RICHARD T. ELY LECTURE

Self-Command in Practice, in Policy, and in a Theory of Rational Choice

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An increasingly familiar occurrence for obstetricians is being asked by patients to withhold anesthesia during delivery. The physician often proposes that a facemask be put beside the patient who may inhale nitrous oxide as she needs it. But some determined patients ask that no such opportunity be provided: if gas is available they will use it, and they want not to be able to.

The request is interesting for decision theory, and raises questions of ethics, policy, and physician responsibility, even if the woman is merely making a mistake—if she simply does not know how painful labor will be and how glad she will be, even in retrospect, if the pain is relieved. But some women who make this request have had earlier deliveries during which they demanded anesthesia and received it. They are acquainted with the pain. They anticipate asking for relief. And they want it withheld when they do. They expect to regret afterwards any recourse to anesthesia.

This particular instance of attempted self-denial has features that are special but many that are common. The woman is, so far as we know, in good health physically and mentally. She anticipates a transient period when her usual values and preferences will be suspended or inaccessible. She has reasons for wanting to frustrate her own wishes at the critical time. She needs cooperation. She may ratify her choice afterward by expressing herself grateful that no anesthesia was offered, even when requested. There are ethical dilemmas and legal issues, and there is conflict, if, say, the husband disagrees with the physician in the delivery room about what his wife really wants.

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I. Anticipatory Self-Command

This obstetrical example, though special in certain respects, is not a bad paradigm for the general anomaly of anticipatory self-command. That is the phenomenon that I want to discuss—that a person in evident possession of her faculties and knowing what she is talking about will rationally seek to prevent, to compel, or to alter her own later behavior—to restrict her own options in violation of what she knows will be her preference at the time the behavior is to take place. It is not a phenomenon that fits easily into a discipline concerned with rational decision, revealed preference, and optimization over time.

Attempting to overrule one's own preferences is certainly exceptional, as consumer behavior goes, but not so exceptional that anyone who reads this is unfamiliar with it. Let me remind you of some of those behaviors that share with obstetrical anesthesia the characteristic that a person may request now that a later request be denied. Please do not give me a cigarette when I ask for it, or dessert, or a second drink. Do not give me my car keys. Do not lend me money. Do not lend me a gun.

Besides denial there are interventions. Do not let me go back to sleep. Interrupt me if I get in an argument. Push me out of the plane when it's my turn to parachute. Don't let me go home drunk unless you can remove my children to a safe place. Blow the fuse if you catch me watching television. Make me get up and do my back exercises every morning.

Keep me moving if I am exhausted in the wilderness. Pump my stomach if you catch me overdosed with sleeping pills.

Then there is restructuring of incentives, often with somebody's help. Wagers serve this purpose, and are often used by people who share an interest in losing weight. Confessing something incriminating that can be revealed in the event of a lapse, or just making a ceremonial display of determination to exercise or to stay off cigarettes, can threaten oneself with shame.

Most of the tactics used to command one's own future performance probably do not depend on someone else's participation. I mentioned some that do, partly for comparison with the obstetrical example, partly because our experience with purely individual efforts is usually restricted to our own and we are unaware of the efforts of others unless a need for cooperation makes them visible. Further, the legal, ethical, and policy issues arise mainly when a second party is enlisted. And these are the cases that appear to call for a judgment about the ambivalent person's true interest—which set of preferences deserves our loyalty or sympathy.

The obstetrical case is rich in its ethics and legalities. To which patient is a physician obligated? The one asking for anesthesia or the one who asked that it be withheld? Can the physician enter a contract that will both protect against malpractice and compel compliance with the woman's earlier preferences? Do we like policies that make such contracts possible; do we like policies that make such contracts void?

Physicians, of course, are bound by a professional code as well as their personal ethics, and are subject to criminal and civil complaints. In the same way, our personal ethics are challenged when the drinking guest who entrusted us with his car keys wants them back, or snatches them and heads for his car. Our ethics are even challenged when he didn't ask but we know he intended not to drive himself home, he has a momentary alcoholic confidence in his driving ability, he will certainly thank us tomorrow if we disable his car, but he demands now that we let him alone.

Professional discussion of suicide indicates that anticipation of changing preferences is common. There are two symmetrical cases here. One is preventing suicide when a person has asked for protection against his own determination during periods when he unmistakably prefers to be dead. The other is the contrary, being begged to expedite someone's departure in the event of some ghastly condition, even if the condition is accompanied by such horror of dying that he will beg us to perpetuate that horror in violation of our earlier promise. There is also the person who elects death but cannot face the finality of bringing it about, and, like the parachutist who asks to be shoved out if he grips the door jam, implores our help in getting him over the brink.

Legal issues arise in some attempts to abdicate rights that are deemed to be inalienable. I cannot get a court injunction against my own smoking. I cannot contract with a skydiving pilot to push me out of the airplane. I cannot authorize my psychiatrist in advance to have me hospitalized against my wishes in circumstances that we have agreed on. I cannot contract with a fat farm to hold me against my will until I have lost some number of pounds; they have to let me out when I ask. (If we are clever we can arrange it; I go to a remote fat farm that requires a 24-hour notice to order a car, a notice that I can rescind during a moment's resurgent resolve to lose weight. I have heard that what keeps cruise ships from offering this kind of service is the inability to keep the crew from smuggling extra calories on board for the black market.)

An interesting issue is the ethics of prohibition—against, say, the display and sale of rich desserts in the faculty dining room, or against cigarette smoking in the workplace—not to keep others from overeating or smoking, as is usually the motivation behind prohibitions, but to keep ourselves from succumbing and to reduce the pain of temptation. There is a legal test in Massachusetts now of whether nicotine addiction is a protected species of handicap and a person has a right to relief through smoking in the workplace.

The most serious cases are those that involve, one way or another, actively or passively, taking your own life—one of your selves taking the life that you share. The law takes sides with the self that will not die. Someone who lives in perpetual terror of his own suicidal tendencies can welcome the law's sanctions against people whom he might, during a passing depression, beg to help with suicide. People for whom life has become unbearable but who cannot summon the resolve to end it have the law against them in their efforts to recruit accomplices. In December a California judge ruled against a quadriplegic woman who wished to die and asked the hospital's help in starving herself to death. The judge ordered forcefeeding, with the comment that "our society values life."

Besides legal issues there are regulatory policies. Nicotine chewing gum is being introduced as a prescription drug. The National Academy of Sciences has proposed that cigarettes low in tar and high in nicotine be developed to see whether people can better regulate their intake of tars, carbon monoxide, and other gasses if they can more readily satisfy their need for nicotine. And female hormones are being administered to violent male sex offenders who volunteer for treatment.

There are now remote monitors that can be attached to a parolee that will transmit encrypted messages at scheduled times through an attachment to the parolee's telephone to monitor whether he is abiding by a curfew. But he could voluntarily submit to surveillance by a friend, spouse, or other guardian; and I remind you of the electric-shock dog-training collars that can administer a deterrent to misbehavior. There is no technical difficulty in devising an unremovable blood-alcohol monitor that could activate a radio signal, or even administer a painful shock.

There are dangers. One can imagine a variety of self-restraining or self-compelling measures that could be used as conditions for employment, for election to office, for borrowing money, or for parole or probation, if it were known that one could incur an ostensibly voluntary enforceable commitment. The polygraph is a current example. Sterilization is another.

Many heroin addicts are alcoholics. Methadone is legally available for some heroin addicts; it replaces the need for heroin. Antabuse is legally available for alcoholics; it interacts with alcohol to produce extreme nausea, and precludes drinking. Methadone is attractive—at least in the absence of heroin—but antabuse is unattractive when alcohol is available. Some therapists provide the methadone only after the patient has taken the antabuse in the presence of the therapist.[1]

II. Self-Command and the Rational Consumer

How can we accommodate this phenomenon of strategic self-frustration in our model of the rational consumer? We can begin by asking whether there is a single phenomenon here, one that can be epitomized by addiction, appetite, or pain.

Adam Smith, by the way, included a chapter on self-command in his *Theory of Moral Sentiments*. He meant something different—courage, generosity, and other manly virtues. In my usage, self-command is what you may not need to employ if you already have enough of what Adam Smith meant by it. You don't need the skillful exercise of self-command to cope with shifting prefer-

[1]There is an "interaction effect" that sometimes has to be taken into account in judging the merits of voluntarily incurred coercion, or even involuntarily. Physicians who advise their cardiac and pulmonary patients about smoking, and psychiatrists who deal with hospitalized (incarcerated) heroin addicts, report a common phenomenon. Addicts suffer noticeably less withdrawal discomfort when in an establishment that has a reputation for absolute incorruptibility, unbribable guards and staff, and no underground market anywhere, compared with a hospital in which it is expected, rightly or wrongly, that appropriate effort and willingness to pay will produce relief. Cardiac and pulmonary patients who are told flatly that they must stop completely, at once, if they want to survive the year not only quit more frequently than patients merely advised to quit if they can, or, if they can't, to cut down or switch brands, but—this is the parallel to the heroin example—report surprisingly less withdrawal discomfort than those who succeed in quitting after getting the less absolute advice.

ences if you've already got your preferences under control. I cannot resist quoting a passage that I'm sure he'd like an opportunity to edit once more. "We esteem the man who supports pain and even torture with manhood and firmness; and we can have little regard for him who sinks under them, and abandons himself to useless outcries and womanish lamentations."

There is a quite heterogeneous array of types and circumstances and it will be useful to recall them. What they have in common is that they invite efforts at anticipatory self-command. Many of them are quite ordinary.

We can begin with behavior anticipated when one is fatigued, drowsy, drunk, or coming out of a sound sleep. Or for that matter asleep: people do misbehave in their sleep. They scratch; they remove dressings from wounds; they adopt postures not recommended by orthopedists. Wearing mittens to frustrate scratching or putting the alarm clock across the room are perfectly familiar techniques of self-command.

Quite different are acute thirst and hunger, panic, pain, and rage; some athletes drink water through straws to avoid gulping, and many people forego the advantages of a gun in the house for fear they'll use it.

There is captivation—books, puzzles, television, argument, fantasy—that engage a person against his earlier determination not to be so engaged. Keeping your mind from misbehaving on its own is somewhat different from keeping it from making wrong decisions; still, the mind that sneaks off into reverie without permission, or that won't stop chewing on some logical paradox, can be thought of as actually consuming—against orders.

There are phobias—reactions of admittedly unreasoning fear to heights, enclosures, crowds, audiences, blood, needles, reptiles, leeches, filth, and the dark. These, too, look sometimes like the mind misbehaving; several of them can be brought under some control by shutting one's eyes. It is not only pediatricians who suggest looking away when the knee has to be drained through a four-inch needle. I've seen many references to a phenomenon I experienced as a child—the dark is not so frightening if you shut your eyes, especially under the bedclothes.

There are compulsive personal habits involving faces and fingernails that are difficult to frustrate because we cannot take a trip and leave our cuticles behind.

Certain illnesses entail such protracted depression that, just as a person may attempt to make decisions now that he cannot change when he becomes aged, a person may put certain decisions beyond reach during an anticipated postoperative depression. It is not for nothing that we have the phrase, "a jaundiced view"; hepatitis does change one's outlook profoundly. Medication can change a person's values; self-administration of drugs, stimulants, and tranquilizers is used deliberately to alter one's effective preferences, and can have similar effects inadvertently. Alcohol makes some people brave when they need to be brave and some foolhardy when they can't afford to be. People for whom medicinally induced swings in mood are an unavoidable chronic way of life shouldn't be disqualified as the rational consumers that our theoretical assumptions are supposed to represent.

Some of those behaviors, like falling asleep, may not sound like consumer choices, possibly because we do not usually identify them with the marketplace, and some may not seem altogether voluntary. They do remind us that attempts to achieve self-comand are familiar, not necessarily abnormal, and when abnormal not uncommon.

There are many such behaviors that we have to acknowledge do look like consumer choice: smoking, drinking, overeating, procrastination, exercise, gambling, licit and illicit drugs, and shopping binges. And remember, I am speaking only of people who want to deny themselves later access to the foods, drugs, gambling, sexual opportunities, criminal companionship, or shopping splurges that constitute their own acknowledged problems in self-command. Anyone who is happily addicted to nicotine, benzedrine, valium, chocolate, heroin, or horse racing, and anyone unhappily addicted who would not elect the pains and deprivations of withdrawal, are not my subject. I am not

concerned with whether cigarettes or rich desserts are bad for you, only with the fact that there are people who wish so badly to avoid them that, if they could, they would put those commodities beyond their own reach.

It is not an invariable characteristic of these activities that there is a unanimously identified good or bad behavior. Some dieters try to stay below a healthy body weight. Some people are annoyed at teetotalers, successful dieters, compulsive joggers, or people who never lose their tempers. And somebody who pleads for help in taking his own life, and alternately pleads not be be heeded on the occasions when he does, offers no easy choice as to who it is we should prefer to win the contest. The same is true of people who take steps to prevent their own defection from some religious faith.

While all of the cases I mentioned, from scratching to religious conversion, are within the subject of self-command, not all of them need to be recognized in a theory of rational decision. The person who prefers not to get out of bed we can consider just not all there; there are chemical inhibitors of brain activity that play a role in sleep, and until they have been metabolized away his brain is not working. His case may typify important decisions, but not the ones our theory is about. You can't make rational decisions when you're not rational, and you should rationally keep yourself from trying. Noisy alarms out of reach represent a rational choice.

What we can do is to append to our consumer a list of disqualifying circumstances in which his decisions are likely to be mistaken ones, and we make it the ordinary consumer's business, if he can't keep out of those circumstances, to take steps in advance to keep himself from making any decisions, or to arrange in advance to have his decisions disregarded. An important part of the consumer's task is then not merely household management but self-management—treating himself as though he were occasionally a servant who might misbehave. That way we separate the anomalous behavior from the rational; we take sides with whichever consumer self appeals to us as the authentic representation of values; and we can study the ways that the straight self and the wayward self interact strategically. We can adopt policies that, if they don't cause troubles elsewhere like interfering with civil liberties, help the consumer in his rational moments to control that other self and to keep important decisions from falling into the wrong hands.

But what about the person who, having given up cigarettes six months ago, succumbs after dinner to an irresistible urge to light a cigarette, who does so in apparent possession of his faculties, who six months earlier, or six hours, would have paid a price to ensure that cigarettes would be unavailable at the moment he changed his mind? If he were crazed with thirst or acutely suffering opiate withdrawal we could disqualify the decision: the mind is partly disconnected, a level of mind has taken over that is incapable of handling more than a couple of primitive dimensions of desire. But the person lighting that cigarette doesn't look as though he's bereft of his higher faculties.

The conclusion I come to is that this phenomenon of rational strategic interaction among alternating preferences is a significant part of most people's decisions and welfare and cannot be left out of our account of the consumer. We ignore too many important purposive behaviors if we insist on treating the consumer as having only values and preferences that are uniform over time, even short periods of time.

Just to establish the magnitude of the problem, consider cigarette smoking. There are thirty-five million Americans who have quit smoking. Most of them had to make at least three serious tries in order to quit. Of those thirty-five million, about five million are in danger of relapse, and two million will resume smoking and regret it. Most of those will try again, and three-quarters will fail on the next try. There are fifty-five million cigarette smokers, among whom some forty or forty-five million have tried to quit; nearly half have already tried three times or more, and some twenty million of those cigarette smokers made a serious try, and failed, within the past year. More than half of all young smokers, of both sexes, tried to quit within

the past year and failed. A third of all young smokers have unsuccessfully tried three times or more. They know that smoking is dangerous, and we know that it is worth some years of their life expectancy. Smoking behavior alone is a major determinant of consumer welfare, one that a theory based on stable preferences and rational choice cannot illuminate without some modification; and smoking is only one such behavior.

There has been interesting work on how time preferences, as among future points in time, can change as time goes by—how one's preferred allocation of resources between the decade of the 1990's and the next decade after that can change between 1980 and 1990. I have in mind ideas associated with Robert Strotz (1956), Edmund Phelps and Robert Pollak (1968), Pollak (1968), and Jon Elster (1977, 1979). And we know the anecdote of the politically radical twenty-year-old whose conservative father infuriates him by putting a sum of money in trust that the son may use for political contributions only when he reaches the conservative age of forty. I propose we admit not only unidirectional changes over time, but changes back and forth at intervals of years, months, weeks, days, hours, or even minutes, changes that can entail bilateral as well as unilateral strategy.[2]

There are different ways to say what I'm describing. Two or more sets of values alternately replace each other; or an unchanging array of values is differentially accessible at different times, like different softwares that have different rules of search and comparison, access to different parts of the memory, different proclivities to exaggerate or to distort or to suppress. We know that the sight of a glistening bowl of peanuts can trigger unintended search and retrieval from memory, some of it subliminal, and even changes in the chemical environment of the brain. In common language, a person is not always his usual self; and without necessarily taking sides as between the self we consider more usual and the other one that occasionally gains command, we can say that it looks as if different selves took turns, each self wanting its own values to govern what the other self or selves will do by way of eating, drinking, getting tattooed, speaking its mind, or committing suicide.

III. Strategy and Tactics

From this point of view we can be quite straightforward in examining the strategies and tactics with which different selves compete for command. Here are some of the strategies I have in mind.[3]

Relinquish authority to somebody else: let him hold your car keys.

Commit or contract: order your lunch in advance.

Disable or remove yourself: throw your car keys into the darkness; make yourself sick.

Remove the mischievous resources: don't keep liquor, or sleeping pills, in the house; order a hotel room without television.

[2]An imaginative and comprehensive treatment of this subject, including comparisons with animal behavior, is George Ainslie (1975). An intriguing philosophical approach is Elster (1977, 1979). In economics there are attempts to fit self-control within the economics tradition and some outside that tradition. The best known effort to fit self-control within the economics tradition is George Stigler and Gary Becker (1977); their formulation denies the phenomenon I discuss. On the edge of traditional economics are C. C. von Weizsacker (1971) and Roger McCain (1979). Outside the tradition and viewing the consumer as complex rather than singular are Amartya Sen (1977), Gordon Winston (1980), Richard Thaler and H. M. Shefrin (1981), and Howard Margolis (1982). Winston, Thaler-Shefrin, and Margolis recognize a referee or superself, or planner-doer dichotomy, that I do not see; whether the difference is perception or methodology I am not sure. The most pertinent interdisciplinary work I know of by an economist is the brilliant small book by Tibor Scitovsky (1976). For related earlier work of mine, see my 1984 book.

[3]These strategies exclude "seek professional help," even "get a good book." There are therapies: some are based on fairly unified theories and some are quite eclectic. Good examples in print of the more eclectic are K. Daniel O'Leary and G. Terrence Wilson (1975) and David Watson and Roland Tharp (1981), intended for use as college textbooks, and Ray Hodgson and Peter Miller (1982), a serious work designed for popular use. Many of the strategies I mention are represented in books like these. A more focussed self-help book is Nathan Azrin and R. Gregory Nunn (1977), now unfortunately out of print; it deals mainly with "grooming" and other personal habits.

Submit to surveillance.

Incarcerate yourself. Have somebody drop you at a cheap motel without telephone or television and call for you after eight hours' work. (When George Steiner visited the home of Georg Lukacs he was astonished at how much work Lukacs, who was under political restraint, had recently published—shelves of work. Lukacs was amused and explained, "You want to know how one gets work done? House arrest, Steiner, house arrest!")

Arrange rewards and penalties. Charging yourself $100 payable to a political candidate you despise for any cigarette you smoke except on twenty-four hours' notice is a powerful deterrent to rationalizing that a single cigarette by itself can't do any harm.[4]

Reschedule your life: do your food shopping right after breakfast.

Watch out for precursors: if coffee, alcohol, or sweet desserts make a cigarette irresistible, maybe you can resist those complementary foods and drinks and avoid the cigarette.

Arrange delays: the crisis may pass before the time is up.

Use buddies and teams: exercise together, order each other's lunches.

Automate the behavior. The automation that I look forward to is a device implanted to monitor cerebral hemorrhage that, if the stroke is severe enough to indicate a hideous survival, kills the patient before anyone can intervene to remove it.

Finally, set yourself the kinds of rules that are enforceable. Use bright lines and clear definitions, qualitative rather than quantitative limits if possible. Arrange ceremonial beginnings. If procrastination is your problem, set piecemeal goals. Make very specific delay rules, requiring notice before relapse, with notice subject to withdrawal. Permit no exceptions.[5]

IV. Implications for Welfare Judgments

An unusual characteristic of these two selves, if you will permit me to call them selves, is that it is hard to get them to sit down together. They do not exist simultaneously. Compromises are limited, if not precluded, by the absence of any internal mediator. I suppose they might get separate lawyers or agree on an arbitrator. If the obstetrician with whom I began this lecture insists on taking the pain somewhat more seriously than his patient wanted him to, we would have an arbitrated compromise between the two selves.

For this reason we should expect outcomes that occasionally appear Pareto nonoptimal compared with the bargains they might like to strike:

Not keeping liquor or rich foods in the house, both selves suffering the detriment to their reputation as host;

Not keeping sleeping pills in the house, both selves suffering occasional insomnia;

Not keeping television in the house, both selves missing the morning news.

The simplicity with which we can analyze the strategy of self-command by recognizing the analogy with two selves comes at a price—a price in terms of what we value in our model of the consumer. When we identify a consumer attempting to exercise command over his own future behavior, to frustrate some of his own future preferences, we import into the individual a counterpart—I

[4] There is a cocaine addiction clinic in Denver that has used self-blackmail as part of its therapy. The patient may write a self-incriminating letter that is placed in a safe, to be delivered to the addressee if the patient, who is tested on a random schedule, is found to have used cocaine. An example would be a physician who writes to the State Board of Medical Examiners confessing that he has violated state law and professional ethics in the illicit use of cocaine and deserves to lose his license to practice medicine. It is handled quite formally and contractually, and serves not only as a powerful deterrent but as a ceremonial expression of determination.

[5] My back book prescribes exercises that are to be done faithfully every day. I am certain that some of them need to be done only two or three times a week. But the author knows that "two of three times a week" is not a schedule conducive to self-disciplines. My periodontist tells me that patients told to perform certain cleansing operations faithfully every day are pretty good at it, but told they can get along on two or three times a week relapse to two or three times every two or three weeks; he cannot then credibly insist they go back on the daily schedule.

think an almost exact counterpart—to interpersonal utility comparisons. Each self is a set of values; and though the selves share most of those values, on the particular issues on which they differ fundamentally there doesn't seem to be any way to compare their utility increments and to determine which behavior maximizes their collective utility.

I should remark here that it is only in talking with economists that I feel at all secure in using the terminology of "selves." Philosophers and psychiatrists have their own definitions of the self, and legal scholars may resist the concept of the multiple self when it seems to raise questions about which "self" committed the crime or signed the contract, and whether the self on trial is the wrong one and we must wait for the "other" to materialize before trial, sentence, or incarceration. It is only in economics that the individual is modelled as a coherent set of preferences and certain cognitive facilities; and though economists are free to deny the phenomenon I'm discussing, if they recognize the phenomenon I think they have little difficulty with the language of alternative selves.

What about that woman who denies herself anesthesia, pleads for it during delivery, and denies it again at the next delivery? What about the person who drops by parachute with survival gear into the wilderness to go a month without smoking, drinking, overeating or sleeping late as he beats his way back to civilization, cursing all the way the self that jumped, then pleased with himself when the ordeal is over? Is there a way to formulate the question, did the individual maximize utility? Or can we only argue that one of the selves enhanced its own utility at the expense of the other? When we ask the mother who an hour ago was frantic with pain whether she is glad the anesthesia was denied her, I expect her to answer yes. But I don't see what that proves. If we ask her while she is in pain, we'll get another answer.

As a boy I saw a movie about Admiral Byrd's first Antarctic expedition and was impressed that as a boy he had gone outdoors in shirtsleeves to toughen himself against the cold. I decided to toughen myself by removing one blanket from my bed. That decision to go to bed one blanket short was made by a warm boy; another boy awoke cold in the night, too cold to go look for a blanket, cursing the boy who removed the blanket and swearing to return it tomorrow. But the next bedtime it was the warm boy again, dreaming of Antarctica, who got to make the decision, and he always did it again. I still don't know whether, if those Antarctic dreams had come true, I'd have been better able to withstand the cold and both boys would have been glad that the command structure gave the decision to the boy who, feeling no pain himself, could inflict it on the other.

The person who can't get himself up in the morning I said was not quite all there. Why does that count against him? Apparently because he cannot fully appreciate what it will be like to be late to work. But does the self who sets the alarm, and arranges with a tennis partner to roll him out of bed, fully appreciate the discomfort of getting out of bed? My answer is yes. But notice: I am not in bed. I lecture only when I am awake, and the self that might prefer to stay in bed goes unrepresented.

In another respect I am not impartial. I have my own stakes in the way people behave. For my comfort and convenience I prefer that people act civilized, drive carefully, and not lose their tempers when I am around or beat their wives and children. I like them to get their work done. Now that I don't smoke, I prefer people near me not to. As long as we have laws against drug abuse it would be easier all around if people didn't get hooked on something that makes them break the law. In the language of economics, these behaviors generate externalities and make us interested parties. Even if I believe that some poor inhibited creature's true self emerges only when he is drunk enough to admit that he despises his wife and children and gets satisfaction out of scaring them to death, I have my own reasons for cooperating with that repressed and inhibited self that petitions me to keep him sober if I can, to restrain him if he's drunk, or to keep his wife and children safely away from him.

Consider the person who pleads in the night for the termination of an unbearable existence and expresses relief at midday that

his gloomy night broodings were not taken seriously, who explains away the nighttime self in hopes of discrediting it, and pleads again for termination the next night. Should we look for the authentic self? Maybe the nighttime self is in physical or mental agony and the daytime self has a short memory. Maybe the daytime self lives in terror of death and is condemned to perpetuate its terror by frantically staying alive, suppressing both memory and anticipation of the more tangible horrors of the night. Or the nighttime self is perhaps overreacting to nocturnal gloom and depressed metabolism, trapped in a nightmare that it does not realize ends at dawn.

The question, which is the authentic one, may define the problem wrong. Both selves can be authentic. Like Siamese twins that live or die together but do not share pain, one pleads for life and the other for death—contradictory but inseparable pleas. If one of the twins sleeps when the other is awake, they are like the two selves that alternate between night and day. The problem seems to be distributive, not one of identification.

A few years ago I saw again the original Moby Dick, an early talkie in black and white. There was a scene—not in the book—of Ahab in the water losing his leg, and immediately afterward below deck under a blanket, eating an apple with three of the crew. The blacksmith enters with a hot iron to cauterize the stump. Ahab begs not to be burned. The crewmen hold him down as he spews out the apple in a scream, and steam rises where the iron is tormenting his leg. The movie resumes with Ahab out of pain and apparently glad to be alive. There is no sign that he took disciplinary action against the blacksmith or the men who held him while he was tortured.

When I first began contemplating this episode I thought it an incontestable case of the utility gain from denying freedom of choice and ignoring revealed preference. I wondered whether Ahab might have instructed the blacksmith that in the event of a ghastly wound to any member of the crew it was the blacksmith's responsibility to heat an iron and burn the wound, even if the wounded man were Captain Ahab. However much he implores us now not to burn his leg, Ahab will surely thank us afterwards. But now I wonder what that proves.

If one of *you* were to be burned so that *I* might live I would probably thank the people who did it. If you burn *me* so that I may live I'll thank you, afterward, but that is because I'll be feeling no pain and not anticipating any when I thank you. Suppose I were to be burned and Ahab in the next room needed to be cauterized too. Would you, while holding me down in disregard of my plea, ask my expert advice on whether to burn Ahab, and his advice on whether to burn me?

How do we know whether an hour of extreme pain is more than life is worth? Alternatively, how do we know whether an hour of extreme pain is more than death is worth?[6] The conclusion that I reach is that I do not know, not for you and not for me.

I do feel sure that if I wanted in such circumstances to endure the pain I would have to rely on people who were tough enough in spirit to hold me down, or at least to tie me down. And if any violation of the Captain's express orders constituted mutiny punishable by death, you would have to gag Ahab to keep him from screaming "don't" and thus condemning himself to a fatal infection. (Still, if the Captain himself presides over the trial of the mutineers who held him when he shouted "stop," they will be in no danger of his wrath; so, anticipating acquital with thanks, they may as well hold him down.)

I have found, in conversations about Ahab's plight, that people like me approve of his being burned against his express wishes, not merely burned despite his involuntary

[6]Many discussions of ambivalence toward suicide, especially for the wretchedly or terminally ill, suggest a comparison with the case of Ahab. The ambivalence appears less an alternation between preferences for life and for death than a preference for death and a horror of dying. Death is the permanent state; dying is the act of getting there, and it can be awesome, terrifying, gruesome, and possibly painful. Ahab can enjoy life—minus a leg—only by undergoing a brief horrifying event, just as the permanent relief of death can be obtained only by undergoing what may be a brief and horrifying event, especially if the healing professions will not help or are not allowed to.

screams and thrashings but against his horrified begging before he went out of his mind with pain. I interpret that to mean that people like me prefer a regime in which we ourselves would be held and burned even if we asked not be be. Yet our willingness to consider the need to be held against our will is an acknowledgement that, being certainly no braver than Ahab, we would in the event react as he did. That could mean that, at a position remote in time or in likelihood from the event we are better able to appreciate the relative merits of pain and death. But when I examine my own attitude, I usually find the contrary. If I try to imagine my way into Ahab's dilemma I find myself becoming so obsessed with immediate pain compared with immediate death that I begin agreeing with Ahab.[7]

If there is any wisdom in my current choice, which is to be held and burned if I am ever in Ahab's situation, it is the wisdom of choosing sides without fully acquainting myself with their merits. What I avoid is identifying myself with that person who may be burned, even though I know that it could be I. In the same way afterwards, I shall thank you because I do not much identify with the historical I who was burned in the recent past. But I shall know then that if I had to do it again I would prefer death. It is hard for two selves that do not simultaneously exist to compare their pains, joys, and frustrations.

In exploring this problem of identity I have been tantalized by some imaginary experiments: imagine being offered a chance to earn a substantial sum, say an amount equal to a year's income, for undergoing an exceedingly painful episode that would have no physical aftereffects. Upon hearing what the pain is like, you refuse; maybe you'd undergo it for twice that sum. The experimenter is embarrassed; anticipating your favorable response, he has already initiated the experiment with you, perhaps through something you drank. You suffer the pain and are confirmed in your original judgement that you wouldn't do it for a year's income. When the pain is over and you've recovered from the shock, you receive the money. Question: when you see the experimenter on the sidewalk as you test-drive your new Porsche, are you glad he made that hideous mistake?

A second experiment: some anesthetics block transmission of the nervous impulses that constitute pain; others have the characteristic that the patient responds to the pain as if feeling it fully but has utterly no recollection afterwards. One of these is sodium pentothal. In my imaginary experiment we wish to distinguish the effects of the drug from the effects of the unremembered pain, and we want a healthy control subject in parallel with some painful operations that will be performed with the help of this drug. For a handsome fee you will be knocked out for an hour or two, allowed to sleep it off, then tested before you go home. You do this regularly, and one afternoon you walk into the lab a little early and find the experimenters viewing some videotape. On the screen is an experimental subject writhing, and though the audio is turned down the shrieks are unmistakably those of a person in pain. When the pain stops the victim pleads, "Don't ever do that again. Please."

The person is you.

Do you care?

Do you walk into your booth, lie on the couch, and hold out your arm for today's injection?

Should I let you?

[7]I find it difficult to predict my choice if I were in a situation comparable to Ahab's but with a choice whether to initiate my remaining life with the agonizing episode or to postpone the pain until later. It always seems to me that anyone able to elect the pain at all would be tempted to take it now. Pain in the future may be discounted, but pain past is discounted more. Faced with an episode of frightening pain, people often do try to get it over and done with.

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