

## Dissolving the “Other Person” Problem

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### **ABSTRACT**

Recent medical advances in detecting genetic dementia allow individuals diagnosed with prospective dementia to prepare for their futures as dementia. Typically, planning takes form in an advance directive, which allows prospective patients to detail their health care decisions in case of loss of capacity for consent. However, the validity of advance directives for dementia has recently come into question through what is known as the “other person” problem. The “other person” problem claims that advance directives should not be considered binding or valid in situations where the dementia patient seems to be a different person than the author of their advance directive: what right can one’s plan for oneself have to guide the care of another individual? Those seeking to defend the validity of an advance directive have mainly sought to establish a robust metaphysical theory of identity which can account for personal identity persistent through dementia onset. In light of the demonstrable failures of these approaches, I argue that there seem to be consistent moral intuitions already held in many applied ethical cases which, when mapped onto the case at hand, suggest that advance directives should be considered valid. In this way, this paper argues that it is a mistake to think that the continuity of personal identity is necessary to establish the validity of advance directives, and seeks to dissolve the “other person” problem.

### **KEYWORDS**

Advance Directives, Alzheimer’s, Applied Ethics, Dementia, Ethics, Future Planning, Identity, Personal Identity

### **PUBLICATION DETAILS**

A previous version of this paper was published as Dalrymple-Fraser, Charles. 2014. “Eliminating the ‘other person’ problem for advance directives.” *Mindful* 6: 68–91.

This paper has four sections. In section one, I introduce the “other person” problem for dementia. In section two, I indicate how our predominant intuitions in other applied ethical cases seem to map onto the case of dementia and advance directives, and suggests that validity may be constituted in the coherence of our current practices and intuitions. In section three, I respond to a few objections to the project at hand. Finally, I offer a brief conclusion in section four.

## **1. DEMENTIA AND THE “OTHER PERSON” PROBLEM**

As a result of medical and technological advancements, more young individuals are being offered the opportunity to know, and the chance to prepare for, their possible futures as patients of dementia. One way for individuals to prepare for their futures as dementia patients is to draft an advance directive. Advance directives are legally protected documents which detail the wishes of a person toward their health care, in case of an event in which they have lost their capacity to make decisions. Advance directives are becoming increasingly legally—or “quasi-legally”—binding in many countries and can work to ensure that a patient’s wishes and autonomy are respected, even when they are incapable of decision making (Burnette and Heck 2012; Epstein 2007). Accordingly, advance directives offer a unique opportunity for future dementia patients, in that an advance directive allows them to determine their own health care without placing faith in and a burden on surrogate decision makers. However, with an increasing number of individuals turning to advance directives, there has been a corresponding increase in attention to whether advance directives ought to be considered valid for dementia patients.

In particular, concerns are raised as to whether the person receiving treatment in accordance with the advance directive—the moral patient—is necessarily the same person who details the advance directive—the moral agent. Indeed, radical change is a hallmark of dementia, with many patients suffering from: (i) memory impairment; (ii) changes in character; (iii) aphasia, apraxia, and agnosia; (iv) disturbances in executive functioning; and (v) significant impairments in social and occupation functioning (DeGrazia 1999). If it is possible that the moral agent is a numerically distinct person from the moral patient, then it becomes difficult to see whether advance directives for dementia patients should be considered valid.

This is the “other person” problem: the concern that an advance directive is invalid if there is no continuity of identity between the moral patient and the

moral agent. If the moral agent is not the same person as the moral patient of their advance directive, it is not clear that the agent should have the right or ability to make decisions for that patient, let alone that their decisions should be able to override the decisions of the patient. Yet, we retain an intuition that a person told that they will develop dementia should have a right to make decisions for what appears to be their future selves. Indeed, it seems odd that a future dementia patient can give power of attorney or otherwise have a surrogate decision maker, whose is able to make decisions on their behalf when they are suffering from dementia, but that a future person cannot themselves make decisions toward such future states. Granted, there is a distinction to be made between a surrogate decision maker and an advance directive, in terms of the ability of the former to react to different situations, but it is not clear that an advance directive is not capable of providing a rigorous anticipation of different events and changes in technology or condition.

Traditionally, philosophers have sought to resolve the apparent “other person” problem by attempting to identify a robust theory of personal identity which accounts for the intuition that there is some semblance of continuity of identity. However, it is not clear that any of these attempted solutions have resolved the issue. Indeed, an attempt to find continuity in physiological and psychological accounts of identity seem to fail to make any progress toward a resolution of the “other person” problem, precisely because they depend on the immutability of those features which suffer drastic change during dementia: the physiology of the brain, and the psychological characteristics and memories of the individuals. And, social accounts of identity which locate identity in the relations one holds to other people are strained by the changes in relationships between patients and their social networks: dramatic changes in patient character and memory, and the very strain of caring for a dementia patient all affect the relations which a dementia patient bears to other people. An extensive evaluation of the problems which theories of personhood face for dementia patients is beyond the scope of the present paper, and it is not my intent to discard the metaphysical project entirely. For, should an account of identity be constructed which can ground the validity of an advance directive, then that should sufficiently resolve the issue at hand.<sup>1</sup> Rather, I move to present a new account, which locates

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1. Indeed, in later papers, I argue that an intersubjective account of narrative identity may be able to perform just this task. See Dalrymple-Fraser 2014, 2015a.

the validity of an advance directive as constituted in something other than personal identity, and hence dissolves rather than resolves the “other person” problem.

## 2. VALIDITY WITHOUT IDENTITY

In this section, I defend the claim that identity is not necessary for the validity of an advance directive by demonstrating that such an alternative account finds support in our common moral intuitions toward a number of other applied ethical cases. In particular, I will demonstrate that: (i) there are cases wherein we seem to have a moral right or obligation to make decisions for individuals who (a) are not yet in a position to make decisions for themselves, (b) cannot form moral or social contracts with us, and (c) are incapable of reversing our actions or the effects of our actions; and (ii) these intuitions map onto the concerns about dementia.

### 2.1 Conception

An interesting feature of the “other person” problem is that it concerns a person which may not yet exist. So, in prospectively considering the validity of an advance directive presently being signed, we are concerned with a possible future person.<sup>2</sup> There are a number of current ethical cases in which we seem to think we have moral rights or obligations to future persons, even if they do not yet exist or cannot form moral contracts with us. In this section, I look at such intuitions in the matter of conception. In §2.2, I turn briefly to future persons in the context of climate change.

An emerging theme in the discourse surrounding conception is the intuition that we may have obligations not to reproduce when it is for the betterment of possible people. In particular, Laura Purdy (1996) argues that persons who suffer from Huntington’s Disease ought not to reproduce, given the high probability that their offspring would suffer from Huntington’s Disease. Specifically, she argues that a life ailed by Huntington’s Disease can be so terrible that it is morally reprehensible to bring into existence a person who is extremely likely to be

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2. Philosophers, particularly Derek Parfit (cf. Parfit, 1976), tend to be careful to distinguish between possible people and future people. Here, I will take upon the practice of referring to the moral patients here as possible future persons. For, if they do exist, then their existence is not contingent on our present actions (unless a cure is found); but their existence is not certain. I will keep the terminological distinction intact for the other discussions which follow.

plagued by that disease; this position is motivated by our contemporary knowledge of the disease, its symptoms, and its 50% inheritability. Furthermore, given a context where alternative means of raising a family are available, such as adoption or surrogacy, the risk of conceiving an individual with a tragic inheritable disease seems unjustified. If Purdy's intuitions are met, then we have a case of moral obligations to numerically distinct persons. Moreover, the nature of the relation is such that the moral patients (the possible children) are incapable of consent and of entering into a moral contract with the moral agents (the potential parents), and are unable to reverse the decisions made by the moral agents. Still, the prospective parents have a right and obligation to make decisions affection those possible children.

However, Purdy's argument stands against other philosophers' claims that existence is inherently better than nonexistence, and it is not immediately clear that her position is the most common one, even if it is very intuitive. It is not the purpose of this paper to decide such disputes. Yet, it is worth noting that many of those philosophers who hold that existence is categorically better than nonexistence would not be averse to the claim that, should it be proven better in a case for a possible person not to exist than to exist, then a moral agent would have an obligation not to reproduce. Indeed, the difference between the positions seems to fall to whether there does exist such a situation wherein it is better not to exist. Hence, it seems that the salient matter stands, namely that we can have certain moral obligations to possible future people, and rights to make decisions concerning them.

## 2.2 Climate change

The motivation for thinking that we have moral obligations to future generations in the case of climate change seems to consist in the same principle which drives considerations of obligations not to conceive: the intuitive principle that we should prevent or mitigate harm to others. In this manner, climate change can be considered akin to a hereditary disease like Huntington's Disease: the severe predicted effects of climate change will negatively impact the quality of life in a very extreme manner for those future generations, and given the extreme likelihood that climate change has anthropogenically causes, it appears even more of a 'hereditary' risk than does Huntington's Disease (IPCC 2013, 15).<sup>3</sup> Here,

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3. I defend this pathologization argument in further detail elsewhere. See Dalrymple-Fraser, 2015b.

then, we sustain an intuition that we have a moral right, if not an obligation, to make decisions which affect future generations and future persons, which are numerically distinct from ourselves. Furthermore, future generations are incapable of forming moral contracts, given that they do not yet exist when the relevant decisions need to be made, and are incapable of reversing the effects of our decisions (IPCC 2013, 25–27).

Accordingly, we can draw another parallel to the matter of advance directives. It seems that common intuitions about climate change ethics fit uniformly in line with what would be required of an account of validity for advance directives, without personal identity.

### 2.3 Nonhuman animals

Perhaps more common than discourse on environmental ethics as a whole, is the discourse on whether we ought to extend morality to animals. Again, one need not delve into the literature to meet the common intuition that we ought to treat animals with a particular moral regard. Such an attitude is reflected in the common treatment of pets, and the disgust which meets reports of animal cruelty. Regardless of the philosophical approach to animal ethics (e.g., consequentialist, deontological),<sup>4</sup> there tends to be strong agreement with the claim that we have obligations to treat nonhuman animals in a particular moral regard, regardless of whether that treatment is exactly equal to the treatment of human animals. The typical force of this intuition is such that I will not examine it in detail, but demonstrate how it maps onto our present case of advance directives. For, it should be obvious that nonhuman animals are distinct from us, that they are incapable of the communication required to form a moral contract, and that they are largely incapable of reversing our decisions: our choices to conserve or display animals, to breed them or let them expire, to log and depreciate their habitats, are actions which nonhuman animals are largely incapable of offsetting. Again, we find an intuitive fit between our current ethical intuitions and practices, and the case of advance directives.

Granted, not everyone holds that we have moral obligations to treat nonhuman animals in certain ways. Yet, most of these objectors hold that we have rights to make decisions about the treatment of animals—to zoo them, to hunt them, to raise them for the sole purpose of consumption, and so forth. And, even

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4. See, as exemplary, Singer (1974) and Regan (1983), respectively.

if we have a mere right to make such decisions, again, it is a right to treat certain numerically distinct entities in particular ways, entities incapable of consent and of reversing our decisions. Indeed, both sides on the animal ethics debate seem to allow room for the sort of intuitions and practices we wish to bring to bear on dementia.

#### 2.4 Guardians and minors

Finally, let us briefly consider parenthood and guardianship over minors. This case is useful in that it regards a widely visible practice and calls upon strong intuitions, as with the case of nonhuman animals. Indeed, it is widely regarded that children are rarely capable of making their own informed decisions. In these circumstances, it is their parent or legal guardian who provides consent, and who makes decisions which concern those children. It does happen on occasion that a parent or guardian makes a decision which is deemed wrong for the child, but it is not contested that parents have a right—if not an obligation—to make decisions for their children.

This strong intuition maps readily to the matter of dementia. It is widely regarded that those suffering from severe dementia are frequently incapable of making their own decisions; indeed, it is because of this diminished capacity that questions regarding advance directives are raised at all. Furthermore, we wish to attend to the possibility that the moral patients of our advance directives are numerically distinct persons, whence the “other person” problem arises, and children are clearly nonidentical with their parents. Moreover, children are also widely incapable of reversing the decisions set out by their parents or guardians, as are patients of dementia acted upon through the advance directive. In these manners, parent–child relationships map readily to our advance directive case.

#### 2.5 Interim Summary

The cases considered here are not meant to be exhaustive nor conclusive. However, there is clear precedent for accepting the possibility of a theory of the validity of advance directives which does not rely on the continuity of personal identity. Indeed, there is a wealth of intuitions supporting the claim that we may make decisions for other persons and entities, and a number of these cases find reasonable congruency with the case at hand. Hence, we may seek to establish

the validity of advance directives in the coherency of our currently adopted systems of intuitions and practices.

However, it is worth remembering that the purpose of this paper is not to advance a strong theory of what this validity may precisely consist in. Rather, its purpose is to demonstrate that a survey of common intuitions shows a consistency within those intuitions which may inform such a theory. For example, we might find that the validity of an advance directive can be constructed from the particular strength or closeness of the relationship between the moral agent and the moral patient, just as it seems that the particular closeness of relation between a parent and their child grants the right of the former to make decisions concerning the latter. However, an examination of such speculations is beyond the scope of this paper. Still, the cases presented suggest the possibility that a theory may be constructed which, in accounting for these above intuitions, accounts also for the validity of advance directives in cases of dementia.

### **3. OBJECTIONS CONSIDERED**

In showing that common intuitions about many applied ethical cases map uniformly onto the debate over the validity of advance directives for dementia patients, this paper has paved the way for a theory which can account for intuitions in favour of the validity of advance directives, even in circumstances without promise of continuous personal identity. However, it is worth noting that a few objections may be raised against this move, even before such a theory has been fully articulated. In this section, I briefly examine three such possible objections, and demonstrate how they fail to undermine the current project.

#### 3.1 Acting on Intuitions

A first objection may be raised, that it is not clear that moral intuitions ought to guide our moral theories or practices. Indeed, our intuitions may be wrong or poorly grounded. Certainly, each case in the above section is a matter of philosophical contention: debate rages over whether we have obligations to animals or to future and possible generations. Accordingly, it is not clear that these intuitions are sufficient to motivate an account of validity for advance directives.

However, predominant moral intuitions do seem to play a role in informing policy and practices. It is a mistake to treat the issue at hand as a debate to be



merely relinquished to the philosophical armchair. Rather, the project of reconciling advance directives with the concern of non-continuity of identity is one which plagues our current affairs. Ethics in practice requires decisions to be made, and policies to be enacted, and there is a wealth of evidence to support the claim that these decisions are made with consideration to such moral intuition: one need only to look at the increasing number of abortion clinics, to movements against climate change, and progress toward an animal ethics, in order to identify that our moral practices do not wait for theoretical unanimity, and that do not they take place in an intuitive vacuum. It may be the case that our intuitions are wrong, but this should not prevent us from making progress in practice and policy at present, where such progress should be made in an attempt to solve the problems at hand. Rather, we should recognize and contend that policies may be corrected as we gain more moral data or theoretical constructs, just as we tend to do for other practices which are updated with the changes in scientific knowledge. In this regard, the objection seems to miss the applied matter at hand, focusing too strongly on the need for a coherent theoretical system.

### 3.2 Transferring intuitions

A further objection may be raised that it is not necessarily the case that moral intuitions carry across seemingly similar cases. That is, even if we permit moral intuitions to play a role in practice and policy, it is not necessarily evident that the moral intuitions in the above cases do carry precisely to the matter of advance directives. Indeed, examinations of trolley-like cases have demonstrated apparent contradictions in our intuitions. It is not clear that our moral intuitions about other applied ethical cases should carry into the moral matter of advance directives and dementia patients. That is, there may be a subtle and morally relevant difference between the cases we have considered, which renders our intuitive bridging invalid.

The response to this objection is brief: the burden of proof falls to the interlocutor to demonstrate wherein this difference consists. For, it seems intuitive that a future dementia patient has a right to make decisions for what appears to be their self, even if it turns out to be the case that the dementia patient in the future is a different person. Unlike other cases in conflict, there is not a strong difference of intuition which suggests a morally relevant difference between the cases presented in section three and with advance directives for dementia

patients. Accordingly, it falls to the interlocutor to demonstrate either where our intuitions separate, or wherein a morally relevant difference consists.

### 3.3 The “other” person

Following the above objection, one might gesture that there is a critical difference between the dementia case and the other cases considered. The concern with the “other person” problem is that the decisions we make for ourselves ought not to be applied to other dissenting parties. That is, the problem is a problem in particular because we are choosing to act for ourselves, not for others as we do with children and future generations.

The tentative response here comes in two parts. The first is that we can conceive of one filling out an advance directive for the dementia patient, where one’s becoming the dementia patient is but a high likelihood. With a lack of phenomenological understanding of the disorder, many prospective patients are uncertain of how much of “them” remains through dementia onset. Accordingly, so long as one anticipates that the dementia patient may not be them, then if the author of the advance directive and the dementia patient are sufficiently related—an articulation of which is beyond this groundwork, but an intuition of which should carry—the validity ought to stand. A second brief note is that few people are perhaps best able to make decisions for dementia patients than those who are related to those patients through the anticipation of being those patients. We largely lack a phenomenology of dementia, and it certainly seems reasonable that a prospective dementia patient be given priority in decision making over a more detached surrogate decision maker. Ultimately, an adequate rejection of this objection will depend in part upon the theory established to account for our coherent intuitions and practices. Still, even with these few notes, it seems that the objection raised can be similarly dissolved in practice.

## **4. CONCLUSION**

This paper advanced the position that validity need not necessarily consist in personal identity, and demonstrated how this position found support in pre-established moral intuitions across an applied ethical field. In doing so, we marked a novel approach to dealing with the “other person” problem, which does not rely on personal identity but keeps advance directives intact.

The content of this paper should present without surprise, for it does nothing more than to dissect the cases toward which we have ready intuitions. It should be plainly evident that it is consistent to hold a theory regarding the validity of an advance directive, without appeal to identity, given that we share these intuitions and practices in other applied ethical debates. Yet, despite their intuitive ease, these arguments are ultimately valuable as they may drive common intuitions back toward acceptance of advance directives for dementia patients, where physicians and families today are often faced with uncertainty. It is in this regard that we may rekindle optimism about the futures of future dementia patients.

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