Rationality and the wish to die—a response to Clarke

SIR

In a scholarly and thought-provoking paper, Clarke sets out to debunk the concept of “rational suicide” as nonsensical. His motivation in this is to undermine any support that the notion of rational suicide might give to a “categorical right to suicide”. If his enterprise were successful, however, it would go far beyond the “rights issue” and would have a profound impact on all arguments raised in support of euthanasia or physician-assisted suicide.

Clarke’s major thrust might be termed the argument from posthumous ignorance. He begins with a claim that the process of making a rational decision involves the process of “gaining all possible facts and ‘imagining’ all possible consequences”. He goes on to say that making a rational decision “in the consideration of life or death . . . would seem to be impossible”. It is “impossible” because the person making the decision cannot know what death is like, and therefore cannot weigh up the risks and benefits of his or her choice to die. One just can’t know what it is like to be dead—“it is essentially of an unknown quality and a matter of faith rather than rational thought”.

Before examining where Clarke has gone wrong, let us leave aside the obvious impossibility of gaining all possible facts and substitute the notion of gaining all relevant facts. Further, let us gloss over the considerable difficulties in deciding what counts as relevant, by allowing that knowing what it would be like to be dead would be relevant to a decision concerning the possibility of dying. Finally, let us overlook the fact that many of us feel we have a pretty good idea what death would be like anyway.

It is quite common for people to make what we are happy to term rational decisions in situations where they do not and cannot know a fact of apparent primary relevance. We do that the first time we make a rational decision to eat a mango. Of course, we may ask others what mangoes taste like—“sort of mangoey”—but we cannot know (in Clarke’s strict sense) until we’ve done it ourselves. It would seem very odd to deprive any decision involving any novel activity of any possible rationality.

Clarke might respond, of course, that we are talking about something far more unknowable than the taste of mango. No one knows what death is like. “Although one can imagine that death will be like dreamless sleep or being under anaesthetic, it is an assumption or at best a guess. Nobody knows.” Perhaps Clarke’s position is that it is not possible to make a rational decision, where one of the relevant facts is not known (in Clarke’s strict sense) by anybody.

However, even this position will flounder. People make decisions, that we are happy to call rational, with exactly this limitation all the time. Nobody knows what the future will hold, but people make rational decisions that concern future possibilities. More specifically people make all sorts of rational decisions about issues that concern death. I have made a rational decision to take anti-hypertensive medication, primarily because I want to stave off death. People frequently decide to have life-saving operations for exactly the same reason. Others opt for treatments, such as bone marrow transplants, where death is a relevant possible adverse outcome. Clarke would presumably not argue that these decisions are necessarily non-rational, despite the fact that they must involve the consideration of the ultimately unknowable quality of death.

It is not necessary to gain all relevant facts to make a rational decision, it is only necessary to gain those relevant facts that are reasonably obtainable and to have an understanding of the limits of one’s knowledge. It is OK to guess, as long as you know that you are guessing. It is possible to make a rational decision about suicide.

Clarke is right to caution us to be wary of the motives of those who ask to die. A genuine request to die uninfluenced by mental illness and based on a considered weighing of the pros and cons of continued life, is a very rare beast. Rare it may be, logically impossible it is not.

References
2 See reference 1:458.

DR CHRISTOPHER JAMES RYAN
MBBS FRANZCP
Consultation-Liaison Psychiatrist, University of Sydney and Department of Psychiatry, Westmead Hospital, Westmead, NSW 2145, Australia

Hymenorrhaphy: what happens behind the gynaecologist’s closed door?

SIR

Premarital sex is socially and religiously unacceptable in some cultures, with grave consequences such as shame, rejection, divorce, or even death to “cleanse the shame”. Hymenorrhaphy or hymenoplasty has emerged as a procedure which attempts to restore the ability of the hymen to bleed at intercourse on the wedding night, thus protecting women from violent reprisals.

A few articles have recently appeared in the English literature debating whether hymenoplasty is clinically indicated or ethically justified. If we review the English literature, we find only one article addressing the success
of this operation in a group of 20 patients. The authors claim that all 20 were satisfied with the outcome and none had regrets. Long term follow up is available on only 10 patients (50%) and they report that the procedure provided a satisfactory outcome. This single article can hardly be convincing in an era of evidence-based medicine. There is the theoretical risk of infection which might disrupt the repair, thus defeating the purpose of the operation, and there is the potential risk of bleeding with intercourse, which might be traumatic to the couple. Well controlled studies to assess success rates before marriage are necessary to ensure that such an operation has not been done. Such operations will make all women suspects in the eyes of their prospective wives before marriage to present in our clinics requesting a justifiable in asking for? A few men are dressed before considering the procedure. The second problematic aspect of Dr Campbell’s argument is the fact that euthanasia is not voluntary. In cases where patients are unable or unwilling to express their wishes. And these are precisely the cases with which Dr Campbell is concerned.

The second problematic aspect of Dr Campbell’s argument concerns the specific recommendation that he believes follows from the fact that a request for euthanasia is not known to be voluntary. He maintains that in such cases the request should not be followed. Apparently it is the responsibility to act on the request only if it is known to be voluntary. But this is a very demanding standard, and one that is not at all reasonable in most areas of medicine. If a patient in great pain presents in the emergency room of a hospital and consents to recom-mended surgery, we do not hesitate to perform the procedure because the patient renders the consent not voluntary. It is question-begging to return...
that this case is different from euthanasia because the surgery is obviously rational and in the patient’s best interests. For as Dr Campbell rightly concedes, if a patient’s pain is irredeemable and can be ended only by hastening death, then it may well be rational for that patient to choose to end his or her life.

In many contexts of medicine, doubts can be raised about whether a patient’s consent is informed or fully voluntary. The best that fallible humans can do is to look for additional evidence of what the patient wants. That we do this demonstrates our commitment to the precepts dubbed “the advance directive principle” and “the substituted judgment standard”. We even appeal to these precepts when patients clearly lack decision making capacity. Evidence does not always produce certainty, but we do not demand certainty even when the results will be life-altering or irreversible. Were we to demand certainty, in many cases we would not be authorised to act. In the cases discussed by Dr Campbell, refusal to act in the absence of certainty makes it more likely that we will fail to honour these patients’ wishes; in addition, we will deny them relief from their agony.

References
3 Flew A. Advance directives are the solution to Dr Campbell’s problem for voluntary euthanasia. Journal of Medical Ethics 1999;25:245-6.

TERRANCE MCCONNELL, PHD
Department of Philosophy
University of North Carolina at Greensboro
Greensboro, NC 27402-6170, USA
E-mail: tcmcconn@uncg.edu
Hymenorrhaphy: what happens behind the gynaecologist's closed door?

Ihab Usta

doi: 10.1136/jme.26.3.217-a

Updated information and services can be found at:
http://jme.bmj.com/content/26/3/217.2

These include:

**References**
This article cites 2 articles, 0 of which you can access for free at:
http://jme.bmj.com/content/26/3/217.2#BIBL

**Email alerting service**
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/