

The implications of identity-relative paternalism

Dominic JC Wilkinson^{1,2,3,4},

Affiliations:1. Oxford Uehiro Centre for Practical Ethics, Faculty of Philosophy, University of Oxford, UK. 2. John Radcliffe Hospital, Oxford, UK 3. Murdoch Children's Research Institute, Melbourne, Australia, 4. Centre for Biomedical Ethics, National University of Singapore Yong Loo Lin School of Medicine, Singapore.

Correspondence: Prof Dominic Wilkinson, Oxford Uehiro Centre for Practical Ethics, Suite 8, Littlegate House, St Ebbes St, Oxford, OX1 1PT, UK. Tel: +44 1865 286888, Fax: +44 1865 286886 Email: dominic.wilkinson@philosophy.ox.ac.uk

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I am grateful to the commentators for their thoughtful engagement with my paper.[1] I am unable in this short response to reply to all of the important questions raised. Instead, I will focus on the practical application of identity-relative paternalism. Some commentators felt that this novel concept would yield implausible implications,[2] others that it would have no impact because of uncertainty,[3] or because existing ethical principles would yield the same conclusion.[4]

In the paper, I proposed the following principle:

Identity relative paternalistic intervention (IRPI): Individuals should be prevented from doing to future selves (where there are weakened prudential unity relations between the current and future self) what it would be justified to prevent them from doing to others.

What sorts of intervention might fit under this principle? Garstman et al give the example of living kidney donation.[2] They imagined 'Beth', who altruistically decides to donate a kidney to a third party. Beth's decision would mean that a future Beth_{T2} would be deprived of a kidney, be at risk of immediate perioperative complications and would be at (somewhat) higher risk of long term health complications including renal failure. But they argue that we would be justified in preventing someone from inflicting such harms on a third party (eg we should stop someone from stealing a kidney). Hence, they claim that identity relative paternalism would rule out living kidney donation.

However, this conclusion is mistaken for several reasons. The first is that the psychological harm of stealing a kidney is considerable. Even if future Beth regretted her decision to donate, there is no reason to think that would be comparable to the trauma of waking up to find a kidney removed without consent. Second, we do not have reason to think that living kidney donors are usually harmed by their decision to donate. Most do not have medical complications. Ninety-six per cent of Swedish altruistic kidney donors were very satisfied and would donate again if possible; many reported increased self-esteem and happiness after the donation.[5] Only 2% of donors in a large US series regretted their decision.[6] Third, Garstman et al combine both short and long-term risks of kidney donation. However, the short term risks would be experienced by a future Beth who is closely psychologically connected to the Beth who consents to donation. It is only the longer-term complications (which are less common) that would be experienced by a future version of Beth who we might think of as more akin to a different person.

We could change the example in a way that is relevant. Imagine that during work-up for her kidney donation, RiskyBeth is found to have a medical illness that puts her at high risk (>80%) of developing renal failure in 10-20 years if she were to donate a kidney now.¹ Would it be justified to stop her from donating? In fact, existing guidelines in relation to living kidney donation are highly conservative; they frequently exclude potential donors with medical conditions that increase even by a small degree the risk of complications of donation (for example, donors who are overweight or have diabetes). In a recent paper, Weightman and colleagues have argued that such exclusion criteria are unjustifiably paternalistic, and should be liberalised.[7] But Weightman et al accept that transplant programs should still exclude donors like RiskyBeth who are at high risk of complications. How might we justify this? If the harm is great enough or sufficiently probable, we might

¹ Imagine that this is an illness that does not affect the viability or longevity of her donated kidney.

think that conventional paternalism would be justified. However, an alternative would be to draw on identity-relative paternalism. If RiskyBeth were to donate her kidney, the future RiskyBeth who would experience the harm of renal failure will potentially be sufficiently psychologically distant to be more like a different person. As Saunders points out, we could either claim (as I do in the original paper) that this makes paternalism more easily justified, or we could claim that this is not actually paternalism.[8] (One interesting implication of the view that I have defended is that we have more reason to refuse an intervention if the harm will occur in the distant future (eg 10-20 years), than if it would occur in the near future (eg 1-2 months).²

In the original paper, I pointed out that even if harm to the future self is more like a case of harm to a third party, there are limits to the steps that we would be justified in taking. One useful allied principle may be the ‘duty of easy rescue’. This is the idea that individuals are morally obliged to take steps that involve small sacrifices or cost where the benefit to a third party is large.[9] If we use such a threshold, that may help us to identify which interventions are justified to prevent harm to future selves. For example, foregoing living kidney donation (to prevent certain future renal failure) would potentially count as an easy rescue. The burden for RiskyBeth of not being able to donate would be small. However, the opposite – forced kidney donation, would be a ‘difficult’ rescue, and therefore not morally obligatory to prevent harm to a third party or (hypothetically) a future self. As I noted previously, vaccination would arguably count as an easy rescue.

Rebecca Dresser, in her thoughtful commentary, drawing on her own illness experience, suggests that vigorous argument and persuasion “are perfectly appropriate”, though imposing interventions against opposition is rarely justified.[10] If we set aside compulsory treatment as not usually an example of ‘easy rescue’, it is worth noting that sometimes argument and persuasion (or other forms of decision-influence including ‘nudging’) are also viewed as problematically ‘paternalistic’. For the reasons given in the original paper – identity relative paternalism might help us respond to such concerns.

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² This conclusion is counterintuitive, but it is important to control for several confounding factors. The first is uncertainty. Typically, we are more uncertain about harms in the further future than the near future. Secondly, harms in the near future will often be exerted over a longer period of time eg yielding more years of renal failure/need for dialysis etc. Third, sometimes harms will be greater if experienced earlier in life than later (eg because they will disrupt careers/education/family life to a greater degree). If we control for all of those variables, the implication that self-inflicted far future harms are more ethically significant than near future harms becomes more plausible.

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