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Advance directives need full legal status in persons with dementia

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Abstract

Currently, in the United States, there is no legal obligation for medical professionals or civil courts to uphold patients' Advance Directives (ADs) regarding end-of-life care. The applicability and standing of ADs prepared by Alzheimer's patients is a persistent issue in bioethics. Those who argue against giving ADs full status take two main approaches: (1) appealing to beneficence on behalf of the Alzheimer's patient and (2) claiming that there is no longer any personal equivalence between the AD's creator and the subject of the AD. In this paper, I present profound arguments against both approaches. Firstly, I argue that the principle of beneficence cannot apply in the case of Alzheimer's patients, and, secondly, that the moral and legal authority of the AD need not depend on strict equivalence of personal identity. I conclude by arguing that valid ADs protect the dignity and autonomy of Alzheimer's patients and that, therefore, there are moral obligations to uphold ADs which should be reflected in public policy and legislation.

Keywords

Advance directives, dementia care, legal status, beneficence, autonomy, dignity, Alzheimer's disease

Introduction

United States civil jurisprudence states or implies that state courts of law presently have no legal obligation to uphold patients' Advance Directives (ADs). ADs are legal documents prepared by individuals outlining, among other things, the kinds of medical treatment they prefer or prefer not to receive in the event of future incapacitation or inability to express their wishes fully. This raises the question of why courts would not have an obligation to uphold a citizen's AD when that individual prepared their AD with a sound body and mind.

In such cases, proponents of the current policy provide two primary rationales: (1) the state and medical practitioners face a moral duty and obligation to beneficence which justifies—in the case of some Alzheimer's patients—not upholding the AD if it is seen as being at odds with said duty to beneficence; (2) medical practitioners and the patient's next of kin should only uphold an AD if there is psychological continuity

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between the creator of the AD and the subject of the AD, which, allegedly in the case of Alzheimer's, does not exist.

After some preliminary exposition concerning the nature of ADs and Alzheimer's dementia, I argue that both defenses are weak. I show that the first is weak by clarifying what beneficence requires and its applicability in most circumstances. In the case of Alzheimer's, one is rarely able to act beneficently, if at all, and may, in fact, cause harm by voiding the AD. If the state is not able to act beneficently, then the state has no such duty and, by extension, no grounds to void the AD.

I show that the second defense is weak by arguing that the moral authority of the AD does not depend on the creator of the AD sharing personal identity with the subject of the AD. Instead, the moral authority of the AD need only derives from the creator of the AD having a more legitimate claim to decide on the treatment of the subject of the AD than any other individual or group. As this is indeed the case, the AD retains moral authority even if there is a lack of personal identity between its creator and subject.

I conclude by offering two reasons in favor of upholding ADs in the case of significant Alzheimer's dimentia. Doing so is a means of protecting the dignity and autonomy of these now cognitively disabled patients.

Preliminary clarifications

Advance Directives

Advance Directives (ADs) are "legal documents that outline an individual's preferences regarding major medical decisions…[which] specify the healthcare options that (an) individual desires or rejects, currently and in the future."[1] These documents also, at times, specify an individual (or group of individuals) who may act on behalf of the patient if that patient becomes legally incapacitated on medical grounds.

Advance Directives take a variety of forms, including living wills, power of attorney, and instructions regarding life-sustaining treatment. They can include the individual's preferences, ranging from lifestyle and religious choices (such as retaining a kosher diet) to medical procedures and medication the patient would or would not like to receive (such as refusing the use of feeding tubes or allowing natural death). Notably, civil courts and medical professionals have no legal obligation to uphold the preferences outlined in an individual's AD.[2,3] Thus, ADs can be disregarded by civil judges or medical professionals at their discretion and have no binding legal status enforceable in a Court of Law, and family members of patients have no legal recourse if this occurs.[4]

Alzheimer's disease

Alzheimer's is the most common type of dementia, resulting from the degeneration of cells in the brain. As their brain cells degenerate, Alzheimer's-diagnosed patients progressively decline in cognitive capacity as well as in locomotive independence. As this brain degeneration worsens, they lose the capacity to communicate, fall into a semi-vegetative state, and, ultimately, die.[5] Alzheimer's is fatal, and the cellular degeneration it causes is medically and scientifically proven to be irreversible. Many Alzheimer's patients, therefore, prepare living wills upon first being diagnosed with the disease presumably prior to significant dementia. They do so often because they know with certainty that it is only a matter of time before they will be unable to communicate their care needs and end-of-life preferences. There is a scarcity of data on the rate of AD creation amongst patients with Alzheimer's—while around less than a third of the general population has created an AD, that number increases to over 80% among individuals with dementia who receive care.[6–8]

Typically, these ADs focus on their preferences concerning the kind of life they would like to lead as their condition deteriorates and their preferences concerning the life-sustaining treatment they may receive. Many

Alzheimer's patient's ADs include requests to withhold lifesaving procedures such as cardiopulmonary resuscitation (CPR), endotracheal intubation, or mechanical ventilation. Refusal of these practices is often central to their advance directives and even allows individuals control over their manner of death. Individuals must express these preferences early because in the later stages of brain cell degeneration, they will become unable to communicate them.

The argument from beneficence

In some instances, in the eventuality that their core cognitive capacities are sufficiently degraded, some individuals with Alzheimer's ask not to be resuscitated. Take, for example, the case of the professor whose identity and work have revolved around a "life of the mind."[9] In the professor's AD, he or she may include a desire to receive at-home hospice care while avoiding life-sustaining treatment if rationality is lost. Agnieszka Jaworska notes that, even if this individual loses cognitive capacities, the person can still live a life consisting of simple pleasures, such as drinking hot cocoa and listening to familiar music. In other words, there is still a measure of good that can be done for such an individual through effective efforts by caregivers or by family members.

Whenever one can do good, one must consider the principle of beneficence, which in the context of healthcare demands that we do the best we can to further the well-being of patients.[10] An alternative formulation of the principle of beneficence is the principle of non-maleficence, which instructs us to avoid causing harm to patients. Dresser (1996), Callahan (1996), and Kadish (1992) have argued that the principles of beneficence and non-maleficence provide the state and healthcare officials with strong reasons in particular cases to void the AD and preserve the individual's life, claiming that the well-being of the present Alzheimer's patient supersedes the wishes recorded in the AD.[11–13] These figures have claimed that since an Alzheimer's patient is still capable of some pleasures in life, the sustenance of these allegedly provides grounds for voiding provisions in the AD that would otherwise lead to death.

These claims were developed in response to Dworkin's arguments, from *Life's Dominion*, in favor of late-stage Alzheimer's patients being able to request that they do not receive life-sustaining treatment in their ADs.[14] Dworkin's argument rests on a distinction between what he calls *experiential* interests and *critical* interests.[15] The former refer to things such as "playing softball… eating well, or watching football, or seeing *Casablanca* for the twelfth time"—they are experiences which are regarded as a good because they feel good.[16] The latter represent "critical judgements rather than just experiential preferences"—they consist of someone's closest relationships, most important aspirations, and other such fundamental interests which are taken to provide life with meaning.[17] The relevance of this distinction to end-of-life care has to do with, Dworkin claims, the crucial role death has as the final stage in our lives: it represents our final act and we wish it to be representative of our character, values, and overall life plan.[18]

Dworkin relates this back to ADs by claiming that the principle of beneficence is taken to support voiding ADs only because people prioritize experiential interests and neglect critical interests. The reasoning is usually as follows: as the late-stage Alzheimer's patient is unable to make critical judgments, they are taken to not have any critical interests. Instead, they only have experiential interests. If these interests contribute to an overall level of well-being for an Alzheimer's patient, then the principle of beneficence gives the state and medical practitioners a good reason to sustain the patient's life, and therefore neglect any ADs that have expressed wishes to the contrary. Against this, Dworkin affirms the importance of autonomy: we think people ought to live their lives as they wish to live them, even if their actions might not always be in their best interest, because we have "a right to make important decisions defining [our] own lives for [ourselves]."[19] ADs represent a form of what Dworkin calls *precedent autonomy*: respecting self-determination of incapacitated persons means following the directives they set out when they did have autonomy.[20] An AD represents the

patient's critical interests—the interests who make them who they are—and thus it is in the patient's interests to have their ADs followed, independent of ongoing experiential interest-based well-being.

Dresser responds to Dworkin through focusing on beneficence and personal identity (the latter argument will be addressed in the following section). Her argument casts doubt on the importance and relevance of critical interests and reaffirms the importance of experiential interests. Firstly, Dresser objects to the role Dworkin accords to death in our critical interests. She cites studies that record that only a relatively small percentage of the overall population have ADs while also casting doubt on the claim that most people want their lives to have narrative coherence, anecdotally reporting that many people "take life one day at a time."[21] Because of this, Dresser suggests that "issuing explicit instructions to govern the final chapter of one's life is not a major priority for most people" and that this thereby undermines the relevance of precedent autonomy and critical interests for determining end-of-life care.[22]

Dresser's point about the total percentage of people who have ADs is true but misleading. Recent studies show that below a third of the adult population have completed ADs.[23] More important than this, however, is *who* is preparing ADs. One study shows that a majority of those 65 and over have ADs, whereas another found that 81.6% of patients who had dementia and received care had completed ADs.[24,25] This suggests not—as Dresser alleges—that most people do not care about their end-of-life care but rather the inverse, with the caveat that most people neglect it until its relevance to their lives is made apparent. These statistics, however, are somewhat beside the point. What is important is not the empirical tendency of people to prepare ADs, but whether we have good reasons to do so, and the extent to which our precedent autonomy should be respected by the state and medical practitioners. AD completion rates could be in the single-digits and this would have no moral bearing on the authority of someone's AD, as the hypothetical fact that most people do not care about their end-of-life care is irrelevant to the question of whether someone has the right decide on their own.

Dresser provides two further, more concrete, reasons as to why one might be skeptical regarding the use of ADs among Alzheimer's patients. The first relates to a lack of information regarding ADs and the nature of Alzheimer's. She cites a study which found that two-thirds of dialysis patients who had created ADs regarding Alzheimer's consequently also claimed to want their families and physicians to be able to override the AD, another wherein over a third of individuals agreed with the contradictory sentiments that they would never want to be on a respirator and that they would want to undergo a short period of extreme intensive medical care if it could return them to a normal condition.[26] The second has to do with the so-called changes of heart. The hypothetical professor discussed at the start of this section, for example, might change her mind about the life she is willing to lead—initial repugnance at the idea of a life consisting only of experiential interests might dissipate with time and as she becomes accustomed to living with the disease.

Both objections are weak. The first relates to current education levels around ADs rather than ADs themselves. If, as I will go on to advocate, we overhaul our current public policy regarding ADs, this problem can be resolved. Moreover, ignorance regarding the nature of procedures and of diseases pertains to almost every medical issue rather than just ADs—it is unfair to single them out this way. Insofar as these changes of heart are occurring to a lucid person, before the symptoms of late-stage Alzheimer's have taken hold, then the second issue is irrelevant as ADs can be revised or scrapped. If Dresser is making an equivalence between the decisions of the patient when they made the AD and their preference for experiential interests during late-stage Alzheimer's, then this is a misrepresentation. As will be demonstrated in the following section, what occurs is not a change of the heart – a mere change in the preferences one has—but a qualitative shift in one's capacity to make judgments and decisions.

In a confusing turn, Dresser then goes on to consider a series of arguments that pertain only to late-stage Alzheimer's patients who have not prepared ADs but nonetheless concludes that experiential interests "furnishes a defensible basis for state limitations on the scope of… precedent autonomy."[27] Dresser is careful not to claim that all ADs regarding Alzheimer's should be overridden, specifying that her conclusions only

apply to contented and conscious patients who have received "a systematic evaluation by clinicians" which suggests that a "minimally intrusive life-sustaining intervention" would save their lives.[28] Despite this, however, we have a good reason to doubt the overall relevance of Dresser's claims and whether we can meaningfully talk about beneficence in this case whatsoever.

To see an instance of how it could be that the state might have an obligation to infringe on an individual's autonomy due to the principle of beneficence, consider a schizophrenic individual suffering from an acute episode of psychosis. The state may apprehend the individual and force institutional commitment upon him or her in an involuntary psychiatric facility for treatment. The state has several reasons to do so: It ought to prevent individuals from harming themselves or others (non-maleficence) and also provide treatment that will improve the individual's condition (beneficence).

There is an essential distinction, however, between the case of the schizophrenic patient and the Alzheimer's patient, which shows that the state is not able to act for the good of the Alzheimer's patient in the way that beneficence or non-maleficence demands. Unlike the schizophrenic, Alzheimer's patients do not present an immediate threat to those around them. Nor do they typically present an immediate threat to themselves. They may harm themselves as a result of an accident, although this possibility is not sufficiently likely to justify removing the patient from in-home care and forcing them into an assisted living facility, as the latter would not provide any specialized aid that is not available at home (as in the case of the schizophrenic patient). Furthermore, unwanted life-sustaining treatments can cause severe harm to patients. CPR can cause damage to internal organs and rib fractures and lead to adverse clinical outcomes such as hypoxic brain damage or increased physical disability, whereas intubation is associated with higher risks of pneumonia and pressure sores.[29] Thus, in these instances, there is no case for non-maleficence. The voiding of such individuals' ADs might, in fact, cause significant harm to patients. Given that Dresser claims her stipulations do not apply to forms of life-sustaining treatment which can be harmful or "invasive and immobilizing," then the only plausible common request her claim applies to would be the refusal of antibiotic treatment.[30] Here, we might ask how many Alzheimer's patients with ADs request that they do not receive antibiotic treatment while still lucid and otherwise healthy. While the data is scarce, one study found that only 8.6% of Alzheimer's patients in hospice care requested this (the most requested wishes forbade artificial food and nutrition and ventilation).[31] We can reasonably expect that the percentage of lucid patients outside of hospice care requesting this would be even lower. Therefore, although Dresser criticizes Dworkin for the viability of his conclusions as policy, her own conclusion that ADs should be disregarded only applies to a minimal percentage of ADs.

Regarding beneficence, however, unlike schizophrenics, Alzheimer's patients cannot receive any treatment that would improve their condition or return them to a state comparable to their situation before their cellular degeneration. We may think that the principle of beneficence can work well in schizophrenia cases precisely because this is a genuine possibility. The only possible benefit that life-sustaining treatment can provide to Alzheimer's patients is the sustenance of their current condition, but that is not necessarily a genuine good for Alzheimer's patients in all cases. While this condition might include genuine pleasures such as drinking hot cocoa or listening to music, it is debatable whether these superficial and momentary enjoyments are sufficient to count as genuine benefits. This is because of their transitory nature and the patient's inability to properly communicate his or her wants, needs, or preferences. We cannot know whether, outside of these brief moments, the patient does not live a life of suffering, or whether these moments are sufficient to provide the patient a good or happy life, all things considered. Dresser herself recognizes that her argument rests on the assumption that "observers can accurately assess the experiential benefits and burdens of patients with neurological impairments and decreased ability to communicate."[32] Given the stakes involved in this, however, we should expect more than an assumption to ground the voiding of ADs. Until an argument or evidence is provided, we can conclude that the sustenance of a life that features some momentary pleasures, but whose overall quality is unknowable, does not necessarily count as a genuine good, as no directly identifiable benefit is accrued.

Furthermore, we have the patient's AD, which specifically includes a statement of preferences *not* to be given such intrusive care. If it is not a genuine good for the patient, then the state has no obligation to appear to act beneficently by ignoring his or her wishes as expressed in the AD. Indeed, the state has a moral requirement to *uphold* the AD of the Alzheimer's patient. Given all of the above considerations, Dresser's claim that the principles of beneficence and non-maleficence justify the voiding of ADs is essentially unconvincing and unfounded.

The argument from personhood

In the literature on Alzheimer's and ADs, there is a distinction drawn between what is called the "person of a lifetime" (PoL) and the "person of the moment" (PoM).[33] The PoL is the person as consistently constituted in the years and decades before the disease degrades memory and sense of self. The PoM is the individual as existing in the moment-to-moment experience of advanced dementia.[34]

Dresser's second argument against upholding ADs relates to personal identity. It has spawned a wealth of responses.[35–38] In brief, Dresser claims that Ronald Dworkin's precedent autonomy account erroneously assumes and depends upon an unrealistic continuity between persons of a lifetime and persons of the moment.[39] Instead of this being the case, she claims that personal identity degrades throughout the advancement of Alzheimer's to the extent that the PoL is no longer identical to the PoM, and that, therefore, the PoL has no authority over the PoM—as they are now two distinct persons—and that the AD is no longer valid.

Dresser gives the example an individual with dementia who has previously expressed in an AD a desire not to receive special life-sustaining treatment. Dresser claims that there is a rupture in personhood due to the mental degradation caused by dementia and that the PoL therefore no longer exists in the advanced stages of Alzheimer's and the PoM is a new person. The AD, however, only has standing because it is prepared by the same person it applies to. Given this is no longer the case as a result of the identity rupture, the AD loses its moral authority and thus can be disregarded.

However, for Dresser's argument to be convincing, two contentious positions must be accepted: (1) her preferred account of personal identity and (2) Dresser's assessment of the extent to which late-stage dementia threatens the continuity of identity. The literature overwhelmingly focuses on these two claims, with detractors seeking to demonstrate that there is no rupture and adherents arguing that there is. Even though we have a good reason to believe that the claim of identity rupture is false, I will remain agnostic on the question whether the PoL is the PoM.[40,41] Instead, I will argue that standing of the AD does not depend on identity between the PoL and the PoM—it requires only that the PoL has greater moral authority regarding the treatment of the PoM than any other individual or entity involved. As we have a good reason to believe this to be the case, Dresser's objection fails.

Moral authority through psychological continuity

We might consider that ADs are an attempt to answer the following question: *Whose say ought to have the most significant consideration in determining a given patient's treatment?* Views that reject ADs suggest that the determiners should be external stakeholders: family members, doctors, judges, or the state. On the other hand, ADs can be seen as identifying the PoL as the figure with the most significant competence and moral authority for deciding upon the PoM's treatment. This can be the case even if it is granted that the PoL and the PoM are distinct persons. In this case, the PoL would have a more extraordinary claim to legitimacy in deciding upon the care of the PoM than any other person. This is because there is at least *some* element of psychological continuity between the two individuals, given their sharing of a single life.

To see why this is the case, consider a young adult, Person A. This individual will make life-changing decisions regarding their future. This future—according to different accounts of personal identity, such as

Derek Parfit's—might be lived by another person, Person B, as a result of illness, accident, scientific experiments, the ravages of time, or any other potential causes of psychological rupture.[42] Granting the uncontroversial premise that a single life or body can be shared in this sense by two (or more) persons—a view generally accepted by philosophers—it would seem similarly acceptable to assert that such an individual (Person A) is typically taken to have the right to decide how their joint life will be lived—what job they will do, whom they will marry, etc.—even if this life is lived by the other person (Person B).[43] A young adult is allowed to decide upon their life, even if by the end of said life, they might have become a different person.

Most importantly for our purposes, the fact that the PoL and PoM share some psychological continuity means that Person A is taken to have more of a right than anyone else to decide essential matters affecting Person B. Put in another way, Person A shares a life with Person B, and this gives them a greater say on how that life will go than anyone who does not (Person C), because it is *their* life. For example, the spouse or family members (Persons C) of someone who suffers from global permanent amnesia do not get to decide what life they (Person B) will live simply because they are no longer who they used to be (Person A). In such cases of rupture in personal identity, individuals are not treated as blank slates. The legacy of their lifetime is rightfully accorded legitimacy and authority.

One might respond to this point by arguing that if our concern is the legitimacy of a figure's decisions, then surely the PoM's (Person B) judgments ought to have greater legitimacy than those of the PoL (Person A). This is precisely Dresser's claim that the PoM's present desires morally outweigh the PoL's past wishes. In the case of the amnesiac, surely if the person suffering from amnesia (Person B) desires to live a totally different life from who they were before (Person A), then they have that right, and the previous wishes of the latter do not matter.

To respond to this, we must return to the subject of the case: an individual with advanced dementia who has become incapable of making rational judgments or major life decisions. And this is the major difference between the amnesiac and the Alzheimer's patient. The former, despite losing their memory, retains autonomy and cognitive abilities, whereas the latter does not. Given this fact, it is absurd in the Alzheimer's case to assert some sort of disagreement between the PoL and the PoM. The latter is incapable of making the kinds of judgments required to choose whether they want life-sustaining treatment. If the individual is lucid and rational enough to be still capable of making major life decisions, then they are, by definition, still a PoL.

Hence, the question is not whether Person A or Person B has more legitimacy regarding decisions about Person B but rather whether Person A has greater legitimacy than outside third persons to make such decisions regarding Person B. Given that Person A shares a life with Person B and that others do not, it is intuitive that Person A has a more legitimate say as to how this life should be lived.

This principle can be spelled out as follows: A person (Person A) who has psychological continuity with another person (Person B) has more of a legitimate claim to deciding upon their shared life than someone who is not part of that life. In the context of Alzheimer's, then, the PoL (Person A) has more of a legitimate say about the PoM's life (Person B) than any external stakeholders, such as doctors, family members, or judges. Thus, contra Dresser, this argument clearly affirms the legitimacy of the AD as an expression of the PoL's will while not depending on the view that the PoM and the PoL are necessarily the same person.

Two further reasons to uphold advance directives

In the previous two sections, I provided objections against the main arguments often used in favor of the state's right to dismiss or ignore ADs in civil court proceedings. I believe this to be sufficient to conclusively demonstrate the need for legislation that protects the legal standing of ADs, as the onus falls upon those who would justify current practices that do not so respect ADs. In this section, I supplement that argument by offering two further reasons as to why we have a moral duty to uphold ADs.

Dignity and autonomy are critical concepts in bioethics and public health. "Dignity" is defined as the inherent worth that all humans share by virtue of their common humanity. "Autonomy" is defined as the capacity of individuals to make major decisions regarding their lives, free from externally imposed constraints or limitations. These two concepts are interrelated. Beyleveld and Brownsword argue convincingly that dignity is grounded in autonomy.[44] I take this stance for granted in what follows.

Autonomy is foundational in both bioethics and in the American legal system, although it has not had quite as significant a role in public health until the last several decades.[45] Autonomy often appears in public health discussions under circumstances where the rights of the individual might contravene the needs and well-being of the public, as in debates regarding mandatory vaccinations. ADs, however, represent an area where the rights of individuals and public health needs are not in conflict but rather coincide. This is especially true if one considers the interests of public health as consisting of the public's physical health, mental health, and general well-being.

The form of autonomy that ADs protect is called *precedent autonomy*, given that ADs often apply to individuals who presently lack autonomy; respecting their capacity for self-determination means following the directives they set out when they did have autonomy.[46] Upholding ADs, therefore, functions as a means of respecting the autonomy of their makers. This is because they serve as explicit documentation of an individual's desires when he or she still had a full agential capacity. Moreover, doing so respects the patient's dignity, even when he or she is incapable of expressing or acting on a personal conception of his or her existence. When ADs are overridden by judges, doctors, family members, and other stakeholders, this fails to respect the autonomy of the individual, whose own will is disregarded and superseded by that of another.

Possible changes to public policy

The Ninth and Tenth Amendment to the United States Constitution states that matters not explicitly determined as Federal or national responsibilities fall to the states or to the people to decide. Historically, this has been especially true for issues related to health care. Roughly one-third of state constitutions recognize and discuss issues related to health, whereas the U.S. Constitution fails to address the issue at all.[47] Federal legislation has been passed regarding ADs, with the most significant being the Patient Self-Determination Act, which was an amendment to the Omnibus Budget Reconciliation Act of 1990. This legislation required that, upon admission to a healthcare facility, patients must be notified in writing about their decision-making rights and their current state of residence's policy regarding ADs. These notices included the right to facilitate one's own healthcare decisions, the right to accept or refuse medical treatment, and the right to make an AD.[48]

This legislation, however, did not go so far as to guarantee the legal standing of ADs, only necessitating that patients be informed of their right to make them. In the case of Alzheimer's, where the patients can no longer express their will, ADs can be voided at the discretion of a judge in a civil court or by a medical practitioner in a healthcare setting.[49]

Whether people have the right to determine their medical care in their most vulnerable moments is not something that should be left to the vagaries of which state one inhabits. Moreover, if the issue were left to states to decide, citizens could have to deal with 50 different legal frameworks, and conflicts arise over whether an AD made in one state would be honored in another state.

These issues, in addition to our prior considerations, entail the need for a federal protection of the legal standing of ADs, as is the case in other countries such as the United Kingdom.[50] By what means this is to be best achieved—be it through federal legislation, executive order, a constitutional amendment, or a Supreme Court decision—is beyond the means of this paper. What is clear, however, is that in an overwhelming

number of cases, there is no sound moral reason for ADs regarding end-of-life care be overridden. It is a significant failure in public health policy that this is allowed to be the case, as it represents a paternalistic violation of the autonomy of some of society's most vulnerable members, as well as a significant drain on time and resources.

Conclusion

In this paper, I have presented vital objections to two critical arguments offered routinely to justify disregarding ADs created by Alzheimer's patients—arguments which totally fail to justify this extreme position. Beneficence does not demand that the state fail to uphold an AD; if anything, it demands that they do. Furthermore, the legitimacy of ADs need not be based on the continuity of personal identity between PoL and PoM, although we should be skeptical of any accounts that purport to provide conclusive answers regarding the question of personal identity in Alzheimer.

Moreover, given the extent to which upholding ADs respects their maker's autonomy, respect of values, preferences, and dignity, the current lack of binding legal status to ADs represents a moral failure of current public health policy. Indeed, legislation that goes beyond the Patient Self-Determination Act of 1990 ought to be created to protect and preserve the legal standing of ADs. Importantly, this policy does not rest on dubious or unverifiable claims regarding moral principles or the metaphysics of personal identity. Rather, this stance—and its implementation—represents a rare opportunity for common sense, autonomy, and the interests of American public health to all coincide.

Envisioning a future with a HIPAA-compliant AD national registry, we can anticipate a healthcare landscape where nurses and physicians are empowered to adhere to the end-of-life care plans set out by patients. This transformative tool will significantly reduce the moral distress experienced by patients' families and clinicians and lessen the burden associated with making significant decisions regarding end-of-life care. This, in turn, will foster a more positive and supportive healthcare environment. While clinicians are extensively trained in providing medical care to sustain life, the importance of respecting individual decisions to refuse care and decline life-sustaining treatment, concurrent with private personal cultural considerations, is presently underemphasized. Principles and values in end-of-life decision-making should be more prominently integrated into initial and ongoing training in healthcare professionals, instilling a sense of respect for autonomy and enabling a more patient-centric healthcare system to be developed.

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