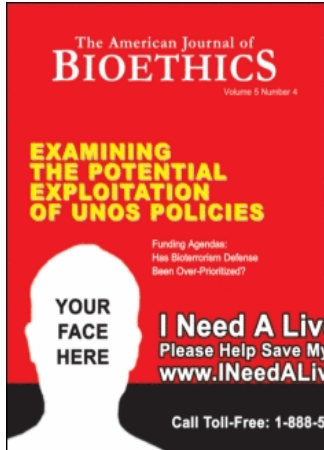


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Conflicting Preferences and Advance Directives

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Hertogh and his colleagues argue that “the condition of advanced dementia can never be a reason to perform euthanasia based on an [advance euthanasia directive] AED” (Hertogh et al. 2007, 48). The main reason given for this conclusion is based on the issue of conflicting preferences or desires. As they discuss, people often compose AEDs in case they later suffer from dementia and cannot make fully autonomous decisions. Following tradition, we will refer to such preferences as *now-for-then preferences*. However, once people suffer from dementia, the authors mention that their desires may change as they adapt to the new situation (Hertogh et al. 2007). If this is accurate, we can then maintain that such people also have a *now-for-now preference* or current desire to continue to live. Because of this situation, we have conflicting preferences that identify mutually inconsistent states of affairs as contributing to their welfare. The authors seem to assume that either current preferences are always stronger than now-for-then preferences or, when there is a case of conflicting preferences, that there is no way to determine which preference is stronger. So we may ask are these assumptions correct? To answer this question, it is instructive to appeal to the literature regarding desire satisfaction theories of welfare. Desire satisfaction theories purport to show that a person’s life goes well for her if most of her strongly held and typically informed preferences or desires are satisfied.

According to an unrestricted version of desire satisfaction theories, preference strength is simply a function of felt intensity. If we appeal to such a theory, there is no good reason to suppose the now-for-then desire is stronger than the current desire, and it is even possible that the current desire is even stronger. Unrestricted desire theories, however, face many problems including the scope problem; therefore, most theorists reject the unrestricted theory in favor of a restricted version such as the informed desire theory (Brandt 1998; Griffin 1986; Hare 1981; Harsanyi 1977). Once this change is made, the strength of a desire is not a function of only its felt intensity, whether the desire is informed also plays a role in determining its strength and thereby its place in preference ordering. The stipulation of the term *informed* places certain epistemological requirements on our desires, and so desires based on misinformation, lack of relevant information, oppressive social conditioning, and other kind of errors may not contribute as much to our welfare as contrary desires based on full information. This stipulation also

implies that we have the capacity to think rationally and to weigh certain options.

With this restriction in place, we can query, in the case before us, whether their now-for-then desire to die if they develop Alzheimer’s disease is more informed than their present desire to live. Once dementia sets in, people’s ability to make autonomous choices is impaired. Although, as the authors mention, such persons can still express somewhat trivial preferences, it is doubtful that their current preferences are as informed as their now-for-then preferences. Do they fully understand what the future holds for them? Do they realize that they can no longer identify and often communicate with their children? Do they even remember that they once firmly believed that they would not want to live under such conditions? Furthermore, as Dworkin (1994) has cogently argued, it is doubtful that their current preferences are consistent with their critical interests such as their life plans and their deep values that they were still mindful of when filling out such a form. And critical interests can give rise to global desires that also impact welfare such as I want to live my life autonomously in accordance with my deepest values and first-order desires, such as I want to want assistance dying when I have lost a coherent sense of self. The authors also mention that when people complete this type of advanced directive, they are told that their desires may change when they become demented. As Hertogh and his coauthors write, “the subscriber explicitly declares . . . that regardless of what he wishes or states after having become demented, only the patient’s earlier opinions as expressed in the advance directive are to be respected” (2007, 48). Since such now-for-then desires are more informed than their current desires, are more in accordance with their critical interests they were mindful of when completing such a form, and are related to certain global desires about how they want to live, it is plausible to argue that their now-for-then desire to die is stronger than their current desire to live.

Another possible assumption is that there is no way to deal with conflicting desires, and so now-for-then desires must be thrown out of the preference ordering. This thought has had some hold on the theoretical literature (Brandt 1998; Hare 1981). However, a contemporary philosopher has come up with a plausible solution to this problem. Arneson (1990) suggests that we simply include all preferences past, present, and future, and when we do the

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preference ordering, the preferences are weighed accordingly. If some preferences happen to conflict, this is no problem as the one that is the strongest, in terms of its hypothetical rationality, is the one we should satisfy. Even though we have a now-for-then desire and a present desire that identify inconsistent states of affairs as contributing to welfare, we can simply disregard the desire that is lower in the preference ordering. In this case, it again appears that the present desire would be weaker since it is not as informed as the now-for-then desire.

As I have demonstrated, current preferences are not always stronger than past preferences, and it is possible to deal with conflicting preferences. Because of this, the authors' conclusion does not necessarily follow from the main reason given. They have provided no strong theoretical reason for denying such people the option of euthanasia if their now-for-then desire to have their lives terminated was fully informed and in accordance with their precedent autonomy. Furthermore, if welfare is understood as preference satisfaction, then thwarting their now-for-then preferences may cause their lives to worsen, and it is certainly possible to use this theory of welfare to derive an account of best interests. If this is done, then both the best interest standard and precedent autonomy standard may point in the same direction.

As in the case of Ulysses, who told his crew to disregard his pleas to be released on hearing the enticing cries of the sirens, both precedent autonomy and welfare beckon us to disregard their present desires, and since their now-for-then desire, as explicitly stated in their AED, is more informed than their present desire to live, we have a strong reason to honor it. ■

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An Islamic Perspective on Euthanasia

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And take not life, which Allah has made sacred, except by way of justice and law.

— Holy Koran, Al-An'am, Verse 151

In Iran, in contrast to European countries such as the Netherlands (Hertogh et al. 2007), the laws and regulations regarding such subjects as euthanasia are based on Islamic (Shiite) jurisprudence. This jurisprudence has four main sources. The first and most important one is the *Holy Koran*, the primary source of Islamic law. The second source of Islamic law is *Sunnah*, which is what the prophet (and Imams in the Shiite school) said, did, or agreed to. The third source is *Ijma*, which is consensus of Islamic scholars, and the fourth one is *Aghl*, which is the reason.

Based on a convincing interpretation of the Koran, Islamic jurisprudence does not recognize a person's right

to die voluntarily. According to Islamic teachings, life is a divine trust and cannot be terminated by any form of active or passive voluntary intervention (Sachedina 2005). All Islamic scholars regard active euthanasia as forbidden or *haram*, and the Sunni (Al-Qaradawi 2005) and Shiite (Khamenei 2007) scholars are in agreement on this matter.

There are two instances, however, that could be interpreted as passive assistance in allowing a terminally ill patient to die and thus would be permissible under Islamic law: 1) administering analgesic agents that might shorten the patient's life with the purpose of relieving the physical pain or mental distress, and 2) withdrawing a futile treatment with the informed consent of the immediate family members who act on the professional advice of the physicians in charge of the case, and allowing death to take its natural course (Sachedina 2005).

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