PHILOSOPHICAL ISSUES CONCERNING THE RIGHTS OF PATIENTS
SUFFERING SERIOUS PERMANENT DEMENTIA

I. Introduction

A. Dementia

This is an essay about the rights of seriously and permanently demented people. Is some minimum level of mental competence, which the demented cannot reach, essential to having any rights at all? If demented people do have rights, do they have the same rights as normally competent people, or are their rights altered or diminished or extended in some way in virtue of their disease? Do they, for example, have the same rights to autonomy, to the beneficence of their custodians, to dignity, and to a minimum level of resources as sick people of normal mental competence have? These are complex questions, and will require an extended analysis of various philosophical issues.

My emphasis will be on these philosophical issues. I shall not consider, except in passing, the present structure of legal rights and other provision for the demented, or the present practices of doctors and other custodians or officials who are charged with their care. These are the subjects of other papers prepared for the Office of Technology Assessment as part of its overall project on senile dementia, and though I have
read several of these, and taken account of them in considering the is-
ues I discuss, I make no effort to summarize or repeat their content.
Nor shall I attempt any comprehensive report of the behavior, detailed
 Capacities, physiological characteristics, prognosis or treatment of de-
mented people. These, too, are the subjects of other papers in the over-
all project, several of which I have read and relied on.

I must, however, make plain the circumstances of dementia as-
sumed in my various arguments and conclusions. I am considering what I
several times call serious dementia. I mean the situation of patients who
have lost substantially all memory of their earlier, competent lives, who
cannot, except periodically and in only a fragmented way, recognize or 1
respond to other people to whom they were formerly close, who are in-
capable of sustaining plans or projects or desires of even basic or simple
structure, and who cannot themselves attend to or appreciate their own
simple needs of nourishment and cleanliness. I am also considering what I
call permanent dementia. I mean the condition of patients whose
dementia is based in physiological deterioration that cannot, with
presently conceivable medical technology, be reversed to a point at
which serious dementia would disappear. Since dementia is normally a
progressive disease, there are stages of dementia, and my various argu-
ments apply, with full force, only to the very late stages I call serious
and permanent. I believe that it is crucial to decide what rights people
retain or have in that tragic condition in order to consider the different
and in some ways more tractable question what rights they have in ear-
lier stages on the road towards it. But this essay is only about the rights
of the people I describe.
B. Rights as Trumps

Many of the rights I consider are in one way or another political rights: rights people may or may not have that their community as a whole treat them, or arrange for their treatment, in specified ways. I understand political rights in the way suggested by a metaphor: that rights are trumps. The normal, general responsibility of legislators and other political officials, in the United States and in other Western democracies, is to improve the "general welfare," or the "public interest"; to work, that is, for the "collective good" of the community as a whole. This collective good is normally understood in a roughly utilitarian way. Political decisions advance the collective good, that is, when they improve the average individual welfare throughout the political community as a whole. Any decision is likely to benefit some people and put others at a disadvantage; these gains and losses must be traded off to decide whether the decision is in the interest of the community as a whole by seeing whether gains outweigh losses, and so improve the average welfare, or vice versa.¹

Individual rights act as trumps over these calculations of collective welfare, in the following way. If a community recognizes an individual right, it recognizes that it would be wrong to disadvantage particular individuals by violating that right even though that decision would be in the general interest. It is widely accepted, for example, that people who are seriously ill have a right to a certain level of medical
care whether they can afford it or not. That means they are entitled to that care even though it would serve the general welfare of the community best by denying it to them. This essay considers whether even people who are demented should be understood to have rights that act as a trump over the general welfare in that way, and, if so, what these rights are.

C. Demented and Past Selves

A single question runs through almost all the discussion of particular rights I shall undertake, and it is helpful to identify that question, in an abstract way, at the outset. We are considering the rights, not of someone who was born and always has been demented, but of someone who was competent in the past. We may therefore think of that person, as the putative holder of rights, in two different ways: as a demented person, in which case we emphasize his present situation and capacities, or as a person who has become demented, in which case we emphasize that his dementia has occurred in the course of a larger life whose whole length must be considered in any decision about what rights he has. We shall have to face a series of problems that seem to contrast, in different ways, the interests of the person conceived in one of these two ways with his interests conceived in the other.

Does a competent person's right to autonomy include, for example, the power to dictate that life-prolonging treatment be denied him later, even if he, when demented, pleads for it? Should what is done for
a demented person be in his contemporary best interests, that is, such as to make the rest of his life as pleasant or comfortable as possible? Or in the best interests of the person who has become demented, that is, such as to make his life judged as a whole a better life? (Suppose a demented patient wants care and treatment that would make him a serious burden to other members of his family, and we think that people lead better lives when they are not a serious burden to others. Is it in his best interests, overall, to allow him to become the burden he is now anxious to be? Someone's dignity seems connected, in some central way, to his capacity for self-respect. Should we care about the dignity of a dementia patient if he has no sense of his own dignity left? That seems to depend on whether the dignity of a competent person is in some way still implicated in how he is treated when he has become demented. (If it is, then we may take his former capacity for self-respect as requiring that he be treated with dignity now: we may say that dignity is necessary to show respect for his life as a whole.) Should the resources available to a demented patient depend on what his competent predecessor has actually put aside by way of insurance for his own care in that event, or at least would have put aside if insurance were available on a competitive and realistic basis. Insurance schemes, both private schemes and mandated public schemes, play an important part in the way we provide resources for catastrophes of different sorts. But is the insurance approach, as I shall call it, the proper model to use in thinking about provision for the demented? That must depend on whether a competent person has the requisite concern for himself in a later demented stage: whether he has what I shall call a prudential concern.
Many of the most prominent issues, then, about the rights of the demented, seem to call for a study of how their interests relate and connect to the interests and decisions of their past competent selves, and this connection will be a recurring theme of our discussions. But every aspect of that claim rests on an assumption I must now acknowledge: that it is correct to regard a demented person in the way I said we can, as a person who has become demented. That conception of him supposes that the competent and demented stages of his life are stages in a single life, that the competent and demented selves are parts of the same person. I relied on that assumption in the various suggestions I just made about how the interests and decisions of a competent person might affect his treatment when demented. I assumed, for example, that the control a competent person might seek to exercise over how he is treated when demented is correctly described as autonomy rather than paternalism, that is, that it is the kind of control people seek to have over the course of their own lives. I assumed, in describing the problem raised by beneficence, that it makes sense to treat the different kinds of interests I mentioned — the interest of the demented person in comfort and of the competent person in not being a burden — as competing interests of the same person, so that someone trying to act in that person's best interests would therefore have a conflict to resolve. I raised the question whether a competent person's dignity might be still at stake when he has become demented, which would not be a possibility unless his demented stage was part of his life, and whether a competent person can have prudential concern for the demented person he becomes, which
would be out of the question unless he remained the same person throughout.

Many philosophical theories about personal identity, however, challenge the assumption that identity survives serious and permanent dementia. They argue that personal identity requires psychological continuity, so that a person who becomes seriously demented, and has no important connections of memory and personality with his former self, has ceased to exist, and the demented person he has become must be treated as a new person altogether. So the question of personal identity, in this context at least, is not a mere academic philosophical issue or a barren semantic question. It must be faced, and resolved, in any competent theory about the rights of the demented. I shall postpone a detailed study of this problem, however, until the discussion, later in the essay, of the issue in which its force is most important and the matters at stake most apparent, which is the issue of whether the insurance approach is appropriate for considering the rights of demented people to resources for their care. I shall argue, there, that personal identity does survive even the most serious dementia. But I am assuming that answer to the problem of personal identity in the various arguments and conclusions, about other rights of the demented, that precede my defense of that answer. If my claims about personal identity are wrong, and identity does not survive dementia, many of these other arguments and conclusions would have to be abandoned.

II. Competence and the Domain of Rights
A. Domain and Character of Rights.

I just said that when a normal person becomes demented, we may think of him in two different ways: as someone who is demented, in which case we are attending only to his present situation, or as someone who has become demented, in which case we are surveying his whole life, his past as well as his present. The type and character of rights we recognize he has may depend, for the kinds of reasons I suggested, on which of these perspectives we believe ourselves entitled and obliged to take. In either case, however, if we claim that he now, even when demented, has interests that must be protected by rights, we are claiming a moral status for someone who is now demented: we are claiming that he now has the necessary standing to be eligible for rights. We must therefore consider, as a threshold question, whether that claim can be sound. Is some contemporary level of mental competence a necessary condition of his now having any rights at all? That question asks whether competence should be taken to define the domain of rights, that is, whether only people with a certain level of mental capacity are even candidates for rights. That is a different and more fundamental question than the question whether mental competence counts in defining the character of rights: whether and how the actual rights demented people have are affected by their incapacities. We shall see that the rights of the demented are indeed different from those of other people, just because they are demented. But we must first consider the more fundamental challenge: that the demented are excluded from the domain of people who can have any rights at all.
Discussion of that question has, unfortunately, sometimes been distorted by various confusions about the concept of a "person". It is a very popular idea that only persons can have rights, and that if someone who is seriously demented is no longer a person, or fully a person, he is therefore no longer within the domain of rights. That proposition is not universally accepted: many people think animals, for example, can have rights. But it is sufficiently popular to force us to consider the claim that the demented are not persons at all. (That is, of course, not the serious question I have postponed: whether he is, in a fundamental sense, the same person he was before he became demented. If psychological continuity is a requirement of personal identity over time, then someone who becomes demented does not, in that fundamental sense, remain the same person. But it does not follow that he is not a person at all).

B. Rights and Persons.

Much of the literature of what is called "philosophical anthropology" considers the distinction between "persons" and other animals.\(^3\) Rationality in some form has seemed, to many philosophers, essential to the distinction: hence the slogan that "man" is a rational animal. But it is perfectly consistent with that idea to insist that rationality, at most, defines the biological species of people -- the species that can be rational -- and that non-rational members of that species are also persons. That is the view ordinary understanding takes of the matter. We count infants as people, for example, even before they have become rational,
and we can therefore count the incompetent as persons after they have ceased being rational. On this view, the connection between rationality and rights presupposed in the idea that only persons can have rights is more subtle than it might first appear. The point of rights, we might say, is to mark the special status of beings who can be (or perhaps at some point in their lives actually are) self-conscious and reflective. If so, then the demented are people who belong to the community of those eligible for rights.

Even if we decide that the main value or point of rights lies in the protection they give to actually and presently rational beings, we may still decide that securing that protection requires, as a practical matter, extending protection to beings throughout their lives who are rational only over part of that life. We can explain why infants have rights in that way: we protect the rational beings infants will become by insisting that they have, even as infants, the rights they need then to become rational beings of the right sort later, and to have the later opportunities such beings have a right to have. We can construct a parallel argument for assigning rights to the permanently demented, who will never be rational again. We might say, for example, that we protect rational beings from anxiety by assuring them that they will continue to have rights of some sort even if they become demented.

I draw, from the argument so far, only this limited conclusion: the debate of philosophical anthropology, about whether rationality is essential to personhood, is not decisive over the practical question whether
the demented fall within the domain of rights. We must approach that question from closer in: we need, not a conceptual argument about what does or does not count as a person, but a moral argument about the role of competence in defining the domain of rights, an argument that begins in some thesis about the point of the institution of rights.

C. The Kantian Tradition

The Kantian tradition in moral philosophy might be thought to furnish an argument that connects competence to the moral point of rights. For that tradition, the fundamental point of morality is freedom, defined as the situation of someone whose constraints are self-legislated in a metaphysical sense. Kant captured that idea in this general formulation: people should always act consistently with maxims or principles they can consistently legislate as governing the rights of everyone including themselves. This general idea suggests an important connection between morality and capacity: it suggests that morality is an institution for beings who can be free in Kant's sense, who can act on principle or in accordance with self-legislated laws. People who are seriously demented plainly lack that capacity. It is doubtful (I shall discuss the issue later) that they have autonomy at all. It might seem to follow that they are ineligible to participate in the institution of morality as Kantians understand it, and then that they can have no rights if that understanding is sound.

The first of these two steps seems correct. The demented are often capable of understanding the difference between right and wrong in
what we might call a crudely behavioral way. They can, and do, make claims in the vocabulary of morality, about what ought or ought not to be done to or for them. (They seem capable, for example, of the complex emotion of resentment, an emotion that presupposes moral judgment of some kind). But they are not capable of the sustained and integrated moral legislation that, in the Kantian tradition, defines freedom and gives morality its most fundamental point. The second step, however, does not follow from the first. For the question whether the demented have rights is a matter of how others should treat them; in particular it is a question of how the non-demented majority should protect them from political or personal decisions that would disadvantage them for the sake of the general welfare of that majority. The Kantian idea I have been describing has this implication: the majority should act towards the demented only in the way that each member of the majority could consistently wish everyone, including himself, to be treated if he became demented. That formulation provides no reason to exclude the demented from the domain of rights. Once we realize that the freedom in question is the freedom of those competent people whose interests can conflict with those of the demented, we can accept that the demented are themselves incapable of acting morally and still insist that they must be the objects of moral recognition.

The Kantian tradition, broadly understood, includes John Rawls' famous treatise, A Theory of Justice. Rawls describes the demands of justice through an expository device that is often misunderstood, and that might also wrongly be thought to suggest that the demented cannot
have rights. Rawls argues that we should formulate principles of justice by asking what principles people would agree upon, as in their own "rational" best interests, if they were ignorant of all knowledge of their own background, abilities, tastes and projects. Obviously demented people are incapable of that kind of calculation. But that is no more an argument, under Rawls' theory than Kant's, that they cannot have rights. For people in Rawls' imaginary situation might ask themselves what rights they would want if, when the veil of ignorance was lifted, they discovered that they were about to become demented. Rawls has recently developed the philosophical foundations of his theory of justice more explicitly. He argues that it assumes a particular political conception of human nature: not that actual people are the rational egoists presupposed in the expository device I just described, but that they have what he calls the "higher-order interests" of being both "rational" and "reasonable". But once again, even if only people like that can be the subjects of his kind of morality, it does not follow that only people like that can be its objects. People with those higher-order interests need to ask how they should treat their demented fellow-citizens. That includes our question, whether the demented fall within the domain of rights, but it does not settle that question one way or the other.

D. The Humean Tradition.

There is a different moral tradition that we might call Humean. This tradition argues that the overall point of morality is not metaphysical freedom but mutual self-interest, practical co-operation and co-
ordination. Hume gave this simple example to illustrate the overall suggestion: conventional morality requires neighbors to help one another in need, and that requirement works ultimately for the benefit of all. Neighbors together harvest the crops of each farmer, in the right season, more effectively than if he harvested his own alone. More sophisticated illustrations are easy to find. Morality so conceived seem to provide, for example, a solution to what are called "prisoner dilemma" problems. Each of us may have a reason of self-interest to dump waste into a lake running through our village, no matter whether others dump into the river or not. But if we all act on that reason each of us has, we will all be worse off because the river, and the village, will be ruined. Morality comes to our rescue: if we collectively accept a moral reason not to do what is in our individual self-interest, then we will all be better off than if we did not. This mutual-self-interest picture of morality seems to sponsor the following argument for excluding the demented from the domain of rights: the domain should be limited to those who can contribute to the regime of mutual co-operation morality fosters. The demented would be free-riders in any such scheme. They cannot provide, and so would never be called upon to offer, the assistance to others that rights would guarantee for them. Nor do they have the capacity to be guided by rational morality in the way fully competent people can be guided: they are unlikely to accept, for example, that it would be immoral to pollute the village river for the kinds of reasons the Humean tradition furnishes.

We must, however, distinguish two different versions of the Humean thesis that the ultimate point of morality is mutual self-
interest. These take different views of how membership in the com-

munity of those whose self-interest morality is meant to serve is fixed. 

On one version, membership of the moral community is fixed by prin-

ciples whose purpose is itself to insure the highest average welfare 

within the group they select. According to that version, people are 

entitled to belong to the scheme of co-operation created by morality, 

and enjoy rights under that scheme, only so long as they can contribute 

to the welfare of other members, regardless of how much they have con-

tributed in the past. For when they are unable to contribute, it would 

raise the average welfare within the community to exclude them from it. 

On the second version, membership in the moral community is fixed in 

accordance with some standard or standards that serve some other value 

or point, or reflect some other concern, than simply the concern to 

achieve and maintain the highest average welfare within the group they 

select. For example, everyone who is a member of a particular political 

community, might automatically be regarded as a member of the moral 

community. Then the rules and principles of the scheme are chosen so as 

to work in the mutual-self-interest of that community, that is, of all 

those who are members in accordance with this independent principle. 

The difference between these two interpretations of the mutual interest 

thesis is dramatic. Under the first version, the demented have no moral 

standing, and so no question arises about their rights. Under the second 

version, the demented have rights if they satisfy the appropriate inde-

pendent test for membership in the community, because then the moral 

rules of the community must be in their interest as well as everyone 

else's.¹²
The first version is barely coherent. Its basic idea — that membership in a co-operative scheme must be limited to those who can contribute to the goals of that scheme — is appropriate only when that goal is an external one, that is, when the scheme aims at something beyond the welfare of its own members. It makes sense, for example, to suppose that a specialized military unit, or the executive board of a corporation, should be limited to those now capable of contributing to the goals of these enterprises — to commando raids or profits — and that no one should remain in such groups only as a reward for past contributions. It makes no sense, however, to suppose that membership in some organization whose goal is only the welfare of its members should be determined in order to make the welfare of the resulting group as high as possible. That treats average welfare as a commodity valuable for its own sake rather than valuable for the people whose welfare it is. It would recommend, carried to its logical extreme, a policy of murder to produce a community only of the most efficient welfare producers. We must therefore understand the Humean thesis as the second version of the idea that the point of morality is mutual self-interest. On that version, if the demented have become members of the community on whatever independent test is used, they must have rights to insure that they as well as the competent majority benefit from the community’s morality.

E. The Egalitarian Tradition

I believe that the best account of the point of political rights is egalitarian. It holds that rights are required in order to enforce the un-
derlying, fundamental principle that government must treat all members of the political community as equals, that is, with equal concern. Once again, applying that principle to the demented requires an independent judgment about whether they must be counted fully "moral citizens," that is, members of the political community to whom equal concern must be shown. If they are — if government must treat the demented with the same concern it shows to everyone else — then the demented are obviously candidates for rights. People who become demented have been moral citizens. So the crucial question becomes: is incompetence an event that terminates its victim's standing as a moral citizen of his political community?

The concept of moral citizenship figures in a great variety of political and moral issues. It plays an important role in the question, for example, of what standard the government of one community should adopt in making decisions that affect both its citizens and the citizens of other communities, in deciding on programs of foreign aid, for example, and immigration policy. The most intractable such issues, however, are issues not about how a government must treat non-citizens, to whom it owes some but less than equal concern, but about whom it should count as citizens who are entitled to equal concern. Fetuses present one such problem. (The debate about abortion often takes the form of debating whether fetuses are yet persons. It is a distinct, and perhaps more important question, however, whether fetuses are moral citizens even if they are persons, for, just as we regard foreigners as people but not citizens, it would be coherent to treat fetuses as persons
who have not yet reached that standing. It might follow that though our present community owes them some concern, it does not owe them concern equal to the concern it must show for pregnant women; someone who takes that view will accordingly take a more permissive attitude to abortion than someone who does not.) Future generations raise a parallel problem. Our collective policies of saving and conservation, broadly understood, require some assumption about the concern to which future generations are now entitled. Once again it is plausible to insist that those these will be persons they need not be counted as citizens the present community must treat with equal concern.

The demented stand in a different position from foreigners, fetuses and future generations, however, in the way I indicated. For the demented were moral citizens before they fell ill, so their case demands that we consider the conditions under which moral citizenship once acquired can be lost. It can, of course, be lost through voluntary act, someone ceases to be a moral citizen when he abandons his political citizenship for that of another nation; his former community need no longer treat him with equal concern. It is a very popular idea that moral citizenship can be forfeited as well as abandoned: that the government need not treat convicts with equal concern, for example, and that this justifies keeping them in jail, or even killing them, for the general good. But treating the demented as no longer moral citizens is justified only if moral citizenship can be lost involuntarily, through no fault of the former citizen. Allowing that would destroy the principal value of citizenship: it would make the obligation of the community, to treat all
its members with equal concern, largely illusory, because the concern could be withheld when most needed. Citizenship defines the category of those whose misfortunes command the community's full attention; that principle would be fatally undermined, and left with no coherent force, if the most serious misfortunes released the community from its obligation to show any concern at all. Moral citizenship, once acquired, cannot be lost so long as the community's concern is appropriate. It embraces at least all sensate citizens, who can suffer pain or anxiety, and embraces them equally without regard for the degree of their rationality or general competence. The demented are not second-class moral citizens.

We have therefore answered our initial, threshold question from a variety of moral perspectives: even advanced dementia patients are within the domain of rights. We must now consider the more complex and detailed problem of the character of their rights, that is, of which rights they in fact have. In the next three sections of the essay we consider the three important and related rights I described earlier: rights to autonomy, beneficence and dignity. Then we consider the rather different and even more complex question of the rights demented people have to resources, and we shall finally inspect, as part of that discussion, the crucial assumption I have been making: that it makes philosophical sense to treat a demented person as the same person as the competent person who formerly occupied his body. It is worth noticing (as one more indication of its centrality) how that assumption figured in the argument of this section, the argument that the demented are within the domain of rights. I relied on it particularly in the egalitarian argument just com-
pleted. I said that the demented are moral citizens because moral
citizenship, once acquired, cannot be lost voluntarily, and that assumes
that the moral standing of a competent person remains attached to the
demented person he becomes. If my assumption that personal identity
survives dementia is unsound, the arguments of this section would not es-
ablish that the demented are within the domain of rights. Perhaps no
arguments could.

III. Rights to Autonomy.

A. Contemporary Autonomy

It is a familiar idea in political philosophy that adult citizens of
normal competence have a right to autonomy, that is, a right to make
decisions about the character of their lives for themselves. Except in
very special circumstances, we reject paternalism — forcing people to
act in what the government deems to be their best interest — because
paternalism denies that right to autonomy. So competent adults are free
to make poor investments, provided others do not deceive or withhold in-
formation from them, and smokers are allowed to smoke in private,
though cigarette advertising must warn them of the dangers of doing so.
Autonomy is often at stake in medical contexts. A Jehovah’s Witness,
for example, may refuse blood transfusions necessary to save his life
because he believes transfusions offensive on grounds of religious convic-
tion. Or a patient whose life can be saved only if his legs are amputated,
but who prefers to die soon than to live longer in what he would regard
as intolerable circumstances, is allowed to refuse the operation. American law quite generally recognizes the patient's right to autonomy in circumstances like those.

How far do the demented have a right to autonomy? How far, that is, to they have a right to make decisions for themselves that others would deem not in their best interests? Should they be allowed to spend or give away their money as they wish, or to choose their doctors, or to refuse prescribed medical treatment, or to decide which of their relatives will be appointed as their guardian? How far does this depend on the importance of the decision, and the degree of their incompetence? There may, of course, be some other reason, beyond autonomy, for allowing them to do as they please. They may become so agitated, for example, if prevented from doing as they wish, that though the decision they make is not itself in their interests, we do them more harm than good by opposing them. Our present question is whether we have reason to respect their decision even when this is not so, even when we think it would be in their best interests, even all things considered, to take some decision out of their hands.

We cannot answer that question without reflecting on the point or value of autonomy, that is, on why we should ever respect the decisions people make when we believe these are not in their interests. One popular answer might be called the evidentiary view: it holds that we should respect the decisions people make for themselves, even when we think these decisions imprudent, because as a general matter each person
knows his own interests better than anyone else does. We may be right, on some particular occasion, in thinking that we know someone's best interests better than he does, but experience teaches us, according to this argument, that in most cases we will be wrong. So we do better for peoples' well-being by recognizing a general right to autonomy, which we always respect, than by reserving the right to interfere with their lives whenever we think they have made a mistake. If we accept this evidentiary account of autonomy, we will not extend the right of autonomy to decisions made by the seriously demented. For it is very implausible to assume that someone who is demented, who has lost the power to appreciate and engage in reasoning and argument, even generally knows what is in his own best interests as well as trained specialists, like doctors, do. In some cases that assumption would be incoherent: when, for example, as is often the case, the wishes and decisions of a demented person change radically from one bout of lucidity to another.

But the evidentiary view of the point of autonomy is very far from compelling. For autonomy requires us not only to allow someone to act in what he takes to be his best interests but to allow him to act in a way he accepts is not in his interests at all.\textsuperscript{14} This is sometimes a matter of what philosophers call "weakness of the will". Many people who smoke would prefer not to; they do not think that smoking, all things considered, is in their best interests, but they smoke anyway. If we believe, as we do, that autonomy requires allowing them to act in this way, we cannot accept that the point of autonomy is to protect an agent's welfare. Sometimes people act against what they believe to be their own
best interests for more creditable, even admirable, reasons. A Jehovah's Witness who refuses a blood transfusion acts out of convictions most other people think mistaken and irrational; but he acts out of conviction nevertheless not a mistaken view of self-interest. If autonomy requires us to respect such decisions, then once again autonomy is poorly explained on the view that the right to autonomy promotes the welfare of people making apparently imprudent decisions.

This suggests that the point of autonomy must be, at least to some large degree, independent of the claim that people know their own best interests better than other people can, and in that case it would not follow, just from the fact that a demented person will often be mistaken about his own best interests, that others are entitled to override the choices he makes. So perhaps the demented have a right to autonomy after all. The most plausible alternate view of the point of autonomy emphasizes, however, not the welfare of the choosing agent, but his integrity. The value of autonomy, on this view, lies in the scheme of responsibility it creates: autonomy makes each of us responsible for shaping his own life according to some coherent and distinctive sense of character, conviction and interest. It allows us to lead our own lives rather than being led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what he has made himself. This view of autonomy focuses not on individual decisions one by one, but the place of each decision in a more general program or picture of life the agent is creating and constructing, a conception of character and achievement that must be allowed its own distinctive integrity. We
allow someone to choose death over radical amputation, or even blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values even when these are not ours.

If we accept the integrity view of autonomy, our judgment about whether some patient has a right to autonomy will turn on the degree of that patient's capacity for integrity. When a mildly demented person's choices are reasonably stable, and reasonably continuous with the general character of his life before he became demented, he can be seen as still in charge of his life, and he has a right to autonomy for that reason. But if his choices and demands, no matter how firmly expressed one by one, contradict one another, or reflect no coherent character, or perhaps even if they are radically discontinuous with his previous life, then there is no longer any integrity for autonomy to honor. He will not then have a right that his choice of a guardian, or about the use of his property, or about his medical treatment, be respected for reasons of autonomy. He has the right to beneficence to be discussed below, that is, that decisions on these matters be made in his best interests; but he has no right, as competent people to, himself to decide contrary to those interests.

I should emphasize that the decision whether a particular patient is sufficiently competent to have autonomy must be a general, overall judgment about his capacity for integrity, not a specific, task-sensitive judgment. The literature of dementia points out, perfectly properly, that competence, in the sense of capacity to grasp the factors on which some
decision must be made, is relative to task: a patient who is not competent to administer his complex business affairs may nevertheless be sufficiently competent to decide whether to remain at home or to enter an institution, for example. Competence, in that task-sensitive sense, means the ability to grasp and manipulate information bearing on a particular problem, and this always varies, sometimes very greatly, among ordinary, non-demented people. I am more competent than you at some tasks, perhaps, but probably much less competent at others. Competence in the overall sense presupposed by the right to autonomy is a very different matter. It means, not the capacity to solve particular problems, but the more diffuse and general capacity for integrity: the capacity to see and evaluate particular decisions in the structured context of an overall life organized around a coherent conception of character and conviction. There will of course be hard cases, in which we will be unable to say, at least with any confidence, whether a particular dementia patient is competent in that overall sense. But the question of autonomy requires that overall judgment, not some combination of judgments about specific task-capability.15

B. Precedent Autonomy

So neither the evidentiary view of autonomy, nor the more plausible integrity view, recommends any right to autonomy for the seriously demented. But we have so far been considering the contemporary autonomy of a demented person; we must now consider the precedent autonomy of the person he was before. Suppose a patient is
now incompetent in the general, overall sense just discussed, but that, years ago, when perfectly competent, he executed a "living will" providing that he was not to be kept alive by expensive medical treatment if he became permanently demented, or that his property was to be given to charity rather than used for his care. Does autonomy now require that such provisions be respected, by those in charge of the patient, if they think them against the patient's best interests? If we accept the evidentiary view of autonomy, we will think the case for respecting such precedent choices very weak. People are not the best judges of what their own best interests would be under circumstances they have never encountered, and in which their preferences and desires will undoubtedly have changed. If we accept the integrity view, on the other hand, we will be drawn to the view that precedent autonomy must be respected, because it seems essential to someone's control of his whole life that he be able to dictate what will happen to him when he becomes incompetent. A competent person, making a living will providing for his treatment if he becomes demented, is making the kind of judgment that autonomy, on the integrity view, respects, a judgment about the overall shape or character of the kind of life he wants to have led.

But it might now be objected that the right to autonomy is necessarily contemporary: that it is only a right that someone's present decision be respected. Certainly that is the normal force of recognizing autonomy. Suppose that a Jehovah's Witness, whose religious convictions so require, has signed a formal document stipulating that he is not to receive blood transfusions even if he, out of weakness of will, requests
them when he will otherwise die. He wants, like Ulysses, to be tied to the mast of his faith. But when the moment comes, and he needs a transfusion, he pleads for it. We would not think ourselves required, out of respect for his autonomy, to disregard that plea to honor his former, formal request. We can interpret that example in two different ways, however, and the difference becomes important when we consider whether autonomy requires enforcing prior decisions about one's treatment when demented. We can say, first, that the later plea countermanded the original decision because the plea expressed a contemporary desire. On that view, it is right to defer to past decisions only when we have reason to think that the agent still wishes what he chose then: we treat the past decision, that is, as evidence of present wish, and disregard that decision when we have reason to think it is not in fact good evidence of that. So precedent autonomy as an illusion: we attend to past decisions only as rebuttable evidence of contemporary preference or choice. Second, we can say that the later plea countermands the original decision because the later plea counts as a fresh exercise of autonomy, that if we disregarded it we would be treating the person who pleads as no longer in charge of his own life. The difference between these two accounts of the force of autonomy is crucial when the conditions of autonomy no longer hold when someone changes his mind. Suppose that the same accident that made a transfusion medically necessary for the Witness also deranged him and, while still plainly deranged, he demands the transfusion. On the first view, we would not violate his autonomy by administering it; but on the second we would.
Which view of autonomy is right? Suppose we were confident that the Witness, if he receives the transfusion and lives, will become competent again, and will then be appalled at having had a treatment he believes was much worse for him than dying. In those circumstances, I believe, we would be violating his autonomy by nevertheless giving him the transfusion while he is deranged. That argues for the second view of autonomy, the view that endorses precedent autonomy. The deranged Witness does not object to the transfusion: he wants it. This is not, that is, like the case in which someone who objects to a treatment is asleep or unconscious when he needs it; in that case we can say (using a dispositional sense of objecting) that he continues to object then. If we withhold the transfusion from the deranged Witness, we withhold it in spite of the fact that he wants it then. We are relying on the fact that he does not have the capacity necessary for his wants to count in countermanding what he wanted when he was competent, and that means we are relying on the second view of autonomy's point. Someone might object that we are actually relying, not on any lack of capacity, but on the assumed fact that the Witness will regret the transfusion, if he receives it, when he becomes competent again. But we would take a different view if the Witness had not become temporarily deranged: suppose he pleads for the transfusion at the moment when he needs it, not because he is temporarily deranged, but just because he finds he wants to live at that moment, though we are confident that he will change his mind and be appalled at his decision tomorrow. If we would accede to his request for the transfusion when he wants it (as I believe we should), that shows that we are not relying, in the case when he has become
deranged, just on the fact that we predict he will have a different opinion when he recovers his senses. That fact seems important, in that case, only because it confirms that he had not changed his mind when he was still competent to do so.

Our argument, then, supports the idea of precedent autonomy. A competent person's right to autonomy requires that his past decisions, about how he is to be treated if he becomes demented, be respected even if they do not represent, and even if they contradict, the desires he has then, provided he did not change his mind while he was still in charge of his own life. If we refused to accept precedent autonomy, and instead insisted that past decisions made when competent will not be enforced unless they represent the present wishes of the incompetent patient, we would be violating the point of autonomy on the integrity view. For competent people, concerned to give their lives the structure integrity demands, will naturally be concerned about how they are treated when demented: someone anxious to insure that his life is not then prolonged by medical treatment is anxious exactly because he thinks the character of his whole life would be compromised if that life were prolonged in that way. This argument has austere consequences, however. Many would be outraged by the prospect of denying an incompetent patient life-prolonging care he pleads for, of allowing someone to die who very much wants to live, just because, years earlier, he signed a document requiring this. I have been arguing that his right to autonomy — the right of the person he has become and remains — unambiguously requires that his pleas now be denied; he is not like the imagined
Jehovah's Witness who changed his mind when he knew he was dying.\textsuperscript{16} We may be unable to deny him. We may think that people who refuse pleas for life for any reason are inhumane. Or we may have other good reasons for treating him as he now demands. But if so these are reasons that violate, rather enforce, his autonomy.

I end this discussion of autonomy with one final distinction. We must distinguish the precedent autonomy we have now recognized from other ideas with which it may easily be confused. Commentators and judges have said, for example, that crucial decisions affecting the care of dementia patients should reflect the decisions the patient probably would have made himself if he were competent. (So a patient's family succeeded in persuading a judge to terminate his care by arguing that he was a vital person who would not have wanted to languish in inactivity).\textsuperscript{17} We must understand these statements as appeals to precedent autonomy. So we must require, before allowing these supposed past wishes any effect, evidence of an actual past decision or belief that contemplated at least the general circumstances the patient is now in. It is not enough to argue that a particular conviction (for instance the desire not to have one's life prolonged) would be more consistent with the patient's former habits and patterns of life than any contrary conviction. The point of autonomy, on the integrity view, is to allow an agent to construct his own life and character according to his own lights, not to allow others to make, for him, a life they think most consistent in ideal or character.
IV. Rights to Beneficence

A. A Fiduciary Right

When one person is entrusted to the charge or care of another, the former has what we might call a right to beneficence: a right that the latter make decisions in the former's best interests. This fiduciary right is a familiar idea in both law and morals: a trustee must act in the interests of the trust's beneficiaries, the directors of a corporation must act in the interests of its shareholders, doctors and other professionals must act in the interests of their patients or clients. The right to beneficence is not a right that any particular person assume that duty of care; no one has a right that anyone else take up a fiduciary's duties towards him. The right takes hold only when someone does take up that role. Nor is it a right that any particular resources be put at the disposal of the fiduciary; that right, for the demented, will be considered later. The right of beneficence is only a right governing the use of whatever resources are made available for the beneficiary's care.

Since a beneficiary may take a different view of his own interests from the view a fiduciary takes, the right of beneficence is different from the right to autonomy we just discussed, and may in some circumstances conflict with it. We noticed one potential conflict a moment ago, between the best interests of a demented patient and the precedent autonomy of that patient before he became demented. We should postpone considering such conflicts, however, until we have a better grasp of
the content of a seriously demented person's right to beneficence. We have no reason to doubt that he has such a right: it would be wrong for his doctors and others charged with his care to ignore his interests in what they do. But we face an obvious problem in considering the consequences of that right. What are the best interests of someone seriously and permanently demented? We must begin by noticing an important distinction between two crucially different kinds of interests people have. The distinction is important in philosophical psychology generally, and throughout moral and political philosophy. But it is indispensable in disentangling the various issues raised by our present question, about the nature of a demented person's right to beneficence.

B. Experiential and Evaluative Interests

Most people in normal mental health worry or are concerned about two general kinds of interests they believe they have. First, they care about the felt quality of their future experiences. They dread future pain or discomfort, anticipate a good film or meal, and relish the prospect of travel, or of other forms of pleasure or enjoyment. I shall call these their experiential interests. Second, they care about the overall value or worth of the life that they are leading. They want it to be a good life, a life full of the associations, experiences and achievements a good life should have, unmarked by the blemishes that make a life bad: the kind of life in which they can take pride or some other form of satisfaction. These concerns describe their evaluative interests. Most people think about their evaluative interests much less frequently than about their ex-
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periential interests; the former come into play, self-consciously, only on those occasions when people are aware that a particular decision will affect the character of their life as a whole for better or worse. Many people never attend deliberately to their evaluative interests at all (though some of these, who want a spontaneous life because they think a planned or often re-examined life unattractive, are pursuing what they take to be their evaluative interests precisely by not attending to them).

The distinction between these two kinds of interests is very important and complex, and I shall explore it, in this essay, in only a cursory way, not even noticing several of the philosophical issues an extended treatment of the distinction would encounter. I shall try to show only that it is a distinction crucial to understanding the situation and rights of the demented, and most of these philosophical issues can be neglected for that purpose. Some philosophers would reject the distinction as superficial. Some utilitarians, for example, think that all interests are at bottom experiential. We take an interest in having a life good as a whole, on their account, only because we predict that we will be unhappy when we grow dissatisfied with the life we have already led. That seems to me to put the matter the wrong way around: I do not care about the shape of my life as a whole because I predict I will be unhappy if I think my life a poor one, but rather I am unhappy, in that event, because I think it so important that it be good. Other philosophers collapse the two kinds of interests in the other direction: they think we dread pain to come, for example, only because we think a life with pain a worse life to have led. That also seems wrong: we worry about painful
or disagreeable moments in our future not because we think these mar
the overall success of our life, but, at least often, in spite of the fact
that we do not, and when the pain or discomfort is past we may count it
as no blemish at all, or even as a kind of achievement. No doubt the two
kinds of concerns do overlap to a considerable extent for many people:
they think their life will have been a worse life, in the evaluative sense,
if it includes or avoids what they hope for or hope to avoid experientially.
But the quantitative accounting is nevertheless usually very different
even in such cases. Even when an old person fears future pain intensely,
or despairs because he has learned he will die soon, he is unlikely, except
in very special circumstances, to think that his life as a whole is made a
dramatically worse life by that pain, or would have been dramatically
better if he had lived some years longer. We understand the complexity
of human emotion better by contrasting rather than assimilating the two
ways in which people attend to their own interests.

One of the differences is specially important for this essay: time
plays a different role in each kind of concern. Experiential interests are
forward-looking and therefore radically time-sensitive. I care, in the ex-
periential way, about pain to come, but not about pain I have already
suffered. I want, in that way, not to die soon, because this will cheat me
of experiences to come, but I do not want already to have lived longer,
that is, to have been born earlier than I was. Evaluative interests, in
contrast, are not temporally indexed in that way. If I want my life to in-
clude certain kinds of achievement, only because these will make that
life a better one, I will be indifferent as to whether the achievement is
in the past or to come. If I would prefer my life to be longer than in fact it will be, not because I anticipate pleasure or enjoyment in future experiences, but because I count living longer in itself an achievement, as many people do, then I would be indifferent as to whether the longer life would have been secured by my having been born earlier than I was or dying later than I will.

A second difference is also important for us: though a person can judge his own interests differently at different stages of his life, the character of the conflict between these judgments is different with respect to the two kinds of interests. People's opinion about both kinds of interests often change over time. Someone may work to bring about particular kinds of experiences later — he may plan and budget for a trip — that he finds he does not enjoy, or enjoy as much, as he predicted. Or he may take important decisions — become a lawyer and join the bar — because he presently approves of a kind of life he later, when it is too late, thinks not a valuable life for him to have led after all. In both cases, as we might put it, his later self "disagrees with" the judgments his earlier self made. But the character of this disagreement is different. A disagreement about experiential interests proves that the original judgment, which was in the character of a prediction, was in fact wrong as things turned out. The earlier self made a mistake about what the later self would in fact enjoy: the former thought the latter would delight in a safari, but he did not. In the case of evaluative interests, it does not follow from the disagreement that the earlier self made any kind of mistake. The judgment someone makes deciding to go to law school, that
the life of a lawyer is a valuable one for him, is not a prediction in the
way that the judgment that he will enjoy a safari is. If he changes his
mind later external observers will not be entitled to say, for that reason
alone, that his original opinion had been proved wrong. They may think
that he was right the first time, that his later, changed opinion was a
change for the worse.

A fiduciary — someone who acts in the best interests of another
— must attend to this distinction. He acts in that person's experiential
interests if his decision in fact improves the experiential quality of that
person's life, if, that is, that person then enjoys his life more. But it
does not follow that the fiduciary acts in that person's evaluative in-
terest just because his decision has that consequence.\textsuperscript{18} We need further
distinctions to describe a range of possibilities here. A doctor, for ex-
ample, acts in his patient's \textit{subjective} evaluative interest when he
changes the patient's life in a way the patient regards as an improve-
ment.\textsuperscript{19} He acts in what he takes to be the patient's \textit{objective} evalu-
ative interest when he changes the patient's life in a way that he, the
doctor, believes makes it better. Of course, any reader who is skeptical
that lives can be "objectively" better or worse will think that no one
ever does or could act in another person's objective evaluative interest
when he acts against his subjective evaluative interests. In any case, ac-
ting against someone's subjective evaluative interests is normally an in-
sult to that person — a particularly objectionable form of paternalism —
that at least usually cannot be justified.\textsuperscript{20}
C. What Interests do the Demented Have?

Even a seriously demented person (unlike a permanently comatose person) has experiential interests. He remains capable of enjoying comfort and reassurance, and he has fears about his future and perhaps, to some diminished degree, even pleasurable anticipation. But by the time his dementia has become serious he has lost the capacity to attend to or even appreciate his evaluative interests, because these can have no meaning for him. He is ignorant of self not just in the way an amnesiac is, not just because he cannot identify his past, but more fundamentally because he has no sense of a whole life — a past joined to a future — that could be the object of any evaluation or concern as a whole. He cannot have the kinds of projects or plans, or survey and compare sets of these, in the way evaluative concern demands. Our normal use of the idea of best interests, in other words, presupposes that the person whose interests we are judging has a coherent, stable, complex and structured system of values. Even when we are tempted to set aside his particular choices, on the paternalistic assumption that we know what is in his interests better than he does, we appeal to his underlying structure of values, which we feel his present choice disserves out of ignorance or weakness of the will, to justify our choice for him.

He has then no contemporary subjective evaluative interests. But does he nevertheless have objective evaluative interests to which a fiduciary might attend? It is certainly not true that someone lacks objective evaluative interests whenever he lacks opinions about them. We
often say, of someone who lives for the moment and cares only for experiential interests, that he is wasting his life, and that judgment assumes that he has evaluative interests even though he is wholly unaware of them. Does it make a difference that the demented person, unlike the person wasting his life, lacks even the capacity to attend to his evaluative interests? Babies and young children do not have that capacity either, and yet we assume that they have evaluative interests. A large part of early education is designed to enable them to lead valuable and not just enjoyable lives. Of course, there is an important difference, which we can express temporally, between a baby and someone permanently demented. A baby already has evaluative interests, it might be said, because what happens to him or her later in life can make that life more valuable than it would otherwise be. But nothing that happens to someone after he has become demented can improve the evaluative quality of his life overall, making it a more valuable life than if he had died instead of becoming demented.

There is an important truth in the comparison. If we think of a demented person's life in only a forward-looking way, as the life he will lead from now on, there seems very little point in speculating about his evaluative interests, about what would make that life, so defined, more or less valuable, because he will from now on be capable of none of the achievements or attachments that we normally think give value to a life. Value, we might say, cannot be pored into a life from the outside; it must be generated by the person whose life it is, and this is not possible for someone who will always be demented. But we are now assuming that
a demented person is continuing the life of someone who was competent before. So when we consider how what happens to a demented person can affect the value of his life, we must consider his whole life and not just the sad final stages of it. The question whether a demented person has evaluative interests (and if so what these are) therefore asks whether and how events in the life of a demented person can affect the overall character or value of his whole life.

Most people think the value of their life can be affected by events after their death: they think their life would be a better one, for example, if projects they have begun flourish after they are dead, or if they are remembered affectionately or well, and worse if their projects fail or they are forgotten or remembered badly. So events taking place after a person has lost control of his life can, or so most people think, affect its value, and if so evaluative interests survive death. It is at least equally as plausible that evaluative interests survive dementia, and most people who have considered the possibility of dementia plainly think they do. Many people who are now competent, for example — almost all those I have discussed the matter with — would prefer to die immediately than to live on even in comfort if they became demented. That preference makes sense only as a judgment reflecting evaluative rather than experiential interests. They think that their life would have been a worse life overall if it includes a substantial period in which they are demented.

What reasons might they have for that view? They fall into three types. The first tracks some of the reasons people have for caring,
prudentially, about what happens after their death. People might think, for example, that their life is a worse life if they are remembered as demented, if their situation then dominates the image others are likely to have of them. The second is more attractive. People might think their life is made overall a worse life if they become a substantial burden to those they love, as demented people typically are. The third is specific to dementia: many people simply hate the idea of being demented, whether or not others think less or differently of their lives for that reason or whether or not they burden others. We cannot dismiss that sense as irrational. We noticed, in considering autonomy, that people think it crucial to the value of their lives that they be in charge of them: being in charge, we might say, is a fundamental, even constitutive, evaluative interest. Since people have a sense that their life continues even when they are demented, they can sensibly regard that part of their life, in which they are not at all in charge, as damaging its quality overall, because dementia is not, for them, a neutral state. They count it bad to be alive in that state.

D. Conflicts of Interest

We are considering not whether competent people think they have evaluative interests even after they become demented, but whether they do. I appeal to familiar beliefs of competent people only to indicate the popularity of the opinion that the demented have such interests, and to suggest the character of these interests if they do exist. We might decide, after reflection, that the claim that the demented have such in-
terests is a mistake. We might well reach that conclusion, for example, if we decided, after our later consideration of the matter, that it is a mistake to think that personal identity survives dementia, that is, that a demented person is leading part of the same life as the competent person who occupied his body before. We might then think that since the opinion of competent people, that it matters to their lives how they are treated after they become demented, rests in large part on a mistaken belief about personal identity, it is therefore itself a mistake. Even if we decide that my assumption about personal identity is correct, we might still decide that the popular opinion that the demented have evaluative interests is wrong, or disagree with particular people's opinion about what these evaluative interests, considered objectively, really are. We might think, for example, that it does not affect the value of someone's life how he is remembered, or whether or not he is in charge of it during some period in which he lacked the capacity to take charge.

How should we approach the question, then, of how far and how a fiduciary should attend to the evaluative interests of a demented person? We can sharpen that question by supposing that the evaluative interests of a demented person, if he has any, might conflict with his experiential interests. We should therefore return to the difficult case we considered earlier. Suppose someone who is seriously and permanently demented is ill and will die without life-prolonging medical treatment, and that resources are available to provide that treatment. Suppose his experiential interests would be served by prolonging his life: he wants to live, and will have pleasurable experiences if he does. Should a fiduciary — a
doctor, for example — consider whether he has competing, evaluative interests that recommend against prolonging his life? If so, what standards should he use to decide whether he has such interests, and how the conflict, if he does, should be resolved?

I argued, in the last section of this essay, that if the patient had addressed these issues himself, and made a decision about how he wanted to be treated in this event, his right to autonomy would normally require others, including fiduciaries, to respect that decision. In order to concentrate on the different right to beneficence, therefore, we should now assume that he has made no decision himself, that he never considered whether he would want his life extended if he were permanently demented. A fiduciary would then have to choose between the following two strategies. He might decide that in these circumstances the patient's evaluative interests should be ignored and only his experiential interests taken into account in deciding where his best interests lie. Or he might decide that the patient's evaluative interests do count, in which case someone — the fiduciary or someone else — would have to decide what those evaluative interests, properly understood, require, and how weighty, in contrast to the experiential interests, they are. (I shall ignore the question, here, of which person or group should in fact make this decision. The candidates include the fiduciary, relatives or the community itself through some political decision. If we decide that someone should try to determine and enforce the patient's evaluative interests, the question of who should do so would obviously be of very great practical importance, but it will be helpful to abstract from that question in considering whether anyone should).
Autonomy requires that competent people be left in charge of their own lives: that is, that they be permitted to decide what is in both their evaluative and experiential interests and, if conflicts arise, how to resolve them. It is paternalism for a fiduciary to act on his own judgments about the interests of another when these do not reflect what that other person believes himself, and the paternalism is most serious and objectionable when the fiduciary's judgments are judgments of evaluative rather than experiential interests. (My autonomy is insulted when government requires me to wear seat-belts in my own interests. But the insult is much greater when it censors my reading on the ground that some books might persuade me to a worse view of what a valuable life is.) These observations might be thought to require the first of the two strategies I just distinguished. We might say: "Since paternalism is wrong, a fiduciary should avoid it whenever possible, and particularly when it means foisting his own judgments about what makes life valuable on the patient. We are assuming that a demented patient can and does have opinions about his own experiential interests: he wants some things and experiences and to avoid others. So it is not necessary for the fiduciary to make any evaluative judgments for him, because the fiduciary can be guided by the patient's experiential interests alone. So if we accept that the fiduciary should act in whatever way will minimize paternalistic interference in the life of the patient, we would recommend that course, and so recommend, in the case we are considering, the life-prolonging treatment."
But this argument makes an assumption we must now expose. Why is evaluative paternalism wrong? What is its special vice? When we considered the point of autonomy, in the last section, we distinguished two views: that autonomy is desirable on evidentiary grounds, because people are more likely to know their own best interests than others are, and that it is desirable because people must be allowed to take responsibility for their own lives. We can distinguish two matching accounts of why evaluative paternalism is wrong: because others are likely to make someone's life a worse life when they intervene, and because intervening spoils the control people should have over their own lives. Neither of these reasons why we might think paternalism normally wrong holds in the case of dementia. Since someone demented is incapable of judging his evaluative interest, we cannot say that he is likely to know his own interests better than others can, and since he is not in control intervening cannot spoil his control. The argument of the last paragraph therefore takes some different view of the vice of evaluative paternalism: it holds that this is wrong in itself and not just because of the consequences it might have for its object. Most people do not think evaluative paternalism wrong for young children: their education is normally designed with the end that their lives be better lives. It might be objected, to that comparison, that good education broadens the choice a child will later have; it does not dictate one choice irrevocably, as a fiduciary would do for his charge if he withheld life-prolonging treatment on the grounds that an early death made his life better. But in the circumstances we are considering, either choice a fiduciary makes is irrevocable, and his decision to ignore what most competent people would
think the main issue the choice involves — whether living in a demented state makes the whole life worse — seems perverse, a piece of methodological fiat that makes it more likely that, of the two irrevocable choices that might be made, the wrong one will be selected.

So the argument for ignoring evaluative interests drawn from paternalism turns out to be very weak. We must now consider a different argument: that in the circumstances of dementia evaluative interests become less important and experiential interests relatively more important, so that fiduciaries have that reason for ignoring the former and concentrating on the latter. But both wings of that suggestion are flawed. It is of course true — it is part of what we are assuming in setting our problem — that a demented person has no sense of his own evaluative interests. He is no longer capable of appreciating the character of his life as a whole, or why that life might be a better one, all things considered, if it ends soon. But he was concerned, when he was competent, that his life be a good one, and his concern, then, included a concern about how he would be treated during his whole life and not just that part of it during which the concern was lively. If we suppose that the interest ends when the concern does then we have made one of the mistakes we noticed earlier. Either we have collapsed evaluative into experiential interests, or we have divided the person whose interests the fiduciary is charged with promoting into two people, a competent predecessor who had evaluative interests but who has now disappeared and a demented successor who has no evaluative interests at all. In either case we have begun to think of people not as they think of them—
selves.

Nor do we have any reason to count experiential interests as more important when someone is demented than when he is competent. On the contrary, they seem less important then, even as experiential interests. We noticed, in considering the difference between experiential and evaluative interests, the overlap between them and the way in which satisfaction of one set contributes to satisfying the other. We take more pleasure in experiences that develop and use capacities we think we ought to have, for example, and we count our life better, in the evaluative sense, for being rich experientially, that is, for being full of experiences in which we can take delight. In dementia, however, even pleasant experiences make no evaluative contribution, because they cannot be perceived as exploiting desirable capacities. Many people recognize this in the popular judgment I reported: that it would be better for them to die than to live even a comfortable life with sharply diminished mental capacity. They are not merely recording, in that opinion, the triumph of evaluative over experiential interests, but also their sense that any pleasure they cannot savor, by connecting it to some larger and satisfying view of character and achievement, is thin and trivial.

Fiduciaries, then, have no justification for simply ignoring a demented person's evaluative interests. They have a responsibility to act in his interests overall and they (or some other person or group) must decide, for example, whether it is against his evaluative interests to receive life-prolonging treatment, and, if so, how the conflict between
evaluative and experiential interests should then be resolved. The view that prolonging his life would be against his evaluative interests is, as I said, a popular view. The argument for it is straightforward and powerful. Some kinds of experiences and achievements make a life that contains them a better life to have led; some make it a worse one. The seriously demented stage of a life can contain almost nothing that could plausibly be thought to make that life better in the evaluative sense. Experiences in such a life cannot be considered rewarding, because that requires a sense of personality and agency that serious dementia excludes, nor as achievements, because that requires continuity of project and fulfillment. Though I remarked, earlier, that some people think a life better just because it is longer, no matter what the value of the additional life considered on its own, that view seems to demean rather than celebrate life, and most people would reject it. The demented stage of a life can certainly, however, contain experiences that make the life of which it is a part worse. Severe pain or anxiety makes a life worse, and so do the various forms of indignity, to which demented people are especially subject, that we consider in the next section. And we have already noticed other ways in which dementia may make a life worse: dependence, burden and image.

A fiduciary (or someone else or some other group charged with the decision) may plausibly decide, therefore, that it is against the evaluative interests of a permanently demented patient to prolong his life. Since that is my own view, I will assume, in the argument that follows, that we decide it is the correct one. (I make that assumption only
to illustrate the importance and consequences of any such decision, and my argument does not, therefore, depend on accepting this particular, or any other, view of what the evaluative interests of a demented person actually are.) What should be done, then, if the patient wants to live, and will not suffer great any pain or anxiety that makes this against his distinct experiential interests? I claim that a great many people, when competent, would want not to have their lives prolonged if they became demented. But I do not claim that all would, and we cannot resolve the apparent conflict by appealing to any supposed consensus. I would myself stand on a different principle: that evaluative interests are both more distinctly human, and more important and fundamental, than experiential ones, and that we honor people by undertaking to look after these fundamental interests when they cannot do that for themselves. The more fundamental standing of evaluative interests flows from their character. It would go too far, I think, to say that people care about their experiential interests only because they care about evaluative ones. Experiential interests seem more biological than reflective in origin. Many people rarely reflect, with any degree of attention, on evaluative interests, and those who do often nevertheless choose a life they regard, in the abstract, as less valuable because it is easier or more pleasant. But evaluative concern nevertheless has a special standing that can be captured in the language of second-order wishes or preferences: anyone who thinks he would have a better life if he did not care so much for his experiential interests is likely to wish he did not. Or that his character would be better — he would think more of himself — if that were so. The principle I recommend — that a fiduciary should take over a per-
son's responsibility to make his life as good a life as it can be when that person is no longer capable of this himself — can therefore be said to take the view of people we are assuming most people would like to take of themselves.

If so, then it follows that the right to beneficence includes the right not to be given life-prolonging treatment when seriously and permanently demented. Of course it includes much else as well — it includes the right to have pain and anxiety alleviated, for example. I have emphasized the life against death issue because that is the most dramatic of the decisions a fiduciary might have to make, or that others may have to make for him. And of course my claim that it is in a demented person's interests not to have his life made longer is controversial. Some people might disagree; they might think that it is always in any person's interests to live longer, at least when this can be done without pain. I have tried, not to support my own convictions, but to explore the complexity of the issue of what is in the best interests of a demented person, to show the strands of decision that must be distinguished and then woven into an overall judgment of what the right to beneficence requires.

We should look back, before leaving that right, to consider how it might conflict with the right to precedent autonomy we discussed in the last section. I imagined this situation: someone when competent provides, in a "living will", that he is not to be kept alive by expensive care if he becomes demented. But when he is demented he insists on and pleads for
that care. We now see that this story need not, after all, present any conflict between autonomy and beneficence. If I am right that it is not in the demented person's best interests to be kept alive, we have no reason of beneficence for providing him the treatment he now demands. We may have other reasons for providing it — we may not want to live in a society that denies pleas for life from anyone — but we may now say that these are reasons of neither autonomy nor beneficence: giving him what he asks cannot be acting for him in either of these ways.

But now imagine a different, almost reversed, story: suppose that someone, when competent, asks that every means be used to keep him alive as long as possible if he becomes demented. (Or that we have good reason to think he would have made that request if he had thought it necessary). Now, if my assumption about his best interests is sound, the story does present a conflict between precedent autonomy and beneficence: what he asked before is against his interests now. How should that conflict be resolved? The right to autonomy is not a right to any particular resource. But suppose that the patient, when competent, provided the resources necessary to prolong his own life, or that his relatives are now prepared to provide these. It would be an act of deep paternalism for fiduciaries to refuse to spend these funds that way. Once again, there might be other reasons for their refusing to honor his past request, or for the community not allowing them to do so. But it would be unjustified paternalism to ignoring them appealing to the patient's contemporary best interests alone.
V. The Right to Dignity.

The idea of a right to dignity is used, in moral and political philosophy, in a variety of ways and senses. Sometimes, for example, it is understood as the powerful if vague right to the conditions, whatever these are, in which genuine self-respect is possible or appropriate. In this section, I shall be considering a different, more limited, idea: that people have a right not to suffer indignity, which means not to be treated in ways that, in the particular culture or community to which they belong, are understood as showing disrespect. Every civilized society has standards and conventions defining these indignities, and these differ, to some degree, from place to place and time to time. We often appeal to these standards in defining the minimum conditions of decent custodial care; we say, for example, that prisoners who have been convicted of even serious crimes are entitled to dignity in their punishment, and think this requires that jails be clean, that prisoners not be abused, and that they be allowed at least a certain level and kind of privacy.

A parallel claim is made on behalf of the demented in the care of the community. It is said that they, too, have a right to dignity, in virtue of which they must be kept clean when they cannot or will not clean themselves, must not be herded together in crowded conditions that allow them no genuine privacy, and must be shown some level of individual attention and concern by, for example, not just ignoring their complaints or sedating them to make them more tractable. This supposed right to dignity is in many ways treated as more fundamental than the
right to beneficence we considered in the last section. That latter right, as I emphasized, is only a right that whatever resources are available for someone's care be used in his interests; the right to dignity is more imperative because it is understood to require the community to deploy whatever resources are in fact necessary to secure the dignity it commands. (The two rights are even more plainly contrasted in the case of prisoners. We do not require that jail conditions must be arranged in the best interests of the inmates, but we do insist that these conditions respect their dignity.)

Do the demented really have that right to dignity? Do they have it even when they are not competent to appreciate or suffer from indignity, or in any case seem not to care about it themselves? Or is our concern for their dignity then only a matter of sentimentality we cannot and should not afford? These are questions of considerable practical importance. It is expensive and tedious to keep seriously demented patients clean, expensive and difficult to provide enough space to assure each of them some privacy when he or she wants it, expensive and exasperating to give each of them the personal attention they often crave. Once again, we can answer the difficult question whether the demented have a right to such treatment, in the name of their right against indignity, only by reflecting further on the point of that right when we acknowledge it for the fully competent. Why do we care about indignity? Why do we care so much?

One theory treats indignity as wrong because very much contrary to our experiential interests. This theory supposes that indignity causes
its victims distinctive and specially severe mental pain, that people resent and therefore suffer more from indignity than from other forms of deprivation. If their indignity is sufficiently serious and protracted, moreover, they will lose the self-respect dignity protects, and then suffer an even more serious form of distress: self-contempt or self-loathing. If this experiential account of dignity is sound, then the seriously demented (or at least many of them) may have no right to dignity after all. Seriously demented people may or may not want to be clean, or to have their privacy respected, but few of them have the necessary sense of self-identity to suffer a distinctive distress, different from the distress they suffer when any other request is refused, through what they can recognize as an insult to their self-esteem. Self-respect, like autonomy, requires a considerable degree of general competence; it requires, in particular, a sense of self-identity over time which seriously demented people have lost. (Self-hatred or loathing requires an even sharper sense of identity, and though some people feel that intense distress when they realize they are becoming demented, it has disappeared when the dementia becomes complete.) So on the experiential account of dignity it seems dubious that the demented have any general right to dignity. Concern for their self-respect does seem, on that view, only an expensive piece of sentimentality, like providing hairdressers for the comatose. Of course, even if we take that view of dignity, we may still think it important to maintain the demented in circumstances of dignity out of respect for the sensibilities of their relatives or others who will otherwise suffer outrage and guilt. But if it is true that the patient himself suffers no distinctive distress of indignity, his relatives might be led
to see that their own indignation and guilt is misplaced. In any case respect for their feelings does not require us to recognize any general right of dignity for the demented, a right a demented patient would have even if he had no relatives or friends who would care.

The experiential theory of indignity, however, is unpersuasive, because it cannot explain central features of the use we make of the idea of indignity. Most of us think that slaves live in the ultimate indignity even if — particularly if — their subjugation is so complete that they believe their slavery appropriate and take no offense in it. The experiential theory also neglects the fact that, for us, dignity has an active as well as a passive voice, and that the two are connected. We disapprove of someone, and say he has compromised his own dignity, when he is so indifferent to hygiene that he lives in filth, or when he neglects or sacrifices the independence we think dignity requires, or debases himself, in ways we call undignified, for some immediate advantage. And we think that someone who acts in an undignified manner acts worse, and has more to be ashamed of, when he does not recognize the indignity he has brought upon himself. If the experiential account of indignity were right, these critical attitudes would be perverse; on that view someone who does not mind what for others would be an indignity might be unusual, but he would not be debased, and an unrecognized indignity would be no indignity at all. Nor can the experiential theory explain why the greatest indignity we can inflict on someone is to make him unconscious of other indignities, for example by sedation or brainwashing.
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We can account for our full concern about indignity, therefore, only by rejecting the experiential theory of that concept in favor of a more evaluative theory. Indignity is a special sort of harm, whether self-inflicted or inflicted by others, not because it causes mental suffering, but because in some way it makes the life of its victim a worse life to have lived. Indignity is not bad, on this evaluative account, because it produces suffering, but rather produces suffering, when it does, because it is recognized as bad, and this explains why the harm of indignity is not less, but if anything greater, when the agent does not recognize that his dignity has been compromised. Is an evaluative account plausible? Is it plausible that living in circumstances of indignity makes a life a worse life? The fact that the content of indignity is at least partly culturally fixed might seem an argument that this is not plausible. How can living in filth make a person's life worse if he does not mind it? How can this depend on whether others in the society happen to believe that it does?

But that objection ignores what we might call the social meaning of indignity. The conventions of dignity furnish a vocabulary for gestures of respect and disrespect, including self-respect and its denial. When we insist that prisoners, for example, must be treated with dignity we mean that it must be recognized, in the way our culture provides for the purpose, that they remain members of the moral community, creatures whose fate is still of special concern to the rest of the community because they are still people. It is very far from absurd that someone's life is more successful when that moral standing has been recognized within his community, and worse when it has been denied. We noticed, in con-
sidering the various forms of evaluative interests most people recognize, that many of these touch reputation and image: we care about other peoples' attitudes to us. We care in the evaluative way: we care about their attitudes even when we are ignorant of them and even after we are dead. In the context of that general concern, it is more than plausible to count the fundamental recognition indignity denies as peculiarly important, and so the view I am trying to defend, that indignity offends our evaluative interests, is neither mysterious nor disconnected from our other beliefs and convictions.

The crucial question, then, when we consider whether the demented have a right to dignity, is not the question I first identified, whether they are capable of sensing indignity the way competent people can, or whether they resent it the way competent people do. It is the different question we have already answered: whether the demented remain members of the moral community who are entitled to be recognized under that title. We must remind ourselves that the interests we are studying, and the right we are considering, do not belong simply to a demented stage of a person, a stage that cannot acknowledge the interest or appreciate the right. We are recognizing, here as in past parts of the argument, the evaluative interests of a person who has become demented. We treat him with dignity, not out of sentimentality or misplaced guilt, but because we believe we would harm him, in a special but nevertheless serious way, if we disowned him now.
VI. Competence and Resource

A. The Costs.

In the remaining sections of the essay we consider the most complex and, from the standpoint of political morality, the most important of the philosophical issues raised by the increasing costs of senile dementia. The expenses of caring for seriously and permanently demented people fall into two main classes. First, the seriously demented require custodial care, and as the disease progresses this must be round-the-clock care. The expenses of custodial care can be monumental: the average nursing home charge in Manhattan, for example, is $_______ a year. Second, particularly because they are mainly old, the demented have substantial medical needs that are quite independent of their dementia: the medical expenses of even the fully competent elderly are disproportionately great. A demented patient may need expensive medical care in order to save or extend his life in the face of life-threatening diseases: he may need treatment for cancer or an organ transplant or coronary surgery.

The present public provision for the demented, in the United States, is complex but it is far from plain that it expresses any coherent welfare entitlement theory. Custodial care is not provided under the Medicare program, which is available to all the elderly. Custodial care may be provided under Medicaid, but Medicaid is available only to the very poor, and therefore not to most dementia patients until their own
resources have been all but exhausted. The poverty threshold for Medicaid has led some victims and their families artificially to exhaust resources: patients becoming demented transfer their property to others, and they sometimes divorce so that their spouses' resources are not counted in deciding their eligibility. The custodial care Medicaid provides is, in any case, considerably less ample than the care provided for people who can afford more. On the other hand, dementia is not taken to be a reason for withholding life-prolonging medical care that would otherwise be available. Many states have adopted legislation providing for "living wills" that allow competent people to provide that they are not to be kept alive if they become demented, and some courts have allowed the family of a demented patient to withhold life sustaining treatment on a showing that the patient's style of life was such as to suggest that he would not want to continue living in those circumstances. But dementia is not in itself taken to be a reason for providing less intensive medical treatment than a patient would otherwise receive.

We need a more systematic and efficient scheme of public support. What form should it take? Is a victim of senile dementia entitled that the community as a whole, through some level of government, bear all or part of some or all of these two groups of expenses? If so, is every victim entitled to that public support? Or only those who cannot, or whose family cannot, afford it themselves? To what kind of treatment and care are victims entitled? To both custodial and medical care, or to one but not the other? If government should provide custodial care, how much such care — at what level of comfort, companionship and privacy
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— should it provide? If it should provide medical care, should the fact that the patient is demented justify providing less medical care for treatment of his dementia-independent disease? If we believe that government should provide life-saving treatment (like renal dialysis) for everyone who cannot afford it for himself, for example, does it follow that government should provide such treatment for the seriously demented as well as the normally or partially competent? Are there limits to government's responsibility for medical care? What standards govern these? Are demented people entitled to every kind or type of treatment that might improve their welfare or life-expectancy? If not, to what lesser level of treatment? What sort of argument could the community use to justify some lesser level of care?

The discussion of earlier sections of this essay, about the rights demented people have to autonomy, beneficence and dignity, is pertinent to all these questions, and I shall draw upon it. But so is a domain of political morality we have not yet considered: distributive justice. Any view about the responsibility of government to provide medical or custodial care for those unable to provide it for themselves rests in the end on some more general thesis about the moral responsibilities of the community as a whole towards each of its members. The American people have been divided about that responsibility over their entire history, and the division is particularly sharp now. We must try to identify the general models or approaches or impulses reflected in the national debate about public responsibility for individuals, and in particular about the role government should play in meeting health care costs, noticing
the philosophical antecedents of each, and its implications for the special
problem of serious and permanent dementia.

B. Models of Welfare Entitlement

Some people would give a short answer to the list of questions I
identified, about the welfare entitlements of the demented. They would
say that since people are responsible, as individuals, for their own fates,
the government has no welfare obligations to anyone, and that someone
who becomes demented must be cared for out of his own resources or
those of relatives and friends willing voluntarily to help.23 The pure ver-

ison of this austere view argues that the government should make no
contribution to the care of dementia victims in any circumstances. But
though the idea that individuals must take responsibility for their own
fates is more popular in American politics now than it has been for some
time before, it is not popular in that pure and relentless form. Even its
most devoted partisans accept that government has some responsibility in
extreme cases, when a fellow citizen is in wretched circumstances
through no fault of his own, and his condition can be improved by rela-
tively small public expense. So even they need some theory or standard
justifying this exception to their general principle, or at least some
general description of when it holds. Most people feel more generous im-
pulses towards the handicapped including the demented. But even those
who support large public programs of assistance are generally unclear
about the basis for this assistance; in particular they are unclear how far
the handicapped have a right to it. That question is crucial not only for
fixing a floor under the overall contribution the community must make for the handicapped, but also for fixing how that contribution must be distributed among them.

We might distinguish four different approaches we might take to the question how far and why the community should make provision for the sick and handicapped. The sympathy approach (as I shall call it) argues that community provision is justified and required because it institutionalizes the sympathy or love or identification citizens of adequate means should feel for less fortunate fellow citizens. That is an attractive description of the general motives many citizens feel they have for sponsoring or supporting public provision. But is not sufficiently detailed or structured to provide a justification for any particular form or level of public support; it states a reason but not an approach. The problem of medical care illustrates that limitation dramatically. Technology has produced devices and procedures of undoubted value in improving life-expectancy, from cat-scans and non-invasive diagnostics to transplants of a variety of organs. A community that undertook to provide the most powerful technology available to every citizen, regardless of cost, would have no resources for other purposes. Sympathy and identification provide no standard for deciding how much and what level of care should be provided for all, short of that unattainable ideal.

The utilitarian cost-benefit approach offers such a standard: it insists that any public expenditure be designed and directed so as to maximize the general benefit of all such expenditure, measured by its total
contribution to welfare, to the community as a whole in the long run. The philosophical background of this cost-benefit approach is utilitarianism, the general theory that all government programs and policies, including policies of taxation and redistribution, should be governed by the sovereign imperative that all such programs should aim to improve the average level of happiness, prosperity and success in the community as a whole, trading off welfare losses to some against greater gains to others. Under the cost-benefit approach so understood, both the overall public budget for health care, as contrasted to other general programs, like defense, education, and other forms of transfer payments to the poor, and the proportion of the health care budget directed to the treatment and care of particular groups of patients, is fixed by comparing the contribution funds spent on health care, or on the treatment of one group of patients, make to the general welfare with the welfare benefits of those funds spent some other way. The approach would therefore direct public medical expenditure mainly to those who can be treated relatively inexpensively, to those who, if they recover, will provide more wealth or other value for the rest of the community, to those whose life is likely to be longest prolonged and enriched by medical treatment, and to those whose general quality of life and mental argument is such that the life they will lead if they recover is likely to be enjoyable and full of interest. The British scheme of distributing scarce health-care resources like expensive diagnostics, renal dialysis and transplant surgery under the National Health Service is a roughly utilitarian cost-benefit scheme. (It is interesting, and pertinent to the problem of senile dementia, that the British use age as a rough rule-of-
thumb proxy for these other factors. Renal dialysis is generally denied to those over 45. 26)

Victims of serious and permanent dementia, particularly elderly victims, would fare very badly in that welfare contest. No treatment will make them useful to the community, they are not likely to live long in any event, and, though custodial care can relieve pain and anxiety, it cannot dramatically improve the quality of life of the seriously demented. (Any policy based on utilitarianism will for that reason work to the disadvantage of the elderly demented, and the disadvantage is aggravated by a fact we noticed earlier: that utilitarianism treats all interests as experiential, and therefore recognizes the dignity of the demented as a value only so far as they perceive and suffer from indignity.) So the cost-benefit approach to our problem would recommend a very low public contribution to the care of dementia victims, and perhaps none at all.

The welfare-floor approach justifies public provision for the handicapped on the ground that a humane society will not allow any of its members to sink below a certain level of well-being if they can be helped by communal support. 27 That approach seems less severe than the utilitarian cost-benefit approach, and more promising for the demented because, on any conception of the proper level of welfare below which a decent society will not allow its members to fall, the demented seem below that level: they are very badly off indeed. But they are in fact so badly off that the welfare-floor approach, paradoxically, may be of no
more help than the cost-benefit one. For nothing can be done for people who are seriously and permanently demented that would bring them up to any reasonable minimum level of welfare that the welfare-floor approach might stipulate generally. Compare the way in which dementia victims might be treated under John Rawls' influential theory that justice requires that the worst-off group in the community be made as well-off as possible. If the worst-off group is defined in terms of welfare, for purposes of that theory, then dementia victims, together with other seriously handicapped people, might well count as the worst-off group. In that case that theory would recommend vast public expenditures on their behalf, continuing so long as any further expense would improve their welfare to however slight a degree. A community that accepted that principle would have very little resources left for any other purpose. Rawls in fact defines his groups in terms of resources rather than welfare, and he does not count the sick and handicapped (let alone the demented) as a social group badly off in resources just because of their illness or handicap. But his theory therefore provides no argument, at least as so far elaborated, that the sick are not entitled to special resources, beyond what others have, just in virtue of their sickness.

The welfare-floor theory is therefore of no help in fixing the right of a demented patient to public resources, unless it can be adapted by defining some level of support they are entitled to have short of the support necessary to raise them about some stipulated level of welfare or well-being. But there seems no way to define an appropriate level of support except by using some question-begging devices, by saying, for ex-
ample, that the demented must be supported at a "reasonable" level of welfare. This is unpromising as well as vague, because nothing society can do will bring them to a level of welfare that is, on any plausible account of welfare, anything like "reasonable", and any society will bankrupt itself, as we saw in considering the implications of Rawls' theory, if it attempts to make their welfare as close to "reasonable" as possible. The failure of the welfare-floor theory suggests an important conclusion. Welfare is an inappropriate concept to use in defining the level of resources to be devoted to those whose welfare is low and cannot be much improved. Our conviction that something must be done for the permanently demented, in other words, is not a conviction we can usefully state as a concern for the overall level of their welfare.

The hypothetical insurance approach draws on ideas latent in the first three approaches we have now found wanting, though it is different from each of these. Its central claim is that people who become handicapped, including those who become demented, should be guaranteed the resources most people would provide for themselves, by way of insurance, if insurance were available to everyone on competitive and equal terms. (The philosophical basis of this idea is complex, and I offer some account of it in a long footnote. 29) Suppose we can calculate, at least roughly, the insurance coverage the average member of the society, with average resources at his disposal, would purchase under those conditions, given the premiums he would in fact have to pay for each level of coverage he might choose. Under the hypothetical insurance approach, the government should collect taxes in the amount of the total premiums
that would be paid for that insurance, and then use those taxes to provide that level of coverage to each person who does in fact become demented. 30

If the calculations the hypothetical insurance approach requires can be made, it has obvious advantages over the other approaches I first described. Unlike the sympathy approach, it offers a strategy for fixing the amount of as well the general justification for a demented person's right to resources. Unlike the cost-benefit approach, it suggests that he has a right to substantial resources. Unlike the welfare-floor approach, it suggests that that right is limited, and is not a right to all the resources the community has. Its design insures, in fact, that the community can sensibly afford any provision it recommends, because it recommends only a total level of provision that members of the community, given all the other demands on their resources, could and would provide for themselves. It gives crucial effect, in designing the dementia-care budget it endorses, to the dominant values and wishes of the community, because these are reflected in the hypothetical insurance transactions that it contemplates. Its results are sensitive, as any rational policy should be, to costs and technology and to changes in these, because these hypothetical insurance decisions would be sensitive to the changing value and cost of new medical and institutional techniques for treating dementia and caring for the demented.

Nevertheless there are also obvious objections to the hypothetical insurance approach, and we must distinguish and then consider three of
these. The first calls attention to the risk of errors the hypothetical private insurers might make, about their own interests, in the hypothetical insurance decisions the approach contemplates. The second notices important externalities to those decisions: it argues that the insurance decisions of private citizens will not take adequate account of the interests of the community as a whole in how its demented citizens are treated. The third objection is more profound and philosophical, and will require us finally to consider the long-postponed assumption I conceded was necessary to a great part of the argument of earlier sections of the essay. It suggests that the hypothetical insurance approach is unfair, in the special circumstances of serious permanent dementia, because the competent person who hypothetically insures is not, in the appropriate sense, the same person as the demented person whose fate is made to turn on the amount of insurance the insurer buys.

I shall consider these objections in turn, though allowing much more space to the third than the first two. I shall use the objections, moreover, to fill out my view of the likely consequences of applying the insurance approach to dementia, and I make use of my earlier arguments about the best interests of people who become demented for that purpose. I assume, then, that people believe that their experiential interests will be relatively unimportant once they become demented, and that their evaluative interests are mainly negative. They prefer to live as short a time as possible, once they have become permanently and seriously demented, but think it important not to suffer indignity so long as they do live. On these various assumptions, people would purchase
only enough insurance coverage to provide minimum conditions of dignity, and would not seek to provide funds, at the greatly increased premium charges that would require, for life-prolonging medical treatment. If the insurance model survives the objections I consider, and others that might be brought against it, the rights of a demented person to resource for his care are therefore limited to that coverage.

C. Will Insurers Mistake Their Own Interests?

The hypothetical insurance approach limits a demented person's entitlement to the insurance it presumes he would have bought if offered the chance when competent. That limitation seems fair, because it seems to be in each person's antecedent interest. Suppose a young and competent person, full of desires and projects, is offered a range of insurance policies providing funds in the event that, when he is old, he becomes demented. These policies vary in the funds they provide, but the larger the coverage the greater the premiums and therefore the greater the sacrifice someone choosing the policy makes in his ability to lead the life he wants now. The hypothetical insurance approach assumes that an insurer would make the choice that, at least in his opinion, best reflects his interests overall. If he buys only a cheap policy which provides little coverage he has judged that it is not in his interests to spend the additional funds now to guarantee more resources if he becomes demented later. If the community disregards that decision, and taxes him more now to provide him with greater coverage if he does become demented, it contradicts the judgment about his best interests he himself has made,
which it would be wrong to do. That is the argument at the heart of the hypothetical insurance approach.

The first objection I consider insists that this argument gives too much credit to each insurer's own judgment; it warns that he may cheat the old person he will become. That is, of course, a misleading description of the danger, provided the assumption I am making and will shortly defend is sound: that the young and the old person are different stages of the same person. It is more accurate to say that the young person will make some sort of mistake about his interests later, that he will exaggerate the importance of his present interests and concerns to his life as a whole, and correspondingly short-change the interests and concerns he will have later, if he does become demented. He may not appreciate, for example, how bad it is to be demented, or not realize how much he will want expensive custodial care then. The insurance approach, the objection insists, is too unforgiving of these mistakes. It holds someone to the decisions he makes when young even though he regrets these when he has grown older.

There are sound and important cautions in this objection. If we accept the hypothetical insurance approach, and speculate about how much insurance people would in fact buy at different stages of their lives, we must of course suppose them to have available, when they make that decision, as much and as accurate information as is reasonable, and that information should include knowledge about the actual manifestations, prognosis and circumstances of serious dementia. And we
know that people do make mistakes about their own interests in the far future, even when fully informed, and often regret the decisions and choices they made in the distant past. That is one of the reasons why pensions and other forms of saving and insurance are often made mandatory: employees are not permitted not to enroll in their company's pension scheme. But once again dementia raises very special problems, and we need to consider, in order to assess this objection's force, the kinds of mistakes people might make in thinking about what their needs will be not merely when they are old but when they are demented as well.

We worry not that they might in some way exaggerate these needs, or the funds necessary to meet them; but that they will ignore or minimize them. Suppose therefore that a young person, asked to insure against dementia, makes the insurance decisions I am now assuming most people would. He argues to himself in the following way. "I will have two kinds of interests at stake if I become demented: experiential and evaluative. I now believe, on what I think the best evidence available, that the quality of my experiences will in any case be very limited. It is important to me, now, that I not be in great pain then, but not important that I have somewhat more of the thin and disconnected pleasures demented people can have, and in any case not important enough to sacrifice full-bodied experiences or plans now. I do have evaluative interests in not living in indignity, or being a burden to others. But I have no evaluative interest in living a longer life when demented, or having my life prolonged by expensive medical care. So I will
buy only enough insurance to provide funds for the relief of pain, and for
the most minimal institutional care in clean dormitory conditions." I shall
call this the "minimal" argument because it justifies only a relatively in-
expensive insurance policy, compared to a policy that would provide
more elaborate custodial care and more extensive medical treatment.
What sort of mistake do we worry that someone who accepts the mini-
mal argument might have made?

In the more ordinary case, when people consider buying pensions
against retirement, the young and old interests being compared are
roughly the same kinds of interests, and if someone buys no pension we
believe him to have made a mistake because his only reason for
denigrating the latter is that they are postponed. But the minimal argu-
ment does not simply choose between interests regarded, time apart, as
on a par. It characterizes the interests in play as different in quality and
importance, and makes an overall judgment that the constitutive evalua-
tive interest everyone has, in leading as good a life on the whole as pos-
sible, is best served by the distribution it chooses. So the mistake, if
any, is not the predictive mistake characteristic of judgments about ex-
periential interests, but the more philosophical mistake of judging
fundamental evaluative interests wrong. What reasons might we have for
thinking that the evaluative judgment of the minimal argument is in fact
a mistake? When someone is seriously demented he cannot regret his
past decision to buy only limited insurance, and that is not an unim-
portant point, because one's desire not to regret is a significant ex-
periential interest. Suppose, however, that a demented person could and
would regret that decision. Would that show that the decisions was wrong? We must distinguish genuine regret, which requires a belief that we should have made a different decision, from a mere desire not to have consumed something in the past we would like still to have now. I would now prefer to have spent much less money in restaurants in the past, but that does not mean that, in the important sense, I regret doing so, that I think it was not in my own overall interest, judged then, to have acted as I did. But suppose the demented person were capable of regretting, and did regret, the minimal insurance in the genuine way. Since the judgment being regretted is a judgment of evaluative rather than experiential interests, it does not follow that it was a mistake. He may be wrong now rather than then.

We may put the point I am making another way. There is a kind of paternalism involved in the now familiar practice of requiring people to make some provision for their ordinary old age. We justify mandatory pension schemes by supposing that people do not attend in the right way to their ordinary interests in the distant future. But this paternalism is not very deep, because it does not contradict peoples' evaluative judgments, but rather enforces the very popular view that pain and distress are not less important when they happen in the distant rather than the immediate future. The paternalism that would be involved if we did not allow people to accept the minimal argument, and to purchase minimal insurance against dementia, is very different. This would, by hypothesis, contradict widespread evaluative judgments. We might be willing to accept the deep paternalism of that contradiction if we had reason to think
the minimal argument obviously or even very wrong. But on the contrary, the discussion of a demented person's right to beneficence, above, supported that argument. So the first objection to the insurance approach, that it allows people to misjudge their own interests, must be rejected.

D. Does the Insurance Approach Cheat the Community?

The second objection is untouched by this reply to the first, because its focus is the interest not of insurers one by one but of the society as a whole. It argues that the decisions of insurers, about their own interests as individuals if they become demented, will not adequately reflect social interests that must somehow be accommodated; it is an argument, in other words, from what the economists call the externalities of private transactions. Assume that the minimal argument I just constructed proves very popular, so that a community guided by the hypothetical insurance approach collects only enough by way of taxes to finance a program of caring for the demented that denies them life-prolonging medical treatment, and allows them only conditions of minimum comfort and attention compatible with their right to dignity. The present objection complains that this program is unacceptable, not because it is not in the best interests of people who will become demented, but because a decent society cannot and will not tolerate that kind of care for its mentally ill. The great bulk of competent citizens, and not just the family and friends of demented patients, will feel outrage, and believe that their own humanity has somehow been compromised. They will insist that it is outrageous to deny life-saving medical treatment
just on the ground that the life that would be saved is an undistinguished life. So the community will insist on providing more care than the hypothetical insurance approach would justify, which demonstrates, according to this objection, that that approach to the rights of the demented is flawed.

Should a decent society insist on providing life-saving treatment to everyone whose life can be saved? We have no difficulty in finding popular arguments that it should. Many people appeal to what is called the "sanctity" of life. Some doctors, for example, insist that any relaxation of their normal responsibilities to save life whenever possible would weaken the fierce and combatative professional instincts that force doctors to the limits of their energy when life is in the balance. They believe that weakening the taboo-like quality of that instinct, by recognizing nice exceptions, would damage the complex fabric of medical ethics woven around it. That argument can be generalized: many people feel that a society that does not unreflectingly insist that life be saved whenever possible cheapens the value of life generally and is more ready to decide against it in other contexts.

These may or may not be good arguments in favor of not relaxing normal medical practice when the patient is demented. Good or not, they appeal to social value and not to the good of the patient himself: they are arguments, if my earlier suggestions are sound, for sacrificing the good of the patient to the moral integrity or safety of the community generally. The insurance model, among its other virtues, captures that
distinction. It is meant only to define the rights of the demented to resource, and limiting their rights to the resources they would have provided themselves, in hypothetical insurance transactions, in no way prohibits the community from supplying more in what it takes to be its own distinct interests, or out of its own moral compunction. So the second objection is not, after all, an objection to using the insurance approach for the purposes for which it is meant, so long as we do not make the mistake of thinking that the community is barred from spending more on the demented than they have a right to have spent on them.

The objection does, however, provide an opportunity to consider an important question about the insurance approach that I earlier postponed. If we accept that approach in principle, should it be used to finance the care, to the level of resources it fixes, only of those who cannot afford that level of care themselves? In that case government would collect, in general taxes, only enough for that purpose, and those who have adequate resources in their own savings or, perhaps, in the savings of relatives, would be required to spend these before turning to society to make up any shortfall below the social provision. Or should the insurance approach be used to finance the care of everyone to the minimum level? In that case a tax structure would collect enough for that purpose, and everyone who becomes demented would be entitled to the minimum provision whether he could afford to pay for it himself or not.

There has been a long and complex debate, among those who generally favor social provision for the sick and handicapped, whether
that provision should be needs-tested, that is, available only to the poor, or provided to everyone without reference to other resources. Our answer to the second objection is pertinent to that debate in the following way. The insurance approach argues for a general, non-means-tested program for the care of the demented, if society insists that more be spent, for their treatment, than would be justified on the insurance approach. Suppose the community insists, for the kinds of reasons we have just been canvassing, that expensive life-prolonging treatment must be supplied to anyone who is demented and wants it, or at least to those who did not provide, when competent, that it should not be used for them. If hypothetical insurance calculations show that that policy is not in the specific interests of people who become demented, who would choose, in advance and considering their own interests alone, not to provide for such treatment, then it should not be charged to their account when they are demented even if they can afford it then. The interests served by the policy are, by hypothesis, social interests only, and society should pay, out of general tax revenues, for what it wants or believes it needs or believes it moral integrity requires.

We can, I believe, generalize this argument so that it shows why society should assume responsibility, not only for life-prolonging medical treatment, but for the full custodial care of all demented patients. We have been assuming, in our discussion, that insurers would recognize that it is not in the interests of people who become demented to have their lives extended by medical treatment, and that insurers would therefore not pay the premiums necessary to provide such treatment for them.
People who do recognize this are also very likely to accept that it would be in their interests, if they became demented, to be killed as quickly and painlessly as possible. Suppose there were an insurance market for dementia in which insurers have the option of providing that they should be killed if they are judged, by an appropriate committee of competent physicians with proper safeguards, to be permanently and seriously demented. In that market a policy would be available, for people exercising that option, that provides only enough funds to pay for the administrative costs of the decision and the medical costs of carrying it out. That policy would be very inexpensive. Suppose that, in these circumstances, most people would exercise that option and choose that policy as the strategy in their own best interests overall.

In fact the option just imagined would not be possible in the United States, at least for the foreseeable future, or almost anywhere else. It is ruled out by the collective opinion that it is intolerable deliberately to kill even seriously demented people. People would vote collectively against a program of deliberate killing in spite of the fact that many, at least, would want to be killed themselves if they became demented. When they consider a general program of killing the demented, they focus on their own potential responsibility as killers, or as people who live in a community that kills: they think that no one could or should bring himself to kill another innocent human being, and they would not want to live in a society of people who would be willing to do that. That sense is much stronger, among us, than the different conviction I said some people have, that we must always seek to prolong life. Our moral
philosophical Issues in Senile Dementia

Traditions draw a firm distinction between "killing" and "letting die", even though many philosophers find that distinction untenable. Some people approve, in principle, of voluntary euthanasia: they think it would be permissible for a doctor to kill a terminally ill person in pain, for example, if that person then had a settled and informed desire to die. But voluntary euthanasia, so defined, is not a possibility for the seriously demented who are incapable of informed and sustained wishes of that sort, and most people would be horrified at the idea of deliberately killing a demented person who says he wants to live, even if he had asked, when he was competent, to be killed in that situation. They think that deliberate killing of even the most seriously demented would do irreparable damage to the "sanctity of life" instincts I described earlier, instincts they think indispensable to civilization. Refusing to honor an earlier, competent wish to be killed is not a violation of precedent autonomy. It is a violation of my autonomy not to allow me to kill myself, but autonomy does not include a right to be killed by another.

So the policy I am supposing a great many people would prefer — a very inexpensive policy contemplating that the insurer will be killed — is not in fact one of the possibilities. Insurers would only have available, and we are now supposing would mainly choose, the minimum policy I described earlier, which does not provide funds for life-prolonging treatment, or comfortable custodial care, but does meet the minimum requirements of dignity. That policy defines, on these assumptions, what demented people are entitled to have. But the fact that the much cheaper policy that contemplates being killed is not available, though it
would be in the interests of many people who might become demented to choose it if it were, provides a strong argument that society should make that minimum level of care available to all those who become demented, even those who have the resources to provide it for themselves. I do not mean to be relying, in making that claim, on any assumption that people have a general right to be compensated when they are denied opportunities that run against social interests or that would offend sound moral principles. Plainly that is not generally true: I have no right to compensation when I am not permitted to use my property in a way forbidden by sensible zoning restrictions, for example, or in an immoral way. But the case of dementia seems special in this context also.

People who have become demented have lost control of their lives: their important evaluative interests are at the mercy of others, and if the community takes some decision that cuts strongly against those interests, the demented person can do nothing to repair the damage it has done. A competent person who believes it much in his best interests to die can usually kill himself whether or not others help him. A person who has become demented, therefore, is specially damaged when we refuse to help him by appealing to our own, competing interests and principles, and we ought to minimize the damage if we can. When he was competent, we are now assuming, he would have preferred being killed if he became demented to having whatever property he has then used to support him. He would have preferred, perhaps, that that property be available to his family. If we decide that we cannot honor his overall preference, in virtue of our unwillingness to kill him, we should at least try to give him as much control over his life as we can.
If the community limits its program of taxation for the care of the demented to those who cannot afford the care it would provide, and private insurance providing that level of care is not available, on comparable terms, for the rest, then someone of adequate means has not been allowed to protect his family in the way he would have chosen to do. So we have that reason for making the public program a comprehensive one, and no reasons of comparable power against this. A comprehensive program would not, after all, increase the total expense to the community of caring for the demented. It rather distributes the same total cost over all citizens, those who do and do not become demented alike.

E. Insurance and Personal Identity

The third objection in our list challenges the hypothetical insurance approach in a more fundamental way than the first two. It denies that a dementia victim is, in the sense the insurance approach requires, the same person as the person occupying his body earlier who purchased, as we are now assuming, insurance providing for the victim's care. Of course, in a perfectly familiar and idiomatic sense of identity, a demented person is obviously "not the person he was," just as someone whose personality has changed less dramatically, or who becomes suddenly more vigorous, is often said to be "a new person". That idiomatic expression is not meant to challenge the continuity of what the philosophers call "personal identity"; it is not meant to suggest that
someone suddenly more vigorous is actually a different person, in the much more fundamental sense in which one twin is a different person from the other no matter how alike they are in personality. We assume, on the contrary, that any particular person remains the same person in that fundamental sense — that the life he leads is a single life — from birth to death, even though both his body and personality change dramatically between those two events. The insurance approach presumes that this normal assumption holds even when this putatively single life is punctuated by irreversible dementia.

It assumes personal identity in two ways: it assumes that the insurer who buys a certain level of coverage for his care when demented acts out of what he takes to be prudential concern, and it assumes that the dementia victim is bound by the insurer's decision because his life is part of the same temporally co-responsible life as that of the insurer. The first of these assumptions is familiar in ordinary life. Normal people have a special, forward-looking concern for themselves, which we call prudential concern, that is different in character from the concern they have for other people in general. Prudential concern need not be, as this contrast might suggest, selfish in the ordinary sense; everyone, not just people indifferent to the needs or claims of others, is distinctively concerned about himself, about both his own evaluative and experiential interests. People characteristically distribute resources available to them in two ways or at two levels. They make distributions between themselves and others, deciding how much of what they have should be devoted to the good of other people, who may be strangers or people to
whom they are specially attached by blood or affection. But then, with whatever is left for them, they must make prudential distributions over their own lives, deciding, for example, how much to consume now or soon and how much to save or invest for the future. The insurance approach assumes that the decision someone makes insuring against later disease is a prudential decision of that character: it assumes, that is, that someone who pays a particular premium for a particular level of coverage for later illness has made a judgment that spending either less or more for insurance would distribute resources within his life as a whole in a less satisfactory way.

The second assumption — the assumption of temporal co-responsibility — is the backward-looking correlate of prudential concern. It is a moral assumption, about the special connection between events in one stage of a person's life and what he is entitled to have, or how he is entitled or deserves to be treated, at other stages. We rely on temporal co-responsibility when we suppose, for example, that someone who has been given more resources than others have early in his life is for that reason entitled to less than them later, even if he has consumed rather than saved those extra resources. We also rely on it in almost every moral or legal judgment we make about ourselves and others: in our judgments about property, guilt, shame, pride, punishment, reward, respect, and integrity, for example, and also, though perhaps in a somewhat attenuated way, in our emotional assignments of love, friendship, community, jealousy, resentment and hatred. These various judgments and emotions presuppose that, though we may think of our lives as
divided into temporal stages, these stages are mutually co-responsible in the strong sense that each stage must share responsibility for, and adjust its claims of entitlement and desert to take account of, what other stages have done or will do. That assumption seems necessary if we think it fair to make a patient's insurance coverage depend on the prudential decision of the insurer, typically made many years earlier.

I do not mean that we insist on enforcing temporal co-responsibility in all circumstances. We think that that would sometimes be too stringent, because, as we say, people should not always be held to imprudent decisions, particularly those made much earlier, or blamed or punished for mistakes made long ago. Indeed, our sense that it would be wrong to do this contributes to our willingness to accept certain paternalistic constraints of the kind we noticed in discussing the first objection to the insurance approach. We insist that employees contribute to a pension plan because, among other reasons, we think not contributing would be a mistake that it would be wrong, as well as inefficient, to hold people to when they are old and retired. The hypothetical insurance approach, applied to dementia, assumes, however, that we have no reason to relax temporal co-responsibility between the dementia victim and the insurer on any grounds of that sort, and I tried to support that assumption in my reply to the first objection.

Are the connected assumptions of prudential concern and temporal co-responsibility really essential to the insurance approach? Suppose someone suggested that public provision for a dementia victim should
depend on what insurance someone who was obviously a different person — a relative or a stranger — would have purchased, in a hypothetical insurance market, providing for that victim's care. We would find that bizarre. The designated relative or stranger might have bought no insurance for that purpose at all, preferring to use his resources for his own benefit than to provide insurance for someone else. It would not follow that the victim should have no funds available to him. Or the stranger, out of altruism, might have purchased extravagant insurance, cheating his own life to pay the premiums. That does not matter either: the insurance approach argues that someone should have, for his care, not the amount that might have been provided for him in some way had the past been different, but that he would have provided for himself out of prudential concern, that is, out of a judgment that his evaluative and experiential interests would be best served overall by distributing his resources among different parts of his life in that way. So the insurance approach does seem to depend on the plausibility of the two assumptions I have been describing: that the hypothetical insurer decides out of prudential concern, and that hypothetical insurer and the patient are temporally co-responsible in the way different stages of the same person are. These two assumptions in turn seem to require — it might be better to say that they seem to constitute — a further assumption, that the hypothetical insurer and the patient are the same person, that is, that dementia does not destroy personal identity. And I have taken pains, throughout this essay, to identify other ways in which our judgments about the rights of people who have become demented also seem to require that assumption about personal identity.
VII. The Identity of Persons

A. Two Continuities

Is the assumption I have been making, that dementia does not destroy personal identity, sound? Even serious disease does not normally destroy personal identity. Someone obviously remains the same person after he becomes cancerous or contracts pneumonia. But in the special case of serious and permanent dementia, survival of personal identity might well seem more problematic, for the following reason. In the normal, unproblematic cases, the later stage of what we unhesitatingly assume to be the same person is continuous with the earlier stages of that person in two ways. The stages are physically continuous: the state of the physical body each stage inhabits is the product of a series of changes in the body earlier stages inhabited, and none of these changes is itself sufficiently great to regard the body it produced as a new one. The stages are also psychologically continuous: the belief, convictions and projects each stage has are in the main those of an earlier stage; changes in these beliefs, projects and convictions are mainly themselves guided by other beliefs, projects and convictions held constant, so that mental life develops, in Otto Neurath's famous image, like the repair of a boat, one plank at a time, at sea, and the various stages are sewn together by overlapping experiential memories.

Dementia does not destroy the first kind of continuity -- physical continuity. Though the various diseases that produce dementia have a
physiological basis, and most of them produce important changes in brain structure, these changes are not more radical, judged simply as physical changes, than amputation of a limb or other changes no one would think made a body a different body. But the second continuity — psychological continuity — is indeed destroyed in serious and permanent dementia. Someone seriously demented loses intellectual and emotional continuity with past stages of "his" life. He suffers total disintegration of personality, so that none of the beliefs, convictions and projects he may have can any longer be seen as mainly fixed by earlier ones, and he has total amnesia of prior experiences, identity, and attachments.

Are both forms of continuity essential to preserve personal identity? If not, is one or the other essential? Which one? There is an extensive, ancient and enduring, philosophical literature on exactly these questions. Philosophers disagree, as we shall see, about whether personal identity over time depends on physical or psychological continuity. They debate this question largely by puzzling over enormously unrealistic science-fiction examples like this one. Suppose all A's beliefs, convictions, memories and so forth are in some way drawn out of his brain and transferred to the brain of B, and B's beliefs, etc., are in turn transferred to the brain of A. If physical continuity is necessary and sufficient to personal identity, then the person in A's old body is still A, though he now has all B's former beliefs and memories. If psychological continuity is necessary and sufficient, then the person in A's old body is now B. If both physical and psychological continuity are necessary, then both A and B have disappeared, and the people inhabiting their
former bodies are wholly different people. If either of the latter two views are right, then the normal assumption, that personal identity is preserved in spite of even serious disease, would fail for the case of dementia, and the hypothetical insurance approach to public provision for dementia victims would be undermined. We should then have to find some other device or principle or theory on which to construct an argument fixing and limiting the entitlement of the demented to communal resources, and also other arguments different from those I used earlier to decide whether demented people had any rights at all and, if so, what rights they had.

B. Does Identity Really Matter?

It therefore appears that we must puzzle over the vast philosophical literature I mentioned, to decide whether physical or psychological continuity, or both, are required to preserve personal identity over time. Many people, however, would think it absurd that an important practical issue of social justice, like the issue of public provision for the care of dementia, could depend on arcane philosophical problems of that sort. How can it matter so much whether it would be right, as a matter of accurate use of language, to say that a dementia victim is the same person as the former inhabitant of his body? One contemporary philosopher, Derek Parfit, argues, supporting that instinct, that personal identity is not after all what matters when issues of personal or political morality are at stake. It is worth pausing, therefore, to consider whether we can use his arguments to disentangle the practical question, whether the
hypothesical insurance approach is sound in the case of dementia, from the mysteries of personal identity.

Parfit argues his claim, that personal identity is a matter of little real importance, through a series of examples, in which the following imaginary exercise is crucial. Suppose that all my cells are destroyed but simultaneously new, identical cells are created in some distant place, so that a replica then exists there who has exactly the same physical attributes, memories, emotions, attachments, and so forth that I did. Is the replica then me, in a suddenly different place, or not? Orthodox theories, Parfit believes, suppose that a great deal turns on that question. If the replica is still me, according to these theories, then I have survived the experiment, and have nothing to regret; on the contrary I should be happy to have traveled so quickly. But if the replica is not me, then I have died, and this is, for me at least, a tragedy. Parfit argues that it is implausible to suppose that so much could turn on the decision. When we know the ordinary facts — that the cells are identical, that memories are preserved, and so forth — we know, he says, everything there really is to know. The question whether we should count the new body as my body, he says, is only a question of classification, like the question whether we should count France as the same country it was, say, a century ago. He believes that the better classification scheme -- the one he thinks we actually use -- provides that the new body is not me, but someone else I might call Backup. I have died, but the situation is not significantly worse, for me, than if I had survived. The connections I have with Backup are the same, in all important respects, as those I
would have had with myself if the transformation had not taken place. If I had just died, and no one existed like Backup, the situation would certainly be much worse for me. What makes the difference is not my failure to survive, which holds in both cases, but the fact that someone connected to me in all important ways does survive in one case but not the other. If follows, Parfit argues, that identity is not important. What is important is the matters of ordinary fact, about psychological (and perhaps physical) connections, which we can describe without making any assumption, either way, about the issue of identity.

We must try to apply Parfit's argument to the hypothetical insurance approach, to see whether we can free that approach from the assumptions about personal identity I argued it required. The following strategy suggests itself. I said that the insurance approach presupposes both prudential concern and temporal co-responsibility, and that these in turn presuppose personal identity. We might now question the second of these claims. Perhaps we can show that prudential concern is appropriate, and temporal co-responsibility justified, when certain psychological or physical connections hold whether or not we count these connections as either necessary or sufficient for personal identity. Then we can decide whether the hypothetical insurance approach is justified in the case of dementia by asking a normal question of fact — whether whatever connections we decide are necessary for prudence and co-responsibility in fact hold in serious and permanent dementia — without having to puzzle about personal identity after all.
Parfit suggests that we should decide which connections between a person and his putative survivor are important by considering which connections would matter to a person contemplating some event that calls identity into question. So we might begin, looking for connections that justify prudence and temporal co-responsibility, by asking that question about people contemplating insuring against dementia: which connections would they think important? But we must now notice an important distinction between two ways in which someone might regard any particular connection between himself and the survivor of some experiment or event as important. It might be important to him that someone who is connected to him in that way survive the experiment, important, that is, that someone so connected to him continue to exist. Or it might be important to him how the life of someone connected to him that way goes, how good a life that is.

These are plainly very different matters, as we can see by reflecting on Parfit's examples of why it might matter to me that my Backup exist when I no longer do. It might matter to me, Parfit explains, because Backup, having the same projects and attachments as I do, would be likely to finish my book, care for those I love, and so forth. But if those are my reasons for wanting Backup to survive, they give me nothing but an instrumental concern with Backup's welfare; they give me, that is, no reason to care about Backup's well-being, about the overall value of his life, about whether he is happy or miserable or able to carry out new projects he develops for himself; indeed I would want Backup to be less happy, and less busy with his own new projects, if that would
make him more likely to devote himself exclusively to my books and concerns.

Parfit is right in supposing that the first of these questions -- whether it is important to an insurer that someone survive with the connections to him a dementia victim has -- may be answered independently of any assumption about whether the insurer and the victim are the same person. If the insurance approach presupposes an affirmative answer to that question, however, we must reject that approach. Most insurers would give that question a negative answer. Most people, as I said, would in fact prefer death to survival in that form, and the few who would prefer survival would not much prefer it. But the first question is plainly not the question on which the plausibility of the insurance approach turns, because it is not the question made pertinent by the assumption of prudential concern. Prudential concern requires that the connection between the insurer and the victim be important to the insurer in the second way, that it matter to the insurer not whether someone in the condition of the victim survive but what happens thereafter to the victim, how his life goes. It requires, moreover, that this matter to the insurer in a certain way: prudentially. Otherwise the insurer's decision to buy or reject insurance would not be the distributive decision, among stages of a single life, that the insurance approach presupposes. Those who would prefer to die than to become demented do have that kind of concern: they believe that the demented person is, in the phrase normally used, better off dead, and would prefer him dead, not out of indifference for his fate, but on the contrary out of prudential concern for it.
Their concern, in other words, seems to involve the assumption we are hoping to avoid in describing the connections necessary to make prudential concern appropriate: they assume that the demented stage they worry about is a stage of their own life.

So we have not succeeded, after all, in distinguishing the question about which psychological or physical connections are vital for prudence and co-responsibility from the question about which of these connections are essential for identity. For an insurer has to answer the second of these questions (or assume an answer to it) in order to answer the first. We encounter the same difficulty, though in a different form, when we concentrate on the second assumption on which the insurance approach depends: the assumption of temporal co-responsibility. Our strategy requires us to identify the kinds of connections that must hold, between an insurer and a victim of dementia, in order to justify our assumption that provision for the latter may fairly be made to depend on decisions made, and resources consumed, by the former. At least when psychological continuity has been destroyed, the only connection that could justify that assumption is the connection of identity itself. Suppose we believe, after having reflected on the philosophical issues raised by the problem of personal identity, that the insurer and the demented person are, in fact, the same person, that these are stages in a single life. Then it will seem right to us that co-responsibility should hold with respect to resources, at least. If the insurer acted out of prudential concern for the victim, and these are in fact the same people, why should the fact that the victim does not remember the insurance decision, or remember en-
joying the benefits of money the insurer saved by not buying more expensive, make it unfair for others to be guided by that decision in providing care for him? Suppose, on the other hand, that we believe that personal identity does not hold, that the victim is not the same person as the insurer. Now it seems wrong, for that reason alone, to apply co-responsibility through the insurance approach. Then we can say, to someone sick and lacking funds, only that he would have been entitled to help if the former occupant of his body had had more altruistic concern for him, but that as that former occupant was indifferent to his fate, or too selfish to share resources with him, he must go without. He would rightly complain that, until we claim that the earlier inhabitant was him, we have supplied no reason why he should have less than another victim of the same disease who happened to share a body with a more generous antecedent.

The general point is clear enough. The assumptions of prudential concern and temporal co-responsibility are deeply connected, as two sides of the same coin, just because they share and depend on the idea of personal identity, the idea of a single life lived in stages each of which is co-responsible for the value and fate of the whole. They are, as I said, not so much consequences as aspects of personal identity. All the judgments we make, about rationality, prudence, and fairness as well as all the other judgments we make about persons, are tied together in a scheme woven around and through personal identity. So we cannot conclude, as the strategy I constructed from Parfit's argument hoped to conclude, that personal identity does not matter for the insurance model.
We are considering whether the two assumptions, about prudence and co-responsibility, which that approach requires are sound in the case of dementia, and for that issue the connections between and insurer and the victim he becomes matter only if, and then because, they constitute identity. Identity, for our present problem, seems to be all that matters.

I want to guard, however, against a misinterpretation of my argument. I do not mean to contest Parfit's claim that decisions about personal identity are at bottom a matter of classifying facts about connections rather than adding a further fact to them. In the next section I try to explain the sense in which problematic decisions about identity, in bizarre and speculative cases, are indeed classificatory, and why it is nevertheless sensible to treat these decisions as having the great force I claim for decisions about identity in the context of dementia. The argument of this section itself suggests, moreover, an important virtue of Parfit's general approach. Arguments and issues about personal identity are indeed usefully seen as arguments about connections between stages of a person's life rather than about some metaphysical fact in some way independent of those connections, and that is important in deciding what kind of philosophical issues puzzles about identity raise. But the crucial connections in point are not what we might call, in this discussion, the brute physical and psychological connections on which Parfit's discussion concentrated, but rather the more morally infused connections of prudence and co-responsibility we have been considering. We must aim, at least, at an account of personal identity that respects and make sense of these latter, crucial connections.
C. When Am I Still Me?

I said, before we turned to Parfit's claims, that orthodox theory divided about whether physical or psychological continuity, or both, are essential to the kind of personal identity the insurance model requires. What kind of question is this? What would count as a good argument on one side or another? We need some distinctions to confront this threshold issue. Is personal identity properly understood as an "independent" or a "supervenient" fact? I must explain the distinction I have in mind. Imagine two people, A and B, each of whom undergoes exactly the same science fiction transformation; each of whom, for example, is simultaneously extinguished and fully-replicated, in exactly the same way, to produce A' and B'. Is it conceivable (whether or not physically possible) that A and A' are the same person, but B and B' are not? If so, then personal identity is an independent fact that might conceivably happen to hold in the connection between A and A' and not in the otherwise identical connection between B and B'. If not -- if that is conceptually impossible -- then personal identity is a supervenient fact: it holds in virtue of other facts and so cannot differ when these other facts are identical.

Some people are said to think that personal identity is carried in a soul. The problem of personal identity, for them, is a problem of deciding whether when A's cells are simultaneously destroyed and replicated, for example, A's soul sometimes or normally or always sets up shop in
A. On that view of personal identity, identity is an independent (or, in Parfit's language a "further") fact. Puzzles about personal identity call for discovering, or at least speculating about, such facts. We must ask whether, on the assumption that souls always behave in the same way, they follow physical or psychological continuity or both or neither, and we assume this to be a matter of discovering what, as a matter of fact, the soul does faced with this sort of challenge. And we might well discover that, as it happens, the soul does not always behave in the same way, that it follows psychological continuity in some kinds of cases — brain bisections, for example — and physical continuity in others, like dementia.

Most philosophers who write about personal identity do not think it plausible that personal identity is in that way a matter of independent fact. They assume that personal identity is a supervenient fact: identity exists, when it does, in virtue of the connections that, on this view, constitute identity. The problem of personal identity is then not a matter of discovery in the normal sense; we do not look to see whether personal identity, as things fall out, follows one kind of continuity in one kind of case and a different kind in others. Instead we reflect on whether personal identity follows from or is constituted by one rather than another kind of continuity. But what kind of reflection is this? Again, two views are available, and must be distinguished.

They begin in different stories about the way judgments about personal identity function in our everyday lives. On the first, or formula,
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view we make these judgments by applying some shared general rule or formula, of which we are not fully aware, that for us defines the concept of personal identity. Philosophical reflection, on this view, aims to help us discover what that hidden rule or formula actually is: we ask what formula explains the various judgments we actually, unreflectingly, make. Once we have discovered the formula, in that way, we can then use it to solve problematic or controversial cases, like, perhaps, the case of serious dementia. On the second, or Wittgensteinian, view we treat our ordinary judgments about identity as deep, perhaps wired-in assumptions that are presupposed, individually and socially, in the lives we lead, but that do not necessarily represent or answer to any general rule or formula. Puzzling or problematical cases arise, on this view, only when we imagine new possibilities, like those of science-fiction, that we have not confronted in our ordinary lives, and so have not captured in our ordinary, concrete intuitions of identity. We cannot solve these speculative cases by applying some latent formula or algorithm of identity we already have, because we have none. But we can reflect on them in a different way if we choose: we can try to assimilate them to more ordinary cases by asking how it would be best to reform or adjust or extend our ordinary, intuitive assumptions to embrace the speculative cases if that were for some reason necessary.

The majority of the philosophers who have written about personal identity seem to hold the formula view. They see the science-fiction cases they construct as crucial testing cases in the following way. In normal cases, when we unhesitatingly assume that a small boy of seventy
years ago and an elderly man now are two stages of the same person, for example, too many formulae fit our assumptions. We would make the same judgment whether we held that physical continuity or psychological continuity or both constituted personal identity. So we need science-fiction cases to separate and test these different formulae. If we have uniform and unhesitating reactions to these cases -- if almost everyone agrees that personal identity either does or does not hold -- and if these uniform reactions to different cases support the same formula, then we can, in that way, discover the latent constitutive rules we are following unawares. But this procedure has an Achilles heel. It cannot tell us how to decide some case we find genuinely problematic. For the existence of any deeply puzzling case of that sort, when we simply don't know what to say, would be a counter-example to any formula that decided it crisply one way or another. The most a philosopher could say, in the face of a recalcitrant case of that sort, is that conceding (or denying) identity would be consistent with what we think and say in other cases. But that is not enough: since a great deal turns on whether we concede or deny identity, consistency in language is not in itself a central concern. That fact, indeed, explains the reaction I anticipated much earlier: many readers will find it odd that the appropriateness of the insurance approach to dementia could turn on whether normal linguistic practice warrants saying that identity survives dementia.

In any case the philosophical literature hardly suggests that we do have the uniform, consistent and unhesitating reactions to science-fiction cases that the formula view needs. Many people, confronted by the
bizarre examples of the texts, are uncertain; those who are certain
divide; and many of their opinions, certain or hesitant, are internally in-
consistent. An elegant series of examples constructed by Bernard Wil-
liams is instructive. Imagine (he asks) that you are in the power of a vil-
lain who tells you that all your mental states — beliefs about yourself,
memories, and so forth — are to be transferred to another body, so that
the person in that body will think himself you. Then one of two bodies
(your old body or the body now housing your mental states) is to be tor-
tured, and you must choose which now, in advance. Which possibility do
you dread, that is, hate in the prudential way: the villain torturing your
old body or the body of the person thinking itself you?

Most people (Williams thinks) would dread the torture of what
they would consider their "new" body. Each assumes, that is, that he has
changed bodies, that he is the person inhabiting the body he did not in-
habit before. This suggests that the formula underlying personal identity
makes identity track psychological rather than physical continuity. But
now (Williams continues) imagine this different case. The villain proposes
nothing about transferring your mental life into another body. He
proposes only, in a more old-fashioned way, to torture you, in an hour.
Your prudential concern is certainly aroused: you dread what will happen.
Then he tells you that just before your pain begins he will make you
permanently demented: you will think yourself Napoleon and lose any
memory of or sense of being the person you are. Williams believes that
this new information will not eliminate or even ease your prudential con-
cern. In fact, he suggests, you will think your situation worse than you
did before you received this latest news, because now you believe that you will both go mad and be tortured. This (natural) reaction seems inconsistent with the (natural) reaction to the original mental-transfer-then-torture case, for it assumes that personal identity does not require psychological continuity after all, that mere physical continuity, in these circumstances, is enough to preserve prudential concern and therefore identity.

This argues, not that we have made some mistake we must correct in one or the other of our replies, but that our judgments do not answer to any formula framed in the vocabulary of necessary and sufficient continuities. So we do better to take up what I called the assimilationist view of the problem of personal identity. Our situation, on that view, is this. We live our lives on the basis of fundamental and unquestioned convictions fused together in the package of ideas we have been considering: that each of us is a person continuing over time with forward-looking prudential concern for later stages and backward-looking co-responsibility for acts and decisions made at earlier stages. This package of ideas includes, among much else, an account of the dimensions of life, that is, the period over which prudence and temporal co-responsibility hold. People's opinions about the exact dimensions of life vary from culture to culture, even from person to person. People who believe in a straightforward conception of a life after death, for example, which includes the idea that what happens to someone in Heaven properly depends on what he does during his life, have a different dimensional belief than people who accept no such idea. Fortunately
most differences in the dimensional beliefs members of a particular community may have do not significantly affect political decisions: the same rules about ownership and rights in property, for example, and the same assumptions about the plausibility of the insurance model, fit the dimensional convictions of all groups. So we share, and our political life depends upon, a more limited and public set of dimensional assumptions structuring prudential concern and temporal co-responsibility for public purposes. We agree, for that purpose, about what a basic life or "life on earth" is: we agree that someone's life, in this basic and shared sense, begins with the birth and ends with the death of his body.

I have been suggesting, since the early pages of this essay, that there is a serious problem about personal identity and dementia. I want now to qualify this suggestion: you will probably think there is a serious problem about identity only if you are persuaded to the formula view of that matter. On this Wittgensteinian view, there is no problem about the continuing personal identity of a demented person. It falls within the dimensional beliefs of our culture, and within our public dimensional settlement, that a single life may have a demented stage, which can be the last stage. My evidence is the unhesitating convictions I have been reporting throughout the argument, like the conviction many people have that they would prefer to die, quickly and painlessly, than to continue living demented. The formula approach, I now suggest, creates a problem about the identity of demented people, in the following way. It demands that we account for all the features of our natural and unhesitating opinions about identity by producing a formula. We then realize that a
formula that fits most of the ordinary dimensional convictions — that personal identity is a matter of psychological continuity — fails for the demented. We are attracted to that formula in at least some of the science-fiction cases philosophers create, like Bernard Williams' first case, and we think worry that perhaps personal identity does not hold in dementia after all. But if we accept that the search for a formula is itself misguided, and take the assimilationist approach to the science-fiction cases, we have lost our reason for challenging the view we already hold, and the ordinary, common-sense view, that personal identity survives dementia, is unshaken.

Some readers, however, may not be as confident as I am about the common-sense status of that view: they may find themselves troubled rather than clear about whether personal identity does survive dementia, and think that this must be regarded as at least a hard case that, on the assimilationist view, calls for adjusting rather than simply applying the system of moral, political and metaphysical ideas in which personal identity figures. So it will be useful (and is anyway desirable as giving more content to the assimilationist view) to consider at least briefly how the process of assimilation might actually work, on that view, in genuine hard cases about identity. Truly bizarre or novel cases call for something extraordinary and unknown in ordinary life: a decision about the dimensions of life. Suppose replication became commonplace, and people actually began to "travel" by having their cells extinguished and replicas instantly created someplace else very far away. Our institutions and practices — of property, emotion and blame, for example — could not
operate without personal and communal decisions: we should have to
decide whether, at least for public and quasi-public purposes, prudence
and co-responsibility hold between me and my replica. It seems plausible
(and, if such cases actually arise, almost inevitable) that we would
decide them so as to require the least adjustments in the ordinary, intui-
tive scheme of ideas we are extending to the new situation. That would
require us to decide, I believe, in favor of identity in the travel-by-
cloning case; indeed, we would already have reached that decision, per-
haps without much worrying about it, I we took up that method of
"travel". 45

It is important that hard cases are not to be decided all at once,
on the assimilationist approach, by settling on some new formula about
necessary and sufficient continuities and holding to that new formula in
all novel and bizarre circumstances. The issue is rather, for any new
puzzle that actually arises, more practical and retail: given the charac-
ter, point, and efficacy of the complex set of ideas woven around per-
sonal identity, is it all things considered better or worse to regard
identity as continuing in these circumstances? We may, however, notice
certain principles or rules of thumb which, while they may yield to
countervailing considerations in some cases, nevertheless pick out im-
portant considerations we would expect to be very weighty generally. We
should try to extend or adapt the ordinary dimensions of life, when this
is necessary, with an eye to the efficiency and fairness of the public
system of prudential concern and temporal co-responsibility. The ef-

ciency of that system argues against what we might call unconnected
lives, that is, persons whose rights and attachments cannot be traced backwards and forwards to the birth and death of a human body in the way our elaborate legal schemes of property, inheritance, and family assumes and the dense and complex pattern of emotional life I described earlier presupposes. Unconnected lives challenge these institutions and systems of judgment and emotion, and that is a powerful reason for extending our dimensional convictions, in the face of challenge, in favor of connection. Of course, under some circumstances enforcing that presumption for connection would be infeasible, because prudential concern would be unnatural and unstructured: someone told he must be prudent for the combination of himself and someone else, whose fate he cannot connect with the value of his own life, has no way to be prudent as distinct from altruistic. In other circumstances enforcing the presumption would be unjust, because temporal co-responsibility would be in some way unfair to portions of the experiences it yolks together (I shall offer an example of that kind of unfairness just below). So the presumption of connection, while powerful, cannot be absolute.

These reflections suggest the following rule of thumb. If stages of human experience are connected by either of the two main continuities — physical or psychological — then we should assume continued personal identity, for purposes of the twin assumptions of prudential concern and temporal co-responsibility, unless this would be irrational because prudence could take no hold or unjust because co-responsibility is unfair. It does not follow, from this general strategic principle, that personal identity should always be denied when neither continuity is present:
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we might (however absurd this now seems) find reasons for accepting the doctrine of reincarnation that would make it plausible to claim personal identity over what we now regard as entirely separate lives. And the test of "pointless or unjust" the strategy proposes is a relative test: we assume that the ideas of prudential concern and co-responsibility have some point, and are just, in the normal circumstances in which these constitute our lives, and the strategy requires us to ask, in some hard case, whether, given that assumption, that case is different from the normal circumstances in some way as to call these ideas into question there.47

The rule of thumb we are constructing supports what I believe to be already our view, that personal identity should be regarded as surviving even serious and permanent dementia. Physical continuity holds in that case. So we must ask whether there is any infeasibility or injustice in laws and schemes of provision, like the hypothetical insurance approach, which assume that personal identity holds as well. It is hardly infeasible for competent people to take up prudential concern for demented stages of what we propose to consider their later lives. When we considered the evaluative interests of people who become demented, in an earlier section of this essay, we noticed a large variety of ways in which people can and do display that concern, that is, ways in which they believe what happens to them when demented affects the character and value of their life as a whole. We cannot call these concerns irrational without indicting a great many other concerns competent people have. They do not presuppose any dubious facts, as, for example, a belief
in reincarnation does, and they are closely related to other, familiar kinds of concern we do not regard as irrational. It is, for almost everyone, a matter of concern not only when they die but how they die. Some people think a peaceful death important, others a death in action, with their boots on, and others a death not of resignation but of struggle: one should not go gently, they think, into that night. People who would rather die than languish demented have, in effect, that further preference about the manner of their death. Almost everyone thinks, moreover, that what happens after his death can affect how good his life was on the whole. People think their lives have been more successful if projects they began are completed and prove valuable later, and they care about how they are remembered, about what image of them survives among those whose view of them matters. They also care about whether they are a burden to others, and to whom they are a burden. Many people hate the idea of growing old a burden to their children or to society, or of dying with debts others must meet, and these fears are surely not less rational when they are fears of burden when demented rather than incapacitated in some other way or demented rather than dead. All these various preferences, allied to or including dementia-state preferences, are firmly prudential preferences. They are special and vivid in the first-person: someone's views about how he should die are important to him in a way his views about how other people should die are not.

So we cannot regard the concerns people have for their situation when demented as irrational, unless we call into question a host of other, perfectly familiar, concerns of much the same character. We must there-
fore turn to the second part of the test our rule of thumb provides, which asks whether the assumption of co-responsibility would be unjust. We assume that in the normal cases, when people remain competent, it is not unjust to enforce property rules that make what someone has now depend on what he has spent in the past. Does that become unjust, for some special reason, if he has become demented in the meantime?

It might be helpful to design a fantastic case in which we would think that a certain assumption about personal identity is ruled out, on the assimilationist approach, because co-responsibility would be specially unjust. Consider another hypothetical that has occupied philosophers. Suppose all the cells of my body, including those of my brain, are divided, with the consequence that two human beings now exist with bodies identical to mine, and with exactly my memories and other mental life. I cannot be one but not the other because they differ in no way that could justify selecting only one as me. There would, I think, be no logical difficulty in regarding me as both, that is, as regarding my life as now having two independent branches. It would not be incoherent to suppose that if I had known, early in my life, that this operation was forthcoming, I should have had prudential concern for the two lives that would then begin, and that the fate of each of these lives should depend on what I had provided for them. But these requirements might well be thought unjust, because I would then have either to cheat my life before I was divided, in order to make available enough for two lives later, or these lives would have to share what would normally do for one. It is that kind of injustice, rather than any assumption that mere psychologi-
cal continuity is insufficient to sustain personal identity, that provides
the strongest argument, on the assimilationist approach, for denying that
my life continues in the life of both replicas. There is no comparable in-
justice, however, in regarding a dementia patient as co-responsible with
the insurer who earlier occupied his body. From the standpoint of justice,
there is no difference between this case and the normal case: the fact
that the dementia victim cannot remember being the insurer provides no
reason of justice why his provision should not depend on the insurer's
decision. The rule of thumb strategy would endorse most people's un-
reflective assumption, that personal identity survives dementia, even if
we did regard this as a hard case rather than one already decided in the
constitutive assumptions we already have.
Footnotes

1 I do not mean to suggest, even in these sketchy remarks about rights that I think adequate for this essay, that the best account of the collective justification individual rights trump is a utilitarian account. That is a very popular account, and I use it, to suggest the logical character of claims about rights, here. But for a longer discussion of that character, see my remarks about rights and collective justification in my books, A Matter of Principle, particularly Chapter 17, and Law's Empire, particularly Chapter 8.

2 Even if we conclude that no one can have any rights when he or she is demented, we might still decide that the rights he had when he was competent continue to have moral force. (We think, for example, that the rights of people now dead continue to have force, so that we are constrained, for instance, by promises we made to them when they were alive.) Indeed, I shall argue that the rights a demented person had earlier are crucially important. But the character of the rights we recognize as affecting how demented people must be treated will be affected, as we shall see in later sections, if we decide that the interests a demented person now has cannot themselves be protected by rights, because he is no longer the kind of being that can have rights. That is the issue of the present section.

3 Reference to, e.g., Danto's discussion of this topic in the Encyclopedia of Philosophy.

4 In this and the next section I use the names "Kantian" and "Humean" loosely, not to refer specifically to the views of Kant and Hume, but to describe general approaches to moral philosophy their names have been used to describe.

5 Reference to Strawson, Freedom and Resentment.

6 I do not consider (because this issue lies outside our general topic) how far this argument endorses or supports rights for animals.

7 Reference to A Theory of Justice.

8 Reference to the Dewey Lectures.

9 See note x supra.
10 See, e.g., John Mackie, *Ethics*.

11 Reference to Parfit's examples of prisoner dilemmas and the moral solution.

12 That is so even if these independent principles include a provision that no one may be a member of the moral community, even if a member of the political community, unless he can contribute to the scheme of co-operation morality creates. For someone who becomes demented could contribute earlier in his life and so, on the second version, did become and remains a member of it.

13 I am assuming, in this discussion, that it can, at least sometimes, be in a person's overall best interests to force him to act otherwise than as he wants: that it can be in a person's overall best interests, for example, to be made not to smoke, even though we count the fact that his autonomy is to some degree compromised, considered in itself, as against his interests.

14 There is an important debate in the economic literature on the question whether it can be rational to act against one's own best interests. The better view is that it can. See, e.g., Sen, *Rational Fools*, Philosophy and Public Affairs.

15 Problems are presented, for this judgment of overall integrity capacity, when a patient appears only periodically capable of organizing his life around a system of desires and wishes. He may seem able to take command of his life sometimes, and then lapse into a more serious stage of dementia, becoming lucid again only after a substantial intervening period, at which time the desires and interests he expresses are very different, or even contradictory. It would be wrong, I think, to say that such a patient has the capacity for autonomy periodically: the capacity autonomy presupposes includes a capacity for stable desires seen as giving structure to a continuing life, and this is a capacity that cannot be displayed just considering each period of lucidity on its own. Some considerable integration of interests and projects among these periods would be necessary.

16 I am assuming, in this contrast, that at least some cases of what the philosophers call weakness of will — failing to abide by past settled convictions in a moment of great temptation — are nevertheless exercises of autonomy. It would be, I think, a serious mistake to conflate these two different situations: when someone has the general capacity to bend his life to his convictions, and does not exercise this, and when he has become demented and so lost the capacity altogether.

17 Reference to Massachusetts decision.
18 We need this distinction, for example, to explain why mind-changing drugs or other forms of brainwashing that produce pleasure and contentment are not in their victims interests.

19 For some purposes we would need a further distinction: a doctor acts in his patient's ex ante subjective evaluative interests when he improves his life judged by the patient's standards at the time the decision is taken, and in his patient's ex post subjective evaluative interests when he improves it judged by the patient's standards after the decision has had its effect.

20 We shall have to consider the question of paternalism with respect to the demented later. I should add here, however, that the various distinctions between types of interests we have been canvassing allow an improved statement of the forms and degrees of paternalism. Any account of when paternalism is justified must attend to the differences between our stopping someone from taking drugs because we think he is ignorant of what the experiences that will follow will actually be like, or because we think it will lead to the kind of life he now disapproves, or because it will lead to the kind of life we but not he disapproves.

21 Reference to some of these statutes.

22 Reference.

23 The most elaborate philosophical defense of this argument is provided in the libertarian literature; in particular in Robert Nozick's book, Anarchy, State and Utopia. Reference.

24 I call this the "utilitarian" cost-benefit approach because other ways of measuring costs and benefits, different from the welfare calculations we associate with utilitarianism, might be designed, and some of these would appear to be more favorable to the demented. We might, for example, suppose that welfare improvements to those already worse off are to be weighted more heavily, in the overall calculation of costs and benefits, than welfare improvements to those who are already at a high welfare level. But any such special weighting would require a theoretical justification, which would provide good reasons not only for counting welfare improvements to the badly off as more important but also for weighting these in a particular way, and would therefore seem to presuppose one or another of the different approaches to the rights of the demented to resource I consider below.

25 In this discussion I am assuming that the cost-benefit approach I am considering uses what is often called a hedonistic conception of welfare, that is, that it measures welfare in terms of experiential interests. Other forms of the cost-benefit approach use a different conception of welfare: that someone's welfare depends not exclusively on his experiential interests, but more generally on the degree to which his desires have been satisfied. I assume the hedonistic conception of welfare because that
seems to be the conception most often used in the medical literature. The cost-benefit approach would justify somewhat more resources for the demented on the demand-satisfaction conception than on the hedonistic conception, but not, I believe, significantly more.

26 Reference to Robb. Importance of referral as screening.

27 A philosophical basis for the welfare-floor approach might be found in the concept of fundamental "needs." It is a familiar claim, in political philosophy, that people have certain fundamental and crucial interests, and a right that these be satisfied by any community in which they live. Different versions of this claim identify different lists of basic needs, though the lists overlap considerably. Any version must justify the needs it takes to be basic, and this is often a source of difficulty. Most lists of fundamental needs include these: the need for food, shelter, education and medical care. But why, then, is satisfying employment not also a basic need? What test certifies the familiar list but excludes that need? The needs approach has even greater difficulty in defining the degree to which the needs it identifies must be satisfied. What kind of shelter does someone have a right to have in virtue of his need for shelter? How much education: why twelve years, say, instead of six or sixteen? How much medical care, providing what level of life-expectancy? The case of permanent dementia exposes these difficulties, again in a dramatic way. How does dementia affect needs? Does a demented person really need anything — what concept of need is in play if we say he does? How much and what character of custodial care does he need, and does he need to continue living the way competent people might be said to need that?

28 This use of Rawls' theory would be an adaptation rather than a direct application, because he defines the "worst-off" group in terms of its holdings of "primary goods" rather than directly in terms of its welfare. (But since Rawls' counts capacities as resources, the demented would still have a claim to be the worst off group, under his theory unadapted).

29 In the next several paragraphs, I am summarizing a long article, What is Equality? Part II, in Philosophy and Public Affairs, 1981. It begins in a very abstract though not empty proposition: that government must establish and supervise a system of property that treats each citizen as an equal, that is, with equal concern. It then offers an interpretation or conception of that requirement: a property system shows equal concern if no citizen envies the resources available to another citizen throughout his life, that is, if no citizen would prefer any other citizen's life-time assignment of resources to his own. It does not follow, if that envy test is met, that citizens will have the same welfare or well-being on any conception of utility, because one may be happier, or more successful on his own lights, than another even if their resources are, on that test, equal. The test does, however, require an account of resources, and it uses a generous account. Someone's resources include not only his wealth, but his physical and mental capacities as well.

His resources are not, however, regarded as including his important preferences about the character of his own life; they do not include his con-
victions, attachments, identifications and projects. This distinction is not based on any assumptions about how far a person is either psychologically or metaphysically free to choose these important preferences, or how far he can conceive himself disassociated from any particular set of them. (We must be careful, in judging how far someone is free deliberately to alter his attachments, or to describe himself to himself without reference to them, to notice the difference between two claims: that he can abstract, in these ways, from all preferences and attachments, which seems wrong, and that he can abstract from any particular preference or attachment, which seems much more plausible.) It is rather based on the role preferences of that sort play in his life, and in his judgments about whether he is better or worse off, in resources, than someone else. Convictions and preferences are not the objects of these comparisons, but rather the basis on which they are made. Someone who believes he must dedicate his life to an art, or that the fate of particular other people with whom he identifies or for who he feels special attachment is crucially important to him, will not normally count himself worse off than others who do not share these ambitions or attachments even if they make his life more arduous. He will normally count his life, if anything, better because he has realized and accepted convictions of that sort. Of course some of what might be called tastes or preferences do not play that role: I might be subject to an addiction, for example, that I wish I did not have. In that case, as philosophers have put it, my first-order preferences are condemned by my second-order values, and the tastes I wish I did not have but cannot drop do count, negatively, among my resources.

In the real world, an initially envy-free distribution cannot be maintained, for two groups of reasons. First, people differ, naturally, in their productive capacities, by which I mean their capacities to produce goods and services others will pay to have. The distributional defect that follows from these productive differences can be described in two ways, and they are not fully identical. I may, ex ante, envy your superior productive capacities as resources you have and I do not. Or I may, ex post, envy the greater wealth they have allowed you to produce. A just state will transfer wealth to reduce the resulting inequality, though, for various reasons I shall not discuss here, it cannot eliminate it. I have proposed, as the standard a just state will use to fix the level of such transfers, an elaborate hypothetical insurance exercise which imagines people insuring against failure to have productive capacities allowing them to produce a given level of wealth. The operation and plausibility of that hypothetical insurance for productive capacity is problematic, and described in my article in PAPA.

Second, people differ in what we might compendiously call their luck. In particular, some fall ill or are incapacitated in various ways whose harm is not limited to productive capacity. They then need more resources than others and are generally able to produce less. Once again the envy test fails, and a just state will seek to transfer wealth in partial compensation. The hypothetical insurance device is easier to understand and apply as a standard for that transfer. Imagine that insurance is available offering a choice of different levels of compensation, each at the premium that that level of compensation would command in an efficient insurance market. Imagine that we can determine, within reasonable limits, what coverage people would on average buy against particular illnesses or incapacities, for what average premium. We can model a system of taxation and redistribution on these results of the hypothetical
exercise. The state must provide, in kind or in funds, coverage at that average level for at least those who cannot pay for it themselves, and it must pay for this out of taxation aimed to capture the equivalent of the premiums those who receive the benefits would have paid for that coverage in the hypothetical market. See the article in Philosophy and Public Affairs for more elaborate discussion. For a somewhat different account of an approach like the hypothetical insurance approach, see Norman Daniels. [Reference.]

30 I shall later distinguish two versions of a practical program modeled on the hypothetical insurance approach. In the first, government provides coverage only for those who cannot afford the coverage level set by the hypothetical insurance exercise themselves, and collects taxes accordingly, allowing those who can afford that coverage to make their own provision. In the second government provides coverage for everyone, and collects taxes at a correspondingly higher rate. If private insurance is actually available, at rates and conditions like the hypothetical insurance, there is not much difference between the two programs. People who would not be covered by the more selective program will use the taxes they do not pay as premiums for their own insurance. In practice, the two programs would have very different consequences. I shall later argue that, at least in the special circumstances of dementia, the second program is more just.

31 See earlier note.

32 Reference to Phillipa Foot article on euthanasia in Philosophy and Public Affairs.

33 That conviction is not obviously sound: it is arguable that these instincts would not be much weakened by a specific exception allowing for killing people whose continued life can have no value for them. But it is also arguable that the damage to these instincts would be greater, and harder to limit, than other commonly accepted exceptions to the general prohibition against killing, like the exception for self-defense, because it is also an exception to the more discrete and much more fiercely held opinion that doctors must never kill. These reflections are anyway academic: no general policy of killing the permanently demented should or could be adopted now.

34 It might be suggested that the insurance model need only assume, with respect to prudence, that the insurer thinks he his acting out of prudential concern, and that this does not require that the insurer and the patient be the same person, but only that the insurance believes that they are. But I am assuming that no approach to the rights of citizens can be accepted as sound if it presupposes that people are making serious philosophical mistakes, so that the approach would have to be abandoned if the citizens it serves were better informed or thought more clearly. In any case, the assumption with respect to temporal co-responsibility is an assumption about facts not beliefs: the insurance model would seem unfair unless the insurer and the patient really are the same person.
These twin and connected assumptions of prudential concern and life-straddling co-responsibility are even more pervasive, in the way we lead our lives, than these crucial third-person judgments suggest. We can just barely imagine a radically different communal way of life in which assignments of property, and legal and moral responsibility, were periodically extinguished or altered. But we cannot imagine abandoning prudential concern and co-responsibility in the first person, that is, abandoning the idea that important decisions must be made having regard for future stages as well as any present stage, and that future stages must share in the responsibility for these decisions, because these ideas are constitutive of living a life. (We noticed that fact earlier in this essay though in a different form: we noticed how the idea of autonomy assumes and employs a conception of the good of a particular person across a single life.) I do not mean that we cannot imagine people living so as to make the best of a series of life-stages each of whose value was strictly independent of the value of the rest, like a team of relay runners suddenly running independent races against the clock. But that a creature living like that would be living a series of lives in the same body; like the independent relay runners, he would be living as a group of different people.

Thomas Scanlon pointed out, in Tanner Lectures delivered at Oxford University in May, 1986, that we do not withhold public contribution towards the treatment of lung cancer from those who were heavy smokers before they contracted that disease.

That is the conclusion of Nagel, who believes that personal identity is carried by the brain as a physical entity.

That is the theory of Locke and, though in a more sophisticated form, many of his modern followers.

See Derek Parfit, Reasons and Persons.

Except for what he calls the unimportant fact that the causal explanation of the psychological continuity is abnormal in one of the two cases.

Parfit thinks physical connections unimportant, but some people might think they matter.

It will seem plausible to many readers that in some circumstances co-responsibility should hold when psychological continuity has been preserved even though they are doubtful that identity holds. I have in mind this science-fiction case: suppose a murderer, about to be caught, arranges for an exact replica of himself to be created hoping to escape punishment by arguing that the replica and the (now extinguished) murderer are two different people. We might think, whether or not we ac-
accepted his claim that identity was broken by the replication, that the replica deserves to be punished anyway. Reference to David Wiggins' observation that people cannot escape punishment by contriving their own fission. (See the discussion below as to whether we should, in a case of this sort, regard identity as holding between the murderer and his replica. But no one would think the replica deserved punishment if the replication had gone wrong, and the replica had no memory of being the criminal. (Nor, of course, would the murderer have contrived the replication if he expected that result.)

43 "Wired-in" suggests that these assumptions are genetically rather than culturally transmitted, which we can assume for this discussion because nothing turns on it.

44 Comparison with re-incarnation. Brings out the possible need to distinguish two different concepts of a person.

45 Parfit reaches the opposite conclusion about this case, mainly because he worries about the case in which I survive for an hour after the replica is created, and he thinks it impossible that "I" should be in two places at the same time as I then (briefly) would if we counted the replica as me. But, from the point of view of the assimilationist approach, the rule that I cannot be in two places at one time, applied in this strict way, is only another formula we need not accept. Of course, if the person being replicated survived for a substantial period, that would present a different case for the project of adjusting identity to the system of identity-grounded ideas I have been discussing, and we might well, then, decide that I am not my replica. I discuss that different case in the text just below. But it is central to the assimilationist approach that we need not treat automatically treat circumstances as different as those in which the person replicated survives a few minutes and survives indefinitely the same way.

46 Compare Nozick's "closest connector" doctrine. The qualifications would probably apply in those cases, as in the first of Bernard Williams' cases I described earlier, when it would produce two different candidates for the continued identity of a single person.

47 I emphasize the relative character of the test the strategy uses because someone might think that it is, for reasons that might include a radical view of personal identity, always unjust, for example, to hold a later stage responsible for the acts of an earlier stage, even in what we call normal circumstances.
PHILOSOPHICAL, LEGAL, AND SOCIAL ASPECTS OF SURROGATE DECISIONMAKING FOR ELDERLY INDIVIDUALS

Contractor Documents

May 1987

THE OTHER 3 TITLES APPEAR ON THEIR OWN INDIVIDUAL MICROFICHE UNDER THE APPROPRIATE CLASS NUMBERS.

Surrogate Decisionmaking for Elderly Individuals who are Incompetent or of Questionable Competence, Allen Buchanan, Ph.D., Department of Philosophy, University of Arizona, Arizona; and Dan W. Brock, Ph.D., Department of Philosophy, Brown University, Rhode Island. Y 3 T 22/2:2 M 6/2/87 SURR.

Withholding and Withdrawing of Life-Sustaining Treatment for Elderly Incompetent Patients: A Review of Court Decisions and Legislative Approaches George J. Annas, J.D., M.P.H; and Leonard H. Glantz, J.D., Boston University Schools of Medicine and Public Health, Massachusetts. Y 3.1 22/2:2 M 6/2/Patient

Legal Perceptions and Medical Decisionmaking, Marshall B. Kapp, J.D., M.P.H., Department of Medicine in Society, Wright State University, Ohio; and Bernard Lo, M.D., Department of Medicine, University of California at San Francisco, California. Y 3.1 22/2:2 M 6/2/leg

Philosophical Issues Concerning the Rights of Patients Suffering Serious Permanent Dementia, Ronald Dworkin, Department of Philosophy, University College, Oxford, England. Y 3.7 22/2:2 M 6/2/issues

These are contractor documents that were used in preparing OTA's final Assessment Reports, Losing a Million Minds: Confronting the Tragedy of Alzheimer's Disease and Other Dementias, and Life-Sustaining Technologies and the Elderly. OTA makes these contractor documents available for the use of readers desiring a more detailed or technical discussion of an issue than can normally be accommodated in our final Reports. As OTA contractor documents, they have not been reviewed or approved by the Technology Assessment Board. The findings and conclusions expressed are those of the authors and do not necessarily reflect the views of OTA, the Advisory Panel or the Technology Assessment Board.