CHAPTER 8

JUSTICE AND THE ELDERLY

DENNIS MCKERLIE

Ethical concerns about the elderly are usually treated as a matter of justice. This is partly explained by the special status of the elderly in almost all economically developed societies. Public pension systems provide them with financial support, and publicly funded health care programs help to meet their health care needs. Those who are now old will have contributed to these institutions when they were younger, but it remains true that the elderly receive a degree of support from public institutions that the members of other age-groups typically do not receive. This institutional background naturally raises questions about distributive justice. Are the elderly receiving less, or more, than their fair share of health resources and economic wealth?

Moral philosophers have proposed many different theories of justice. However, it is difficult to apply their theories to the elderly. The elderly constitute a particular age-group. They are identified as people in a certain temporal stage of their lives, old age. And philosophical theories of justice are typically concerned with people's complete lives or lifetimes, not with temporal parts of lives. For example, John Rawls's influential account of justice is concerned with achieving fairness between different people's *lifetime* expectations of receiving primary goods (Rawls 1971). Thomas Nagel comments, 'Remember that the subject of an egalitarian principle is not the distribution of particular rewards to individuals at some time, but the prospective quality of their lives as a whole, from birth to death' (Nagel 1991: 69). These theories compare the complete lifetimes of different people to decide whether they have been treated fairly. Because of their broad temporal scope, these theories cannot directly answer the question of whether a person

receives a fair share of income or health care during a particular temporal part of her life.

One response is just to accept that the appropriate temporal scope for a principle of justice is a complete life. I call this the 'complete lives view'. If we make this choice we cannot immediately object to treating the elderly differently from the members of other age-groups, so long as the treatment is maintained consistently over time so that everyone is treated in that way at the appropriate temporal stage of their life. For example, a policy of mandatory retirement could not be automatically criticized as unfair. If everyone at least potentially benefits from the policy when they are young, and everyone faces the same termination date of employment when they are old, the policy will not create inequalities between people's complete lives. The same would be true, for the same reasons, of a policy restricting the use of kidney dialysis to those below a certain age.

However, this does not mean that the complete lives view has nothing to say about fairness and the elderly. Certain ways of treating the elderly might be condemned as unfair because they are likely to lead to people being treated unfairly in terms of their complete lives. For example, many public pension systems—including American social security—have a degree of progressivity built into them. Poorer people contribute less to the institution than better off people, but they receive comparatively greater (although not absolutely greater) benefits in return for their contribution. A possible justification for the progressivity is that it reduces the inequality that would otherwise exist between people's complete lives. So a non-progressive pension system might be regarded as unfair.

Also, someone who holds the complete lives view can give other reasons—reasons that are not a matter of justice—for a particular form of income support or health care for those who are old. Someone who thinks that justice focuses exclusively on complete lives would probably suggest that once the requirements of justice for complete lives are satisfied we should divide resources between age-groups in whichever way would benefit people the most. For example, making a particular form of expensive health care available to the very old will be justified if this use of limited resources improves people's lives more on balance than the alternative policy of concentrating the resources on younger people. According to this view, denying that form of care to the elderly would not be an injustice, but it would be the wrong choice to make.

However, many writers believe that there are distinctive principles of justice for age-groups. For this to be the case, the principles must have a temporal scope other than complete lives. They must make claims about distribution between the temporal parts or temporal stages of lives.

The most influential view of this sort has been developed by Norman Daniels, although many other writers share the same idea and apply it to a variety of questions about fairness to the elderly (see Daniels 1988, 1996; Dworkin 2000, ch. 8; Brock 1993, chs. 11, 12). Daniels calls the theory the 'prudential lifespan account'.

The theory says that the fair social distribution between age-groups should match how a hypothetical prudentially rational individual would choose to distribute the same resources over the different temporal stages of her own life. The elderly deserve, as a matter of justice, the share of resources that prudence would award to the temporal stage of old age in considering a single lifetime.

The theory claims that the distribution established by prudence expresses genuine claims of justice concerned with temporal stages of lives. It differs from the complete lives view in holding that there can be injustice to an age-group even if the principles of justice for complete lives are fully satisfied (for example, even if people's complete lifetimes are perfectly equal). However, the theory does not completely abandon the complete lives perspective. When prudence chooses a distribution over the different temporal stages of a life, its goal is to maximize the quality of the life as a temporal whole. So the distributional constraints that apply to temporal parts of lives are derived from a consideration of a complete lifetime and a concern with maximizing the overall quality of that life. Also, Daniels supposes that the prudential lifespan account operates within the constraint of a theory of justice that is concerned with lifetimes. First we must treat people fairly in terms of their complete lives. When that goal has been realized we turn to the special kind of justice that deals with distribution between the temporal stages of different lives. So the principles of justice focused on lifetimes outweigh the principles concerned with temporal parts of lives if there is a conflict. Finally, since prudence aims at maximizing the quality of a life as a whole, it seems that the distributional conclusions this theory generates will closely resemble the conclusions drawn by the complete lives view if the complete lives view does decide to distribute resources between age-groups in the maximally beneficial way.

Those who appeal to prudence as the test of distributive fairness between age-groups characterize the prudential choice in different ways. Some (Dworkin 2000, ch. 8) allow the chooser to know her own age when the choice is made. Daniels (1988, ch. 3) suggests that the choice should be made behind a 'veil of ignorance'. The chooser should not know her age, her specific needs in terms of health care and other resources, or the goals and values that she will endorse at different stages of her life. She only has generic information about the course that human lives typically take and the health problems that people are likely to face at different ages. The restrictions are designed to rule out bias and to permit a choice made by one hypothetical individual to be used to determine the just distribution over many different actual people who will have different goals and different medical problems.

In principle the prudential lifespan account can provide specific answers to detailed questions about distribution. It is motivated by the recognition that we will not be able fully to meet all of the needs of all people of all ages. Even after we have done as much as we can to ensure that people are treated fairly when we compare their lifetimes, scarcity of resources might force us to choose between,

for example, providing one kind of health care to younger people or providing a different kind of health care to people who are older. The prudential lifespan account sees this choice as involving a distinctive kind of fairness that is concerned with distribution between temporal stages in lives. It tells us that the fair or just choice is the one that prudence would see as the most beneficial to the individual concerned if a parallel choice needed to be made inside one life. The distribution that the prudential lifespan account chooses will have two features that everyone would count as merits. First, it will not create unfairness at the level of people's complete lives because the theory operates within the constraints of principles of justice for lifetimes. Second, the distribution will use the resources being distributed in the most efficient way to produce the greatest amount of benefits taking into account all of the people concerned. The distribution will have that second feature because the theory chooses the distribution between different people that would maximize lifetime well-being in the case of a single person. The distinctive and (I think) controversial claim of the prudential lifespan account as a theory of justice between age-groups is that fairness is simply *identical* to efficiency in the use of resources in the special case of justice between age-groups or justice between the temporal stages of lives. The person who would benefit most from the resources has a claim of fairness to receive them.

When we consider the specific conclusions that writers have appealed to the prudential lifespan account to justify, some seem friendly to the claims of the elderly while others strictly limit the share of resources that they would receive. Daniels suggests that the theory will stipulate that people's incomes during old age should be roughly equal to their incomes at earlier stages in their lives (Daniels 1988, ch. 7). On the other hand, in the case of health care resources, Daniels and others have argued that the prudential lifespan account would recommend (at least under certain conditions) rationing certain kinds of life-extending medical care on the basis of age (Daniels 1988, ch. 5). Some believe the prudential chooser would in general favour ensuring the availability of medical treatment during youth and middle age as opposed to old age (Dworkin 2000, ch. 8), on the grounds that treatment earlier in life would typically have a greater impact on the overall quality of a life as a temporal whole than treatment during old age. Some draw the strong conclusion that the prudential choice would prefer treatment in middle age that was not life-extending to life-extending treatment during extreme old age (Dworkin 2000, ch. 8). And some conclude that prudence would decide not to provide life-extending treatment in old age if the person were suffering from a serious form of dementia (Brock 1993, ch. 12; Dworkin 1993, ch. 8).

Yet other writers are dissatisfied with both the complete lives view and the appeal to prudence (McKerlie 2002; Temkin 1993, ch. 8). Their case against the prudential lifespan account is partly based on the suspicion that its conclusions will sometimes be intuitively objectionable. They think that the theory, if rigorously applied, will tell us to give the elderly—especially those who are very old and very ill—much less

than we feel they are entitled to receive. The severity of the problems faced by such people is precisely what makes it extremely difficult and expensive to promote their well-being. Prudence will recognize this in the case of a single life, and its response will be to concentrate resources in the earlier stages of the life where they can be used more effectively and efficiently to increase well-being. Also, in budgeting resources over a single lifetime prudence will realize that resources set aside or saved for extreme old age have a low probability of actually being used, since the life in question is unlikely to last that long. If this consideration is allowed to influence the prudential choice, it is another reason for favouring the earlier stages in a life. And the critics suggest that we will reject some of the strong conclusions that advocates of the prudential lifespan account themselves draw about health care and the elderly.

The critics agree with the prudential lifespan account that there are constraints of justice applying to temporal parts of lives, as well as to complete lives. However, the prudential lifespan account derives these constraints from a prudential judgement about a lifetime made with a view to maximizing the overall quality of that complete life. The critics think that if people do indeed have moral claims based on the quality of their lives during particular temporal stages in their lives, there is no reason to expect that these claims will be revealed by such a prudential judgement.

Because it is a judgement made about one person's life, the prudential judgement aims simply at maximizing well-being. If we use it as the model for a just distribution across different lives, the view of justice that results will also aim at simply maximizing well-being across those different lives. However, the critics will contend that interpersonal justice—even the kind of interpersonal justice that is concerned with temporal stages of lives rather than lifetimes—does not aim at maximizing in the sense of producing the largest total amount of well-being taking everyone into account. It is more likely that the constraints of justice that apply to old age and the other temporal stages in our lives will be understood by applying some value that is more directly concerned with fairness in distribution—perhaps the value of having a quality of life that at least meets some minimum threshold, or the value of being given priority if one's level of welfare is very low, or the value of equality—to a temporal stage of a life rather than to a lifetime. So these writers propose a theory of justice for age-groups that takes one of these values and changes its temporal scope from a complete life to a temporal part of a life. I will call this kind of theory the 'life-stage view'.

Defenders of the life-stage view should admit that considerations of justice concerned with parts of lives need to be weighed against reasons of justice concerned with lifetimes. Often the lifetime concerns will be stronger. Nevertheless, this view still differs from the prudential lifespan account. Unlike the prudential lifespan account, the life-stage view is not compelled to hold that the lifetime considerations will always be stronger than the reasons concerned with temporal parts of lives.

If we agree with the life-stage view about the temporal scope of principles of justice for age-groups, the next step is deciding which value to incorporate in the theory. The writers who support the life-stage view tend to choose a value that is, in a broad sense, egalitarian. No doubt this partly reflects the widespread sympathy for egalitarianism in contemporary moral philosophy, but the concern that many people feel for the elderly does seem to be egalitarian in its nature. Special institutions for helping the elderly exist because we realize how badly off they would be without them, and we are anxious to spare them from living in that degree of misery.

If it does include a value like equality or priority, the life-stage view can be more generous to the elderly than either the complete lives view or the prudential lifespan account. Since it is focused on temporal parts of lives, it can tell us to help the badly off among the elderly because they are suffering *now*, during their old age. It does not limit their claim to what prudence would have provided for old age in the case of a single life, where prudence is governed by the aim of making that life viewed as a temporal whole as good as it possibly can be.

In considering that single life, the prudential choice might see happiness during youth and extreme misery during old age and then decide to assign more resources to the temporal stage of youth because that would maximize well-being over the life as a whole. When this intrapersonal judgement is transferred to the interpersonal case of comparing the current lives of a well-off younger person and a badly off older person, the judgement would recommend helping the younger person to become even better off because she is the one who can be helped the most. A view that applies equality or priority to the temporal stages of different lives would resist that conclusion. It would compare the current state of the elderly person's life and the current state of the younger person's life and think that because the older person is worse off there is a reason for making them more equal now, or a reason for giving priority to helping the older person. We might decide in the end that this consideration is outweighed by considerations of fairness dealing with lifetimes, or simply by the greater size of the benefits that the younger person would receive, but the reason would still exist.

The value of priority seems to be especially relevant to the elderly. The general notion of priority holds that benefiting a badly off person should be given a certain amount of priority over benefiting a person who is better off. Consequently, a smaller benefit for someone badly off can be more important than, or have more value than, a larger benefit for someone better off (the general notion of priority is explained in Parfit 1995). In the case of the elderly we think that the case for helping them is strongest when they are very badly off in the absolute sense, as well as being worse off than other people. We sometimes feel that we should attempt to do what we can to improve their lives, even if the resources that we devote to them could be used instead to make a greater improvement in the lives of other people. When we apply the notion of priority in the context of the life-stage view, we think that

their needs should be given priority because they are worse off than other people now, considering the current state of their lives. They might not be the people who would count as the worst off if instead we compared people's complete lives.

A particular kind of priority has been regarded as a relevant consideration in the distribution of health care, apart from the debate between the three general approaches to justice between age-groups that I have described. When health resources are scarce, some people think that there is at least an apparent case for giving the health care to the person who needs it most. This person receives priority not because the quality of her life is in a general way worse than that of others, but because her medical condition is the most severe and the most urgent. There is disagreement about whether this reason can be strong enough to resist, at least sometimes, the consideration of efficiency, which tells us to distribute the medical resources to the people who will be helped the most by them so that we will produce the best outcome.

Many writers have explained the criterion of efficiency, and applied it to specific choices that arise in medical practice. Less attention has been given to criteria that might compete with efficiency, including that of medical priority. However, Frances Kamm has defended the importance of the criterion of priority (which she calls 'urgency') in an especially detailed and thoughtful way (Kamm 1993, sect. III).

This issue arises independently of concern for the elderly. Nevertheless, the elderly will frequently be among those the criterion of priority or urgency would favour. Their health care problems are frequently more serious, cause more suffering, and are more debilitating. Often they would count as the worst off in the particular respect of illness. And it will often be the case that the criterion of efficiency would support offering the health care to someone else. Because of their age, and the nature of their problems, we would not achieve the best possible medical outcome by choosing to help them.

In these choices there is a conflict between producing the best outcome and the criterion of priority. Writers about biomedical ethics seem typically to favour the criterion of efficiency. Perhaps this is due in part to the influence of a basically utilitarian moral outlook. The prudential lifespan approach also supports this answer in the end. However, an appeal to priority would at least provide a countervailing reason. There is also a case for helping the individual who needs help the most, even if this person can be helped less. If we agree with Kamm, we will see the choice as one where we must decide between competing ethical reasons that both are important and represent different kinds of moral concern.

Apart from being worse off in a general way in terms of overall well-being, and being worse off more specifically in terms of their health problems, there is another respect in which the elderly are typically worse off than other people. They stand nearer to death than others. Old age is the final temporal stage in a life, and this fact might be thought to have ethical implications.

One implication again concerns the distribution of health care resources. Institutions providing health care are compelled to choose (in distributing existing resources, and at a higher level in terms of the resources that it chooses to create) between providing life-extending treatment to the elderly and important but not life-extending health care to younger people. The latter treatment does not prevent or postpone death, but it does make a person's life better than it would otherwise have been for a certain temporal period of the life. The former treatment does prevent death, but when the treatment is provided to someone very old, death may only be briefly postponed and the quality of life during the remainder of the person's life may not be high.

Which choice should we make? To answer this question some would only consider the gain in terms of welfare that would result from each choice. In some cases, the younger person would experience a larger gain in well-being from her disease being cured than the elderly person would receive as a result of her life being extended. Then the right answer would be to treat the younger person. A theory that uses a prudential choice about a single life to answer this question would arrive at the same result.

Others would find this conclusion disturbing. They feel that it underestimates the significance of death to weigh its importance simply in terms of the amount of well-being that the person in question loses by dying. They might claim that it can be more important to delay one person's death than to improve someone else's life, even if the second option would produce a greater gain in terms of well-being. For this view to be defensible, it must be subject to certain conditions: the postponement of death would have to be for a significant period of time, and the life the person led during this period would have to be of an acceptable level of quality.

Deciding between the two views requires considering the difficult question of whether death counts as a harm or evil, and if it does, what kind of a harm it is. We need to answer the second question if we are to weigh death against other harms that people can suffer, like the harm caused by a debilitating but not life-threatening illness. There is a substantial body of philosophical literature focused on these questions (see Nagel 1979; Kamm 1993, sect. 1; McMahan 2002, sect. 2). Most writers support some version of the so-called 'deprivation view', which maintains that the badness of death, and so its gravity as a harm, is simply a matter of the good that it deprives the person of (this is true of Nagel and McMahan). However, some think that the special nature of death as a harm is not completely captured by regarding it as a loss of welfare (Kamm). If this view is correct, then the idea of priority might apply in another way to the elderly. We might think that preventing the harm of death should be given a certain amount of priority over preventing the harm involved in illness, because death belongs in a different category of harm.

Another fact about ageing raises both theoretical and practical problems in deciding what we owe to the elderly. People's goals and values change during their

lives. In the case of most of us what we want and strive to achieve during our middle years will differ significantly from our most important concerns when we are old. There are some characteristic differences between the aims of middle age and the aims of old age, although we should not expect to find those differences in every life. The differences in goals and values will be more striking when extreme old age is accompanied by failing mental powers or some degree of dementia.

Changes in goals need to be taken into account when individuals make decisions that will affect their futures when their values may well be different. These changes also must be taken into account when society makes distributive choices about age-groups. This is especially so if we accept a view like the prudential lifespan account which uses a prudential decision about a lifetime as the criterion of fairness to the elderly. However, even if we endorse a different account of justice between age-groups, we might have to choose between satisfying the plans that younger people have made for their old age and helping them to achieve the goals they will actually have when they are old. This choice will be particularly difficult if we think that the goals they will aim at when they are old will be less valuable than their earlier objectives for their final years. It might seem unfair not to provide them with the kind of old age that they would relish while they lived it, but it might also seem unfair not to be guided by their own best judgement about how their lives should end.

The problem of changing goals is easier to consider in the case of a choice by an individual. What should a rational person do when a choice he makes now will significantly affect his old age, and he knows that the goals that he holds now are ones that he will reject when he is old, and that the projects he will endorse when he is old are ones that he cannot acknowledge now as having value?

One radical view is that changes in goals and values, and the other psychological changes that occur during our lives, are so fundamental that we should (although common sense does not) question whether it is really true that I am one and the same person in my youth and my old age (Posner 1995, chs. 4, 10–12). If we were to accept this suggestion, it would fundamentally change our understanding of our own lives and fairness to the elderly. Distribution across the different temporal stages of one life would then be appropriately viewed as morally equivalent to distribution between different people, and our views about justice between age-groups would have to be revised accordingly.

I will assume that this view is too extreme, except perhaps in the case of people suffering from extreme dementia when we might literally challenge the application of the notion of personal identity. A more moderate view claims that identity as such is not what matters for rationality and morality. The application of moral values and concepts of rationality depends instead on relations of psychological continuity and connectedness between the different temporal parts of a life. This continuity will vary in strength in an ordinary life, and we should take this into account in deciding what attitude it is rational for a person to take towards his old

age and in making moral judgements about temporal stages in lives (such a view is defended in Parfit 1984, pt. 3, and it is applied to moral issues about the elderly in McMahan 2002, sect. 5).

However, I think myself that the variations in continuity over time in an ordinary life are not important enough to be a significant factor in understanding our moral judgements and judgements about rationality. And I believe that judgements that we do make that might seem to support this view can be explained as responses to other considerations.

Even if changes in character and values do not involve a breach of personal identity, or a serious weakening of the psychological relations that supposedly underlie identity, they do seem to be important for their own sake. How should we respond to them? Should I make provision for my pursuit of the goals I will hold when I am old, despite my current rejection of them? Or if there is something I could do now that would lock me into the kind of life in old age that I now think desirable, would it reasonable for me to make this choice despite my knowledge that my mind will change?

This issue has been discussed in a theoretical way by moral philosophers without reference to its application to ageing (see Nagel 1970, ch. 5; Parfit 1984, pt. 2; Bykvist 2003). Three responses to it have been defended. The first claims that a reasonable person should make the present decision on the strength of his present goals and values, since those are the values that he is now committed to and believes to be valid. According to the second view, a reasonable person should decide on the strength of his future goals and values, since they are the ones he will accept when the effects of his choice on his own life will eventually be realized. The third view claims that a reasonable person should make the decision by taking both sets of values into account and giving them equal weight. He should be neutral between the conflicting values.

The version of the prudential lifespan account that permits the prudential choice to be made by a young person who is aware of his present goals seems to choose the first answer. The other version of the theory appeals to a choice made by a hypothetical individual who does not know either his present or his future goals. This seems to me tantamount to requiring neutrality between present and future goals, and so amounts to a variation of the third answer.

All three answers suppose that some attitude towards the importance of time itself is distinctively rational. The first view thinks that because of the special importance of the present, it is present values that matter for a decision that will be made now. The second view thinks that in assessing a change in the future, it is future values that matter because they are the values that you will hold when the change happens. This view also gives special significance to the present, but it identifies a different present as being relevant to the decision—not the time that is the present when the decision is made, but the time that is the present when the consequences of the decision will occur. The third view holds that rationality

requires us to adopt temporal neutrality, to give equal weight to all times, and it supposes that this means we should also give equal weight to the different values that we hold at different times.

I think that we should have reservations about accepting any of these answers. They all conflict with the belief that some goals and values can be objectively more important than others. If we agree with that belief, we cannot be satisfied with the claim that we should only use our present values whatever they are, or only our future values whatever they are, or that we must automatically give equal weight to both sets of values. If I am right, this would be another consideration that counts against the prudential lifespan account, which is committed to the first or the third answer.

Arguably the best answer to the problem of changing goals is reached by thinking in terms of an agent's well-being. If the agent decides on the strength of his present values then he will not approve of the change in his life when it happens, because he will then hold different values. And if he will not positively respond to the change, this will affect his well-being in the future or the quality of his life in the future. This gives him a reason to take his future goals into account now, even if they are objectively less valuable than the goals he now holds for his future. This suggestion appeals to what might be called the 'positive response condition' on well-being, an idea that has been adopted in one version or another by several recent writers on the nature of well-being (for examples, see Dworkin 2000, ch. 6; Darwall 2002, ch. 4).

The point is not just that the person will feel less contentment if his life has been designed according to standards he used to endorse but has subsequently abandoned. That is the aspect of well-being that depends on hedonic goods. Some believe that the positive response condition can also matter in a different, and perhaps more important, way. They think that endorsing an activity that you perform enhances the value of the activity so that it makes a greater contribution to the quality of your life. A significant artistic achievement might increase the well-being of its creator even if she herself does not value what she has produced or her own actions in producing it. But it will do more to enhance the quality of her life if she herself appreciates what she has done. On this view, there are two factors to consider in deciding how much the activity will contribute to her well-being: the objective value of the activity, and whether she will endorse the activity when she performs it.

The condition applies to choices that we must make about our future selves. A creative writer might correctly think that the most valuable goal she could pursue in old age would be to preserve her legacy as a writer. When she can no longer produce new fiction she can at least lecture on university campuses, prepare new editions of her works, and mentor young writers. Still, suppose she knows that when she is old she will instead think—wrongly—that relaxing with television, games, and socializing is more important. If her interest is in making her old age go as well as possible, she has a reason for planning her old age to fit the values that she will hold

when she is old. The objective value of golfing might be less than the objective value of helping young writers, but if she will positively respond to the former activity, but not the latter, playing golf might contribute more to her well-being.

It may seem that the explanation in terms of well-being is identical to what I originally called the third solution to the problem of changing goals. The goals that matter are the goals the person holds at the time of the event or change in his life that we are evaluating. But the two views are not the same. The well-being view does not claim that because of the special importance of the present we are rationally required to evaluate the change in terms of the goals that the person holds when the change occurs. It explains the relevance of those goals in terms of the positive response condition on well-being, not in terms of the rationality of a particular attitude towards time itself. And the well-being explanation is compatible with the thought that if the person's present goals are less valuable than his past goals, it might be better for his present life to match his past goals, despite the positive response condition.

It has been suggested that younger people tend to disvalue or disparage the characteristic goals of old age. If so, the view that I have explained gives them a reason to change their attitude. However, it is an advantage of the view that it can lead to respect for the goals of the elderly even if we are willing to admit (as I believe many elderly people themselves would) that these projects are not as objectively important for the value of a life as the characteristic goals of middle age.

There is another way—a sadder way—in which changes of goals are relevant to the ethical treatment of the elderly. The very old are sometimes afflicted by severe mental disabilities. The problems can take many different forms and arise in very different degrees of seriousness. The most tragic cases involve dementia, more specifically Alzheimer's disease in its moderate and extreme forms. The frequency with which this disease attacks the elderly, and the increasing number of people who will live long enough so that it will pose a serious threat to them, mean that coping with the illness is now and will continue to be a major issue of public health.

The illness affects characters and minds in complex ways. Impairment of short-term memory, or rather the loss of the capacity to convert short-term memories into long-term memories, is the most familiar symptom, but radical changes in personality and deep cognitive impairments of other kinds are also experienced in more severe cases.

One aspect of the problem is whether we should believe that the most problematic cases involve a change in a person's goals or values at all. Some believe that in the worst cases the sufferer has become incapable of having goals, of having interests that take the form of valued projects rather than unreflective or automatic desires. And some believe that the afflicted person can no longer be regarded as an autonomous agent with the ability to control her life, and so cannot be regarded as possessing a moral claim to be left free to make her own choices about her own life.

If this picture is correct, it obviously has profound consequences for how those who suffer from these diseases should be treated. It might lead us to give broad decision-making powers over their lives to relatives or medical personnel. If the patients had settled goals before their illness and had then expressed their wishes about questions that might arise later in their lives, it might lead us to give authority to their past decisions, even if there is some apparent evidence in their current behaviour that they are now of a different mind. And some would argue that if they lack autonomy and the capacity to hold values, this limits the value that would be gained (meaning value for those suffering from the disease themselves, not value for others) by a prolongation of their lives in a state of dementia. Here some conclude that we should not save their lives if they acquire a life-threatening but curable disease, especially if there is an advance directive from their earlier self requesting this lack of treatment. They would stand by this conclusion if the person seems placid and contented in their present state, and is not experiencing any pain or emotional distress.

Sorting out these issues requires both settling difficult factual questions about precisely what capacities the people in question have and do not have, and answering broader ethical questions about the nature of autonomy and the source of its value, and about what if anything is special about endorsing something as a value as opposed to merely having a desire. This makes worthwhile and sensitive work on the problem very difficult indeed, but a number of writers have made valuable—though conflicting—contributions.

Ronald Dworkin defends the strong thesis that a person afflicted with moderate or extreme Alzheimer's disease lacks an autonomous will (Dworkin 1993, ch. 8). If before the onset of the disease she wished that her life would end without a final stage of dementia, that choice must be regarded as remaining in place as her standing will and it should determine what medical treatment she receives. Dworkin grants that the person can enjoy the circumstances of her limited life with the disease, and that if she experiences contentment, this counts as a good for her. Dworkin characterizes this as satisfying her experiential interests. However, he believes that the disease has rendered her incapable of holding values and applying them to her own life. She cannot form evaluative beliefs about her life as a whole—beliefs like her former view that her life would be better without the final state of dementia. So Dworkin considers her incapable of having what he calls 'critical' interests. Or rather he believes that her past evaluative beliefs, including her view about how her life should end, are still in force and constitute her present critical interests. Since Dworkin thinks that critical interests are more important than experiential interests, he thinks that allowing her life to end is in her best overall interest. According to Dworkin, the two considerations of implementing the patient's will and doing what is best for her both support the conclusion that we should not provide her with life-extending medical treatment.

Dworkin's critics contest his view of the capacities of such a patient (Jaworska 1999; Shiffrin 2004). They think that in the Alzheimer's sufferer who is undeniably contented, we can discern something that deserves to be called a desire to go on living, even if she is no longer capable of thinking about her life as a temporal whole or capable of articulating her desire to others (at least they believe this about many sufferers from moderate Alzheimer's disease and perhaps some patients with extreme forms of Alzheimer's—they might concede that Dworkin's view does fit the most extreme cases). And some also believe that when this desire is present it should be respected as representing her will. So they think that her will has changed, has taken a new direction, as a result of the disease. Respect for her autonomy should motivate us to implement what is in fact her current will, not what her will used to be.

They also think she is capable of more than being pleased by her current experiential states. Her present interests are partly determined by values that she does hold now. In other words she possesses critical interests as well as experiential interests, and the critical interests that now belong to her might differ significantly from those she held before the disease. If she finds value in the conditions of her new life, these critical interests will support the continuation of her life. In effect the Alzheimer's patient has undergone a change in her critical interests or values. Those who see the patient in this light will be tempted to think that what is in her best interest is determined by her new critical interests as well as her experiential interests, but not by the critical interests that she held in the past. So they would think that providing her with the medical treatment that will prolong her life is really what is best for her.

It is not easy to decide between the two views. Most of us will be disturbed at setting aside the careful provisions that the person made, when her mind was clear, for just this eventuality. But we will also be disturbed by not offering life-extending treatment to a person who is now contented with her life and wants it to continue, even if she had previously wished not to live a life of that sort.

Perhaps the issue about autonomy can be answered, assuming that we agree that the patient should be credited with an autonomous will that has as one of its objects the continuation of her life. She now wishes to live, and it seems to me that her wish should be honoured. Since her new will takes the direction it does partly because of the damage the disease has done to her, we might think that her new will is less reasonable—objectively less reasonable—than her previous will. Still, the value of autonomy counts in favour of respecting a person's wishes—meaning by this the person's current wishes—even if they are less reasonable than her past objectives and even if respecting them would be against her best interest. As a value, autonomy seems to operate in this 'present tense' way. Perhaps we would not respect a person's current wishes if their will was grossly irrational, or disastrously opposed to their best interests. But this does not seem to be true of the Alzheimer's patient. Given her condition, it is not grossly irrational of her to want the life she

enjoys to continue, even if we think that it is against her interest for reasons that she can no longer understand. If we accept these ideas, we will feel obligated to provide the life-extending medical treatment on grounds of respecting autonomy, regardless of how we may answer other questions about her condition and interests.

However, we might not find as ready an answer when we turn to the question of what would be in the patient's best interest. Our judgement about the patient's good might differ from our judgement about her autonomy, because autonomy and considerations about a person's good are different moral reasons that might work in different ways. In considering the Alzheimer's patient's best interests, the crucial thing is the status of the critical interest represented by the patient's past conviction that her life would be better if it ended without the postscript of a period of dementia. Does this conviction still apply to her life after she has been changed by the disease in precisely the way that she feared?

On the one hand, it is clear that she no longer explicitly adheres to the conviction. We can suppose that she could not even begin to understand this belief if it were expressed to her. And I would agree with Dworkin's critics that she may now have other interests, no doubt of a much simpler sort, that nevertheless count as critical interests because they involve a kind of valuing—for example, her desire for the company of individuals who love her, even if she might be uncertain of their identities or their role in her past life. Some would conclude that her critical interests have simply changed. The critical interest that Dworkin appeals to has been replaced, and it should not be applied to an assessment of her life with the disease. It is not relevant to a judgement of the value or quality of that life, or in deciding how much well-being she can enjoy. If we think of the change in the patient in this way we will suppose that her life will be better if it continues, so long as she is contented and the limited but important interests that she still possesses are satisfied.

This is how we react to a self-conscious change of values during an ordinary life. We appeal to the person's new values, not to the supplanted values, to determine what is in the person's best interest from now on. We do this even if we think that the new values are less reasonable than the old ones, or that the person changed his mind for bad reasons.

However, this comparison should lead us to challenge the view. The patient did not change her mind, her mind was changed by the disease. She did not reconsider the question of the shape she wanted her life to have and then decide (perhaps for inadequate reasons) that the years of dementia would not after all make her life worse. Rather, the disease took away from her any capacity to even think in those terms. The cause of the change in her—Alzheimer's disease—is a disease or impairment, a condition that does not merely initiate changes in a non-rational way but destroys valuable abilities and damages its victim. In fact the person did not change her mind at all. In virtue of that, it is not clear that the old critical interest

fails to apply to her current life. Arguably it remains one of her critical interests, although she is now unable to understand or express it.

The point is easier to see in an example that does not involve deciding whether to save a life. We can suppose that the Alzheimer's sufferer had lived as a devout Roman Catholic until the disease destroyed her ability even to think in those terms. Perhaps in her final years she took pleasure in the cheerful non-denominational religious services in the nursing home. Her appreciation of them might amount in its own way to a critical interest, but I think we would feel that when her life ends she should be buried according to the rites of the Roman Catholic Church, not with a simple service in the nursing home. In this example, her previous critical interest has not been supplanted by the new one, and it continues to matter in determining what would be in her best interest.

If we agree, then this interest must be taken into account in deciding what would be best for her. It is true that it must compete against the 'new' critical interests and experiential interests that might support enabling her life to continue. But it should be remembered that her own view, before the disease took hold, was that this critical interest was more important than whatever good she might be able to enjoy in the state of dementia. Her new critical interests do not include a revised view about the question of respective importance. So we might be led back towards Dworkin's conclusion that a peaceful death is what is really in her best interest, although we are not basing the conclusion on Dworkin's reasons.

However, this tentative conclusion should not lead us to withhold the treatment if we also believe that the patient's will is that her life should continue. As I have suggested, thinking about autonomy is different from thinking about what is in her best interest. I believe that her new will does supplant and replace her old will, even if her will changed because of the cognitive damage the disease did to her. By contrast we should conclude that her original critical interest was not simply replaced by her new critical interests, when we consider why her interests changed. The old critical interest still applies to her, with at least some degree of force, in her altered condition.

Consequently those who find it unconscionable to withhold treatment in such a case should appeal to autonomy. This means being convinced of two things: that the Alzheimer's patient does currently possess a will capable of some degree of autonomy, and that her will is directed at the continuation of her life. Some might grant the first but question the second. They might argue that because of her cognitive impairment she cannot be said to have as an object of her will something as complex as the prolongation of her life, even if it is true that she is living happily in her current state. According to this view we cannot be accused of frustrating her will if we withhold the medical treatment. If we agree then, as I understand the applicable reasons, we might after all be forced to the conclusion that the treatment should not be provided, assuming that we have decided that it would be against her best interest.

I have discussed a series of issues that I believe involve a special kind of justice holding between the young and the old. Even if we agree that there is a distinctive problem of justice concerned with age-groups, we should also acknowledge that it differs in a fundamental way from justice between different races or different genders. At any given time, the age-groups of the young and the elderly will contain different people, but those who are now old were once young, and those who are young now will eventually be old. So the young should not understand a view about the claims of the elderly as simply a proposal about how they should treat someone *else*. In time that view will determine their own claims. The issues I have discussed—issues about distributing health care and other resources fairly and issues about deciding which goals and values to respect when they differ in significant ways at different times in a person's life—are ones that we will experience from both sides.

The difficult question for moral philosophy to answer is whether there is a way of giving the proper weight to this fact without retreating to the complete lives view and concluding that justice is only concerned with complete lifetimes. The prudential lifespan account responds to this fact in a distinctive way. When a young person views an elderly person, he sees someone who used to be young and someone who is now in the stage of life that he himself will eventually occupy. It is as though he is seeing himself in old age. According to the prudential lifespan account, this makes it fair for him to decide what if anything he now owes to that elderly person by thinking about a single life containing both youth and old age and asking how prudential rationality would divide resources between those two temporal stages. The single life can stand in for both his own complete lifetime and the elderly person's complete lifetime. The result of the theory will be the distribution of resources that would maximize the well-being of the single life considered as a temporal whole, and I have tried to describe the apparent advantages and the apparent disadvantages of this solution to justice between the young and the old.

However, that might not be the only way of responding to the fact that we all have lives that over time will contain the different temporal stages. When the young person sees that the elderly person is experiencing misery now, he may think that there is a reason to help, even if the resources that he contributes would create a larger amount of well-being were he to use them himself. This reason—if we are willing to suppose that it might exist—would naturally be expressed by a value like equality or priority applied to temporal stages in lives.

Critics will object that we will only see this reason—or think that we see it—if we mistakenly regard this choice as a simple choice between the welfare of two different people in exactly the same way that a choice between two members of different races would be a choice between the welfare of two different people. I am not persuaded by their claim. I think the choice is concerned with interpersonal justice, even if it is not exactly the same as a choice between the members of different

races. When the young person views the elderly person, he sees someone else living in a distinctive temporal stage of a human life.

Moreover, I also believe that if we see the reason for helping when we compare the current life of the young person and the current life of the elderly person, it might lead us to change our mind about the prudential choice made about a single life. A concern like that of priority might apply inside lives as well as across lives. If I recognize that my own old age will contain the same kind of misery that the elderly person feels now, I might decide that it would be better to alleviate some of my future suffering even if some other choice would maximize the total amount of well-being in my lifetime.

Applying the value of priority to my own life does not require thinking of my elderly self as being virtually a different person. I am not suggesting that we should appeal to a view about personal identity or a view about the extent of the psychological unity of a human life over time in order to justify this way of using priority. The basic thought is that a benefit is more important when it is received by someone who is badly off, as it is in the case when we apply priority to a choice between benefits for different people. However, if this proposal is reasonable, it reverses the order of explanation of the prudential lifespan account. Instead of learning what fairness requires between the temporal stages of different lives by considering a prudential assessment of the diachronic temporal stages in one life, we might begin by considering how resources should be divided between the simultaneous temporal stages of different lives and discover something about the best way to allocate resources inside our own lives.

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