Is non-voluntary euthanasia ever morally permissible?

Introduction

By ‘euthanasia’ I shall mean the intentional termination of someone’s life where, on account of his distressing physical or mental state, this is thought to be in his own interests. This definition shall include both the intentional termination of life by act (for example, the administering of lethal injection) and by omission (for example, switching off a patient’s ventilator). Some philosophers only view the former as constituting euthanasia. Others label the first active euthanasia and the second passive euthanasia. On my definition both are incidences of euthanasia.

I shall not, however, take acts or omissions which have the foreseen consequence of shortening life to constitute euthanasia. If a doctor administers large doses of morphine to a patient suffering great pain, and the doctor foresees that the morphine will shorten the patient’s life, but administers the morphine with the intention of reducing pain rather than the intention of shortening the patient’s life, this action would not constitute euthanasia on my definition.

I shall understand ‘non-voluntary euthanasia’ to refer to cases of euthanasia where the person whose life is terminated was either unable to express, or unable to form, views on whether or not they wished to die.

There are various medical cases where it seems we might consider non-voluntary euthanasia. Three of the most discussed are: a) babies whose premature birth leads to severe handicaps which may involve combinations of mental deficiency, body paralysis, blindness and deafness. Such babies often require intensive medical treatment for a chance of survival. Questions that arise include: how far should treatment go in attempting to lengthen life; when is it acceptable to withdraw treatment; how do we estimate the quality of life of a person with severe handicaps? b) people suffering from advanced Alzheimer’s disease for whom there is no chance of survival. Questions that arise include: what is it like to be living with advanced Alzheimer’s; how do we know if sufferers desire to live or die when they do not seem to possess the minimum level of mental competence for having or expressing a desire? c) comatose individuals for whom the diagnosis is irreversible coma. Such individuals are kept alive through feeding and hydration tubes. When does it become acceptable to remove the tubes with the intention that the patient should die?

I shall concentrate on the case of irreversible coma. It seems to me the argument for non-voluntary euthanasia is strongest here.

A note on the clause ‘non-voluntary’

Victims of irreversible coma will often have led ordinary lives before some event or accident resulted in a state of coma. There may be cases where a person repeatedly expressed (to friends or family) a desire not to be kept alive in a state of irreversible coma, or conversely, not to be allowed to die. If a person repeatedly expressed a desire not to be kept alive, then it is not clear that allowing the person to die (by removing feeding and hydration tubes) is an incidence of non-voluntary euthanasia. On the one hand it seems that it is what the person would have wanted; on the other hand, the person is no longer in a position to express a view on the matter. The case that I shall consider will assume that the victim of coma never made it clear to friends and family just what he would have wanted to happen. Whilst family members are
likely to have an opinion on what he would want, they concede that they cannot be sure.

**Autonomy**

When a seriously ill person asks to die the supporter of voluntary euthanasia will appeal to the person’s right to autonomy. In the case of the comatose patient we have no way of asking the person what they wish to happen to them. But we can still respect his right to autonomy, to an extent, by asking what he would have wished to happen before he ever became comatose. In the specific case that we are considering — where the person never explicitly expressed views on the matter, and indeed may never have formed views on the matter — the best that we can do is to ask those close to him to make this difficult judgement. We can imagine that in some instances close friends and family will feel that they have a good idea of what the patient would have wanted. In other cases, however, they might be unsure. There will always be an element of doubt as long as views were never explicitly expressed. If this is so, how seriously should we treat this appeal to what family and friends think that the individual would have wanted? It may be that what is more important here is a consideration of the best interests of both the patient and his close family and friends.

**The interests of the patient**

If we are making a choice between keeping someone alive and letting them die then it is clear that we must take into account what would be in the best interests of the person. If a person is suffering great physical distress, and there is no hope of reducing that distress, then it might be in the best interests of the person to bring about their death, in so far as it brings an end to distress. In the case of the comatose patient it is thought that the person has no capacity for sensation and that there is no possibility of future consciousness. It might be argued that the comatose patient cannot have interests beyond an interest in recovery; that it would not matter to the patient what happens whilst he is unconscious. And this would facilitate an argument against euthanasia on the basis of the patient’s best interests; it could not be in their best interests to let them die as there is always some chance whilst they live, however small, of recovery.

There are people who care deeply that they should cling to life for as long as possible irrespective of how much they will suffer. There are also people who care passionately that they should not be kept alive in a vegetative state. Ronald Dworkin argues that this must mean that some people have interests beyond what he calls *experiential interests*; roughly, experiential interests are interests that our experiences be in some way positive. More particularly, he argues that many people have a special interest in the nature of their death. The cancer sufferer who wants to fight to the end is determined that their death should not be a matter of surrender. The person who feels passionately that they should not be kept alive in a vegetative state desires that they should be allowed to die proudly.

If it is correct that many people have an important interest in the nature of their death then it puts pressure on us to ask how we think the patient would have wanted their life to end. If it is decided that he would have wanted to be allowed to die then on Dworkin’s view it would be in his best interests to let him die. Notice how this
compares to our first interpretation of the patient’s best interests. On that interpretation the nature of his death could not be of interest to the patient, and it followed that keeping him alive would do no harm. On the contrary, it would be the only positive step given that some slight chance of recovery always remains.

It seems to me that Dworkin is right to say that many people have an important interest in the nature of their death. If he is not, then it is difficult to account for the passionate views that many people possess on the matter.

The interests of close family and friends

Thus far it has been argued that the central issue is the patient’s interest in the nature of his own death. It is clear, however, that close family members and friends will also be involved. It can be deeply distressing to see a loved one be allowed to die, and similarly, it can be deeply distressing to see a loved one kept alive in a vegetative state. It then seems natural to ask: if the best interests of the patient in some way conflict with the best interests of family and friends, then to which do we give precedence? But it looks likely that in the majority of cases there will be no such conflict. If it is determined that it would be in the patient’s best interests to be allowed to die, then this judgement would have been reached on the basis of the opinions of family and friends. It then seems unlikely that they should prefer for the patient to be kept alive. Whilst it is possible that the interests of the patient and the interests of family members and friends will conflict, it is also true that they will often conform with one another.

Conclusion

I have suggested that we must respect the patient’s right to autonomy to as large a degree as possible. Against this it may be argued that we can never be sure what the patient would have wanted and that it would do no harm to keep him alive, yet ending his life would be to eliminate all possibility of recovery. I have replied by suggesting that people have an important interest in the nature of their own death, and it follows that keeping someone alive may be more harmful than letting them die if it ignores this interest. Finally, I considered the interests of friends and family and suggested that in most cases they will conform with the interests of the patient.

We are now in a position to make a strong case for non-voluntary euthanasia in the case of the victim of irreversible coma: If a) it is determined that allowing the patient to die would be consistent with the patient’s interest in the nature of his own death; and (b) it is in the interests of family members and close friends to allow the patient to die, in so far as they accept it as the least distressing of two alternatives; then c) non-voluntary euthanasia in this case is morally permissible.

Bibliography
