

Is there a moral obligation to respect an advance directive refusing life-prolonging treatment?

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Abstract

Occasionally, individuals can predetermine their future life affairs. One of such ways is by giving an advance directive to refuse a life prolonging treatment in case an individual becomes incompetent to take decision. However, not all predetermined life wishes come to pass, even for persons that remain competent. Therefore, regardless of the incompetent state of the author of an advance directive, there is no moral force on who should implement such directive when the time is due. More importantly, both epistemological and metaphysical reasoning attests to the inherent defects that intrinsically militate against the moral obligation of an advance directive.

Key-words

Living-will, patient's autonomy, personhood, psychological continuity, life-prolonging intervention

Introduction

It is thought that the merits of an advance directive lie in enhancing a person's self-determination, and informed refusal of future medical intervention that can prolong a life not worth-living. It is further believed that it saves the patient's relations and the society burdensome emotions and finances. Overall, it protects an individual's best interests in the treatment options should an individual becomes incapacitated. [1]

Nonetheless, advance directive has major drawbacks in defective autonomy and informed consent. Indeed, the epistemological and metaphysical reasoning has shown that these inherent defects essentially militate against the moral obligation of an advance directive [1]. There is no moral obligation to always respect an advance directive refusing a life-prolonging treatment, notwithstanding its presumed merits.

This paper will examine the concept of an advance directive. This will be followed by arguments against the moral obligation to respect an advance directive to refuse a life-prolonging treatment.

Discussion

What is an advance directive?

Advance directives are statements made by a competent person that indicate her future treatment wishes or choices particularly the unwanted ones should she become incompetent or incapacitated to consent or refuse. [1] An advance directive can be in the form of a living will, a durable power of attorney or mixed. A living will contains specific instructions on the forms of care or treatment a person wishes to have or not to have under certain circumstances. On the other hand, a durable power of attorney entails authorization of a proxy, usually a trusted individual or committee of individuals, to make decisions for a person after he/she becomes incompetent. A mixed form has a proxy designate who has to operate within a limit already lay down in accompanying instructions.[1] In the United States, the Patient Self Determination Act [2] requires health providers to tell patients about their right to refuse medical treatment. However, there is no legal provision for advance directives in the United Kingdom. Though, an advance directive may contain information on preferred treatment choices, even costly heroic procedures, nonetheless, only a refusal of treatment is binding. [3] Moreover, a too specific or too inclusive advance directive may prove contentious and non-implementable. [4] An advance directive saves the trouble of long-wait in decision taking or having recourse to the doctrine of necessity [1]. Notably, advance directives can arise as a result of envisaged incompetence, incompetence and terminal illness, mental health and birth plans, and organ donation [1]. However, the focus of this paper is on life-prolonging treatment (treatment to sustain life) and such may include intubation and oxygen administration, nutrition and fluids administration, drugs

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administration, blood transfusion, dialysis and surgical intervention.

Arguments against moral obligation to respect an advance directive refusing life-prolonging treatment

The epistemological reasoning: Informed consent

An informed consent is a gold standard to any procedure or intervention in medical practice. It requires that any competent patient should know the details about the medical procedure or intervention, the merits, side effects and the likely alternative option. [5] Contemporaneously, full information is an ethical necessity for an informed consent or rejection. Like any other medical processes, an advance directive derives legitimacy from a sound informed consent. There should be adequate information to make a competent person to anticipate the circumstance when an advance directive will take effect, aware in broad term the nature and effect of the procedure before her consent or refusal. [4] However, an advance directive cannot guarantee detailed information on the health condition as it is entirely futuristic. Thus, a person issuing an advance directive cannot be said to have been fully informed. A directive originating from ill-informed or un-informed decision is unethical. Any unethical decision usually, cannot command moral obligation. An informed consent is compromised whenever a consideration is given to choices made from insufficient or mistaken information. This essentially renders an advance directive morally non obligatory and making it lacking in moral force to take precedence over paternalistic decision on what is in the patient's best interests. [6]

Remarkably, it is impossible to get a satisfactory informed consent towards an advance directive. Some useful information, especially future treatment advances, cannot be predicted accurately. Moreover, there is hardly an opportunity to clarify misunderstandings by the author of an advance directive. It is unusual for the author of an advance directive to explain or defend their choices to the physicians and relations who necessarily will share outcome of the directive, play roles in its implementation and probably should modify the person's wishes. [7] There are empirical studies confirming that families often do not have knowledge of their relatives' treatment preferences. [8]

Health professionals are limited by the information at their disposal and cannot give what they do not have to a person at the time of an advance directive. As a person is also limited by the available information, the reason for issuing an advance directive may not necessarily always be true. These shortcomings make an advance directive an imperfect directive that does not command moral force but an optional guide in the care of incompetent patients.

Notably, the natural history of a health condition varies across patients in term of severity and dynamics. It is a fact that the future of a health condition cannot be accurately predicted. Suppose a 30-year-old Jones, fearing an incurable HIV/AIDS would severely affect his quality of life, issues an advance directive in 1985 that should he contract HIV/AIDS, he should not be given any life-prolonging treatment. Imagine Jones has HIV in 2000 and later suffers from diarrhoea and vomiting leading to severe dehydration in 2005. Jones' clinical state deteriorates: he becomes weak, confused, and can no longer communicate. It is clear Jones will soon die of shock unless there is urgent fluids rehydration to prolong his life. Also, in 2005, drugs that can improve the Jones's quality of life are available. In 1985, Jones does not envisage there would ever be drugs available for HIV/AIDS. Imagine that even in 2005 Jones is unaware of this fact and has not withdrawn or modified his advance

directive.

It implies Jones' advance directive suffers from inherent defects – there is limited information – leading to inadequate informed consent. A directive that is ill-informed cannot command moral force as it is defective. There is no moral obligation to implement the Jones's 1985 directive. Then, Jones has to be rehydrated to prolong his life based on the understanding that his directive is ill-informed. Moreover, his advance directive is premised on fear for his probable poor quality of life, should he suffer from HIV/AIDS, due to lack of treatment for HIV/AIDS at the time of the advance directive. However, in 2005 such fear is less relevant due to the availability of highly active anti-retroviral therapy (HAART) which has proven to improve the quality of life in people living with HIV/AIDS (PLWA). It would be morally wrong to implement Jones's advance directive as there has been more information on HIV than it was in 1985. Also, there are advances in treatment culminating in improved quality life in people living with HIV/AIDS.

On another note, it is not unusual for people to complete advance directives on their own, at best, following consultation with relatives, physicians or attorney, without necessarily understanding the implications of their decision. For instance, in an empirical study among dialysis patients who had previously issued advance directives refusing any life-prolonging treatment should their Alzheimer's disease become severe, it was found that nearly two-thirds of them wanted families and physicians to be at liberty to override their previous directives to protect their future best interests. [9] The finding suggests that the issued advance directive failed to reflect the actual preferences in most of the study sample. In another survey among twenty-nine people participating in a workshop on an advance care planning, as many as ten agreed to an advance care planning with one person making two inconsistent statements:

'I would never want to be on a respirator in an intensive care unit'; and 'If a short period of extreme intensive medical care could return me to near-normal condition, I would want it.' [10]

Notwithstanding the facts to the contrary, it is of interest to note that some advance directives campaigners have claimed that subjects can complete directives within a fifteen-minute period. [11] Such claim appears unreasonable for an advance directive with consequences that call for sound reasoning and unambiguous understanding. An advance directive can rarely command any moral force as the conditions for its obligation as contained in a Court of Appeal judgment can hardly be met [4]. For instance, the court tactically states that prior refusals of medical treatment would be binding in principle on fulfilling three conditions in *Re T*:

'the patient must be competent at the time the advanced decision is made, the patient must have anticipated the circumstances when the advance decision would take effect and intend his/her decision to apply to those circumstances and the patient must know 'in broad terms the nature and effect of the procedure to which consent (or refusal) was given' and must have understood and fully appreciated the significance of making such declaration.' [4]

It is important to note that with the exception of the competency of the author of an advance directive, the other conditions can rarely be satisfactorily met making the implementation of an advance directive optional, and not morally binding.

On the other hand, there may be uncertainty about the meaning and

application of an advance directive rendering it non implementable even when it is available. [12] When a living will fails the court's criteria of not being recent in origin, not logically consistent or insufficiently specific, there is no moral obligation to implement it. Moreover, it is not rare to find misinterpretation whereby an advance directive appears to suggest a course of treatment and both physician and the patient's relation feel the patient actually wanted something else. Also, it is impossible for an advance directive to address all possible outcomes at implementation.

Metaphysical reasoning: Person and autonomy

Philosophically, a person has 'functionally integrated part of a living human brain', or 'something sufficiently similar'. [13] Psychologically, a person has 'consciousness, belief-formation, and rational thought'. [13] Harris [14, 15] argues that personhood refers to a human being having a 'biographical life' worthy of a full moral status. To Harris, 'human non-persons' or human who are not 'fully fledged persons' may include individuals who are 'brain-dead' (persistent vegetative state).

According to Locke [16] a person is 'a thinking intelligent being, that has reason and reflection, and can consider itself as itself, the same thinking thing in different times and places; which it does only by that consciousness, which is inseparable from thinking, and it seems to me essential to it'.

From these accounts it can be inferred that a person is a human being who is capable of self-awareness and rational thinking or intelligent, while a human non-person lacks these qualities.

The distinction of human being into a 'person' and 'non-person' is very essential to this paper as the morality of an advance directive has basis in competency and autonomy of the person who issues it. Thus, a 'person' is a competent human being while a 'non-person', though, a human being, is an incompetent being. By Harris's account, an infant, the patients who are demented or comatose or in persistent vegetative state are human non-persons [15]. While the infant is yet to be a person (lacking neurological maturation); the demented, the comatose and the persistent vegetative state have temporarily or permanently lost the neurological cognition. Thus, a person can transit to non-person by a disease condition.

Inferentially, personhood defines the right to autonomy and non-person humans lack autonomy. Though, having moral worth, non-person humans lack self-determination (autonomous) and cannot determine own treatments. Autonomy is voided if there is defective information, if an individual has a deteriorating cognitive function or there is a mental impairment. [17] Kant's autonomy holds that an individual has a right to self-determination without any interference [3]. It is a hallmark of informed decision. Like decision on any contemporary medical procedure, an advance directive requires a competent person's autonomy otherwise it is unethical and lacks moral force. It is believed that an advance directive enables the competent person to have control over her future treatment through a previously informed rejection of certain treatment. Also, it respects patient autonomy and removes second-guesses by proxies on what is in the patient's best interests. [3]

It is a fact that competency grants individuals an absolute right to decline medical treatment for any reason, or for no reason, even where that decision is life-threatening. [4] For instance, cigarette smoking is allowed, but there are advertised health warnings of

inherent danger of smoking, making smoking an informed decision. In term of autonomy, competence is, 'the ability to act out of genuine preference or character or conviction or a sense of self'. [18]

Nevertheless, there are concerns about the morality of applying an advance directive by competent individual on incompetent self. This essay will now argue, based on personal identity, psychological continuity and biological animalist view, why an advance directive cannot always command moral obligation. Suppose Jane has a life expectancy of 80 years. At age 50, a competent Jane (J1) issues an advance directive that in an event she suffers from Alzheimer's disease with an accompanying dementia she should not be given any life-prolonging treatment should it be necessary. Imagine at age 60, Jane (J2) has Alzheimer's disease with mild dementia but she appears happy despite the mild cognitive impairment. Consider Jane progressively deteriorates from (J2) until she loses all cognition (J10). Imagine at 65 Jane deteriorates to moderate cognitive impairment but still remain happy (J3). Shortly, J3 suffers from pneumonia that requires antibiotics treatment for her to survive. Jane still has about 15 years to live.

It is incontrovertible that Jane (J1) has every right as a competent and autonomous person to issue an advance directive. She exercises her right to self-determination. J1 deteriorates in competency from age 60 (J2) through (J3) at 65 until the end of her life (J10) that is, becoming an incompetent being (non-person). It can be argued based on different person theory that J1 that issues an advance directive is different from J2 or J3 (the incompetent beings or non-persons) to whom the advance directive is to be applied. Metaphysically, it means that J1 lacks psychological continuity with J2 or J3. [19] Indeed, J1 has transitioned into J2 thus, ceases to exist immediately J2 emerges. By the slavery argument account [19], J1 has moral obligation only to future self but, not to a completely different beings of J2 or J3. The J1's advance directive is non-obligatory on J2 or J3.

A person's autonomy continues only when there is psychological continuity. Consequently, an advance directive is binding only on who there is a psychological continuity. Notably, a person has lost psychological continuity with a non-person. There is no moral obligation to apply an advance directive by a person on a non-person for lack of psychological continuity.

Additionally, it is arguable that since J2 or J3 still has some level of cognition, imposing J1's advance directive on them disrespects or violates what remains of J1's autonomy by imposing entirely different persons' desires on J1, an action that can lead death. Furthermore, J1's advance directive, though an attempt at self-determination wrongly bothers on a future self that is yet to be determined.

Moreover, it is not in J2 or J3 best interests to have J1's advance directive imposed on J2 or J3 since J2 or J3 is happy with life, a fact that is contrary to J1's projection when she issues the directive. Being happy may imply a life worth-living. Arguably J2 or J3 has a life worth-living since despite suffering from the Alzheimer's disease J2 or J3 is still happy. [3] However, suppose there is J10, who is unhappy, and with the disease in its most severe stage, probably with a life not worth-living, there may be a justifiable temptation to consider implementing J1's advance directive. Nonetheless, it cannot be morally obligatory by epistemological reasoning. [4, 5]

This line of thought should also hold for other conditions (a state of

unconsciousness or death) where patients cannot communicate their wishes to continue to live. Contrastingly, Rakowski [6] holds that an advance directive is more complex for demented patients compared to conditions leading to permanent unconsciousness. Thus, there is the need for more caution before authorizing advance directive in dementia.

Furthermore, it is not absolutely correct that an advance directive imposed by a person (J1) is consented to by a non-person (J2) in all situations as the directive would like to suggest. For instance, an individual who is comatose following a road traffic injury but on life support may now prefer to live, contrary to a previous advance directive not to be placed on any life-prolonging treatment. Bernat [20] argues that it is morally wrong to honour an advance directive to allow a patient with a worthwhile life to die just because she cannot express her wish to continue to live.

Another argument towards the morality of an advance directive is based on who is morally relevant subject between a person (J1) and a non-person (J2 or J3). According to Maclean [21] a consideration of prospective autonomy makes J1 the morally relevant subject, while the backward-looking 'precedent' autonomy [2] recognizes the J2 or J3 as the subject. It is arguable that J2 or J3 should be more morally relevant subject as she is not only a human being but also bears the repercussion of the advance directive. Since J1 lacks psychological continuity with J2 or J3, the advance directive by J1 is not binding on J2 or J3. This will ensure autonomy/respect for J2 or J3.

The morality of an advance directive has also been viewed from critical and experiential interests [11]. The experiential interests refer to doing things because of its experience, like travelling to specific places or eating a particular meal. On the other hand, the critical interests refer to the 'hopes and aims that lend genuine meaning and coherence to our lives'. [11] It has been argued by Dworkin [18] that only a person has critical interests as compared with experiential interests of non-person. This implies an advance directive is not enforceable on a person with critical interests but on a non-person with experiential interest. The argument appears discriminatory against non-persons who lack critical interest, but, are happy. For instance, the mentally impaired or disabled who only have experiential interests, but are happy, would have advance directives applied on them compulsorily. This is not necessary on an account of the lack of psychological continuity between a person (J1) and a non-person (J2 or J3).

Dresser [11] argues that in real life there is hardly any distinction between critical and experiential interests. Dresser observes that, in dementia, experiential interests supersede critical interests, thus allowing the 'fiduciaries to concentrate on non-person's experiential interests'. This is even more important, when there is a worthy life, as a course of critical interests will be harmful to J2 or J3. This position is essentially pro-life and underscores a policy against murder or withholding of very effective but non-burdensome therapy like antibiotics especially to a patient (J2 or J3) who still has life worth-living. This argument should also hold in a situation where there is no prior advance directive by J1. Furthermore, it will be morally difficult to justify implementing the advance directive based on best interests that assign priority to critical interests that prefers death to life in a happy non-person (J2 or J3). The testimony to this fact was when a judge denied a court-appointed guardian's request to have the patient's life-prolonging medication withheld. The patient's family strongly opposed the guardian's request as they believed the patient had a life worth-living. [11]

Initially, the argument that a person's advance directive is not morally enforceable on non-person appears puzzling and unreasonable when it is compared with the fact that parents are allowed to decide for their incompetent children. Rather, there is no confusion and the argument is reasonable as in real life where parents make treatment decisions for their incompetent children, they are at least available to make any necessary amendment while the treatment lasts. This is obviously lacking in an advance directive. Rather than imposing an unsupervised advance directive that contradicts the contemporary reality at implementation, it is even preferable to allow the available and better informed paternalistic decision in a non-person's best interests. Moreover, the parents' paternalistic decision cannot be permitted if it seeks to cause the death of a happy but mentally impaired child as an advance directive will suggest. [3]

Dworkin [18] argues that a person's critical interest persists until death, as it affirms her precedent autonomy and that the principle of beneficence commands that such critical interest should be respected by honouring the advance directive. This cannot be true according to a psychological account as a person loses psychological continuity with a non-person, making a person's directive not morally binding on a non-person. Nonetheless, should Dworkin's [18] argument on a person's critical interests be considered in a patient with life not worth-living? It will be a disaster honouring such an advance directive where a non-person still has a life worth-living. The advance directive should rather be set aside on ground of beneficence, paving way for paternalistic decision underpinning any life-prolonging means in the non-person's best interests. Dresser [11] reasons it would be immoral to condemn to death somebody who plainly enjoys herself trading off life with honouring a prior directive. On another note, an evidentiary view of autonomy holds that a person knows her interests better than anyone else while an integrity view of autonomy holds that evidentiary autonomy should be respected [18]. For instance, a person is allowed to choose death over radical amputation or over blood transfusion once there is adequate information to justify an informed decision. However, it can be argued that in an advance directive a person may not be the best judge over her interest in circumstances she has never encountered before, and in which preferences and desires are quite dynamic. [18]

In contrast to the slavery argument anchored on loss of psychological continuity, it has been argued that a person is actually continuous with a non-person in two other separate theories [17]. First, animalist (biological) argument holds that a person is numerically identical to a human animal. Like in an animal, a human animal persistence condition is non-psychological. Second, embodied mind argument holds that a person is essentially a thinking subject, but not numerically identical to human animal since human animals are not essentially thinkers. However, human animals can persist even in the face of radical psychological discontinuity since all that is required for its continued existence is continuity of thinking subject. A person continues psychologically and biologically.

The animalist's continuity persists until death and survives psychological continuity. Even after brain death the biological continuity persists as long as animal functions such as metabolism, respiration and blood circulation continue [17]. The biological account is premised on the fact that human being is a member of species homo sapiens. The animalist's view has a broader perspective: a person persists as human animal till death thus, extends beyond the point of loss of human psychological continuity. A person's identity is preserved in biological account thus, avoiding

the social challenges posed by loss of psychological continuity. This also has implication for advance directives as the preservation of a person implies moral authority over incompetent self whether demented, unconscious or brain dead. [17] However, like the slavery argument where there is loss of psychological continuity, the incompetent human animal is non-autonomous.

Though, a biological or animalist account arguably enables a competent human animal's directive to be implemented on incompetent human animal, the directive is not morally obligatory due to overriding serious epistemological and metaphysical concerns. For instance, epistemologically, the author can hardly be well informed especially considering the possibility of future treatment advances that can alter the prognosis of a disease. A competent person is not the best judge in any unpredictable future event, the unpredictable human nature of a third party proxy, and autonomy can rarely be guaranteed where there is lack of experience of the nature of the future disease state. These inherent limitations make advance directive not meeting the standard conditions in autonomous decision making for a competent moral agent, denying it of any moral obligation. [17]

Other considerations why implementing an advance directive is morally non- obligatory

On a practical note, an advance directive may not be morally obligatory based on the circumstances at implementation. For instance, in an emergency situation a physician is expected to save life first rather than spending time to search for or interpret a living will card. In such situation, it is almost impracticable to disconnect a life-support when a patient is already connected to it, even, when a living will is later discovered [22]. Furthermore, an advance directive lacks moral force if on careful scrutiny it is found out that the patient was coerced by relations to refuse a life-prolonging treatment. An advance directive is essentially an imposition by the competent on the incompetent yet lacking in currency. The implementation of the directive becomes reasonable when it does good (beneficence) and avoids harm (non-maleficence) to the patient. A physician flourishes when she possesses and upholds the virtuous trait of integrity, even, when she operates within the limit of law in treating her patient. Nonetheless, a physician is facing the reality of the patient's condition as opposed to speculation in advance directives which may not be consistent with a clinical judgment. Of course, a physician reserves the right to make clinical judgments about treatment regardless of a patient's request. [23]

There appears to be assumptions that an advance directive overrides a clinical judgment. This cannot be true as a clinical judgment should reflect the patient's contemporary condition. For instance, the patient advocacy group put it in an evidence to a House of Lords select committee:

'it would be bizarre in the extreme to require a skilled, professional doctor to adhere to the stipulations of a living will which did not accord with his/her expert opinion of what would be in the best interests of the patient's health' [24]

Thus, an advance directive cannot be obligatory if it is not in the patient's best interests as adjudged by the physician's expert opinion at implementation of the advance directive. The obligation of an advance directive will necessarily mean coercing a physician to implement the directive even when it is lacking in medical objectivity. This can compromise the medical profession's values and integrity – a trade-off for the patient's precedent autonomy and

critical interests. [11] The danger lies in a serious erosion of health professionals' moral value, degenerating into an immoral culture where an advance directive is preferred, even when it cannot be justified.

Furthermore, there is no moral obligation to honour an advance directive when the patient's family contradicts the terms of an advance directive. It is not advisable for a health professional to proceed to implement any advance directive where a patient's relations object to it. Doing so may imply health professionals coercing the patient's family into withholding life support from the patient, thus, exposing themselves to unnecessary litigation of manslaughter or murder. Therefore, it is logical to err on the conservative side, after all, it is even reasonable to preserve life rather than terminate it.

Finally, the false inference argument [17, 25] posits that advance directives are after all a hoax as the patients just believe or fear life may be unbearable or not worthwhile if in a particular health state. One cannot correctly state the feelings in coma, dementia and persistent vegetative states. One just assumes an individual does not want to exist in a particular state of life. It is not necessarily true that people in the alleged fearful state actually suffer as badly as one may envisage. Even if the autonomy is respected to withhold a particular life-prolonging treatment, and one is even convinced that the individual would not prefer her present state, the individual in her present state might have changed to accept her new tolerable state. The pro-lifers and disabled have argued that the handicapped are happy to live. [25] People often describe a condition as being 'tragic, horrible, degrading, humiliating, to be avoided at all costs' [11], however, Firlik's [26] report of a demented Margo reveals that a life worth-living.

Conclusion

The essay discussed that there was no moral obligation to always respect an advance directive to refuse a life-prolonging treatment. A competent person's advance directive lacks moral force on an incompetent future self. The argument was premised on the major flaws of an advance directive- the epistemological and metaphysical. Epistemologically, the essential conditions for informed consent cannot be met as no one can make a fully informed decision under circumstances beyond one's experience. This is a major reason why the animalist cannot advance a moral obligation for an advance directive. Metaphysically, by a psychological account, a competent person lacks psychological continuity with incompetent non-person, thereby, making the decision for an advance directive not to be transferable or binding. Thus, advance directives lack moral obligation. Furthermore, an advance directive may not be morally obligatory under certain circumstances, such as when it overrides a medical opinion of a health professional, when it does not meet legal conditions, when there is a family disagreement, and when it is ambiguity in interpretation.

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