The trouble with do-gooders: the example of suicide

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Abstract

This paper describes the concept of a do-gooder: a person who does unwanted good. It illustrates why doing-good is a problem and argues that patients should not be compelled to do what is best. It shows the ways in which doctors covertly do-good and offers a critique of these. The discussion focuses on the example of the treatment of patients who attempt suicide.

A friend insists on giving you a lift because it is too far. You wanted to walk in the sun. Your wife is bent on improving you. She takes you to a mediaeval music recital when your football team is playing its most crucial match. Your team wins. A member of a church in Pennsylvania rings your door bell one shimmering summer morning. He interrupts your breakfast in the garden to tell you about salvation.

Not all cases of doing-good are so benign. In 1993, the Australian press reported the case of Joan Vollmer, a middle-aged woman living in a small country town just outside Melbourne. She was loved by her husband and liked in her community. She suffered from chronic schizophrenia. Her frequent episodes of psychosis were very distressing to her and her husband. He and others from their Church decided to rid her of the evil spirits consuming her life. From a nearby town, they employed the services of a minister practised in the art of exorcism. Joan was placed on her kitchen table and various rituals were performed. She was possessed by many demons. Some were difficult to remove. After several days, she died from exhaustion, dehydration and other medical conditions not disclosed in press reports. Her husband and the others were hopeful. Joan's death signified that the last demon had been removed. They expected her to rise in three days. She didn't. After a coronial investigation, her husband and three others were charged with manslaughter.

In December 1994, Mona Rai, a Muslim "holy woman" was sentenced to seven years jail at the Old Bailey for the manslaughter of Farida Patel, aged 22. Rai, together with a disciple and Patel's brother and sister, whipped, punched and jumped on Patel for two days in an attempt to exorcise evil spirits. Do-gooders do unwanted good. The trouble with do-gooders is that, despite the best intentions, they often fail to do good. Joan Vollmer's husband and the others involved in her exorcism had a genuine desire to help her. Sometimes, do-gooders do some good. Yet the trouble is that this good is not wanted. My object is the do-gooder in general. However, my focus will be the medical do-gooder: the doctor who helps a patient out of a sincere desire to do the best for him or her, when the patient does not want help.

One example of doing-good in medicine is the treatment of suicidal patients against their wishes. A patient takes an overdose of tablets, such as paracetamol, and arrives in the emergency department alert. The patient refuses to have a nasogastric tube inserted or to cooperate with treatment. She wants to die. If her life is to be saved, a nasogastric tube must be forcibly inserted and intravenous access established in the face of violent opposition. In other circumstances, this would constitute assault. Should it be done?

Doing-good: why bad?

1. FAILING TO DO GOOD

One much publicised case of doing-good is that of Elizabeth Bouvia. In September 1983, Bouvia entered the casualty department of Riverside Hospital, stating that she wanted to be admitted and allowed to starve herself to death. She was almost totally paralysed in both her legs and arms, and suffered from painful arthritis. In the preceding year, she had married an ex-convict, Richard Bouvia, whom she had corresponded with by mail. She had also had a miscarriage, been refused financial support by her father and sister-in-law, and then been deserted by her husband. She wanted to die because of her physical disability and mental suffering.

The hospital refused to allow her to die. She was force fed. The case came before John Hews, a California probate judge. He found her to be rational, sincere and fully competent. However, he
permitted the hospital to force feed her because of the effect her death might have on the medical personnel caring for her and other handicapped persons.3

Moral right

Bouvia was committed to living a life she did not want to live. She tried two further times to starve herself to death but was unsuccessful. Not all patients who want to die are treated against their wishes. Mrs N was 45 when she developed respiratory failure requiring artificial ventilation. A diagnosis of atypical motor neuron disease affecting her intercostal muscles was made. The disease spread to involve other muscles. She wanted to die. Repeated psychiatric examination found her to be sane. Mr Nicholas Tonti-Filippini, a hospital ethicist in a Roman Catholic hospital, was involved in Mrs N's case. He and the nursing staff involved in her care formed the opinion that "she was competently, freely and informedly refusing treatment, and that opinion was recorded by several independent consultants". He argued that she was not morally obliged to have treatment that she found burdensome and that she had a moral right to refuse medical intervention. Her treatment was withdrawn and she died.4

Suicide is intentional self-killing; homicide is the intentional killing of one person by another; euthanasia is the intentional killing of one person by another for the former's benefit.5 Bouvia's starvation diet was attempted suicide; the withdrawing of artificial ventilation of Mrs N was a case of euthanasia.

There was broad-based agreement from both religious and secular groups that Mrs N ought to be allowed to die. Indeed, based on her case and others like it, the Victorian Parliament passed the Medical Treatment Act 1988. This act provides legal protection and mechanisms for patients to refuse life-prolonging treatment and doctors to respect these refusals. Why was Mrs N allowed to die but Bouvia was not? If Mrs N was allowed to refuse the provision of air her body needed, why was Bouvia not also allowed to refuse the provision of food that her body needed?

One reason has to do with the nature of the treatment which each was refusing. Mr Tonti-Filippini described life on the ventilator as "a precarious, burdensome existence that demands great fortitude on the part of a conscious, competent patient". It was his opinion that people requiring long-term artificial ventilation have no obligation to have such burdensome treatment, although he believed that each person should try.4 This position implies that if Mrs N had not had to endure burdensome treatment, she ought to have been compelled to live.

We can imagine a patient like Mrs N, who has severe motor neurone disease but who does not require treatment with a ventilator. In some ways, this patient's life is worse. He cannot speak. He can only move his eyes. According to standard Roman Catholic doctrine, not only would such a life be worth living, but such a person ought to be compelled to live that life, even if he preferred to die. Today, there is emerging secular agreement that some human lives are not worth living. And Mrs N's life seems just one instance of that.

It is misleading to focus on the burdensome nature of treatment and to equate a person's good with the level of medical treatment she requires. It is not merely treatment which can be burdensome, but life with serious disability and suffering. The reason why many people now believe that a patient such as Mrs N ought to be allowed to die, and a fortiori to commit suicide, is because her life is so bad. If this is the reason, then one reason why Bouvia was compelled to live may have been that those involved in her care believed that her life was worth living. Certainly, many disabled groups argued vocally to this effect. (One lawyer at the Law Institute for the Disabled said: "She needs to learn to live with dignity".6)

Decision overturned

After a complicated series of events and admission to another hospital and another court hearing, the decision to permit the force feeding of Bouvia was overturned by the California Court of Appeals. The trial justices noted that a competent person has a right to refuse life-sustaining treatment. We will return to this. They also noted: "...in Elizabeth Bouvia's view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability, and frustration. She, as a patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless. She is not to be faulted for so concluding...".7

Why was Bouvia prevented from dying? One reason is that do-gooders misjudged what was good for her. The Court of Appeals concluded that she was not making a mistake in considering her life meaningless.

Bouvia was no doubt a difficult patient who engendered little sympathy from her doctors. Compare the way Bouvia's physicians tied her down against her will and force fed her, with the way physicians behave towards Jehovah's Witnesses. Not only are Witnesses allowed to refuse life-saving blood transfusions, but they are given special treatment: extra care is taken to make sure that they do not lose much blood, small bleeding vessels are closed off at operation, they are given other forms of fluid replacement. There is an extraordinary amount of good will towards Jehovah's Witnesses, which was conspicuously lacking in the case of Bouvia. One physician said of Bouvia: "Since she is occupying our space, she must accede to the same care which we afford every other patient here...".8
This difference in treatment is important. It might be argued that Bouvia was not as disabled as Mrs N. Her life was not as bad. That was the reason for the difference in their treatment. This argument cannot be used when comparing the treatment of Bouvia with that of Witnesses. In some cases, Witnesses are allowed to refuse life-saving transfusions when, if they had one, they would not be left with any disability. Why, then, are healthy Witnesses allowed to die but the disabled Bouvia was not?

The reason again has to do with how we construe what is good for others. The reason why many people believe that Jehovah’s Witnesses ought to be allowed to refuse life-saving blood transfusions (and die) is because they believe that it is good to lead one’s life according to one’s values, particularly religious values. They have legitimate reasons to die (Bouvia apparently did not). Michael Wreen puts it this way: “[R]eligion has to do with (i) describing and explaining the human condition at its most fundamental level; (ii) providing a person with a unique concept of personal identity . . . (iii) making sense of ourselves and the world around us in a complete and satisfying way”.

Wreen believes that religious values are special. It is because of these special qualities that people should be allowed to die for them.

“The reason why religious beliefs and values are special, then . . . has to do with this pervasive, supremely important integrating and reconciling function that they have in a person’s life . . . [T]hey fill out the person, and are integral to his personal identity and sense of himself.”

It is important to allow people to live (and die) according to religious beliefs because these beliefs express what is central to that person’s life. They are his commitments and the framework around which he organises his life. They are, in many ways, the most essential beliefs to his being as a person and as an end in himself.

Mr Tonti-Filippini argues that when suicide appears to have been attempted, “[t]he problem is to separate suicidal refusal of medical treatment from refusal of medical treatment because the patient considers the treatment overly burdensome or contrary to his or her religious or cultural beliefs.”

On the one hand some Christian ethicists claim that quadriplegics and other severely disabled people should not be allowed to die on the basis of their judgment of the value of their own lives unless they are being subjected to “burdensome treatment”, but on the other hand claim that Jehovah’s Witnesses should be able to die because this is in accordance with their religious values (and so treatment is burdensome to them). Is this consistent?

People may have commitments to ends other than religious or cultural ends. Most importantly, they may have personal ideals, ends which they take to be the point of their own lives. These judgments of what is important may extend to the kinds of lives they think are worth living for themselves. If Jehovah’s Witnesses ought to be allowed to die for what they think is important, so, too, ought Bouvia have been allowed to die according to her conception of what is important. On this way of thinking, the fact that Bouvia was severely disabled was not in itself paramount in determining that she had good reason to die; what was paramount was that she judged that these difficulties made her life not worth living. That judgment, in the face of real difficulty, provides her with as much reason to refuse life-saving treatment as the Jehovah’s Witness.

In one way there is more reason to respect the quadriplegic’s desire to die, or the cancer patient’s desire to stop suffering, than there is to allow Witnesses die. The Jehovah’s Witness’s desire is based on the following belief: “If I refuse blood and die, I’ll be resurrected”. The former’s refusal of treatment may be based on this belief. “Future life in a dependent and undignified state is not worth living for me”. How should we interpret religious belief is a complicated question. On one view, Jehovah’s Witnesses mistakenly believe that the Bible forbids blood transfusion, when the Bible is only referring to certain dietary practices. If this were so, a Witness’s refusal of blood transfusion would be based on a false belief. Bouvia’s desire to die was not based on any false belief.

2. GOOD IS UNWANTED

Do-gooders often fail to do good. They choose the wrong way to go about achieving good and sometimes are aiming at what is not good at all. But there is a more important problem with do-gooders. The good that do-gooders do is unwanted.

Unwanted good may be intrinsically or instrumentally of less value than good that is desired. An example of the instrumental value of desiring good is that good is more likely to be achieved in a patient who diligently takes his medicine, eats well, monitors his symptoms and attends clinic regularly than in one who is non-compliant and aggravates his condition with various excesses.

The unwantedness of the good do-gooders do is important for a more significant reason. People have the right, or at least are allowed in this society, to refuse benefits or to engage in risky ventures. We do not believe that a person ought to be compelled to do what is best for himself. As Mill put it, “the only purpose for which power can rightfully be exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.” This is Mill’s harm principle.

A person is not compelled to accept money he has won in a lottery, or social security benefits he is due from the state, even if he is particularly destitute. Perhaps a destitute person ought to accept money. But is not true that he ought to be compelled to accept money.
There are two exceptions to Mill's harm principle. Firstly, choice based on inadequate or wrong information need not necessarily be respected. Secondly, some people are incompetent to make an informed choice. In these two cases, doing-good can be justified.

The principle of respect for competent, informed choice has crystallised in common law. In the case of Schloendorff v New York Hospital, Justice Cardozo observed in 1914: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body”. This common law principle grounds the requirement that a competent person must give informed consent before a medical procedure is performed upon him, even if that procedure is life-saving. Whether we should prevent a person attempting or completing suicide depends on whether that person is misinformed or incompetent. If she is informed and competent, as both Bouvia and Mrs N were, then she ought to be allowed to die.

This was the finding by the final court, the Appeals Court, in the case of Bouvia.

“The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions. Its exercise requires no one’s approval.”

Do-gooders may do good. Bouvia’s life may have been worth living. But, as Mill’s harm principle makes clear, people have the right to choose a course which is less than the best. Perhaps it is true that they ought to pursue the best course. But it is not true they ought to be compelled to pursue that course, no matter how attractive it is to others.

How done?

There are several ways the do-gooder attempts to jump the hurdle of Mill’s harm principle.

1. THE MIND-READER

The mind-reader divines what the patient really desires. “The patient,” he claims, “does not really want to die. He is pleading for help. Far from frustrating this patient’s autonomy, I am respecting it.”

It is no doubt true that some patients are pleading for help when they attempt suicide. But some patients are not pleading for help. Mrs N really wanted to die.

Sometimes it is easy to read a person’s mind. When a patient attends casualty for diagnosis of a pain, and the doctor tells him he is going to take a blood test, and the patient holds out his arm, we infer that the patient is consenting. But inferring what a patient really wants in the face of actual competent protest is far more problematic. The onus must be on the mind-reader to prove his case.

There are some very practised mind-readers. Psychoanalysts tell us that our lives are shaped by unconscious motivation. Suicide is often a response to intolerable childhood experience. It is the result of emotional conflict, love and hate, and raging primal desire, such as the desire to punish or manipulate others, to destroy the body, to allow the tortured self to escape, and so on.

These claims may be true. I have elsewhere stressed the important place non-rational desire plays in determining behaviour. People not infrequently choose a course of action that fails to promote what they value. Indeed, the nature of a person’s values is likely shaped by these influences. People often lack insight into the significance of such forces in their lives. This raises deep issues of freedom and the relationship between self-understanding and choice. However, it is also important to recognise that these subconscious forces shape all aspects of our lives: our choice of partner, career, friends, and the way we drive our car and how much alcohol we drink.

The appropriate response is to broaden the medical consultation to take account of those aspects of human life which shape choice. Doctors need to provide not only medical facts, but to help patients to make better, more rational decisions for themselves. Understanding oneself is as important as understanding of the outcome of one’s choices. Psychotherapists should help patients to understand better their own motivations, and indeed themselves. But if a patient continues to want to die after such therapy, the fact that his desire to die is the result of subconscious motivation is not sufficient reason to compel him to live.

2. THE FORTUNE-TELLER

This do-gooder attempts to predict the future. He argues that suicidal behaviour is impulsive and patients who attempt suicide will change their mind in the future. “In the future,” he claims, “they will thank me if I treat them.”

This argument faces the same problems as the last, together with some new ones. One problem is that consent can be constructed. A person attempting suicide may now judge life to be not worth living but, if she is compelled to live on, find it worth living later. This does not imply that her original judgment was wrong, or that she should have been coerced out of it. It may merely show that desires can change.

For example, I may know that if I were to save hard and make sacrifices now, I would thank myself in my retirement. However, I would now judge that such sacrifices are not worth the effort. The mere fact that I will thank myself for making investments now does not imply that I ought to invest my money now, let alone that I ought to be compelled to invest it.

3. THE INQUISITOR

The third species of do-gooder, the most common, exploits Cardozo’s requirement of being of “sound mind”. He claims that the person who attempts
suicide is mentally ill. For this reason, the psychiatrists, Kaplan and Sadock, in their discussion of suicide, claim:

“Danger to self is one of the few clear-cut indications presently acceptable in all states [of the United States] for involuntary [sic] hospitalization.”

Another significant Australian case is that of John McEwan, a ventilator-dependent quadriplegic. He wanted to die and requested his ventilator be turned off. This was refused. So he refused to eat. He was certified insane and force fed. Repeated subsequent psychiatric examination found him to be sane and the certificate was rescinded.4

Does depression or mental illness necessarily make a person incompetent? Is a suicide attempt a reasonable ground for believing that a patient is incompetent?

Firstly, not all patients who attempt suicide are mentally ill. After extensive examination of Mrs N’s mental state, she was declared sane.

But let’s assume for argument’s sake that nearly all patients who express a desire to die are depressed or mentally ill.20 This fact would not settle what ought to be done. One can be depressed and still be competent. Bouvia was competent. Indeed, in some cases, a person is depressed because she has good reason to die.

While suicidal ideation may be a prima facie ground for believing a person to be mentally ill or incompetent, it is clearly not a sufficient ground for establishing either mental illness or incompetence. The Mental Health Act in Victoria, Australia, which stipulates the conditions under which patients can be involuntarily admitted to psychiatric hospitals, does not explicitly define mental illness, but it does state that the following behaviours are not to be considered evidence of a mental illness: holding a particular religious or political opinion or belief, or expressing a particular philosophy.21 Thus the Jehovah’s Witness’s belief that refusing blood will allow resurrection cannot be considered evidence of mental illness. But, as I have argued, religious conceptions of the good are value judgments. The same points apply to other value judgements, including Mrs N’s or Bouvia’s judgment of the value of their own lives.

The claim of Kaplan and Sadock that danger to self is one of the few clear-cut indications for involuntary hospitalisation is incomplete. What they mean is that “imminent danger to self (not based on religious or cultural belief)” is an indicator for involuntary hospitalisation. It would otherwise be false because there are many behaviours which are permitted by society which will result in the same harm to self as a drug overdose or other suicidal behaviour. Society allows people to kill themselves slowly by alcohol addiction, tobacco addiction, and other drug addiction. The morbidly obese literally eat themselves to death.

It might be objected that such behaviours differ from active suicide in that the harm which occurs with the former is merely foreseen, but not intended. This distinction is highly dubious, but there is no space here to demonstrate this.22 If it were valid, we could argue that Mrs N did not intend to die, but only to stop suffering. Her death was foreseen, but not intended. I am told that Bouvia did not want to die; she only wanted not to live as she was.23

Also important to consider alongside intention is voluntariness. There is more reason to intervene in cases of harm-to-self if that harm is involuntary. Alcoholism is a physical addiction. The choice to continue to drink alcohol at dangerous levels is probably considerably less voluntary than to take an overdose of paracetamol. The choice to remain a heroin addict is still more involuntary. Yet society chooses to interfere in the attempted suicides of people like Bouvia, which are not the direct result of any addiction-related, compulsive or other obviously involuntary behaviour. This is inconsistent.

How many people who attempt suicide competently and voluntarily do so? I have no idea. The majority of patients who attempt suicide are in good physical health.24 The majority have some kind of psychiatric disturbance. The level of competence required to make such an important decision ought to be set fairly high. Given this requirement, perhaps very few patients competently desire to die. (However, this has not been systematically studied.) But this should not stop us allowing those few, like Bouvia and Mrs N, who are competent, to die if they so desire.

4. THE BENEVOLENT SCHOOLMASTER

“It is better if we allow people to learn by their mistakes than to interfere and do what is best for them. However, death is a special case. When you are dead, you cannot learn from your mistakes.” This is the “no second chance argument” against suicide.

This argument is inconsistent with other societal practices. Many of the same people who attempt suicide and are resuscitated are allowed to drink harmful amounts of alcohol. We also allow people to engage in risky sports, which may result in paraplegia, or other serious injury. There is no second chance if one becomes a paraplegic from motorcycle racing. There is no second chance for Mrs N or Jehovah’s Witnesses, yet we allow them to die.

5. THE SOCIOLOGIST

“We ought not to allow people to suicide because suicidal behaviour is the result of social forces outside an individual’s control. In the young, it is often due to unemployment; in the old, it is often due to fear, abuse, isolation and a sense of uselessness.”

This argument was well ventilated by individuals representing the disabled in Bouvia’s case. Paul
Longmore, a ventilator-dependent quadriplegic, claimed that Bouvia wanted to die because she was not provided with the social materials to construct a meaningful life.

“The very agencies supposedly designed to enable severely physically handicapped adults like her achieve independence . . . become another massive hurdle they must surmount.

“Reportedly, one of her employers told her she was unemployable, and that, if they had known just how disabled she was, they would never have admitted her to the program.”26

I have presumed in my argument that a person’s choice to die can be as free as other prudent choices which we respect. The sociologist does not offer an argument against respecting competent, informed choice in favour of doing-good. According to this argument, Bouvia desired to die because her overriding competent choice had not been respected: to be useful. This argument just shows that we should respect people’s competent choices and that such choices should be freely made.

However, it is not clear that all suicides are the result of sociological pressures. Mrs N’s desire to die was the result of a judgment about what the value of her life was. That judgment was about as individual as a judgment can be.

Let us assume that suicide is the result of social forces beyond an individual’s control. Disease, such as motor neurone disease, is also beyond an individual’s control. Yet suicide can be a reasonable response to it. Social disadvantage is different from motor neurone disease in that the former is alterable while the latter is at present not. However, practically, social disadvantage may be unlikely to be altered in a person’s lifetime.

The fact that a self-destructive behaviour has a social cause does not imply that that behaviour ought to be altered coercively. Alcoholism, drug addictions, driving stupidly and other destructive life-styles may equally be the result of social forces beyond an individual’s own control. They too are alterable causes of death. Yet we do not believe that coercive interference is justified in these lethal behaviours. Social prejudice ought to change; the disabled ought to be provided with a more substantial social network; but that does not imply that a competent disabled person ought to be compelled to live.

6. THE PRAGMATIST

“Yes, if a patient is competent and desires to die, he ought to be allowed to die. However, it is not often possible to evaluate the patient’s competence prior to the attempt or in the heat of the moment. We must assume that he was incompetent.”

In many cases of attempted suicide, one’s mental state is clouded by metabolic disturbance, hypoxia, etc. It can also be difficult to assess whether a patient was competent prior to his attempted suicide. However, in other cases, patients attempt suicide using means which do not themselves affect their mental state. Paracetamol has no effect directly or initially on the mental state, and only kills the patient after several days. Sometimes we can evaluate a suicidal patient’s competence, as was the case in Bouvia and Mrs N. If we can, we should, and should not assume that the patient is depressed and incompetent.

The Pragmatist can team up with the Mind-Reader. “A desire to die is often the product of subconscious conflict. Suicidal patients need to understand the nature of this conflict and other aspects of their subconscious selves before they can make properly informed choices. This requires psychoanalysis. This takes time. We should prevent suicide at least until patients have received adequate psychotherapy.”

I am sympathetic to this challenge. This response is right for many cases. But there are three qualifications.

Firstly, how informed must such a decision be? The requirement of informedness can be used as an instrument for coercive interference. No decision is ever completely informed. Where should the level be set? The level should be high, but not out of proportion with the level set for other self-harming activities. We are not compelled to achieve complete self-understanding before we receive a motorcycle licence or buy a pack of cigarettes.

Secondly, sometimes being misinformed does not matter. Imagine that Jim wants to suicide. He intends to kill himself with some barbituates he was prescribed but can’t find them. He becomes frustrated and develops a headache. He takes an aspirin. This unexpectedly causes a severe anaphylactic reaction and he is rushed to hospital, still clutching the aspirin packet. He has already tied his suicide note to his lapel. It says: “I have taken this overdose of barbituates . . .” His wife arrives, verifying that he was looking for his barbituates to kill himself, and only took the aspirin for his headache. In this case, if we would have let Jim die had he taken an overdose of barbituates, then we should let him die from his anaphylactic reaction. The reason has two parts: (1) the normative reasons for allowing Jim to die are the same in the two cases, (2) Jim wanted to die. The fact that Jim was misinformed of the effect of taking aspirin is irrelevant if it would not have affected what Jim did. Indeed, his wife says: “If Jim had realised that aspirin would kill him, he would have taken it sooner”. What matters is not how informed we are, but whether further information would change our desires. In many instances, information about the genesis of our desires would not change what we desire.27

Thirdly, it is important to evaluate how informed a person is and whether the information he lacks would change choice. We should not assume that he is misinformed or that information we believe is...
relevant would be relevant to him. In some cases, perhaps few, a person is adequately informed and further information is not relevant. This may be manifest in the organisation of a person’s behaviour and the unambiguous and resolute nature of his desire. It seems more likely when suicide occurs in the setting of significant impairment of quality of life. It is tendentious to say that John McEwan should have been prevented from killing himself because he didn’t understand that his desire was the result of childhood conflict. What is required is an estimation of the contribution of unrealised psychic conflict in this person’s desire to die, his level of informedness and whether further information is likely to change his desires. All we can do is try to make these evaluations in an open-minded way, and as expeditiously as possible.

Two objections

The do-gooder offers two important objections. “If we are to respect what a person values, we might end up allowing patients to die for some very bizarre reasons.” The difficulty with this objection is that a definition of what constitutes a life which is objectively worth living has been elusive. Even if it were possible to come to a defensible judgment, it is hard to see how the Jehovah’s Witness’s belief that if he refuses a blood transfusion and dies, he will be resurrected, is worth dying for, and beliefs like those held by Bouvia and Mrs N are not. Current practice seems committed to allowing people to act on subjective values. (I think that this is problematic. But even if what is objectively good could be settled, this would not imply that a person ought to be compelled to promote it.)

The second objection is that there will be flow-on effects if we allow suicide. Others will be harmed.28 This is perhaps the best argument for a blanket prohibition of allowing people to suicide. But do we really believe that allowing competent people to kill themselves will cause hoards of innocent by-standers to be sucked into a frenzy of self-destruction?

If we set the level of competence required to be allowed to die high, then few people will meet the requirement of competently desiring to die. Indeed, I believe that most desires to die are associated with either lack of information or an evaluative error.16 If this is true, the numbers who are allowed to die will be small. A fortiori, harm to others in the form of death of innocent by-standers will be small.

Assume that my suicide does encourage others to suicide. Unless we believe that seeing my suicide has such catastrophic effects on their psyche that it renders them incompetent, then it is questionable whether societal interference is justified. X seeing Y getting drunk encourages X to get drunk. This observation is not a reason to prohibit people getting drunk.

In a society in which freedoms exist, there will always exist the risk of abuse of these freedoms. But the mere risk, and even actual cases, of abuse, is not sufficient grounds for the abolition of those freedoms. Similarly, nearly all freedoms have some societal cost. The freedom to move from one place to another easily by car is associated with the many costs of motor vehicle accidents, even to innocent pedestrians. Yet the fact that this exercise of freedom has some cost does not justify its abolition. Some freedoms are worth the cost in innocent life. The freedom to finish one’s life when and how one chooses is, it seems to me, about as important as any freedom.

Beyond doing-good

Do-gooders often fail to do good. They often hold mistaken conceptions of what is good. More importantly, the good do-gooders do is unwanted. Competent people sometimes choose to pursue the less than the best course. Perhaps they ought to pursue the best course. But it does not follow that they ought to be compelled to pursue the best course. Do-gooders fail to appreciate this distinction.

If a person is competent and knows all the relevant facts, including facts about himself, and wants to die and takes steps to effect that desire, we ought not to interfere. His choice may be unusual. There is a place for talking with him, evaluating his competence, the way he is thinking, whether his decision is the result of coercion by others, trying to convince him that he is wrong, but not, ultimately, for interfering with him.

It is difficult to stand by and watch people die. But an active response need not take the form of coercion. We ought to try to convince competent people whom we believe have an unjustified desire to die to change their minds. But we ought not to compel them. It can be difficult to understand why a person desires some course that is less than the best. It can be even more difficult to convince him that he is mistaken. These are topics for another paper. But this is where do-gooders should be directing their energy, not in devising new ways of doing-good.

Acknowledgement

Thanks to Dr Helga Kuhse for valuable comments on an earlier draft.

References and notes


6 See reference 3: 31

7 See reference 3: 36.

8 See reference 3: 34–5.


10 Wreen (reference 9) courts this idea but claims that any ideology that meets his criteria is probably best viewed as a religion!


13 211 NY, 125, 127, 129; 105 NE, 92, 93.


15 I thank one referee for this constructive and helpful objection.


21 *The Mental Health Act and other resources: a practical guide.* The Health Department of Victoria, 1992.


23 Eric Meslin, personal communication.


26 See reference 3:34.

27 It is generally assumed that the intended purpose of an act must be to cause death for a person to be fully responsible for that death. If Jim was looking for poison to kill his wife, and gave her an aspirin (with the purpose, say, of stopping her complaining) which killed her, he would not be guilty of murder. This example calls into question the importance of appealing to direct actual intention in attributing moral responsibility. It seems sufficient that one intend the effect (death) and intend the act (giving the aspirin), if one would have intended the act as a means to the effect if one had known the facts. But it is not necessary that one actually intend the act as a means to the effect, given one's present epistemic position.

The trouble with do-gooders: the example of suicide.

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