionally applicable) legal force.

Medical care and advance decisions as contractual

As a reminder from Part I of this article, an advance decision is a written statement specifying in advance the medical interventions the author (a) gives consent for; (b) withholds consent for; (c) according to specific clinical circumstances; (d) in the event of lacking the capacity to do so in the future. Here, I argue that advance decisions, as other healthcare decisions, have a contractual basis.

Michael Hardimon and others argue that normative roles, such as spousal roles, are contractual.[6] Likewise, here I argue that healthcare professionals also have a contractual relationship with patients, with voluntarily acquired obligations, and this provides a contractual basis for honoring advance decisions, as well as other consent decisions. William May, amongst others, claims that the physician–patient relationship is not contractual, though he acknowledges that it constitutes agreement, instead preferring to regard this (somewhat rhetorically) as a "covenant," a compact. May writes: "In my judgment, some of these aims of the contractualists are desirable, but it would be unfortunate if professional ethics were reduced to a commercial contract without significant remainder…"[7] May seems to limit contracts to a merely fiduciary/juridical exchange, however; he suggests they must be signed, and refers to them as "legal instruments" that "presupposes agreement reached on the basis of self-interest,"[8] rather than based on the moral underpinnings of legal theory. The standard form of contracts is: offer, acceptance, and consideration, or an exchange of promises that is voluntarily entered. (Contracts have these basic components but also may involve counter-offers, negotiations, etc.) Both sides agree (promise) to the terms and each benefits from them.[9] If we understand contracts in the theoretical sense, then, as with the role of parent or spouse,[10] physicians have a contractual relationship with their patients.

Part of taking on the role of a doctor means that one voluntarily accepts the terms and conditions that arise out of that role; doctors voluntarily agree to perform within the role's normative parameters in exchange for the privilege to practice.[11] Medical care, including care outlined in an advance decision, consists of a voluntary offer, acceptance, and consideration, and is contractual in nature. Doctors offer patients their services, contingent upon patients' acceptance of that offer. Medical care is an exchange or consideration because the doctor gets paid for his services, by such things as tax-derived state funding, health insurance, or the patient's resources/estate. Even if a medical professional provides care on a *pro bono* basis, the patient can still sue for malpractice since the professional standards remain the same if that professional waives the fee.[12] As with other role-related contractual obligations, doctors are under a moral, and in some jurisdictions a legally binding obligation to honor advance decisions.

If a doctor accepts a patient, he is obligated to provide care, but not necessarily a specific treatment; he may not be qualified to perform a requested treatment or may think that it is not clinically indicated. This highlights a difference between offering specific treatment and general medical care. If, for example, a doctor has a conscientious objection to a particular procedure, such as abortion, she may not be obligated to undertake it herself, but could be obligated to ensure that someone does it—she may turn the matter over to a colleague through a patient referral, depending on the jurisdiction.[13] Jonathan Montgomery notes that, despite a patient's wish to the contrary, doctors have no duty to provide life-prolonging treatment such as resuscitation that is not clinically indicated.[14] Likewise, the General Medical Council guidance outlines that "there is no absolute obligation to prolong life irrespective of the consequences for the patient, and irrespective of the patient's views…"[15] Brazier and Cave note that doctors have no duty to provide treatment that "they believe to be clinically unnecessary, futile or inappropriate."[16] For example, a doctor would not resuscitate a frail old lady under cardiac arrest by putting paddles to her and breaking her ribs. Good medical practice would be to let her die peacefully rather than painfully and violently, even if she consented to resuscitation in advance.

One is a patient voluntarily, although there are specific exceptions to this, as with someone who lacks mental capacity. (Patients with severely diminished capacity may not have voluntarily acquired a contract with their doctor if they never had the capacity to enter such a contract, but they may be equivalent to third-party beneficiaries of a contract between doctors and social institutions.[17]) If a doctor offers treatment, the patient's consent is required. The legal force behind medical consent is profound: In 1914, Judge Benjamin Cardozo ruled:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages… This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained. (*Mary E. Schloendorff v. The Society of the New York Hospital*[18])

This means that if someone has mental capacity, then his medical care must be voluntarily acquired. Notably, Cardozo's classic statement of a patient's right to self-determination is cited in litigation across jurisdictions (e.g.: *Purdy, R (on the Application of) v Director of Public Prosecutions and others: England and Wales Court of Appeal (Civil Division), 19 Feb 2009, at 33).* Also, Margaret Brazier and Mary Lobjoit note on this ruling, "It is an axiom that has its definitive roots within most systems of philosophy, and also indicates the respect for individuals that one wishes to be part of normal behaviour in society."[19]

Paul Walker and Terence Lovat argue that the relationship between clinicians and patients requires both sides to agree upon medical care that is arrived at through consensus.[20] Walker calls this a "shared decision-making model" of healthcare and is also known as a "negotiated contract model."[21] He argues that this model "respects autonomy in a way that is aware of the necessary interdependence between the doctor and the patient (and their family) in the decision-making process."[22] Robert Veatch also endorses a contractual model of the relationship between doctors and patients, as a negotiation and exchange between doctors and patients.[23] For example, a doctor offers possible courses of treatment to a patient with emphysema. The patient requests the option of a bronchial inhalator, but the doctor agrees only on

the condition that the patient agrees to quit smoking, as it is dangerous otherwise. The patient agrees, so they have negotiated the treatment jointly.

James Childress and Mark Siegler concur that the contractual model of healthcare promotes autonomy for patients. They acknowledge that such a negotiation is sometimes severely limited "because one party lacks some of the conditions of autonomous choices," such as when a patient does not have mental capacity to make decisions pertaining to his treatment or care. As such, "there are societal constraints and limits on negotiation."[24] However, in cases where patients do outline an advance decision and have sufficient mental capacity to do so at the time, but later lose capacity, that 'contract' is morally and potentially legally binding unless there is some overriding reason not to honor it. This is not true of children since they cannot enter into contracts. In cases where a patient never has the capacity to make such decisions and is of legal age of consent, someone would have to apply to a court for appointment as a suitable proxy decision-maker.[25] (Children and patients with severely diminished mental capacity may be equivalent to third-party beneficiaries of a contract between doctors and social institutions.[26])

If a patient declines a particular treatment, he may still have a contractual relationship with his medical practitioners. For example, if a patient has cancer and withholds his consent for the chemotherapy, radiotherapy, or surgery offered by his doctor, he still has a contractual relationship with his healthcare providers who nevertheless offer supportive services for access to pain management, arranging in-home care and hospital stays, assistance to his family arranging for hospice, and processing the medical certificate of cause of death.

Advance decisions, as with other medical consent decisions, reflect the contractual relationship between the doctor and patient. The fact that decisions are made for the future does not render them less contractual; we have service contracts, contracts for futures to hedge against risk and guarantee pricing for goods, and insurance policies, as examples. Advance decisions are designed to take effect when a person has lost personhood. This is very like life insurance policies that are fulfilled when the insured party dies (one way that one's selves become psychologically discontinuous), though in life insurance policies the contract benefits a third party (again, much as children may be third-party beneficiaries in the contract between parents and society). The patient's social and legal identity, based upon such things as his persisting body, binds advance decisions in jurisdictions where they are upheld; that persisting social identity obligates doctors to honor the advance decision. If the patient refused a specific treatment, the doctor is obligated not to treat him, and the patient would have had a justifiable complaint for malpractice or even assault.

One possible objection to advance decisions having promissory aspects like contracts is that promises generally require acceptance, and that seems impossible in this case since a future self who has lost capacity cannot accept or reject the terms of the contract. However, the patient who had capacity when the advance decision is drawn up has voluntarily negotiated the terms for the future contract. The decision applies to the future patient because he has the same social and legal identity. However, since people do change considerably over time, they ought to review their advance decision periodically and update it if needed. If someone develops a degenerative disease such as Alzheimer's disease, then she may not have the capacity to review and update her advance decision. In such cases, we may be obligated to honor a decision that was made years prior.

Contracts must include fiduciary obligations to be valid.[27] One could object that honoring an advance decision refusing life-saving medical treatment in cases where people have lost their mental capacity is not beneficent and people in such a position ought to be protected. Ronald Dworkin assesses this possibility with the example of Margo, a woman who has executed an advance decision refusing life-saving treatment while she had mental capacity but subsequently develops Alzheimer's disease. Once she loses capacity, she nonetheless experiences a pleasant enough existence, but she has no memories of day-to-day activities. It may seem that compassion requires us to keep her alive, rather than honoring her advance decision, on the grounds that death is irrevocable. Dworkin says that such a claim does not stand because "both choices… to honour or not to honour her past request—are irrevocable… [it is] wrong to assume there is no harm in a patient's living on as a vegetable, so it would be wrong to assume that there is no harm in living on demented… we cannot disregard [that they once had a sense of their own critical interests] or think it no longer matters…"[28]

His assessment may be clearer if we think of Margo not as experiencing momentary pleasures of eating her daily meal, but rather as follows: Margo is demented but spends her days constantly screaming, as many Alzheimer's patients do. Keeping her in this state against her prior wishes treats her paternalistically, without due respect. Let us further suppose that many such Alzheimer's patients scream because they are suffering from terrifying delusions that they believe to be real. We cannot know what such patients are experiencing as they become less able to think and communicate. Even if Margo's life seems pleasant enough to us, however, this is not sufficient reason to consider keeping her alive in such a state against her advance decision. Degenerative diseases such as Alzheimer's disease involve progressively worsening conditions. While the specific impact of the disease may vary from patient to patient, it could be far more beneficent to allow Margo to die a relatively quick and painless death now rather than facing a life in the not-distant future where she may, in fact, suffer a great deal.

Margo, in preparing an advance decision, is like Odysseus. Rather than being left at liberty to steer herself onto the rocks she autonomously enlists external assistance for when she will lose mental capacity.[29] She has a Ulysses contract with healthcare providers. If, however, a patient loses mental capacity and did not leave an advance decision or appoint a proxy decision-maker, doctors and courts consider what she would have wanted under the circumstances, considering that person's (meant colloquially) own values. If that cannot be determined, healthcare professionals must act in accordance with the patient's best interests.[30]

The basis for ascribing agential unity

If the person who enters a contract is not the same person to whom it applies, the contract may not be legally or morally binding; contracts must be entered voluntarily.[31] However, we have morally relevant reasons to regard the person who issues an advance decision as the same person (meant colloquially) who loses psychological continuity. As Marya Schechtman's person-life view suggests, dementia patients have person-lives within an infrastructure of social institutions and should be treated as persons even if they lack metaphysical personhood; otherwise, the institutions are morally deficient.[32] In this section, I outline some reasons why we regard someone with dementia or other mental incapacity as the same person who, prior to losing capacity, issues an advance decision.

Eric Olson and others argue that a human being's personal identity persists so long as she is a living organism, regardless of whether that organism thinks.[33] Olson argues that persistence conditions "have nothing to do with psychological facts."[34] Rather, we are identical with human animals. This means that we cease to exist when we die and that "there is no such thing as a dead animal, strictly so called… only the lifeless remains of an animal that no longer exists."[35] A corpse, rather than an "animal," exists until that corpse decomposes; an extant corpse is the animal's "remains" and "a dead person is not a person,"[36] though we may use the term "dead *person*" colloquially. A strength of Olson's argument is that it acknowledges the moral significance of the human body/organism, that it is necessary for personal identity. Dowie argues that the organism is not sufficient for personal identity because it does not give adequate moral weight to the importance of relationships; a dead body has significance beyond being a mere corpse but would not constitute a person on Olson's view.[37]

Here I adopt Schechtman's approach, that having a physical human body (organism) is necessary for human identity, but she also suggests that other factors, such as the ability to be a moral agent, are also part of what comprises the "cluster property model" of personal identity.[38] Her view is compatible with Kant's notion that the physical body has moral significance in that it is necessary to navigate the world—psychological states are dependent upon sense perception that requires the physical body.[39] The animal nature (body/organism) and rational agency are aspects or modes of being that are bound to each other. If someone's selves have become psychologically discontinuous due to Alzheimer's disease, for example, he still has a sense of first-person authorship. One understands that this body that one inhabits is "me," and it is by means of the body that "I" perceive, unless his mind has deteriorated to the point where he no longer understands what it means to live as a first-person experiencing the world.[40]

In agreement with this approach, I suggest, similar to Maclean, that we relate to our various selves, including our physical bodies, over time as we do to other people. These selves may be closer to or further apart from each other. Self-consciousness is an example where we stand in very close relation to ourselves. We have a closer relationship with our own bodies than that of a parent–child relationship; the relationship with oneself is reflexive in a way that parent–child relationships are not. As a physical body undergoes change, so may one's relationship with one's body, but much of our sense of self and personal identity is tied up with how we perceive our bodies, as is how other people perceive us.

For example, someone may commit suicide because he feels that his physical body undermines his psychological/mental self; someone's psychology may be harmed if she has undergone a substantial physical change, such as losing bodily control or becoming disfigured or is in constant pain. The interests of various selves that are housed in a single body can conflict, much as the interests between different people may conflict. For example, a person with a male body may consider himself to have a female psychology or female identity. We could say that these selves are different selves; one is male (the physical body) and the other female (the personality), and these may conflict when the female person makes decisions for the male person, and yet we do not claim that it is morally wrong for the one to make decisions for the other since we regard them as the same person.[41]

While identity in terms of our legal infrastructure is generally established at birth, our social identities begin before that; people often know the sex and names of their children before they are born and refer to the unborn fetus in terms of that relational identity, "our child." In some jurisdictions, an unborn fetus has the same legal status as its mother. Even when someone never gains psychological states, such as someone born with anencephaly, we ascribe a social and legal identity to him because he is part of our social structure. Likewise, after a spouse loses psychological continuity, or even dies, our relationship with her or him still persists much as our relationships with our selves do.

As such, the Russian Nobleman's wife has a contract with her husband even if his values change over time; for example, if the Nobleman's values had not changed until the onset of dementia, his wife would have good reason to honor her original promise rather than his later wish. (See Part I for discussions of Parfit's Russian Nobleman example.) If, however, his values had changed a year or two after his original decision, well before such dementia, then she would have to choose whether to honor her promise. In this case, she is not required to honor the original promise and she could agree to his request, as it is in the nature of such promises and contracts that if both parties agree the contract can be voided. Or, she may decide that her own values on the matter have not changed, or she could have misgivings about his own reasons for the promise to be revoked, so she could refuse his later request.

Our social and legal identity relies upon our persistent bodies by which others recognize us; for example, an immigration official knows that I am who I claim to be because my passport photograph has the same physical appearance as I do when I appear before him, that is partly why it must be routinely updated. This is similar to why we must update advance decisions periodically; not only do we change over time, but so does the social infrastructure, including what medical treatments are available and what constitutes evidence for our identities changes with emerging technologies and shifts in governmental policy. We even have legal and social identity after we die, in the form of memorial markers, photographs, legal documents, and historical accounts, and the law protects rights of deceased persons, including confidentiality, for example.

This does not only have implications for advance decisions, but it also may be relevant to forms of suicide other than those that are a result of an advance decision; it may involve killing one's conjoined twin or a fetus, for example. If one twin kills himself and as a result the other twin dies, then the first twin has killed the other. If the second twin is a willing party, then it may be considered a type of assisted suicide or suicide pact. One can imagine cases where it is not entirely clear whether the conjoined twins have completely independent psychological continuities. Such cases may be on a spectrum and whether there are two persons or a single one may be a matter of judgment, just as whether a woman's fetus may or may not be considered a distinct person, according to the stage of development; this may be a matter of degree. If a woman who is pregnant kills herself, she also may kill another person metaphysically when she does so; however, for pragmatic and social reasons we must draw a line where her fetus should be considered a different person or merely a cluster of cells inhabiting her body.

I have shown that advance decisions are contractual and we have social and pragmatic reasons for regarding the person who issues it as the same person to whom it applies. As with contracts, there may be circumstances where advance decisions should not be honored, as I address next.

When we should honor advance decisions

If someone who already has severe mental deterioration due to Alzheimer's disease issues an advance decision refusing treatment for the first time, we have good reason to doubt that such a decision should be honored. Even if we accept Parfit's view of psychological continuity, I propose that the threshold for honoring advance decisions is the point at which the patient still has sufficient mental capacity to make medical consent decisions, as an advance decision is a type of medical consent decision. A self's decision relating to her body extends to the end of her life or beyond. The scope of honoring such decisions extends from the point where one has last had mental capacity. It applies to one's future incapacitated selves who have the same social/legal identity. See Figure 1. The person who issues the advance decision can change her mind about the decision, so long as she is deemed to have capacity to do so. This is similar to how the scope of a last will extends beyond one's lifetime and one's will can be changed so long as one has sufficient mental capacity.

Medically, mental capacity is the patient's ability "to understand what is at stake and act on that information. The rationality of the decision itself should not determine the capacity of the decision-maker… A person is not to be treated as lacking capacity because he makes an unwise decision… A person must be assumed to have capacity unless proven otherwise, and all practical steps have been attempted to help him do so."[42] While capacity should be presumed unless there is evidence to the contrary,[43] there may be a point at which medical staff determine that a patient no longer has mental capacity, and this is not an 'all or nothing' issue since someone may have capacity to make some decisions but not others. For example, respecting someone's autonomy may require explaining how one decision impacts another that may be more important to him in terms of his own values. Capacity can be understood as being on a spectrum—one can have it by degree and have capacity for some decisions but not others.[44] One way capacity has been defined is as follows: *1. The person understands information relevant to the decision; 2. The person can remember that information; 3. The person can use or weigh that information as part of the process of making a decision; 4. The person can communicate the decision.*[45]

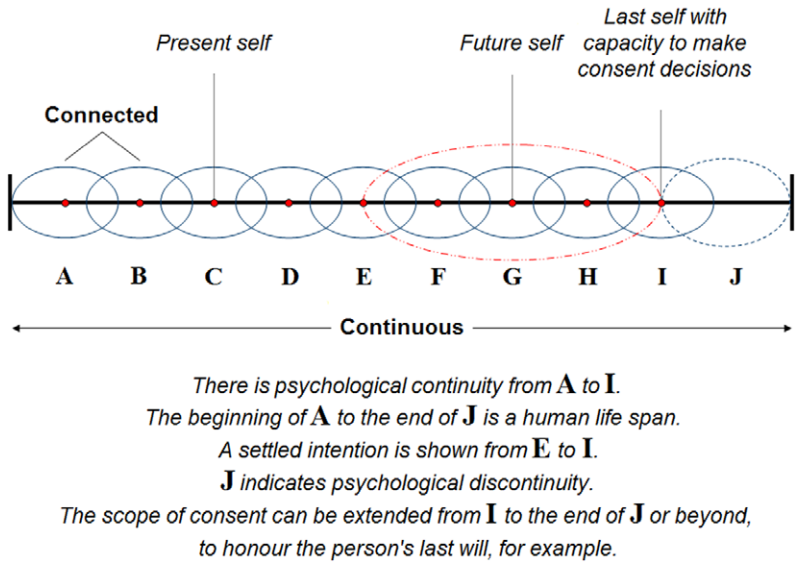

Figure 1. My schematic of extending the scope of a consent decision.

There may be material shifts in the preferences held by one's future selves from those of one's present self. When we make decisions, we must choose whether that decision is what we want for us now in the long term. We may also have to choose between what is best for all parts of our lives, as opposed to a single aspect.[46] A settled intention is an indication that someone has had long-standing and strongly held intentions or convictions. It is meant to serve as evidence that the person is not behaving precipitously. In the UK-proposed assisted suicide bills, for example, legal philosophers and medical ethicists endorse the idea of a settled intention as a protective measure against the claim that people may commit suicide impulsively or because of being unduly influenced to do so.[47] If someone's views and intentions/goals are held over a significant time, and over a course of successive selves, this could be regarded as a settled intention that provides additional evidence that her decision was not impulsive and is indicative of her own values (Figure 1).

This raises the question—what if someone changes his mind about an advance decision and either fails to revise it or is unable to communicate that amended decision? Medical consent requires a clear indication of the patient's acceptance of the proposed treatment and so requires communication with the medical practitioner, though consent may be demonstrated through such things as gestures, such as blinks with locked-in patients, as well as written and spoken language. One may argue that allowing someone to die in such cases where no communication is possible would be a great wrong; it may be that a patient who cannot communicate would prefer to be alive, particularly if she has interests to sustain her, such as close family who continue to care for her. For example, Ms. Terri Schiavo was kept alive in a persistent vegetative state for 15 years while her husband and parents disputed whether she would want to be kept alive. This was complicated by the fact that she had not established a prior advance decision. Finally, the courts determined to allow her to die.[48] It is not clear that keeping someone alive under such conditions as a default position would be acting in their best interests, however.

It may be the best one can hope for in such cases where the patient cannot communicate is to weigh what is in their best interests with what they previously expressed they would want, though this is not always possible. Joseph Fins notes that coma is a short-term condition (typically ten to fourteen days) and medical care has improved notably, so that people in such a condition are increasingly more likely to recover; we should not simply dismiss the rights of such patients or their families, or assume that the condition is permanent.[49] At some point, however, keeping people who are in a permanent vegetative state, and possibly minimally conscious, alive in the hopes they could recover, may be a cruelty. The Mayo Clinic Proceedings, in response to the Schiavo case, suggest: "We… need to be more effective in facilitating the preparation of advance directives for ourselves and our patients. More importantly, we need to facilitate discussions between patients and their surrogates and other family members about medical issues, particularly [life-sustaining treatments]."[50]

However, it is in the nature of advance decisions that they can be disputed under certain circumstances; for example, doctors may dispute the validity of an advance decision in cases where they think that the consent refusal did not adequately consider up-to-date medical treatments or where the circumstances outlined in the decision are not equivalent to the circumstances of the case. They may also be challenged where someone has partial capacity to make consent decisions when his advance decision was issued. As with last wills that are also sometimes disputed, there must be sufficient evidence to establish that the self who issued the advance decision was lacking capacity to make such a decision before such a 'contract' is voided.

To return to the example of the Russian Nobleman, the wife may decide, many years after his plea for her to revoke her original promise, that her husband had since established a settled intention rather than making a hasty or impulsive decision, and she may then revoke her original promise without worry that she had betrayed her husband; people's values do change over time and it is in the nature of marriage to honor this. Even where personhood is gone, she still has reason to regard the Nobleman as her husband, even if his is in a permanently vegetative state, or even after he has died.

Continuity and discontinuity between homicide and suicide

As discussed in Part I, there are borderline suicides that have elements of both homicide and suicide. This happens in cases where there is more than one person contributing to a death, such as with suicide

bombers, suicide pacts, or in cases where a suicidal agent leads others into their own deaths, as with Ahab in *Moby Dick*.[51] Advance decisions that refuse life-saving medical treatments may have elements of both homicides and suicides metaphysically, but the self who dies is physically continuous with his other selves, and has the same social/legal identity, making it a suicide in the pragmatic/legal sense. Elsewhere, I argue that there is causal and definitional symmetry between suicide and homicide, that where we can say one is the proximate cause of a homicide (killing another person), we can also say that an equivalent act upon oneself is suicide (self-killing). I show that suicides, like homicides, can be characterized according to intention, voluntariness, mental capacity, diminished responsibility, and foreseeability. As such, "there are types of suicides similar to homicides: self-murder, justifiable self-manslaughter, voluntary self-manslaughter, involuntary self-manslaughter, and suicides that are mistaken, accidental, or negligent."[52]

I also argue elsewhere that whilst suicide and homicide are definitionally equivalent, homicide and suicide are only weakly morally symmetrical in that even if a given suicide is morally impermissible, we do not normally have the right to prevent it forcibly, though this may be altered by juridical laws under some circumstances.[53] One of these circumstances may be if someone has sufficiently diminished mental capacity that renders him incapable of making such a decision.

With advance decisions, the only self-killings that would be considered permissible are those that are premeditated (as they are outlined in the advance) and strictly intended by the person who issues them. Furthermore, they are not permissible if the person who issues them is suffering from severely diminished capacity to make consent decisions. Advance decisions require that one has at least sufficient mental capacity when one chooses an assisted death (provided that choice is available), or to allow oneself to die, for such a decision to be honored. Even if a given suicide is morally wrong or imprudent, this does not entitle a doctor to force treatment upon a patient with sufficient mental capacity, though the doctor may have obligations to assess a patient's capacity to make such a decision. As noted in Part I of this article, we may be justified in forcibly preventing a suicide whereby the agent also intends to harm others.[54]

Possible objections

One possible objection to my view is that advance decisions may be intuitively problematic in cases where patients have manic-depressive disorder or where a decision to die may more ambivalent, conflicted, or fluctuating. For instance, Bernard Williams addresses the case of a woman, Miss Beauchamp, whom he describes as having what was considered multiple personality disorder; in modern terms, we can refer to this as a dissociative personality disorder. Each of her personalities is distinctive and separate from each other, with different memories, skills, tastes, and so forth. We can talk of "Miss Beauchamp" as bodily identified, no matter which of her persons or distinctive personalities is present.[55] For the sake of argument, let us suppose this sort of disorder occurs as described, although there is debate about this. We can individuate a person as a whole even though she has many parts and they are all *her*. This means that if one of her personalities swallows poison and, while dying, another personality comes forward to replace the prior personality, we still regard her as having killed *herself*.

In such a case, the patient's mental capacity may be in question. Such cases fall under the medical determination of whether the patient has capacity to make a specific decision at the time that decision is made. If the doctor does not know if the patient has a settled intention or is acting fully autonomously or voluntarily, if he does not know the patient, for example, then he may be obligated to delay in following the patient's wishes while this is further assessed and the patient is given more time and resources to make this decision for herself. Ultimately, however, if we are to treat people with dignity for their distinctive characters, we may have to honor their decisions as made autonomously if appropriate measures are taken to ensure that the decision is not coerced or manipulated, *etc*., just as people without these disorders may be acting autonomously, even though they may have ambivalent, conflicted, or fluctuating feelings, impulses, and desires over time or with regard to different aspects of their lives.[56]

However, if the patient is deemed to have the capacity to make consent decisions, the most recent decision would trump past settled intentions. As in medical consent decisions generally, the most recent self that has the capacity to make a consent decision should take priority over prior selves and her decision should be the one that is honored above past selves' decisions, indicating a moral asymmetry

between the current self's choice and those of past selves. This is because the most recent self is the one who has the most current information in terms of available options. She is also the one who suffers so knows better than some past self what is in her own best interests and how much discomfort or pain or loss of dignity she can actually endure.

A second possible objection arises from thought experiment 'brain transfer' scenarios that Eric Olson and others discuss:[57] It may seem that we ought not to honor advance decisions that were made before a brain swap (or mind swap), since each mind is in a different body than was specified under the advance decision. However, I suggest that if it were possible to swap bodies, we would have to change the nature of much of our social structure and the notion of personal identity would have to be reevaluated since we would not be able to gauge reliably who was the psychologically continuous entity in any given body. We would not be able to honor contracts, marriages, or personal property, nor would we be able to hold people accountable for honoring promises or obeying the law, since much of our law is dependent upon regarding our psychological identities as interconnected with our physical bodies. Given our social structure, if someone was able to transfer his mind to a new body and loses psychological continuity in the process, we may have grounds to void the advance decision if the circumstances were not laid out in the advance decision or if the legal system did not support such postulated mind-swapping.

Conclusion

If we apply my analysis to the five cases in Part I, we give priority to the nearest self with sufficient capacity to make relevant decisions and extend the scope of that to his future incapacitated selves. If his selves are not connected but are still continuous, then we should ensure that his decision is current. If someone's current self is not continuous with prior selves, but still has residual mental capacity (as in case #3 outlined in Part I), we should determine what his current self decides. If someone no longer has capacity to make this decision but has a properly drafted advance decision in place that was made when she did have capacity, then we should honor that advance decision.

We have social and pragmatic reasons for regarding someone as the same person over time because the selves have the same legal identity that is arrived at for pragmatic and social purposes. Therefore, it may be permissible to kill a future self, where it may not be permissible to kill someone else. I have argued that we have pragmatic bases for ascribing a persisting personal identity, and that failing to do so undermines the distinction between homicide and suicide. As such, we have a moral and legal basis for honoring advance decisions refusing life-saving, life-sustaining, or life-extending treatment. Advance decisions, as with other medical consent decisions, reflect the contractual relationship between the doctor and patient; if the doctor treats a patient against the patient's decision to refuse consent for lifesaving treatment, he has breached this contract, and he may even have committed an assault. I argue elsewhere that contracts are relevant for more than advance decisions in self-killing; that the conceptual framework of contracts provides guidance about more difficult cases of suicide with respect to the obligations that suicidal agents have towards other people.[58] The Russian Nobleman and his wife, for example, by virtue of their roles, have voluntarily acquired obligations to each other regarding suicide; that such duties may involve either preventing the other's suicide, at least for a time, or may involve assisting in a suicide under some circumstances, and where legally permissible.

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