THE PERMISSIBILITY OF SUICIDE IN LIGHT OF THE RIGHT TO REFUSE TREATMENT

by

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The thesis advances the argument that the rationale for permitting informed, competent adults to refuse or withdrawal life-saving treatment also supports permitting some individuals to die by suicide if they so choose. This argument will begin by first recounting the consensus that has developed in the United States, which holds that the refusal of life-saving treatment by competent adults can in some circumstances be ethically justified on the grounds of respect for the autonomous decisions and promotion of the individual wellbeing of such persons. This will be followed by an examination of the concept of autonomous decisions-making and the related concept of competence to make such decisions, with consideration of their applicability to determining whether permitting some suicides can be ethically justified. It will then be argued that, in addition to satisfying the criteria of competence, autonomy and personal wellbeing, the decision to die by suicide must also be authentic in order to be permitted. Moreover, consideration will be given to the harms to others that may result from suicide, and sufficient non-harm to others will be proposed as a criterion for judging whether a suicide should be permitted. While the rationality of the decision to die and the presence of terminal or chronic conditions have been considered important in evaluating the permissibility of suicide, I argue

that these should not be treated as criteria for judging a suicide's acceptability. I will argue that applying criteria of competence, respect for autonomy, wellbeing, authenticity, and sufficient non-harm to others is necessary and sufficient for determining whether a suicide ought to be permitted. The implications of this conclusion for clinical practice will then be considered. This will include consideration of the special nature of the clinician-patient relationship, as well as how satisfaction of the five criteria may be evaluated in the clinical setting. Case examples are included to help illustrate how the framework could be employed. Finally, the limitations of the framework will be addressed to consider how doubts about satisfaction of the criteria may be handled and the possibility that dogmatic adherence to the framework could be morally untenable.

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PREFACE

I extend my deepest gratitude to the members of my thesis committee. Their steadfast support, honesty, and guidance have made this possible.

1.0 INTRODUCTION

End of life decision-making has been a central focus of bioethics since the field emerged. Bioethics in much of the twentieth and beginning of the twenty-first centuries has focused on issues such as a competent patient's right to refuse life-saving medical intervention, the right to physician aid in dying, and the right of once competent patients to have previous wishes regarding withdrawal of life-sustaining interventions honored. Highly publicized court cases and legislation have brought each of these to public awareness, and the "right to die" has entered the lexicon in the United States. Apart from physician-assisted suicide, however, the issue of suicide has not received widespread attention or been the subject of substantive social reform.

In Part One, I will argue that the same considerations underlying the right of competent patients to hasten death by refusing or withdrawing life-sustaining intervention also support allowing some individuals to die by suicide. The argument will begin with an examination of the ethical and legal consensus regarding refusal of life-prolonging treatment by competent persons. Part Two will explore each of the criteria used to determine when, according to this consensus, it is acceptable to permit patients to die. Throughout this exploration, it will be shown that each criterion applies equally well to cases of treatment refusal and cases of potential suicide. I will also argue in Part Two that the decision to die by suicide must be an authentic one in order to be potentially worthy of respect, but that no criteria in addition to this and those discussed before it will be required. Then, in Part Three, attention will be paid to the changes in clinical practice *vis-*

à-*vis* the suicidal individual that would be warranted by the account developed. This focus on the clinical context is appropriate, as the predominant modern view on suicide is medical rather than legal (Battin, 1995, p. 131). Moreover, the substantial moral conflict arises in the clinical setting because the presumption is that suicide intervention and prevention are always justified (Szasz, 2011). Finally, in Part Four, the limits of the framework laid out in the body of the work will be explored.

1.1 THE CONSENSUS

By the early 1990s, a consensus had emerged in the United States concerning the right to refuse treatment (Meisel, 1992). This consensus holds that competent patients may refuse to initiate or continue any treatment even if such refusals are likely to result in grave harm to them, up to and including their death. This right of competent patients to refuse life-saving medical treatment is an instance of the broader right of competent patients to refuse medical treatment in general, which is in turn grounded in the right of competent patients to make informed decisions regarding treatment. Informed decisions can be of two forms – informed consent and informed refusal. A patient provides an informed consent to a treatment, procedure, etc. when she autonomously authorizes a clinician to perform said treatment or procedure on her. An informed refusal is likewise an autonomous act, but instead denies the clinician the permission to perform the act for which such permission is sought (Faden & Beauchamp, 1986, p 277).

The consensus further holds that there is a morally relevant distinction between killing someone and letting him or her die. In the medical setting, this means that, *prima facie*, doctors

may discontinue life-prolonging treatment when requested to do so by a competent patient and thereby allow a terminal illness to run its course, resulting in the patient's death. On the other hand, the physician may not take an "active" role in ending the competent patient's life even if requested to do so by the patient. To take such an active role is alleged to be morally and legally wrong because it violates the dictum that physicians should "do no harm" and because the harm in question is that of killing an innocent person, an act the state has a strong interest in preventing in general (Meisel, 1992, p. 317)

As Alan Meisel and others (e.g. Rachels, 1998, pp. 21-26) have convincingly argued, this distinction between killing and letting die is a false distinction. It rests on the assumption that one can clearly distinguish between cases in which action resulted in death versus those in which inaction resulted in death. For example, it seems arbitrary to say that administering a lethal substance is an action, while turning off life support, thereby allowing a fatal disease to run its course, is an inaction. What is morally important is not simply the means by which an end is reached, but the motive behind and the expected consequences of the action (Rachels, 1998, p. 24). Furthermore, as was discussed earlier, the patient has a right to consent to or refuse intervention by a medical professional. In both cases, the motive may be to relieve suffering and the intended, or at least expected, consequence will be the death of the patient. However, a physician could rightly be accused of murder if he deliberately injected a patient with a lethal dose of morphine or if he removed the same patient from her life-support system if, in either case, the patient did not both make and express the decision to die and give doctor permission to take part in her death.

Since the consensus of the 1990s, and running contrary to it, five U.S. states have legalized the practice of physician-assisted suicide for competent individuals who voluntarily

request such assistance and who have also been diagnosed as terminally ill. This legalization has been accomplished through public referendum, legislation, and court rulings. The position supported by such changes seems to hold that the right to refuse life-sustaining treatment and the right to physician aid in dying represent two points along the continuum of the right to die. However, courts in the United States generally have not treated them as rights resting on similar foundations. As Meisel notes, legalization of physician-assisted suicide challenges the weakest pillar of the consensus, that of the clear distinction between killing and letting die (Meisel, 1992, p. 331). His prediction that such challenges may ultimately undermine the consensus entirely does not seem to have come to fruition, thankfully, as the right to refuse life-saving treatment has thus far not been curtailed as the physician-assisted suicide has gained ground.

This right and the associated debate have centered primarily on two normative ethical principles – namely, respect for individual self-determination and concern for individual wellbeing (Brock, 1998). Concerning the principle of individual wellbeing, it has long been recognized that the individual whose wellbeing is of concern is, generally, in a better position to make judgments about and to take actions to promote said wellbeing than any third party (Mill, 1901, p. 54). Of course, this qualified view leaves room for others to consider whether a person is *actually* better situated to make such judgments. This leaves us with three criteria which it may be necessary for an individual's decision to die to meet before said decision can be respected: 1) the decision must be made by a competent person; 2) the decision must, *prima facie,* promote the subjective wellbeing of the person; 3) the decision must demonstrate a sufficient level of self-determination.

Respect for the autonomous actions of competent persons has limits; however. It is not difficult to find examples of actions that meet the criteria just enumerated that would,

nonetheless, be impermissible. Take for instance the commission of a premeditated murder. While this is an extreme case, it is representative of a larger set of cases in which it is necessary and appropriate to take into account the welfare of others when preparing to judge whether an act by a particular individual is permissible. If the impact of the action is question is found to be sufficiently harmful to others, third parties can rightly intervene to prevent said action (Mill, 1901, p. 55). Sufficient non-harm to others, then, constitutes the fourth criterion worthy of consideration.

1.2 A DEPARTURE FROM THE CONSENSUS

Both the finality of death in general and the uniquely personal decision to bring about death by suicide suggest a question that deserves an answer – is death by suicide what the person intending to die in that fashion genuinely wants? The concern, put another way, is whether said decision is authentic. Authenticity has been considered, if only to be rejected (see Faden & Beauchamp, 1986, pp. 262-268), as a necessary feature of a decision in order for it to merit respect. However, considerations of authenticity are distinctly lacking in the consensus that competent patients have a right to refuse life-saving treatment. That is, the decision to forgo such treatment need not be authentic for that decision to be respected. A defense of authenticity as the fifth criterion that must be met for a decision to suicide to be *prima facie* worthy of respect is therefore a departure from the consensus. However, it will be suggested that the reasons for accepting an authenticity criterion in the case of suicide extend to cases that do fall within the consensus.

In what follows, I will argue that an act of suicide is permissible if and only if the individual intending to die made that decision competently, autonomously, authentically, in line with his or her subjective wellbeing, and if the act is sufficiently non-harmful to others. I will further argue that whether these criteria are met is an empirical question and that, therefore, each case in which a person desires to die by suicide must be investigated in its own right before that suicide can be judged permissible or not. I draw the conclusion that anyone whose decision to die is found to meet these criteria ought to be allowed to die by suicide, regardless of the presence (or absence) of psychological and physical disorder and/or suffering. I will then sketch the changes to clinical practice that acceptance of these conclusions would require.

2.0 THEORY UNDERLYING THE CRITERIA FOR PERMITTED SUICIDE

Competence, wellbeing, autonomy, authenticity, and sufficient non-harm to others have thus far been proposed as criteria which must be considered when a determination of the permissibility of a suicide is to be made. In what follows, the meaning of each criterion will be elaborated, and the characteristics an agent or action must exhibit in order to be said to meet each criterion will be examined. Special attention will be paid to the decision to die by suicide and whether such a decision can in principle meet the above criteria. Finally, it will be argued that no other additional criteria should govern determinations regarding the permissibility of a given suicide.

2.1 AUTONOMY AND COMPETENCE

2.1.1 Autonomy

Respect for individual autonomy is a foundational value of modern Western societies and has, unsurprisingly, found a central place within the bioethical cannon. In the simplest terms, the principle of respect for individual autonomy requires that, *prima facie*, those persons who meet criteria that allow them to be deemed autonomous agents should be permitted to act as they choose. To be understood and applied, the principle requires an explication of the term "autonomy" in order to be of any practical value. As the concern throughout this piece is with the

permissibility of allowing particular actions, the operative concept will be parsed in terms of what constitutes autonomous action. An account of this principle and the rights of autonomous agents would be incomplete without a demarcation of the limits of both, so this too will be addressed in what follows.

According to Ruth Faden and Tom Beauchamp, an action can be correctly judged "substantially autonomous" if it satisfies three criteria. The first of these requires that an act be intentional, meaning that said action must be willed in accordance with a plan in order to count as potentially autonomous (Faden & Beauchamp, 1986, p. 243). On this view, actions are categorically either intentional or not; therefore, an action that is not intentional also fails to be autonomous. In order to count as an intentional act, the agent carrying out the act must have a grasp of the relevant steps involved in performing the act as well as an understanding of the probable consequences of the action (Faden & Beauchamp, 1986, p. 248).

Understanding is the second criterion which must be met by a decision-maker for her act to be deemed potentially autonomous. This term can be parsed in several ways: one may understand *how* to do something, such as arithmetic or turning a table leg on a lathe, or one may understand *that* some fact or that something is the case, such as the value of the square root of two or that the onramp to the highway will be closed. These two types of knowledge do not, of course, exhaust the uses of "understand"; however, they reflect the primary relevant distinction between "understanding or knowing how", and "understanding or knowing that". Both are important for the issue at hand, though in radically different ways. For instance, understanding how to kill oneself, what has been called competence regarding suicide (Joiner, 2007, p. 73), is important when assessing the risk that someone will die by suicide. With regard to assessment of whether a person has competence regarding suicide, however, knowledge of how to kill herself is

not the understanding that must be assessed to determine whether an act or decision is autonomous. Instead, it is propositional *knowledge that* particular consequences are likely to follow from a decision to die or from the act of suicide that is relevant for assessment of the autonomy of the decision, the act of deciding, and the act of acting on the decision.

Specifically, this criterion requires that the agent performing the action understand the nature of the action, what the action entails, and the foreseeable consequences of the action. It does not require, however, that the agent understand the act under all possible descriptions, nor does it require the agent to apprehend all possible consequences of the act. Rather, it requires the agent to apprehend the material or important descriptions of the action under consideration, where "important descriptions" refers to those descriptions of the action and its consequences that the agent would like to have available for the purpose of evaluating whether to engage in the act (Faden & Beachamp, 1986, pp. 300-302). This *substantial,* rather than *full*, understanding of an action is both necessary and sufficient for an action to be deemed potentially autonomous (Faden & Beachamp, 1986, p. 302).

It is readily apparent that understanding of this kind can vary in degree, ranging from a complete grasp of the nature and consequences of an action to a complete lack of such understanding. There are also different levels at which understanding can occur. For example, a patient may be informed that one consequence of treatment will be extreme itching. If asked, the patient may repeat this information verbatim or, as is preferable, in his own words. However, until the symptom arises, he may not appreciate just how impairing the sensation will be. This is an example understanding as appreciation of 'what it would be like and "feel" like to be in possible future states and to undergo various experiences' (Buchanan & Brock, 1995, p. 24). Appreciation is therefore richer in content than mere propositional understanding. However, both

appreciation and propositional understanding can vary in the degree to which they are possessed and demonstrated by a decision-maker. Thus, the level of autonomy with which an action is performed (or a decision is made) can vary.

The third criterion for autonomous action is that it must be substantially noncontrolled by external influences or internal states that significantly diminish the ability for self-directed action (Faden & Beauchamp, 1986, pp. 256-262; Beauchamp & Childress, 2013, pp. 137-139). External influences on a particular individual refer specifically to intended attempts by an agent or agents to direct the behavior of that individual (Faden & Beauchamp, 1986, p. 256). Such influences take three forms: coercion, manipulation, and persuasion (Faden & Beauchamp, 1986, p. 258). By contrast, states internal to a decision-maker, such as addiction and psychological disorder, can "diminish or destroy voluntariness" without the influence of another agent (Beauchamp & Childress, 2013, p. 138). Noncontrol is analyzed in terms of influence exerted on a decision-maker and her ability to resist that influence (Faden & Beauchamp, 1986, p. 256). As such, there can be great variability as to what counts as a substantially controlling influence as individuals will have varying degrees of resistance to a given form of influence. As in the case of understanding, only a *substantial* degree of noncontrol is needed for an action or decision to be potentially autonomous. This is an important qualification, as the choices people make are generally arrived at within the context of several influencing factors, such as family needs, financial obligations, and personal desires which are not necessarily unduly controlling (Faden & Beauchamp, 1986, p. 262). Here, an act carried out under substantial noncontrol is one that is still up to the agent to choose to perform or not because she is able to resist those influences on her decision-making (Faden & Beauchamp, 1986, p. 259).

2.1.1.1 Can Suicide be an Autonomous Act? With this brief sketch of a widely respected account of autonomous action, it is now possible to ground the discussion of the potential permissibility of suicide in light of this account to determine whether there is anything unique to the act of suicide that would preclude it from being deemed an autonomous act. If it can be shown that there are incongruities between the conditions for an act to be considered autonomous and the nature of suicidal acts, then it would be the case that no *actual* suicide would be autonomous, thus providing grounds for intervention in almost all actual instances involving suicidality.

Can suicide be intentional in the way described above? There would seem to be no contradiction in a suicide being a planned event that was willed to occur in a particular way by an individual. In fact, suicide is, at least in part, defined in the philosophical literature as an act of intentional self-killing (Cholbi, 2011; Cosculluela, 1995). Furthermore, assessing individuals for the presence of "resolved plans and preparations" to die by suicide is useful for determining the likelihood of a potentially lethal suicide attempt (Joiner, 2007, pp. 78-80). It would seem reasonable to conclude that suicide can be and in many cases is an intentional act.

Whether in deciding to commit suicide a decision-maker can adequately fulfill the criterion of understanding is a more difficult, though not insurmountable, conceptual problem. "Understanding" as described above requires that the individual intending to die by suicide comprehend both the nature of the act he is to commit and the foreseeable consequences of that action. Grasping the nature of the act poses little difficulty: the sequence of events and the objects and persons involved in those events are, in general, readily available to the suicidal individual. This presumes, of course, that the agent intending to die by suicide possesses the abilities required to apprehend this straightforward set of information. The concept of suicide

does not include a lack of such abilities, so it is reasonable to grant that the agent in question could possess them. It could be argued, however, that understanding and appreciation of all of the consequences of suicide are not available or able to be understood. Namely, it can be stated that, if successful, the person will be dead, but it is not possible for the person to know what this truly means; it is logically opaque because one cannot adequately learn about death by either experience or through the accounts of others (Cosculluela, 1995. p. 93). This thesis, put forth by philosopher Philip Devine, is intended to show that death can never be chosen rationally because one cannot know what one is choosing. If we have no reason to doubt this line of thought, we must conclude that suicide cannot in fact be an autonomous act, because it will always be made with less than substantial understanding of what is arguably the most important consequence of suicide – namely, death.

I do, however, find several problems with this conclusion. First, there are many accepted accounts of what occurs when one dies. Such accounts can be divided into two categories – physiological accounts and philosophical accounts. The former includes items such as the cessation of metabolism and the onset of bodily degradation, while the latter is concerned with ideas such as the nature of a good death, whether there is an afterlife, and the nature of such an afterlife. While physiological considerations about death and the dying process certainly may factor into philosophical accounts (e.g. the aesthetics of physiological death influencing what counts as a good death for a particular person), it is the philosophical accounts that are relevant to the determination of the degree of autonomy of the decision to die by suicide.

On the view that death is annihilation, there would appear to be nothing more to know about what happens as a result of suicide; the issue of "what it is like to be dead" does not arise. Under this conception, death can be a sufficiently understood consequence of the act of suicide

(Cosculluela, 1995, pp. 92-94). Other conceptions of death as involving an afterlife are also widely held and accepted as a sound basis for action in this life. For example, the commonly cited belief held by Jehovah's Witnesses that consumption of blood is prohibited by their God is sufficient ground for these individuals to refuse even life-saving blood transfusions. For them, to do otherwise would negatively impact their standing in the afterlife. There is no standard by which one can choose with certainty which of the available philosophical conceptions of death is correct; "correct" may in fact be an inappropriate term to apply to the subject. Furthermore, as we have already seen, there is a consensus that life-prolonging intervention may be terminated or refused by competent adults. Generally speaking, the mere fact that a patient holds a philosophical view of death differing from her clinician's view does not provide grounds for her to be deemed incompetent. Devine's analysis would lead us to conclude that such choices should not be respected because they would always involve a lack of sufficient understanding regarding the nature of what is being chosen – death. However, the preceding line of thought demonstrates that, in everyday practice, not only are there multiple philosophical accounts of death, but that these accounts sometimes serve as the basis for individuals deciding how to structure and live life. It would therefore seem that Devine's claim (that suicide can never be rationally chosen due to the logical opaqueness of death) can be refuted, not necessarily because he is incorrect about a lack of knowledge regarding the nature of death, but because requiring such knowledge is simply the wrong standard to employ for rationality as the term is employed in daily life. A standard of justified belief (whether true or false) ordinarily suffices as the basis for rational decisions.

Finally, it must be considered whether suicide always involves an element of control so significant as to lead us to conclude that the criterion of substantial noncontrol can never be met. Certainly there are imaginable cases of self-killing in which one party uses such coercive

methods as to render another agent unable to do anything other than take his own life.[1] I will set to the side the issue of whether such coerced self-killing should, in fact, be called suicide and will accept for the sake of argument that the idea of a coerced suicide is coherent. In such instances of coerced suicide, however, it is obvious that the decision to die is not sufficiently noncontrolled so as to count as even potentially autonomous.

Concerns have also been raised regarding whether a situation can be coercive and, if so, whether decisions made in such circumstances are necessarily less than substantially autonomous. I am inclined to agree with Faden and Beauchamp on this issue – situations cannot be coercive because coercion of one (or more) persons requires that there be an intent, a will that is forcing a particular option, features that situations lack (Faden & Beauchamp, 1986, p. 344). Therefore, strictly speaking, situations cannot be coercive. However, concern may still remain as to whether a choice made among extremely limited options within given circumstances can count as an autonomous choice. Does the man who steals bread rather than starve to death truly act autonomously in doing so? If the mere presence of limited options presented by a situation were itself counted as significant, autonomy-eroding control, most, and perhaps all decisions would have to be accounted non-autonomous. Though scenarios that may prompt an individual to suicide may be tragic (e.g. warfare, extreme poverty, and starvation), it is still possible for persons in such situations to understand the options before them and to make a reasoned choice in light of their own values and, in this way, to choose autonomously (Faden & Beauchamp, 1986, p. 344).[2]

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[1] Such cases may include those of a captive who is faced with a choice between a credible threat of protracted, excruciating torture or a relatively painless death by calibrated, self-administered barbiturate overdose.

[2] Coercive or freedom-limiting situations in which suicide may be one of a limited number of options present a moral choice for those with the power to intervene. Should someone be forced to live even if it means continuing in a state he has deemed unacceptable? Or should society be re-structured in such a way as to reduce the

Of greater and more practical concern are the potential internal states that may prevent an individual from acting autonomously with regard to his decision to kill himself. Of obvious interest are those internal states constituting or associated with a psychological disorder.[3] As will be discussed in greater detail in Section 2.1.2.1, psychological disorders can impact an individual's capacity for autonomous action and choice, for example, by interfering with cognition and undermining intention. It may be the case that all suicidal individuals have a diagnosable psychological condition, but this is a matter that must be settled through empirical investigation. Furthermore, even if such conditions are found in every case of potential, attempted, or completed suicide, whether the disorder presented an irresistible influence that significantly curtailed the capacity for self-direction would also be an empirical question.

Thus far, I have argued that it is conceptually possible for suicide to be an intentional action that can be carried out with understanding in the absence of substantially controlling external and internal influences, i.e. suicide can be an autonomous act. This does not mean that in practice every case of suicide or a particular case of suicide will be found to be an autonomous act; all suicidal individuals could fail to meet one or all three conditions requisite for autonomous action. The preceding analysis sought to show that the question of whether a given suicide is autonomous, and therefore *prima facie* worthy of respect, cannot be settled *a priori* and must therefore be investigated on a case by case basis.

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incidence of such situations in the first place? Could someone with the power to do so provide another option for the suicidal individual to consider? For example, though it may be super-erogatory to do so, I may prevent a person from dying from suicide by relieving her of the extreme poverty that prompted her choice to die.

[3] An oft cited example is the individual with Obsessive Compulsive Disorder who knows that he need not continue washing his hands, states that he in fact does not want to continue washing, but then does so anyway to the point that his skin begins to break down (Faden & Beauchamp, 1986, p. 268).

2.1.2 Competence

Judgments of individuals' competence to make decisions are utilized to separate individuals into two groups: those whose decisions should be putatively respected because they have the requisite decisional abilities to make them, and those who lack those abilities, whose decisions do not garner putative respect, and for whom decisions must sometimes be made. In the context of suicide, the decision to be evaluated is whether to live or die. In some cases, particularly those of patients with a terminal illness, this decision, may involve decisions regarding the acceptance or refusal of life-prolonging treatment. In other cases – indeed, the cases to which the argument of this project most directly applies – the decision of whether to die by suicide does not (or need not) involve acceptance or refusal of medical intervention.

Strictly speaking, determinations of competence are the purview of the courts and can be handed down only by appropriate representatives thereof. These judgments will also likely take into account societal norms such as age. Clinicians, on the other hand, make judgments regarding patient decision-making capacity; that is, they determine whether patients have the requisite abilities to meet the demands posed by a particular treatment decision. This distinction is made here only to be set aside for, in practice, within medical contexts at least, capacity judgments made by clinicians often have the same results as legally rendered judgments of competence (Grisso & Appelbaum, 1998). The primary result is that those deemed to have decision-making capacity are allowed to make particular decisions for themselves without third-party interference, while those who are deemed incapacitated may be subject to such interventions.

Four capacities relevant to competence/decision-making capacity have been widely utilized in determinations of competence within the United States: the ability to express a choice,

the ability to understand the choice and its consequences, the ability to appreciate the consequences of the choice and other related information as being relevant to one's own case, and the ability to utilize this information in a reasoning process that leads to the decision in question (Grisso & Appelbaum, 1998).[4] In addition to these four capacities, Allen Buchanan and Dan Brock note that "a competent decision-maker also requires a *set of values* or *conception of what is good* that is at least minimally consistent, stable, and affirmed as his or her own" (Buchanan & Brock, 1995, p. 25). Such values are necessary for an individual to determine what decisions, actions, and consequences count as goods or harms for him- or herself (Buchanan & Brock, 1995, p. 25).

The ability to express a choice when presented with a decision is a threshold criterion in determinations of decision-making capacity; if a choice cannot be expressed, the individual will be deemed incapable of making the decision at hand (Grisso & Appelbaum, 1998, p. 35). An inability to express a choice can arise from a medical condition that precludes any form of communication, such as catatonia or persistent vegetative state. However, it may also take the form of an individual's inability to make a stable decision; that is, an individual who is ambivalent and who does not express a stable choice over time has not met the requirements for expressing a choice (Grisso & Appelbaum, 1998, p. 36). Though the literal inability to communicate is distinct from being able to communicate but communicating changing or contradictory preferences, in practice they yield the same result – inability of the clinician to act on a patient's expressed choice.

[4] These criteria will be described in what follows as they are defined by Grisso and Appelbaum unless otherwise noted.

The second ability related to competence according to this model – understanding – is arguably the same as the second criterion for autonomous action of the same name. However, it is worth explaining in more specific terms just what must be understood for determinations of decision-making capacity. Thomas Grisso and Paul Appelbaum, considering this question for the purpose of clinical application, hold that it is the information disclosed to a patient during the informed consent process which must be understood. This disclosed information includes the risks and benefits of each treatment option and the likely outcomes of the possible choices (Grisso & Appelbaum, 1998, pp. 37-42). Of course, a relevant conception of understanding need not be confined to understanding within the clinical realm; it can be applied to other types of decisions to determine whether the nature and implications thereof have been adequately comprehended.

Appreciation again can be viewed as a specific kind of "understanding that" as discussed with respect to autonomous action. Clinically, appreciation refers both to a patient's understanding that he has a particular disorder and to his understanding of the course of that disorder and the possible outcomes of different treatment options for *his own case* (Grisso & Appelbaum, 1998, pp.42-43). This is a practically useful distinction as it is possible for individuals to understand all information presented to them regarding a disease and treatment but to also fail to acknowledge that said information applies to them (Grisso & Appelbaum, 1998, p. 42). There are at least two ways in which "appreciation" can be understood. The first is in terms of the subjective experience, for example, of a disease process, the what-it-is-like to have a particular symptom. The second is parsed in terms of acceptance of the relevance of information for one's own circumstances (Grisso & Appelbaum, 1998, p. 43). The latter version is the one employed by Grisso and Appelbaum. However, this does not mean that the former is

unimportant or that assessment of appreciation of this kind is impossible from an objective perspective. Much of the import of what a person believes a future state will "feel like" can be captured by questioning what changes in lifestyle or quality of life the individual foresees. For example, when asked about the aftermath of a lumbar spine surgery, a patient may report that she anticipates "a lot of pain". The surgeon can inquire as to what the patient means by this; she may reply that she anticipates having difficulty bending over to tie her shoes, feeling a constant dull ache for several weeks, and needing to modify how she sleeps to keep pressure off of the incision as it heals.

For both appreciation qua understanding future subjective states as just described and qua understanding that a particular description of a state of affairs applies to oneself, there is the possibility of failure to appreciate material information due to the presence of false beliefs. The sources of such beliefs vary and include misinformation, inadequate information, misunderstanding of the facts as they are presented, denial, and delusion. Distinguishing false beliefs from other types of belief is a difficult task that is only mentioned here so as to illustrate the role it has to play in determinations of competence/decision-making capacity.

The final ability related to competence/decision-making capacity is the ability to reason utilizing relevant information in order to select from among various options. Reasoning is taken to be the process or series of processes by which information is manipulated to reach a conclusion through a series of logical steps (Grisso & Appelbaum, 1998, p. 52). The reasoning process is further broken down into various functions that must be performed in order for a conclusion to be reached: focusing on the problem to be solved and/or the choice to be made, considering available options, considering and imagining the consequences of the various options, assessing the likelihood that a given consequence will obtain, evaluation of potential

consequences “based on one’s own subjective values”, and final deliberation involving weighing the potential consequences in light of their probabilities and desirability (Grisso & Appelbaum, 1998, p. 54). The nature and importance of the aforementioned subjective values will be discussed at length in Section 2.3 “Authenticity”.

Now that the Grisso and Appelbaum model of the abilities relevant to competence /decision-making capacity have been outlined, it is possible to discuss how the authors believe these abilities should fit into judgments about a person’s capacity to make a particular decision. The question they suggest the evaluator should keep in mind when performing an assessment is “Does this patient have sufficient ability to make a meaningful decision; given the circumstances with which he or she is faced?” (Grisso & Appelbaum, 1998, p. 147). Answering this question, in their view, requires the evaluator to balance the person’s abilities against the risk involved with the decision they have to make. With this model, the threshold level of competence varies directly with the risk of the decision. While I find the way in which this model characterizes the abilities to be weighed to be extremely cogent and useful, there remain issues about how this model might be applied. As Tom Beauchamp and James Childress note, there is no reason to assume, as Grisso and Appelbaum do implicitly, that more risky decisions require greater abilities than do lower risk decisions as the latter may, in fact, be more complicated and therefore more demanding than the former (Beauchamp & Childress, 2013, pp. 119-120). This does not mean that risk should not be taken into account. On the contrary, a greater level of risk may rightly require a higher standard of evidence that the decision-maker has the requisite capacities to meet the challenge presented by a decision (Beauchamp & Childress, 2013, p.121). This distinction is particularly important in cases of potential suicide, as the risk to the individual considering suicide is, at least from an objective standpoint, considerable. Appelbaum and

Grisso's assumption would automatically set the threshold for competence high in all cases in which suicide is under serious consideration, even though it is an open question as to whether such a decision does in fact place higher demands on the decision-maker than other less risky but more complex decisions. It is for these reasons that, while I accept the Grisso and Appelbaum model of the abilities relevant to competence/decision-making capacity, I would question some of the authors' assumptions about how the model would be used.

2.1.2.1 Suicide, Psychological Disorders, and Competence/Decision-making Capacity

Suicidality is closely associated with a variety of psychological disorders including, but not limited to, borderline personality disorder, anorexia nervosa, and major depressive disorder (Bernal et al., 2007; Granello & Juhnke, 2010). Such disorders can impair decision-making capacity in a variety of ways. For example, the ability to process information relevant to a decision may be diminished (as in disorganized schizophrenia), the decision-maker may cease to care about previously important goals that otherwise would be taken into account during the decision-making process (as can occur with certain mood disorders), or the stability of a decision may be compromised (as might occur with dissociative identity disorder). However, the mere fact that a person meets the diagnostic criteria for a psychological disorder does not mean that it will necessarily lead to impairments in the capacities and values important for making decisions. An individual evaluation would be required to determine in what way, if any, a diagnosed condition impacted the person's decision-making ability with respect to his decision to die by suicide.

This case-by-case evaluation is important for three reasons. First, it is the practical instantiation of the maxim that competence is decision-relative. Second, if it is determined that a psychological disorder has compromised a person's competence with respect to the decision to die by suicide, this is sufficient grounds not to respect that decision. Finally, this recognition allows for intervention in the form of medically indicated treatment for the competence-compromising disorder. Such treatment may help to restore the person's decision-making capacity and thereby lead to a person changing his mind with regard to suicide. However, the desire to die may persist, which should prompt another competence assessment, as the desire to die cannot be assumed to result from compromised capacities.

2.2 WELLBEING

The second ethical principle underlying both the arguments for a patient's right to refuse life-sustaining treatment and a patient's right to physician-assistance in dying is that of concern for individual wellbeing (Brock, 1998; Arras, 2009). That is, such interventions can be withheld or discontinued, or where physician-assistance is permitted, lethal agents administered, because the patient determines that the prolongation of his life no longer promotes his interests. The issue that was a great source of the debate concerning the right to die centered on the question of who was best qualified to determine what is in the individual patient's interests. The answer that has since been upheld in both the legal and ethical consensus was articulated by the California Court of Appeal in its decision in *Bouvia v. Superior Court*: "As in all matters, lines must be drawn at some point, somewhere, but that decision must ultimately belong to the one whose life is in

issue" (Bouvia v. Superior Court, 1986). This conclusion is consistent with the structural view of competent, autonomous decision-making presented above. With respect to the content of the values and beliefs that are the foundations of individual decisions, it is only how this content fits into the overall structure of the process used to reach a decision that is open to third party evaluation.

Thus, competent individuals, when adequately informed of the implications of their decisions, are allowed to determine what best serves their interests, i.e., what is their choice given the beliefs and values that they actually have. In that sense, in cases of decisions made by competent substantially informed patients, respecting their autonomy and their decisions encompasses or meets the ethical requirement that a patient's interests be served or wellbeing be promoted. While this is the case for decisions to forgo life-sustaining treatment, it remains to be determined whether these same criteria are necessary and sufficient for making a determination with regard to whether a particular decision to die by suicide ought to be respected. The following section will examine whether the decision to die by suicide must also be authentic in order to garner respect.

2.3 AUTHENTICITY

It would seem an uncontroversial claim that, when permitting someone to die by suicide, that someone's decision to die should be one's own. However, the full force of this claim cannot be appreciated until it is determined what is meant by a decision or action being "one's own". It could be that whatever this means is adequately addressed in the foregoing criteria. However, if

this is not the case, it will be justifiable to claim that an additional criterion is required for an act of suicide to be deemed potentially permissible. In addressing the question of what it means for a decision to be "one's own", a plausible characterization is that such a decision must be authentic with respect to the decision-maker's identity. Here, there are two ideas to explore: personal identity and what makes a decision authentic to a given identity.

A widely held theory concerning personal identity is that of psychological continuity (Buchanan & Brock, 1995). This reductionist theory posits that what matters with regard to personal identity is the psychological continuity between beings at different points in time, and that there are no "deep further facts" such as souls or Cartesian egos that define particular selves. This theory further asserts that psychological continuity is a matter of degree (Parfit, 1987). For example, it would seem reasonable to claim that an individual who enters college at the age of 18 is significantly changed by the experiences she has during the ensuing four years. At minimum, she will acquire a new academic skill set in line with her degree of choice. She may also develop a more mature, circumspect worldview that incorporates commitments she did not have while in secondary education. On the psychological continuity view, facts of this type are all there are; the question of whether someone is the same person is not useful. Even so, the question of whether the decisions she made or the values she acquired throughout this period of time were authentic remains to be answered, for reasons to which the discussion now turns.

Authentic actions and decisions are derived from authentic values. This relationship between decisions and values should not be surprising as it has already been established that values are necessary for the deliberative process involved in the exercise of one's capacity to reason about the benefits and costs of carrying through with a particular decision; the ability to reason and deliberate is one of the four abilities required for competent decision-making. Thus, the issue of what makes an action or decision authentic leads to the question of what makes the values underlying such decisions authentic.

Several criteria have been proposed. One proposal is that the relevant value must be consciously affirmed after reflective acceptance by the holder of the value before it can be considered authentic (Faden and Beauchamp, 1986, p. 263-264). This seems too stringent a position, however, as it would lead to the conclusion that many values and subsequent actions usually held to be authentic, such as a parent acting out of love for his child, would in fact be inauthentic simply because the value was not affirmed prior to the act (Hyun, 2001, p. 201). A more inclusive formulation would be that a value is authentic just in case it is not repudiated by its holder (Faden & Beauchamp, 1986, p. 267). However, this too poses a problem. We would not, for example, want to say that the value a heroin addict places on having access to his drug of choice is authentic just because he has not repudiated it (Faden & Beauchamp, 1986, p. 268). Perhaps he is in fact disposed to repudiate this value, but the opportunity for reflection has not arisen.

To resolve this matter, I propose the following reformulation: values should be *treated as* authentic until evidence arises to the contrary. As Ishoo Hyun points out, such evidence may not arise until a person is challenged to defend a choice she has made or an action she has taken (Hyun, 2001, p. 200). Taking this fact into consideration, the new formulation takes the

following form: Values should be treated as authentic unless evidence arises to the contrary when the holder of the value is presented with a challenge to the authenticity of a decision or action and, in turn, to the authenticity of the underlying value. This reformulation allows to be treated as authentic those values, and therefore the decisions and actions derived from them, that are usually considered authentic, while still allowing for the possibility of error. The question remains as to just what counts as evidence in support of or against deeming a value authentic.

As was proposed in the earlier formulations, acceptance or repudiation of a value on the part of the holder of the value in question can be material to determining said value's authenticity. Specifically, an agent's affirmation of a value she holds counts toward it being deemed authentic, while an agent's repudiation of a value she holds counts against it being authentic. I say "counts towards" rather than "definitively shows" because there are at least two other types of evidence that could count against even an affirmed value as being worthy of the label "authentic". These may be called evidence of coercion and evidence of inconsistency.

An example of the former, what Gerald Dworkin has called "lack of procedural independence" (Dworkin, 1976, p. 25), would be the case in which it was apparent that a particular value had arisen due to direct and subversive interference from another agent. To be more specific, it would be true for cases in which a value was caused to be held by a person through coercive means. Here, "coercive" is utilized broadly in the sense already discussed – a person is coerced if another agent has irresistible influence over him. This could take the form of a direct and credible threat by an agent to another, or through means that subvert the second agent's rational faculties. That is, rather than by appealing to reason, one agent causes another to act or adopt a certain value, attitude or belief without her conscious awareness. In this sense, the agent in question could be said to be completely controlled by another agent with respect to the

acquisition of a particular value or belief. Such a value would be, at least *prima facie*, inauthentic because it literally was imposed by someone other than the agent who holds the value. However, such a value could become authentic if, when the holder of the value is made aware of and understands the means by which the value was acquired, he affirms it. If this were not the case, many of the values we come to hold from being raised by particular people in a particular culture could never be said to be authentic, since very few if any values are acquired through purely conscious, rational means.

The problem of evidence of inconsistency arises in cases in which a value that is reflectively affirmed by its holder has not in fact served as the basis for action in situations in which it ought to have were it truly a value. For example, a person who purports to value a simple, low stress life but who continues to enjoy the benefits and complications of being a high-power stockbroker would be said to be living so inconsistently with the espoused value that she must not hold it as a value at all. This is not to say that one cannot reflectively affirm a value upon which one does not act. The stockbroker may value the education of her children more than she values a simple, stress-free life for herself and therefore begrudgingly continue working in her current position to ensure adequate funds are available for her children to go to college. In short, a value cannot be considered one's authentically held value, in a morally relevant sense, if it cannot be said to be a value that one holds at all.

The interaction among values over time of this sort *vis*-à-*vis* the actions that arise from them is related to the psychological continuity account of personal identity. The identity of a person is constituted by what she does or is disposed to do based, at least in part, on the values she holds. It should be apparent, however, that the weighting of even explicitly articulated values held and acted upon by a person are not immutable. That being the case, the requirement that a

choice be authentic cannot rely on an immutable set of values and associated beliefs or on the existence of an unchanging self through time. Instead, it must take into account that individuals change with the accumulation of experiences and that even radical changes in values can occur in light of these experiences (Lidz & Parker, 2003). Thus, what matters is that the shifts and changes in the relative weighting of values, as well as changes in what is valued, can be accounted for within the context of the person's life.

It has been proposed that certain actions must be one's own in order to be respected. Actions are said to be one's own if they are authentic, where authentic actions are those derived from authentic values. Authentic values, in turn, are those that simultaneously would not be repudiated by the agent when challenged, are not held because of coercion by another agent, and are actually held by the agent as indicated by a lack of evidence to the contrary. With this account in mind, two questions arise. First, is a distinct authenticity criterion warranted? Second, under what conditions should such a criterion be applied?

The question of authenticity is certainly related to making evaluations of competence and autonomy, and yet it is distinctive in its meaning. As was previously noted, sufficient noncontrol is required for an action to be potentially autonomous. Similarly, it has been suggested that a stable set of affirmed values is integral to competent decision-making. It is fair to claim that the requirement that an authentic action cannot be the result of a value coercively inculcated is just a specific instance of the noncontrol component of the autonomy criterion. It has been shown, however, that mere stability of values is not sufficient for establishing their authenticity and that reflective affirmation of a value prior to making a decision is itself too stringent a criterion for authenticity. Thus, it appears necessary to add authenticity as a criterion whose satisfaction might be required in order for certain decisions to be potentially permissible.

With regard to the issue of the circumstances in which an authenticity criterion should be applied, I am inclined to agree with Bruce Miller when he says, "If the action is not of serious import, concern about its authenticity is inappropriate" (Miller, 1981, p. 24). This view is in line with how questions of authenticity of an action or decision arise: the question of authenticity is asked when the action or decision is one that matters.[5] While it may be impossible to draw distinct boundaries around what counts as "what matters", it is enough here that life and death decisions, like the choice of suicide, are considered quintessential examples of choices that matter. Now that is has been established both that a separate authenticity criterion is warranted and that the criterion should be applied in a particular set of scenarios, attention will be paid to the means by which judgments of authenticity will be made.

Two problems arise at this point. First, how does one discover the information necessary to make a judgment regarding the authenticity of an action or decision? The simplest solution is to ask the decision-maker in question to provide the relevant information. Such persons are, barring some impairment, in the best position to know their history, beliefs, and values. The consistency of the decision at hand with the self-narrative is therefore one measure of that decision's authenticity. They may, however, be unreliable narrators, a doubt which undermines the certainty the first person narrative can instill. Since such is the case, other sources of information should be sought when available in order to corroborate the content of the self-narrative. As will be discussed in Section 3.3.3 "Assessing Authenticity", certain relationships impose restrictions upon whom and what can be utilized as sources for this investigation.

[5] This, of course, excludes scenarios in which the question is posed as a rhetorical device utilized to get someone to reconsider a course of action, e.g., "Are you sure you really want to eat a whole ghost pepper?" or "You don't really want to go outside without a coat in this weather, right?"

The second problem of where to set the threshold separating authentic from inauthentic actions and choices is more challenging. First, while it is true that the values underlying actions and choices are either repudiated or not and either inculcated via coercion or not, the coherence of the self-narrative admits of degrees. Thus, the authenticity of decisions and actions can also be a matter of degree. Accepting this may lead us to conclude that it is not possible to set a threshold for authenticity. However, Buchanan and Brock put forth a compelling argument in favor of setting just such a threshold on the basis of pragmatic considerations.[6] First, there is the sheer epistemic problem of gathering all the requisite information for "fine-grained" determinations about authenticity *vis*-à-*vis* the truth of a person's self-narrative. If rights and obligations are tied to such fine-grained distinctions, there is great room for error in their ascription. Furthermore, it would be costly to set up the institutional structures required to obtain this highly specific information, and the process of acquisition would likely be highly invasive. Finally, such fine-grained distinctions are potentially arbitrary, thus inviting evaluators to impose their own values in determining what counts as a sufficiently authentic decision as to warrant respect. The proposed alternative is analogous to the manner in which competence is treated: authenticity is evaluated in terms of process rather than content, a threshold is defined and, for those above that threshold, the full suite of rights and obligations attendant to the status is granted (Buchanan & Brock , 1995).

If this reasoning is accepted, the question then becomes where to set such a threshold. I would propose that as the risk for personal dissolution increases with differing decisions, so too should the level of authenticity required for that decision to be respected. In this way,

[6] While Buchanan and Brock's proposal is for setting a threshold level of psychological continuity for determining when a person is or is not the same person he was in the past, the same issues arise in setting a threshold for authenticity and, as such, the framework they propose can be applied to that issue as well (Buchanan & Brock, 1995, pp. 178-184).

authenticity judgments would be made on a sliding scale. Decisions where there is a low risk of personal dissolution require low levels of authenticity in order to be respected, while high risk decisions require high levels of authenticity to be respected. This is congruent with the practice of honoring all or most decisions to live without reservation, while requiring greater certainty regarding decisions to die. Notably, this would require that all cases be held to the same threshold in which the dissolution of the person was the outcome, regardless of the means by which that end was obtained.[7] Finally, this approach takes into account the salient, particular contextual elements of each decision point of a given case. Paralleling the manner in which competence is treated, judgments of authenticity are not blanket declarations, but rather address individual decisions.

Throughout the discussion of determining the authenticity of an action or decision thus far, there has been an explicit bias toward accepting decisions as *pro tanto* authentic. This is done because it is in line with the notion, accepted at least in liberal representative democracies, that the person making a claim against another is responsible for providing evidence for the claim. This is true in criminal and civil proceedings, as well as in cases in which the question of a person's competence to make a decision is raised. Just as an adult is innocent until proven guilty, presumed competent until proven otherwise, so too is her action deemed authentic until the contrary is demonstrated.

In summation, a decision, and in particular the decision to die by suicide, can be said to be worthy of respect as authentic if the values from which the decision is derived are not repudiated upon challenge, if there is no evidence of coercion in the acquisition of the values

[7] That is, decisions to die by suicide, decisions to refuse or withdrawal life-sustaining treatment, and decisions to die by physician-assisted suicide would all have to meet the same threshold level of authenticity in order to be deemed potentially permissible.

material to the decision, and if a person sufficiently psychologically continuous with the person whose life is at issue so as to be deemed the same person, as evidenced by the coherence of her self-narrative, made the decision.

2.4 BALANCING THE INDIVIDUAL RIGHT TO DIE BY SUICIDE AGAINST HARM TO OTHERS

If someone wishing to die by suicide elects a method that will result in serious harm to another person, such as jumping from a building onto a crowded sidewalk, a third party would be justified in preventing that particular suicide even if the act was undertaken by a competent individual and was autonomous and authentic. This does not mean that the would-be-suicide's right to die has been violated, but rather that a particular exercise of that right has been overridden by the concern for the welfare of others. The preceding is a clear case in which the balance between the right of the individual to die by suicide and the prevention of harm to others is easily resolved. This case resides at one extreme of the spectrum of such cases. At the other end will be found another set of clear cases in which the exercise of the right to suicide outweighs considerations consisting of minor inconveniences or no harm at all to others. These cases are noted as a means to denote the limits of the discussion, but provide no significant ethical challenges in themselves. There are, however, several possibilities in between. Prolonged, severe grief, as well as guilt, lasting for several years may be experienced by those who experience loss through suicide. Studies have shown, for example, that up to twenty percent of spouses bereaved by suicide reported recovery as either "poor" or "fair" four years from the time

religious and philosophical worldviews to factor into rational decision-making while excluding worldviews resulting from or characteristic of psychological disorders. Both the importance of a realistic worldview and what counts as such a view were discussed *vis*-à-*vis* the autonomy criterion, especially in rebutting Philip Devine in Section 2.1.1.1.

Ability to reason, the second nonimpairment criterion and part of the third empirically-derived criterion, requires both that the individual maintain good logical form throughout the reasoning process and that she recognize the consequences of the choice she makes (Battin, 1995, p. 133). These requirements are captured both by the previously discussed "understanding" and "intentionality" criteria for sufficiently autonomous decision-making and by the "reasoning" requirement for competence. For example, in order for the person considering suicide to do so rationally, her decision to die must follow logically from her initial premises, and she must foresee the consequences of her act of suicide, such as the fact that she will be dead and unable to change her mind.

Adequacy of information, the third nonimpairment criterion, requires that a decision-maker engage in a substantial attempt to acquire reliable, important information with regard to the decision to be made rationally (Battin, 1995, p. 138). This again overlaps with the requirements of reasoning and understanding as appreciation of one's own situation. Furthermore, under the doctrine of informed consent, others are required to respect the *informed*, competent decisions of others (Buchanan & Brock, 1995, p. 17). If one wishes to reason to a sound conclusion, one cannot start from faulty premises or false beliefs, let alone from a substantial lack of information. For example, a decision to die would be less than substantially autonomous (due to lack of understanding) if it was undertaken due to the false and unsubstantiated belief that a facial twitch was the first sign of inevitable debility due to

Huntington's disease. The decision-maker in this position could come to have adequate information if consultation with a neurologist in light of genetic testing revealed that, in fact, she did have Huntington's. Until such corroboration, she may *understand that* Huntington's results in physical and cognitive decline, but she cannot truly appreciate that such will be true for herself.

Avoidance of harm, the first of the satisfaction of interest criteria, is straightforward: in general, decisions made and actions taken by an individual are *prima facie* rational if they are undertaken to avoid harmful stimuli or circumstances. This criterion is problematic insofar as defining what counts as a harm is a contentious matter. We have already addressed this issue when considering wellbeing as a criterion for the permissibility of suicide. In that section, it was argued that what counted as furthering or running counter to (promoting or harming) a person's wellbeing was to be determined by the person whose wellbeing was at issue. This, of course, presumes that the person was competent to make such an evaluation. If that is not the case, then such determinations would be made by another, and that person's actions with regard to his or her wellbeing would be restricted. If the person was competent to make such evaluations, then it would be up to her to decide whether an action or decision constituted or would result in a harm. This judgment should not be overridden as doing so would violate respect for an autonomous decision, unless sufficient harm to others from acting on the decision provided justification for doing so.

Accordance with fundamental interests, the second satisfaction of interest criterion, restricts rational decisions and actions to those which follow from or promote the agent-in-question's fundamental values (Battin, 1995, pp. 146-147). The importance of this accord between fundamental values and the decision to die by suicide played a central role in defining

the previously discussed authenticity criterion. In fact, the authenticity criterion went further in requiring that actions and decisions can only count as authentic if they are derived from or promote fundamental values which are themselves non-repudiated by the agent-actor upon challenge to those values.

Given the high degree of similarity between the criteria for rational suicide and the criteria for permissible suicide proposed here, it is reasonable to conclude that suicides deemed permissible under this framework must also be rational suicides. However, since the conditions required to satisfy the rationality criterion are met when the conditions to satisfy the criteria already described are met (i.e., they are coextensive), an added rationality criterion for permissibility would be redundant. Rather than rejecting rationality outright as an additional criterion, it can be said that everything that matters with regard to it is captured by the criteria already described, therefore a separate rationality criterion would be superfluous.

2.5.2 Terminal, Chronic Physical or Chronic Psychological Conditions as Criteria for Permissible Suicide

Concern for an individual's wellbeing certainly weighs strongly in favor of allowing a person with a terminal condition to die when he chooses, as such conditions are often associated with a great deal of pain and suffering. The same is true for chronically debilitating physical and psychological conditions. However, as noted before, it is not the third party judgment of whether a life is worth continuing for the person living it that counts; rather, what matters is the judgment of the competent person whose life is at issue.

If the decision as to whether one's life is worth continuing is left to the competent individual whose life it is, then terminal illness and evidence of intractable pain and unmitigated suffering all weigh in favor of third parties permitting that individual's death; however, they are not necessary components in the individual's own calculus. The principles of respect for autonomy and authenticity would dictate that a competent person having neither physical nor psychological pain and suffering should be permitted to terminate her own life at the time and manner of her choosing, so long as the criterion of sufficient non-harm is also satisfied. This conclusion may at first seem counterintuitive: why would we allow individuals who have nothing wrong with them to kill themselves? However, this begs the question: what counts as "wrong", or a state not worth continuing, or a future state to be avoided, are all judgments of the type just discussed – those that the competent individual should be free to make and have respected if they are autonomous and authentic and if the action does not significantly harm others.

In practice, if the criteria of competence, wellbeing, autonomy, authenticity, and sufficient non-harm to others are met, any decision to die by suicide by a particular person should be respected regardless of the reasons given by the person for this decision. The process oriented approach detailed here does not privilege any religious system, philosophical system, or worldview as providing better reasons for dying than any other, nor does it countenance the "objective" weighing of the consequences of a person's acting on her decision to die against her own wellbeing. As was previously stated, to the extent the criterion of wellbeing must be approached from an objective perspective, this requirement is adequately met by the investigation required to determine whether a decision to die by suicide meets the other four criteria set forth here. If these criteria are met, then the person considering suicide is in the best

position to evaluate whether her decision to die by suicide is consonant with her own wellbeing. So long as all five criteria are met, persons who wish to be martyred for a cause, avoid the indignity of dementia, end disease-related pain, preserve finances for children, have an artistic death, have grown tired of living, or who feel their lives are complete should and, under the model proposed here, would have their decisions to die respected by others.

3.0 IMPLICATIONS FOR CLINICAL PRACTICE

Having explicated the theoretical groundwork for the conditions that must obtain for it to be ethically acceptable to permit an individual to die by suicide, it is now possible to address the issue of suicide in the context with which its assessment is most closely associated – the clinical setting. This close association is due in large measure to the view that the decision to die by suicide, and psychological disorders associated with that decision, is primarily a neurobiological phenomenon to be treated and cured, rather than a personal choice that is at least potentially worthy of respect. In the four sections that follow, the issue of permissible suicide will first be examined in light of the unique relationship that exists between a clinician and his or her patient/client. This will be followed by practical considerations of what is necessary for the clinician's assessment of the suicidal individual's decision to take place. The specific recommendations regarding how each criterion proposed in Part Two should be assessed will then be examined at length. Finally, both real and hypothetical case examples taken from the medical, legal, and philosophical literature will be briefly explicated and then analyzed in accordance with the recommended assessment criteria.

3.1 DUTY TO PROTECT

Entering into a professional relationship with a person places certain obligations upon a clinician, one of which is the duty to protect that person (now the clinician's patient/client) from self-harm (Werth and Rogers, 2005). In the case of the suicidal client, this obligation has traditionally been invoked to justify some form of compulsory treatment which, it has been suggested, is equivalent to suicide prohibition (Szasz, 2011). Concern for suicidal individuals and an impulse to protect them from self-harm are understandable, especially in light of the frequent co-occurrence, in cases of suicidality, of mental illness that could compromise decision-making capacity (Bernal et al., 2007; Granello & Juhnke, 2010). It has even been claimed that a moral imperative to prevent suicide arises from the, supposedly, inherently ambivalent nature of the decision to die by suicide (Shneidman, 1996).

As has already been demonstrated, however, blanket prohibition of the act of suicide on the grounds that it is always the result or characteristic of competence-compromising mental illness is unwarranted. This is because such a policy presumes incompetence when instead the competence of the decision-maker is an empirical question requiring investigation and evaluation in light of the discovered information in order for a judgment regarding the person's competence to be made. Likewise, ambivalence need not be an intrinsic part of the decision to die by suicide. Assumptions on either account provide no protection of the suicidal client's right to be presumed competent – a right afforded to all other patients.

Competent patients have the right to make treatment decisions for themselves on the basis of their own judgments of the benefits and burdens of the options available to them. Indeed, competent individuals are considered to have the right to make a wide range of decisions for and

about themselves. This focus on the right to make treatment decisions is relevant because my concern is with the clinician's role *vis*-à-*vis* a person who wishes to commit suicide. From the clinician's point of view, the suicidal person's competence to make such decisions is not at all certain, and the potential for imminent and irreversible self-harm requires action on the part of the clinician in order to meet the duty to protect. I concur with James Werth, Jr. and James Rogers that the means for fulfilling the duty to protect lie not in immediate and compulsory treatment, but rather in evaluating the individual's decision-making capacity (2005). On this model, if a person's decision-making ability is not compromised, she should not necessarily be prevented from undertaking her chosen course of action, even if it would result in self-harm. If, on the other hand, the individual were found to have sufficiently impaired decision-making capacity, the duty to protect would be met by taking steps to ensure that appropriate interventions and treatments were provided to the patient. In contrast to a policy of prohibition based on unfounded assumptions, the investigative process advocated here also has the potential to be therapeutic by allowing suicidal individuals to freely explore possible options and their implications, including death by suicide, rather than being limited by the threat of involuntary treatment (Werth, 1998). However, based on arguments from the previous section, I suggest that this model of evaluation of patient decision-making capacity as a means to fulfill the duty to protect should be expanded to include evaluations of the autonomy and the authenticity of the person's decision to die.

3.2 CONDITIONS REQUIRED FOR EVALUATION TO OCCUR

Before moving to consider the content and structure of the clinical evaluation, it is important to note some conditions that must obtain for such evaluations to occur. First, the person desiring to die by suicide must present to a clinician. This can occur either voluntarily or involuntarily, with the latter case requiring the intervention of at least one other person. In those cases in which a person knows the suicidal individual well, as a close family member or friend might, the question of whether clinical intervention is appropriate may not arise for him or her. Thus, the question of clinical evaluation is moot, since such a person would not seek involuntary evaluation and treatment of the suicidal individual. This could occur in a case in which the decision to die is consistent with what is known about the suicidal individual's values and beliefs, when no errors in that person's substantially informed reasoning are evident, and when it is clear that no agent has coerced the person into choosing to die. Though it is not necessary for the non-clinician who is in the position to permit suicide in this case to articulate the grounds for permitting the suicide in technical terms, it should be apparent that the scenario above includes considerations of the suicidal individual's competence, autonomy in decision-making, and the authenticity of the decision he has made.

The finality and irreversibility of the decision to die by suicide make such decisions special. Given the nature of suicide, it would seem reasonable to allow, as a matter of policy, any party who has sufficient reason to doubt the fulfillment of any of these criteria to enlist a qualified clinician to evaluate and potentially treat the suicidal person or, in the case where coercion to choose death is suspected, to enlist civil authorities to investigate the situation and to take further action if required.

When clinical evaluation is sought, it is important to recognize that this may require paternalistic intervention. This is because time must be set aside for the evaluation to occur, which may require limiting a person's freedom of movement and privacy against his or her wishes. Given the nature of the imposition, clinicians faced with such situations should carry out evaluations as quickly and efficiently as possible. Even when the patient, the clinician, and time are available for the evaluation to take place, the clinician still requires the patient's cooperation in conducting the evaluation. The potential courses of actions that may be taken when patient cooperation is lacking will be addressed in Section 4.1.

3.3 THE CLINICAL EVALUATION

When conducting the clinical evaluation of a person who has decided to die by suicide, it is necessary for the clinician to determine whether the person and her decision meets all the criteria required for her decision to be respected. This requires the evaluator to determine (1) whether the patient is competent to make the decision to die by suicide, (2) whether the decision is sufficiently autonomous, (3) whether the decision is sufficiently authentic, (4) whether the decision promotes the suicidal individual's wellbeing as he conceives it, and (5) whether acting on the decision would be sufficiently non-harmful to others. Given the complexity of these criteria and the importance of the judgment reached at the end of evaluation for the person undergoing assessment, it would be prudent to have at least one other qualified clinician

complete this evaluation.[8] Furthermore, all portions of the evaluation and the rationale behind the conclusions drawn by each evaluator should be fully documented. This allows the evaluators to organize their argument for permitting or not permitting suicide in a particular case, serves to explain the reasoning and circumstances to others, and, if the need arises, provides evidence that the duty to protect was satisfied should the resolution of a case be followed by litigation (Grisso & Appelbaum, 1998, p. 145). What follows are suggestions for how to assess whether each criterion for separating decisions to die by suicide worthy of respect from those decision that are not worthy of such respect have been met.

3.3.1 Assessing Competence

As was noted in the first section, competence in medical decision-making is strictly understood as a legal term. However, I will continue to follow Grisso and Appelbaum in utilizing competence and decision-making capacity interchangeably (Grisso & Appelbaum, 1998). These clinicians apply the concept of competence to the clinical setting in terms of four legal standards of competence to consent to treatment employed in the United States. To recapitulate, these standards are (1) the ability to understand the treatment options presented, (2) appreciation that one has a disorder and may benefit from treatment, (3) the ability to reason utilizing the information presented in order to reach a decision, and (4) the ability to express a choice regarding treatment (Grisso & Appelbaum, 1998).

[8] A similar rule was put in place to regulate physician assisted suicide in Oregon. See "The Oregon Death With Dignity Act: Oregon Revised Statutes" 127.820 §3.02.

Grisso and Appelbaum developed a semi-structured interview known as the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) that includes disclosure of the information material to treatment decisions, in accordance with the doctrine of informed consent, followed by assessments of each of the four abilities described above (1998). This tool has the added benefit of providing a means for documenting both the process of evaluation and the determination of decision-making capacity, and is designed specifically to be employed easily at the bedside (Grisso, Appelbaum, & Hill-Fotouhi, 1997). This being said, the authors emphasize that the MacCAT-T is not intended to be used in isolation, but rather in conjunction with a full clinical evaluation. For example, the information disclosed during the interview process will depend on a comprehensive evaluation including determinations of diagnosis, severity of the diagnosed disorder(s), and the available treatment options (Grisso & Appelbaum, 1998).

However, whether every individual who plans to die by suicide does so because of a psychological disorder is an open question. Since this is the case, it must also be acknowledged that framing the question of competence to make the decision to die by suicide in terms of the ability to consent to or refuse treatment for such disorders may not always be appropriate. Recognition of this requires only slight modification to the MacCAT-T so that, instead of conducting an interview structured to gauge an individual's ability to make a competent treatment decision, it is structured to gauge the ability to make a competent decision to die by suicide.[9] This could be accomplished by reframing the four standards of competence described above in the following fashion: (1) the ability to understand what is entailed by the act of killing oneself and the consequences of that act, (2) appreciation that the consequences of the act of

[9] In fact, Grisso has confirmed that the MacCAT-T could be utilized without modifications to evaluate requests for physician-assisted suicide in Oregon (Werth, Benjamin & Farrenkopf, 2000). It would seem well suited, then, for evaluating those decisions to die by suicide which entail an absence of interference from others, including physicians.

suicide apply to oneself and that the consequences of alternatives to suicide may also apply to oneself, (3) the ability to reason utilizing the information at one's disposal in order to reach a decision, and (4) the ability to express a choice regarding the decision to die by suicide. With this outline in mind, both the information presented to the suicidal individual and the questions used to determine the degree to which the abilities related to competence are present can be tailored.

Even with the modifications just proposed, the end of the MacCAT-T interview is only the beginning of the clinician's process of reaching a judgment regarding the competence of the interviewee to make decisions for himself *vis*-à-*vis* death by suicide. Though the assessment does provide numerical results corresponding to how well the interviewee was able to meet the challenges presented by the questions posed during interview, there is no corresponding numerical threshold a score above which would indicate competence and below which would indicate incompetence (Grisso & Appelbaum, 1998). The assessment's authors note that, in the end, "As with most important decisions in life, we must simply make a choice, trusting that the process has provided a reasonable foundation for a well-informed conclusion" (Grisso & Appelbaum, 1998, p. 141).

3.3.2 Assessing Autonomy

As was demonstrated in Section 2.1.1.1, the decision to die by suicide and acting on that decision are both potentially autonomous. Therefore, clinicians faced with a suicidal patient will be required to conduct an assessment to determine whether the patient's particular decision either meets or fails to meet the criteria for sufficiently autonomous acts and decisions. Briefly, such an assessment must be structured in such a way as to allow the clinician to discover whether the

person's decision to die is (1) intentional in the sense that acting on the decision would consist in following a plan, (2) understood by the person making the decision to die in terms of both the nature of the action and its foreseeable consequences, and (3) made under conditions of sufficient noncontrol by others or influences internal to the person.

Questions regarding condition (1), intentionality, will occur in the course of a typical evaluation of the suicidal patient since determining the presence or absence of resolved plans to die by suicide is essential to determining the severity of the risk of that person's death by suicide (Joiner, 2007). For the purposes of assessing the degree of autonomy of these decisions, it is insufficient for the evaluating clinician to elicit a mere "yes" or "no" response regarding intentionality. Rather, the line of questioning pursued by the clinician should aim to reveal the content of the person's plan to die, including the means, time-table, and involvement of other persons. This information will be integral to determining the degree to which the person understands the action she is proposing to take in dying by suicide.

The need to assess whether the person contemplating suicide understands what acting on a decision to suicide entails for themselves and others has already been raised in terms of the evaluation of that person's competence. As such, evaluating the "understanding" and "appreciation" conditions for competence to make a decision to die by suicide will satisfy the need to evaluate this condition with respect to the autonomy of the decision. Whether parsed in terms of competence or autonomy, this portion of the evaluation provides the opportunity to discuss with the patient the full range of possibilities he has considered in coming to his decision to die by suicide. This both allows for the evaluator to determine the degree to which the suicidal individual understands the circumstances contributing to his decision and to propose alternatives to death by suicide that may satisfy the goals the person hopes to achieve by dying.

Finally, in order to determine whether the sufficient noncontrol condition is satisfied, the clinician needs to evaluate the degree to which both others and constraints internal to the patient may have influenced that person's decision to die by suicide. Questions regarding these issues may occur during the process of evaluating the person's ability to reason during the competence assessment. One might ask, for instance, whether anyone had suggested suicide as a potential option to the patient, or whether someone had told the patient that she ought to or must kill herself. Such questions may lead to someone being named as the source of the idea to suicide or as a coercive influence pushing the person to choose suicide. It then falls to the clinician to determine whether this "someone" is the manifestation of a psychological disorder or a real person. If the former is found to be an irresistible influence, proper treatment should be offered. If instead another person is found to have coerced or unduly influenced the individual, then the individual considering suicide should be isolated from the influencing individual if possible, and contacting civil authorities should be considered so that further appropriate steps may be taken to investigate the situation and protect the suicidal person.

3.3.3 Assessing Authenticity

At the outset, it must be acknowledged that evaluating the authenticity of a person's decision to die by suicide is not an easy task. As was discussed in Section 2.3, people may not acknowledge their own fundamental values as such until they are challenged to defend them or to recognize the place they have occupied in their decision-making processes. They may also be unreliable narrators of their own past actions, beliefs, and values. Acknowledging these facts can result in a persistent shadow of doubt concerning whether a person's decision to die is sufficiently authentic as to be considered potentially worthy of respect. Such doubts may be assuaged, at least in part,

if information corroborating that provided by the person considering suicide can be obtained from third parties who know the person well, such as friends, family, and even other clinicians involved in the person's care. Consultation with friends and family should be conducted only if the patient consents to their involvement. It should be kept in mind, however, that such individuals may also have their own agendas and, as such, may present the suicidal person in a light favoring those agendas.[10]

Others have raised concerns regarding the use of an authenticity criterion (in separating patient decisions worthy of respect from those that are not) in the clinical setting on the grounds that we have a poorly developed understanding of authenticity on both the theoretical and empirical fronts (Hope, Tan, Stewart & Fitzpatrick, 2011, p. 28). This is an important challenge to the present project. If one is to employ an authenticity criterion in evaluating whether a particular suicide ought to be permitted, then it must be possible to do so in a structured way that also prevents abuse of the criterion by the evaluator. While requiring rigorous investigation, the three conditions[11] that must be met in order for the authenticity criterion I have proposed to be satisfied provide for just such a structured assessment. Furthermore, the presumption of authenticity of a patient's decision in the absence of evidence to the contrary places the burden of proof squarely on the evaluating clinician. This helps to ensure that patient decisions that ought to be respected are not dismissed merely because the clinician disagrees with the patient's choice or because the clinician sets an arbitrarily high threshold for authenticity due to his or her own doubts.

[10] This problem also arises in consulting with third parties in order to obtain additional information for assessing patient competence (Grisso & Appelbaum, 1998, p. 92).

[11] These conditions are (1) non-repudiation upon challenge of the values underlying the decision, (2) absence of evidence of coercion in the acquisition of values material to the decision, (3) and sufficient psychological continuity between the person whose life is at issue and the person making the decision so that the latter and the former are the same person as evidenced by the consistency of the decision with the decision-maker's self-narrative.

When assessing the authenticity of a person's decision to die by suicide, the clinician will first need to determine which value or values actually factored into the decision-making process. Such values could be, for example, the importance of personal independence, promoting the welfare of one's family, or ensuring that one will be remembered in a particular way. Once the relevant values have been brought to light, the clinician can ask the person whether those values are ones that she holds as her own and how she came to hold those values. A request for examples of how those values have shaped that person's life to this point may also be made. In the course of this in-depth discussion with the person considering suicide, the evaluating clinician should be mindful of the overall self-narrative the person is relaying, since this may be the best and only source of information regarding the psychological continuity between the person in front of her and the person who has lived the life to this point. As was previously noted, what matters for our purposes is that the shifts and changes in the relative weighting of values and changes in what is valued can be accounted for within the context of the person-in-question's life, and not that the narrative reflects a completely unchanging set of values.

3.3.4 Addressing Harms Posed to Others by the Suicidal Person

Section 2.4 raised the issue of what harm to third parties by a particular person's suicide is sufficiently great as to warrant prevention of that suicide. It was suggested that this question could be resolved by balancing the value of the act of suicide to the suicidal person against the extent of the harms to third parties. It was further suggested that this balancing should employ a

casuistic method, taking into account how similar cases have been resolved. In this way, the prevention of a suicide could be justified by the responsible clinicians on the grounds that it was too harmful to a third party or parties, all other things being equal.

To ask that a clinician perform this kind of balancing on her own would require her to have more than just a passing familiarity with the case law for the jurisdiction in which she practiced. While clinicians could certainly possess such knowledge, it would be too much to ask that each clinician who may be faced with such a case have this level of expertise. Nor would it necessarily be beneficial for clinicians to believe that they could make such determinations unilaterally, since their decisions and actions may place others (e.g. their employers and other members of the clinical team) at risk of litigation. Just as it is advisable to have a consulting clinician assess the competence, autonomy and authenticity of the suicidal person's decision die, so too is it advisable for the evaluating clinician to consult with her institution's risk management attorney when attempting to determine whether a particular suicide should be prevented on the grounds that it is too harmful to third parties.

It is important to clarify two points here. First, preventing a person's suicide because it is deemed too harmful to third parties does not mean preventing all possible suicides the person may undertake. Rather, such prevention has as its target a particular suicide characterized by particular consequences deemed sufficiently harmful to others as to warrant such intervention. Thus, a person may be prevented from undertaking one suicide but be permitted to undertake a different suicide if the consequences of that suicide for other parties are sufficiently non-harmful.

Second, the means by which a sufficiently harmful suicide is to be prevented need not be restricted to those centering on the suicidal person, such as confinement, observation, or physical and chemical restraints. As the *Tarasoff* ruling and later rulings citing it as precedent suggest,

clinicians can prevent harm to others that may be brought about by their patients through a variety of means, including those already listed, but also by taking steps to inform potential victims or law enforcement in the area in which the patient may act against others of the potential danger (Buckner & Firestone, 2010).[12]

The question still remains, however, as to just what counts as a suicide sufficiently harmful to others as to warrant such interventions. As the case of the Jehovah's Witness not being forced to receive treatment for the sake of her children demonstrates, mere psychological harm to others is not sufficient grounds to warrant intervention, even when the person dying by suicide has a strong duty to those who may suffer psychological harm as a result of her death. It could be objected that some psychological harms to others would be sufficiently great as to warrant preventing a suicide that would generate such harms. It is plausible that a given suicide could cause one who lives on after the suicidal person dies to suffer prolonged grief or depression from which he never recovers. However, if we apply the litmus test of what is allowed in cases of refusal of life-saving treatment by informed, competent persons, this objection fails – clinicians simply are not in a position to force treatment on one person for the sake of the psychological wellbeing of another. This does not, of course, prevent the clinician from attempting to persuade the suicidal person to elect a suicide that inflicts the least psychological trauma on others as is feasible in the given circumstances.

This leaves open physical harms to others as potential warrants for deeming a particular suicide a proper target of prevention by the clinician. As was previously noted, suicides that would be the proximate causes of serious physical injuries to others or of the deaths of others

[12] This is framed in terms of the clinicians' duty to protect others from their potentially-harmful patients, a duty which supposedly derives from the mere fact that these clinicians have control over such patients. (Buckner & Firestone, 2000, p. 188).

ought to be prevented if possible. This must be expanded to include instances in which there is a reasonable likelihood that such injuries or deaths would be directly caused by the act of suicide in question, since restricting prevention only to those cases where the harms are *certain* to follow would likely allow several otherwise preventable physical harms to others to occur.[13]

One may here be tempted to argue that one suicide often is causally linked to other suicides, that death by suicide by others constitutes a significant physical harm to third parties, and that this is sufficient warrant to prevent a suicide which is likely to lead to such eventualities. There are two issues with this analysis. First, the first suicide is not directly causing the undesired harm – the suicides of others – but is merely linked to such harm by the psychological impact such a suicide has on third parties. As has been established, psychological harm to others is not sufficient grounds for the prevention of a suicide. Second, viewing the resulting suicides as caused by the first suicide neglects the possibility that the first suicide leads others to reflect on what gives their lives meaning and, after such reflection, to conclude that suicide is an appropriate course of action for themselves. Third parties who wish to die by suicide following the death of another whose suicide was deemed permissible have the same right to suicide as did the first person.

3.3.5 Promoting the Suicidal Person's Wellbeing

The individual's wellbeing is both the clinician's first and last consideration when dealing with persons considering death by suicide. It is first in the sense that concern for the suicidal

[13] For instance, it is not certain that the person who elects to die by suicide by jumping from an overpass onto a busy street below will injure or kill someone, but it is sufficiently likely as to warrant preventing suicide by that means.

individual's wellbeing prompts the evaluation that enables the clinician to determine whether the person should be allowed to act on her own views concerning her own wellbeing. As was established in Sections 2.2 and 3.1, if the evaluator determines that the patient and her decision to die by suicide satisfy all the necessary criteria, then conducting the assessment followed by noninterference is sufficient to satisfy the criterion of promoting her wellbeing. Promoting the suicidal individual's wellbeing is also the last consideration in that, if the person and her decision are found not satisfy the relevant criteria, the clinician must determine how to act in that individual's interest despite her contemporaneous desire to die by suicide. This may include actions such as locating an appropriate surrogate decision-maker for her, initiating steps leading to her involuntary commitment, and administering treatment.

3.4 CASE EXAMPLES

In what follows, cases from the literature will be presented and then evaluated utilizing the framework that I have proposed. The accounts are by necessity brief and, as might be expected, lack some of the details we would like to know were we asked to serve as the principal evaluators of the patients under consideration. Since such is the case, the conclusions reached *vis*-à-*vis* the satisfaction of the relevant criteria by those who actually evaluated the cases will be accepted at face value when no contradictory details are provided. When the need arises, the additional information that an evaluator would ideally need to have will also be noted.

3.4.1 Case 1: Adapted from "Depressed or Just Ready to Die" by Sava et al.

A 91 year old male with a self-inflicted abdominal stab wound was brought by ambulance to the Washington Hospital Emergency Department. Evaluation suggests that he had an intestinal injury from which he would likely recover if surgical intervention were provided within eight to twenty-four hours of his arrival at the hospital. Without such intervention, the man would likely die from his injury. In this case, the patient refused the life-saving intervention.

Discussion with the patient and among the trauma surgeon handling the case, the ethics committee, and a psychiatrist revealed the following information:

1. The patient had a longstanding history of intermittent depression and had been taking antidepressants for a month following a diagnosed major depressive episode.
2. The patient admitted at the time of evaluation that he was depressed.
3. Upon evaluation, the patient was found by multiple clinicians at different times to have decisional capacity.
4. All who evaluated the gentleman agreed that his decision stemmed from his own beliefs about his own best interests.
5. He was not close to his family and his close friends had been dead for years.
6. The patient explained that he stabbed himself at the particular time that he did, so that the Meals on Wheels delivery boy would contact the building supervisor, who had a key to the apartment, when the 91 year old did not answer the door. This was done so that he could be taken to a hospital and thus "reduce the complexities of dying alone in his apartment" (p. 23). He had, furthermore, left instructions regarding his funeral and his will.

3.4.1.1 Discussion The authors are clear that the patient meets the standard criteria for a person to be deemed competent to make decisions for himself: he had expressed his choice (expressing a choice), he acknowledged that he was currently depressed (appreciation that a diagnosis applies to himself), there was no reason to doubt that he understood that he would die as a result of refusing surgery (understanding and appreciation), and finally his choice followed from a chain of reasons consistent with his own values (ability to reason with relevant information).

It is also relatively clear that the patient in question was acting autonomously. First, it is evident that his decision to die by suicide was carried out in accordance with a plan; that is, the act was intentional. Second, he recognized that he would die from his self-inflicted wound and that expiring in a hospital may be less complicated for all involved than if he were to have died alone at home. This would suggest that he sufficiently understood the consequences of his action both for himself and for those who may have found him otherwise. The only mention of other relevant parties, such as friends and family, demonstrates their absence from the patient's life, which strongly suggests a lack of controlling influences exerted on him by others with respect to his decision to die by suicide.

The details of the discussion with the patient in this case that would be required for a thoroughgoing evaluation (by those receiving the story second-hand) of the authenticity of his decision to die are lacking. It is in such circumstances that the temptation to "err on the side of life" arises, but to err on the side of life is to err nonetheless. Doubts creep in regarding whether the patient is acting on his own values or whether he simply does not care about his previously held values due to his depressed state. Questions as to the value(s) underlying his decision to die, whether he repudiated those values once they are brought to light, and the origin of those values would certainly need to be explored in depth before a decision regarding the authenticity of the

gentleman's decision could be reached. However, as was noted earlier, the burden rests on the clinician to demonstrate a lack of authenticity and not on the patient to demonstrate authenticity. If, for example, the man's decision to die derived from values held because of or characteristic of a reversible depression, it would be the responsibility of the treatment team to demonstrate this before their patient's death could be prevented on these grounds. The authors claim that their patient's decision to die by suicide by refusing treatment followed from his own beliefs, which suggests that they believed his decision and the beliefs and values from which it arose were his own in the morally relevant sense. Given only evidence supporting fulfillment of the authenticity criterion, judgment that the man's decision to die by suicide was authentic is the only justifiable conclusion.

The patient in this case also makes it clear that there are no persons to whom he has strong ties or obligations. Furthermore, there is no reason to suspect that the means of death he chose could have posed a likely risk of being the proximate cause of either serious bodily harm or death of others. As such, there is no reason to treat him against his will in order prevent such harms to others.

Given that the man's decision to die by suicide satisfied the competence, autonomy, authenticity, and sufficient non-harm criteria, promoting his wellbeing must consist of permitting him to act as he had chosen to do. That is, we must conclude that he ought to be able to refuse life-saving treatment even though doing so is tantamount to permitting his suicide. While their explicit framing of the problem was slightly different from the preceding analysis, this same conclusion was reached by the team responsible for the patient in this case.

3.4.2 Case 2: Adapted from "What is Wrong with Rational Suicide" by Avital Pilpel and Lawrence Amsel

This hypothetical case is designed to undermine the claim that the concept of rational suicide can be utilized to separate permissible from impermissible suicides.[14] The case is presented as follows: A woman in her mid-50s, who has no close family and very weak obligations to others, while on vacation reads several works by noted philosophers, namely Epicurus, Kierkegaard, Sartre, and Camus. Through this philosophical exploration, she comes to believe that life in general is meaningless. Reflection upon her own life leads her to conclude that she has attained what she wishes to attain in life, that her best years are behind her, and that, on balance, her future holds more pains and disappointments than pleasures and successes. She reasons that in death, there are neither positives nor negatives; there is nothing. She resolves to kill herself painlessly.

In their discussion, the authors of the case note that:

1. While the woman does have depressive beliefs, it would be question-begging to say that she is clinically depressed merely because of this. She does not have a psychological disorder.
2. She is a "bit of a utilitarian", and so utilizes a utilitarian calculation in her reasoning process (p. 114). She considers not only her life, but the impact her death will have on her friends.
3. Her decision to die serves her end, namely, the avoidance of a future existence marked, on balance, by more undesirable than desirable states of affairs. She is therefore instrumentally rational.

[14] Given the complete overlap between a rationality criterion and the criteria that have been defended throughout this work as those needed to separate suicides that ought to be permitted from those that ought not be permitted, it is reasonable to assume that this case will prove to be a relevant test of said criteria.

4. She consulted with spiritual advisors, mental health professionals, and other parties about her decision. While they encouraged her to live, she simply was unconvinced by their arguments.
5. There is no reason to think that she was forced by others to reach the conclusion that death by suicide is preferable to continued life.

3.4.2.1 Discussion While this case is hypothetical, it is useful in that it enables the limits of the framework I have proposed to be explored. The woman under consideration has neither physical nor psychological illness, nor is she currently suffering any notable discomfort, even from her own perspective. She elects to die on, as the authors intended, purely rational grounds following careful consideration of her likely future states. Pilpel and Amsel conclude that the type of suicide they describe should be prevented because it represents a serious, irreversible mistake. Does the current framework reach the same conclusion for this or other reasons?

The middle-aged woman clearly expresses a choice to die. Her decision to die follows from her conclusion that her life will be increasingly unpleasant as she ages and that she wishes to avoid that unpleasantness. She understands that the consequences of this action include both the cessation of existence from her perspective, the emotional impact on her friends, and she does not exclude the possibility that in cutting her life short she may be depriving herself of some future goods. She merely does not think that experiencing those goods is sufficient grounds for continuing to live. Her method for coming to a decision is very circumspect, as evidenced by the fact that she consults objective others in reaching it. By all relevant measures, her decision to die by suicide is a competent one.

She elects a method of suicide that will result in a painless death. While the method is not specified, it is clear that her suicide has been planned. It has already been established that she understood the consequences of this action. Finally, there is no reason to think that either internal or external constraints are leading her to elect suicide. In fact, as with the 91-year-old gentleman discussed earlier, there is good reason to think that no one was in a position to place such pressure on the woman. She independently chose to read the philosophical works that contributed to the change in view that factored into her decision to die by suicide. Given that her decision to die is intentional, the consequences of suiciding are understood, and the decision was reached without coercion or manipulation, it should be considered sufficiently autonomous.

With respect to the question of authenticity, it would be beneficial to have significantly more information about the woman than the case description provides. Her self-narrative would undoubtedly include much of this information, such as what values, if any, beyond the avoidance of harm to herself support her decision to die. Furthermore, with careful interrogation she may reveal pre-dispositions and past behaviors relevant to the determination of the authenticity of her decision to die. Perhaps it would be discovered that she has a tendency to be easily swayed by what she has read or by what she is taught, to act on her newly acquired inclinations for a time, but that she ultimately makes no lasting commitments or life-altering decisions on this basis alone. In the absence of these details, we can only note the need to attempt to obtain them in actual cases and then judge this particular case based upon the available information. We are told that her utilitarian calculation is characteristic of her decision-making style. The books she read that factored into her decision to die were chosen by her as material to indulge in during vacation. Not only has she given reasons for why she elects to die, her decision is fixed even following conversation with multiple individuals, conversations during which the values

underlying her decision would undoubtedly have been challenged by her interlocutors. With all this in mind, there appears to be no evidence to support calling the authenticity of her decision into question.

More information would also be required to determine whether this person's suicide would be sufficiently harmful to others as to warrant prevention on that ground alone. As this information is unavailable, the best conclusion that can be reached is an inferential one – since the designers of the case wish to focus upon the woman's decision to die by suicide as being wrong solely on the grounds that it is a mistake, it is reasonable to conclude that they would have her elect a method of suicide that minimizes harms to others.

Given that all the criteria are met for a decision to die by suicide to be respected, the proposed framework would hold that the woman should not be prevented from following through with her plan. This runs contrary to the authors' conclusion that this suicide should be prevented because it is a mistake. This lack of agreement stems from the fact that the proposed framework evaluates the decision to die by examining the *process* utilized by the decision-maker in reaching her decision, while Pilpel and Amsel inject their own values into the evaluative process when they assert that the woman's decision to die is a bad mistake. If we value respect for autonomous, competent, authentic decisions that do not significantly harm others, there would seem to be no way to exclude even suicides such as the one just described as being within the realm of permissibility.

4.0 LIMITATIONS OF THE FRAMEWORK

The following sections explore the limits of the framework for separating permissible from impermissible suicides that has been developed thus far. First, what clinicians ought to do when faced with doubts regarding the satisfaction of the five criteria will be explored. Second, it will be considered whether it is morally acceptable to adhere to the proposed framework in all encounters with suicidal persons.

4.1 COURSE OF ACTION WHEN DOUBTS PERSIST REGARDING FULFILLMENT OF CRITERIA

In cases of persons for whom determinations are straightforward regarding whether their decisions to die by suicide satisfy the criteria set out above, the course of action to be taken by third parties is equally clear. Either the person is to receive appropriate treatment in consultation with a clinician and surrogate decision-maker with periodic re-evaluations of the above criteria, or the person is to be permitted to act as he or she has elected to act, even when the chosen action is to die by suicide. There will be, of course, cases in which doubt persists about whether a particular criterion has been met.

Such doubts could arise if a person were not to cooperate with the processes involved in determining whether his apparent[15] decision to die by suicide satisfied the five criteria of the proposed framework. For this example, non-cooperation on the part of the patient will take the form of a refusal to divulge any information material to the clinician's investigation. While the clinician may gather some behavioral information about the patient through mere observation, this general paucity of knowledge seems incompatible with drawing a conclusion one way or another regarding satisfaction of the criteria. This is the case because the refusal to cooperate could be due to or characteristic of a psychopathology that is compromising one or more of the patient's abilities related to satisfaction of the criteria, or it could simply be the case that the patient feels that whether he has chosen to die by suicide is none of the clinician's business.

Such a situation presents a difficult dilemma, especially when the patient is believed to be at high risk of dying by suicide if no intervention is made. On one hand, the patient's decision may not satisfy the criteria needed for a clinician to allow him to die, which ought to prompt intervention. On the other hand, the patient's decision may satisfy all of the requisite criteria for the clinician to respect it, which would call for nonintervention. So, in the face of a lack of information, the question appears to be whether to intervene (presuming the criteria are not satisfied) or to not intervene (presuming satisfaction of the criteria). I have suggested that if doubts arise during the investigative process as to whether a particular piece of information favors a finding that a criterion is satisfied, the presumption should be in favor of satisfaction. Counter to this, it has been said that a presumption of satisfaction of the competence criterion is not supported by empirical studies of those desiring to die by suicide (Matthews, 1987, p. 748).

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[15] I say "apparent" here to denote that there must be some reason that the person is slated to undergo evaluation of his decision to die by suicide, even if he has not explicitly stated that such is the case. For instance, he could have been brought to a clinician due to an act of self-harm.

There is, however, a third option – the clinician can start by setting aside such presumptions altogether.[16] Expanding upon an approach proposed by Samia Hurst for dealing with patients who refuse decision-making capacity assessments, she can then explain to the patient that she cannot honor his decision to die by suicide because she is too uncertain as to whether he possesses all the requisite abilities, has gone through the necessary thought process, etc. to have such a decision respected. She can further explain that, without sufficient certainty, she will have no choice but to treat him *as if* his decision did not satisfy the relevant criteria. She may then provide the patient with an opportunity to provide reasons for his decision and to assent to assessment in light of this information. Furthermore, the clinician should offer to find someone to whom the patient may feel more comfortable disclosing his reasons. If, after all these efforts have been made, the patient still refuses to cooperate, the clinician should choose a course of action consistent with non-satisfaction of the criteria (Hurst, 2004, pp. 1759-1760).[17] These actions should, as has been previously argued, include frequent attempts to assess whether the patient's decision satisfies the relevant criteria.

[16] This is inspired by the approach recommended by Grisso and Appelbaum for clinicians who are operating under conditions of uncertainty regarding assessment of a patient's decision-making capacity (Grisso & Appelbaum, 1998, pp. 144-145).

[17] The framework I have proposed can accommodate this resolution in the following ways. First, a person wishing to die by suicide whose decision in fact satisfies the relevant criteria, and who is only separated from being allowed to die by his refusal to assent to assessment, would likely assent given the options presented by the clinician. If he did not, while it may represent extreme stubbornness, the clinician would be justified in counting this as evidence of a breakdown of the patient's reasoning process. If this is not in fact the case, the patient could always challenge the conclusion (Grisso & Appelbaum, 1998, p. 145).

4.2 LIMITS OF ADHERENCE TO THE CRITERIA

It must be kept in mind; however, that blind commitment to the criteria of competence, autonomy, authenticity, and sufficient non-harm in all cases is not advisable. Patients will inevitably be encountered who desire to die due to untreatable pathologies causing or consisting of, for example, defective reasoning, flawed understanding, or inauthentic values. While it is still advisable to attempt treatment in such cases, it must also be recognized that permanent intervention that is degrading or contrary to her wellbeing from the patient's perspective is not justifiable (Cosculluela, 1995; Matthews, 1987, p. 747). In cases where it is not possible to restore such suicidal patients to health, and in which permanent, degrading or onerous interventions will be required to prevent death, considerations in favor of the individual's wellbeing would suggest that allowing death to occur may be the least bad option.

Furthermore, adhering to the proposed framework should also not constitute the entirety of our moral engagement with the issue of suicide. Though it was noted in Section 2.1.1.1 that persons may make autonomous decisions to die by suicide even when faced with limited options in tragic circumstances, this does not mean that conditions in which such limitations and tragedies are present ought to be tolerated. Enacting social policies that reduce the conditions which contribute to individual decisions to die by suicide is at least *prima facie* morally permissible from the perspective of suicidal individuals as such policies need not impose upon the liberty of such persons (Cholbi, 2011, p. 116).

5.0 CONCLUSION

It has been argued that the considerations of individual wellbeing and respect for autonomy that undergird the consensus which holds that sufficiently informed, autonomous decisions to refuse life-saving treatment ought to be honored when made by competent persons also support permitting certain suicides. It has further been argued that, in determining whether a person should be permitted to act on a decision that will likely result in her dissolution, such as acting on a decision to die by suicide, whether that decision is "her own" is a morally relevant consideration. Finally, it was argued that a sufficiently autonomous, authentic decision to die by suicide that also promotes the suicidal individual's wellbeing as she conceives it must also be sufficiently non-harmful to third parties in order to be deemed permissible. Moreover, since whether a particular decision to die by suicide satisfies these criteria is an empirical matter, it was concluded that clinicians must perform thorough evaluations to determine whether a particular decision to die satisfies all relevant criteria when they are faced with persons contemplating suicide, rather than merely presuming that the suicide must be prevented indefinitely. Finally, it was concluded that rigorous adherence to the proposed criteria for separating permissible from impermissible suicides could result in a judgment that even a person in perfect health who chooses to die by suicide ought to have his or her decision respected.

BIBLIOGRAPHY

Arras, J. D. (2009). Physician-assisted suicide: A tragic view. In B. Steinbock, J. Arras & A. London (Eds.), *Ethical issues in modern medicine: Contemporary readings in bioethics* (7th ed., pp. 477-487). Boston, MA: McGraw-Hill.

Battin, M. P. (1995). *Ethical issues in suicide*. (2nd ed.). Englewood Cliffs, N.J: Prentice-Hall.

Beauchamp, T. L., & Childress, J. F. (2013). *Principles of biomedical ethics*. (7th ed.). New York, NY: Oxford University Press.

Bernal, M., Haro, J. M., Bernert, S., Brugha, T., de Graaf, R., Bruffaerts, R., ... & ESEMED/MHEDEA Investigators. (2007). Risk factors for suicidality in Europe: results from the ESEMED study. *Journal of affective disorders*, *101*(1), 27-34.

Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Cal. App. 3d 1986)

Brock, D. W. (1998). Voluntary active euthanasia. In G. Pence (Ed.), *Classic works in medical ethics.* Boston, MA: McGraw-Hill.

Buchanan, A. E., & Brock, D. W. (1995). *Deciding for others: The ethics of surrogate decision making*. New York, NY: Cambridge University Press.

Buckner, F., & Firestone, M. (2000). "Where the public peril begins": 25 years after Tarasoff. *The journal of legal medicine, 21*(2), 187-222.

Cholbi, M. (2011). *Suicide: The philosophical dimensions*. Peterborough, Ont.: Broadview Press.

Clark, S. E., & Goldney, R. D. (2000). The impact of suicide on relatives and friends. In R. Goldney & R. Goldney (Eds.), *The international handbook of suicide and attempted suicide.* New York, NY: John Wiley & Sons, LTD.

Cosculluela, V. (1995). *The ethics of suicide*. New York, NY: Garland publishing, inc.

Dworkin, G. (1976). Autonomy and behavior control. *The hastings center report*, *6*(1), 23-28. Retrieved from http://www.jstor.org/stable/3560358

Faden, R. R., & Beauchamp, T. L. (1986). *A history and theory of informed consent*. New York, NY: Oxford University Press.

Grisso, T., & Appelbaum, P. S. (1998). *Assessing competence to consent to treatment: A guide for physicians and other health professionals*. New York, NY: Oxford University Press.

Grisso, T., Appelbaum, P. S., & Hill-Fotouhi, C. (1997). The maccat-t: A clinical tool to assess patients' capacities to make treatment decisions. *Psychiatric services*, *48*(11), 1415-1419.

Granello, P. F., & Juhnke, G. A. (2010). *Case studies in suicide: Experiences of mental health professionals*. Upper Saddle River, NJ: Merrill.

Hope, T., Tan, J., Stewart, A., & Fitzpatrick, R. (2011). Anorexia nervosa and the language of authenticity. *The hastings center report, 41*(6), 19-29. Retrieved from http://muse.jhu.edu/journals/hcr/summary/v041/41.6.hope.html

Hurst, S. A. (2004). When patients refuse assessment of decision-making capacity: How should clinicians respond? *Archives of internal medicine, 164*, 1757-1760. Retrieved January 24, 2015, from http://archinte.jamanetwork.com

Hyun , I. (2001). Authentic values and individual autonomy. *The journal of value inquiry*, 35, 195-208.

Joiner, T. (2007). *Why people die by suicide*. Cambridge, MA: Harvard University Press.

Jonsen, A. R., Siegler, M., & Winslade, W. J. (2006).*Clinical ethics: A practical approach to ethical decisions in clinical medicine*. (6th ed.). New York, NY: McGraw-Hill.

Lidz, C. W., & Parker, L. S. (2003). Issues of ethics and identity in diagnosis of late life depression. *Ethics & behavior*, *13*(3), 249-262.

Matthews, M. (1987). Suicidal competence and the patient's right to refuse lifesaving treatment. *California Law Review, 75*(2), 707-758. Retrieved from http://scholarship.law.berkeley.edu/californialawreview/vol75/iss2/7

Meisel, A. (1992). The legal consensus about forgoing life-sustaining treatment: Its status and its prospects. *Kennedy institute of ethics journal*, *2*(4), 309-345. doi: 10.1353/ken.0.0124

Mill, J. S. (1901). *On liberty* (Kindle ed.). New York, NY: The Walter Scott Publishing Company, Ltd

Miller, B. L. (1981). Autonomy & the refusal of lifesaving treatment. *The hastings center report*, 11(4), 22-28. Retrieved from http://www.jstor.org/stable/3561339

Parfit, D. (1987). *Reasons and persons*. New York, NY: Oxford University Press.

Pilpel, A., & Amsel, L. (2011). What is wrong with rational suicide. *Philosophia, 39*, 111-123.

Rachels, J. (1998). Active and passive euthanasia. In G. Pence (Ed.), *Classic works in medical ethics* (pp. 21-26). Boston, MA : McGraw-Hill.

Sava, J. A., & the Staff of the Center for Ethics, (2011). Depressed or just ready to die?. *The journal of hospital ethics*, *2*(3), 19-24.

Shneidman, E. S. (1996). *The suicidal mind*. New York, NY: Oxford University Press.

Szasz, T. (2011). *Suicide prohibition: The shame of medicine*. (1st ed.). Syracuse, NY : Syracuse University Press.

The Oregon Death With Dignity Act, Oregon Revised Statutes 127.820 §3.02 (2013). Retrieved from https://www.oregonlegislature.gov/bills_laws/ors/ors127.html.

Werth, J. L. (1996). *Rational suicide?: Implications for mental health professionals*. Washington, D.C.: Taylor & Francis.

Werth, J. L. (1998). Using rational suicide as an intervention to prevent irrational suicide. *Crisis*, *19*(4), 185-192.

Werth, J. L., & Rogers, J. R. (2005). Assessing for impaired judgment as a means of meeting the ‘‘duty to protect’’ when a client is a potential harm-to-self: Implications for clients making end-of-life decisions. *Mortality*, *10*(1), 7-21. doi: 10.1080/13576270500030966

Werth, J. L., Benjamin, G. A. H., & Farrenkopf, T. (2000). Requests for physician-assisted death: Guidelines for assessing mental capacity and impaired judgment. *Psychology, public policy, and law*, *6*(2), 348-372. doi: 0.1037//1076-8971.6.2.348