REFUSAL OF TREATMENT, SUICIDE INTERVENTION AND AUTONOMY

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Abstract

Respect for autonomy grounds a patient's right to refuse medical treatment even when the resulting consequence will be death of the patient. This, in policy, guarantees a patient the right to commit suicide by refusing treatment. However, individuals who attempt suicide by active measures are often subjected to prolonged intervention. This creates an inconsistency in the policies of treatment refusal and suicide intervention. In this paper, I examine the reasons commonly given to justify prolonged suicide intervention and extrapolate their faults. Given the strong value placed on autonomy, the common arguments for prolonged suicide intervention are fatally flawed.

Introduction

To deny someone control of what is one of the most important decisions of life is a blatant disrespect for autonomy and an act of paternalistic tyranny. Prolonged suicide intervention is such a denial and, to be rightfully tolerated, there must be a strong justification for the utility of doing so in order to remain respectful of the value of autonomy.[1] It is this respect for autonomy that, in policy, grounds a patient's right to refuse medical treatment. In fact, it is generally concluded that physicians are both morally and legally obligated to honor refusals of treatment, even when the resulting consequence will be death of the patient (Beauchamp, 1996). Therefore, according to current policy, one can, in certain circumstances, commit suicide by refusing treatment. However, this right to commit suicide by passive means does not extend to more active measures. For those who attempt suicide by active measures, their attempts are often thwarted and subject to prolonged intervention. This creates an inconsistency in the policies of treatment refusal and suicide intervention. If persons should have the liberty to end their lives by refusing treatment without intervention, they should have the right to end their lives by utilizing other methods without intervention. However, many arguments have been offered in support of prolonged suicide intervention. In what follows, I will examine these arguments and extrapolate their failings.

Autonomy and relief of suffering are values that, generally, are not disputed.[2] To quote R.G. Frey, "Control over our own lives is one of the most important goods we enjoy" (Frey, 1998: p. 17). It is this realization of the importance of individual

autonomy that grounds the justification for a patient's right to refuse medical treatment. The Hastings Center Project Group gives voice to this respect for patient autonomy when they write:

> If the patient has decision-making capacity, then the patient is the ultimate judge of the benefits and burdens of a life-sustaining treatment, and whether the burdens outweigh the benefits. Individuals differ in what they see as a burden and a benefit (The Hasting Center project Group, 1987).[3]

Generally, this right is so firmly grounded in theory that, as Dan W. Brock suggests, there is a "firm consensus that competent patients are entitled or have a moral right to refuse life-sustaining treatment" (Brock, 1996: p. 144).

This right to refuse treatment includes patients who would, otherwise, return to a state of health if given treatment. A case that illustrates this is *Lane v. Candura* (Lane v. Candura, 1978*)*. In this case, 77 year-old Mrs. Candura was informed that she would die without an amputation on her gangrenous leg. Her right to refuse treatment was upheld even after her daughter launched a legal battle protesting her decision (Angell, 1998). Likewise, a Jehovah's Witness, who is otherwise in good heath and requires a routine blood transfusion, can decline. The Jehovah's Witness has a right to refuse treatment because it is his/her autonomous choice to do so.[4] In fact, in policy, all competent patients have the right to refuse medical treatment for any reason at any time. However, the story is much different for autonomous choices to commit suicide.

For purposes of clarification, I will define suicide as the intentional termination of one's own life by oneself or through a plan he/she has devised to bring about death.[5] The current of moral detest for suicide flows strong in the United States as The American Foundation for Suicide Prevention receives unprecedented amounts of grant money and public figures speak in support of prevention. For example, on July 28, 1999 the Surgeon General of the United States gave a press conference that unveiled a plan to prevent suicide. The proposed plan called for "strong intervention methods" (http://www.Surgeangeneral.gov). Also, as established in *Washington v. Glucksberg* (Washington v. Glucksberg, 1997), promoting a suicide attempt is a felony punishable by up to five years imprisonment and a $10,000 fine. This support for suicide prevention is not historically novel. In many ways it is reflective of the teleological ethic that has infused many parts of the legal system despite the theoretical separation of church and state; however, it also is backed by a long philosophical tradition.

St. Thomas Aquinas claimed that "life is God's gift to man, and is subject to his power, who kills and makes to live. Hence, who-ever takes his own life sins against God, even as he who kills another's slave, sins against the slave's master" (Aquinas, 1948). To Aquinas, suicide violated a natural law. However, perhaps the most influential philosopher to condemn suicide was Immanuel Kant. Kant argued that suicide degrades human worth, is a moral abomination and is not permissible under any circumstances (Kant, 1963).

Despite Kant's influence, many philosophers have expressed quite a different view regarding suicide. At the extreme are figures such as Schopenhauer and Seneca. Seneca believed that human freedom should include being free to choose when to die (Seneca. Epistle 58). Recently, an argument similar to that offered by Seneca has been expressed by six well-respected philosophers.[6] This group of philosophers filed an *amici curiae to* the United States Supreme Court, in the cases of *Washington v. Glucksberg* and *Vacco v. Quill* (Vacco v. Quill, 1997), in favor of a right to assisted suicide. They contend that the right to liberty entails the freedom to make fundamental decisions, such as the decision to die, without governmental interference. Their argument is that autonomy is violated by interference in a suicide. They write:

> In a free society, individuals must be allowed to make those decisions for themselves, out of their own faith, conscience and convictions. A person's interest in following his own convictions at the end of life is so much a part of the more general right to make intimate and personal choices for himself that a failure to protect that particular interest would undermine the general right altogether…most of us see death…whatever we think will follow it…as the final act of life's drama, and we want that last act to reflect our own convictions, those we have tried to live by, not the convictions of others forced on us in our most vulnerable moment (Dworkin, 1997).

While the suicide debate is far from settled, it is clear that suicide intervention limits autonomy: the same value that is appealed to in the justification of the right to withhold treatment.

Suicide clearly can incorporate passive as well as active means. This is obviously the case for those who commit suicide by refusing to eat or drink. Also, one can commit suicide by refusing treatment. The motives of a person who commits suicide by refusing treatment may differ very little from suicides utilizing other methods. Tom Beauchamp writes, "[T]his makes it difficult to distinguish suicides from treatment refusals on the basis of intention. Like typical suicides, patients who refuse treatment often intend to end their lives because of their grim prospects" (Beauchamp, 1996: p. 1178). In short, both are done to end life because the patient/potential suicide "victim" decides that life, living it as they are, is not worth continued existence. Thus, for those who wish to end their lives, refusing treatment may be a means they could employ. If they find themselves in need of even a simple procedure, such as stitching a cut, they have the right to refuse treatment. Along these lines, R.G. Frey writes:

> If a patient enjoys a legal right to refuse medical treatment per se, if it would be wrong of the doctor, other things equal, to violate this right, and if the doctor alone does not violate, then the patient alone could be viewed as having sufficient control to effect her death. Put this way, a legal right to refuse medical treatment would be a vehicle by which, in effect, a patient could commit suicide (Frey, 1998: p. 38).

Therefore, suicide by refusing treatment is, in policy, guaranteed to those wishing to commit suicide if they have the "luck" to require treatment. The justification is, of course, the autonomy of a patient to refuse treatment.

We are thus faced with the strange conundrum of being able to freely refuse treatment even when it constitutes suicide but being subject to extreme acts of intervention if committing suicide by other methods. Beauchamp writes of this incoherence, "the right of autonomy that underlies allowing patients to die when they refuse treatment seems, in principle, to extend to a patient's choice of suicide or euthanasia" (Beauchamp, 1996: p. 1178). This respect for autonomy should, if only for consistency, be extended to the decision about continued life as well as decisions in one's life. However, this is not the case.

Suicide intervention is freely practiced and is not considered to be as harmful as other clearly invasive actions against autonomy. Forms of intervention can range from pumping stomachs, treatment for depression, to the forceful admittance to treatment facilities where persons are put on "suicide watch" and denied anything with which they may be able to harm themselves. Often this is done to patients who, except for their desire to commit suicide, are otherwise judged to be competent. Beauchamp relates the tragic case of Donald Cowart, a burn victim who decided to end his own life. Although a psychiatrist judged Cowart competent enough to seek release from the hospital he was staying, because he had informed a doctor of his intention to commit suicide upon his release, he was prevented from leaving (Beauchamp, 1980). Of intervention Beauchamp writes:

> In the case of almost any similarly intrusive, liberty-limiting action, the person impeded could successfully sue those who intervene. A physician, for example can be sued for malpractice by a similarly coercive treatment of patients. Yet in the case of suicide, many believe that we have obligations to suicidal human persons, even when they act autonomously (Beauchamp, 1980: p. 95).

Clearly given the nature of suicide, the only justification that could be offered for interfering in suicide is a paternalistic one.[7] That is interference with suicide is justified by reasons referring exclusively to the welfare, of the person whose liberty is being thwarted.[8] Because every violation of a person's bodily integrity is an invasion of his or her liberty and autonomy, the justification for this invasion must be strong. To respect the autonomy of self-determining agents is to recognize them as having a right to determine their destiny, even if it is believed that their evaluations or choices are wrong and/or possibly harmful to them. Even if it is felt that a decision is wrong and suicide may, at times, be a wrong decision, a society that values liberty cannot prohibit citizens from making wrong decisions without strong justifications for doing so. To do this would be a blatant disregard for autonomy. Unless there are sound arguments for prohibiting suicide it is an individual's decision to make, even if, it may be a wrong one.

Justifications for Denying Autonomy

The common justifications for suicide intervention include the following: 1) the argument that a suicidal person is not competent to make an autonomous decision and does not really want to die; 2) the claim that life it sacred; and, 3) the slippery slope argument that suggests that if suicide is not interfered with, we will be lead down a path to atrocities such as the Nazi extermination camps.

One may hold that suicides are never autonomous or at best, those who attempt suicide are marginally competent. This could be argued on the basis that if one is mentally ill they are not competent. This is the argument that has been given by many authors who question the competency of those wishing to commit suicide on the basis that they may be suffering from depression and, if treated, would no longer want to die. In short, it is claimed that when given treatment for depression, most attempters lose interest in suicide. Beauchamp writes, "many who kill themselves have a counteracting desire to live, often suffer from a temporary form of depression or delirium, are treatable by drug therapies, and may be giving a signal of a need for assistance more than effecting a well-reasoned decision to end life" (Beauchamp, 1980: p. 69).

In concurrence, sociologist David Greenberg claims that only about 1% of all surviving suicide attempters kill themselves within a year of the first attempt. This is still quite a bit higher than the suicide rate in the general population, but far lower than would be anticipated if most attempters "unambivalently wanted to die" according to Greenberg (Greenburg, 1974). From this, Greenburg concludes that, since most suicide attempters really do not want to die, some policy of suicide intervention is necessary. However, as Greenburg continues, he admits that at sometime in their lives up to 15% of attempters succeed in killing themselves (Greenburg, 1974).

This 15% lifetime repeat rate is much higher than that of any other population. Also many persons who wish to die may not attempt suicide again due the possibility of traumatic intervention or the numbing effects of drugs given to treat depression. Thus, while Greenburg's argument may partially justify temporary intervention, it will not justify intervention for those who are fully competent and persistent in their desire to end their lives. Even Greenburg concludes that, in an ideal policy of suicide prevention, autonomy would still retain value. He writes, "[C]entral among these would be the right to commit suicide for those who found the pain and distress of living intolerable, and for whom the desire to end life represented something more than momentary dejection or discouragement" (Greenburg, 1974: p. 229). However, Greenburg's ideal is rarely reality.

In many instances, the sole reason for the assertion that a patient is suffering from depression and, thus incompetent, is the fact that they wish to commit suicide. Thus, we are left with a circularity where intervention is always appropriate. Given that depression makes one incompetent and desiring suicide is sufficient for the diagnoses of depression, this argument is clearly invalid due to its circular nature. Such a question-begging argument clearly is not a strong justification for prolonged suicide intervention.

Another common justification given for suicide intervention is the argument that not to intervene in suicide shows lack of respect for human life. Human life, it is argued, is sacred and should be preserved whenever possible, even if the person whose life it is no longer wants to live. This view is commonly expressed; however, it is seriously flawed.

For someone who argues in this fashion, all human life is intrinsically valuable. Therefore, even if one is in a permanent vegetative state, or terminally ill with only minutes to live and in intense pain, we should try to prolong life as long as possible. This remains true even when the quality of life is horribly low. Also, if one should never kill, it may be impossible to justify killing in self-defense. Few, I believe, would want to accept all the consequences of this theory.

When applied to suicide, this theory is especially weak. Clearly there are justified suicides. Consider the case of suicide where a motorist, realizing her brakes had failed on a steep mountain cliff, deliberately steers into a concrete abutment to avoid hitting an oncoming school bus. Also there are cases where suicide is, most would contend, heroic. An example of this is the commonly told story of an arctic explorer who, in a weakened condition that jeopardized the lives of the other members of his party, walked into a blizzard unclothed to die.

In addition, if one denies the intrinsic sanctity of all human life, any attempts to appeal to this argument fail. Certainly, it is not clear that the interests of those who hold such a view can trump the rights of those who wish to end their lives. Therefore, given the counterexamples, and the unacceptable consequences entailed by such a view, the argument based on the intrinsic value of life is not strong enough to limit the autonomy of those wish to commit suicide.

The final argument considered here for prolonged suicide intervention is in the form of a slippery slope. This argument has the general form that if we morally permit suicide or assisted suicide (not intervene), we will be on the road to disrespect for all human life. Proponents of this argument claim that if the life of one who does not want to live is de-valued, we will, easily take another step down the slope and start to devalue the lives of others (Finnis, 1995).[9] Thus, they conclude that we will, ultimately, slip down a path where life is easily devalued and genocide and atrocities such as the Nazi extermination camps are permissible.

As shocking as this argument appears, the slope to the devaluation of human life is generally not as slippery as proponents of the argument make it seem. In general, this argument amounts to speculative observations. It also ignores any relevant distinctions that would make sliding down the slope improbable or why interventions to prevent slipping down the slope are likely to fail (Harris, 1995).[10] To expound upon the improbability of the slippery slope argument in favor of suicide intervention, consider a similar argument with exactly the opposite conclusion: suicide intervention will lead to a flagrant disregard for autonomy. The argument is that if actions such as suicide intervention are morally permissible, autonomy will, eventually, be reduced to the point where using highly invasive life–extending

treatments on unwilling patients is justified. This argument is, at the very least, as plausible as the slippery slope argument given for suicide intervention. Given this plausibility, slipping in the opposite direction, makes it clear that the slippery slope used as a justification for suicide intervention is, at best, unlikely.

Recent advances in medical technology have made it likely that mechanical components and technologies can be used to dramatically extend life and modify the human body. Recent discoveries by Tomas Prolla and Richard Weindruch point to the fact that very soon oxidation may be stopped in cells by locating genetic biomarkers.[11] Also, many scientists believe that senescence is inherently modifiable and that life extension methods will be "an important and difficult challenge in the 21st century" (Carnes, 1996: p. 60-61). Given these advances, it is likely that not far in the future, humans will be able to utilize dramatic life-extending technologies.

Once widely available, humans who chose not to undergo life-extending procedures performed would, in essence, be choosing to die. For the physician who `justifies suicide prevention on the arguments listed previously and sees her job as, Marcia Angell suggests, "to extend life whenever possible," not utilizing such technologies would be morally questionable (Angell, 1998: p. 3). By interfering in suicide, we slip down a slope where forceful use of life-extending technologies will not be uncommon.

State intervention for the purpose of coercively preventing a suicide is a reality, as are other evasive procedures to the human body. This is currently true in cases concerning compulsory vaccinations and blood sampling. Legally, an example of this is found in the 1966 case of *Schmerber v. California* (Schmerber v. California, 1966), in which extraction of a blood sample of a suspected drunk driver was ordered in the face of the defendant's objection. Also, *Jacobson v. Massachusetts* (Jacobson v. Massachusetts, 1905), where the law of compulsory smallpox vaccination was upheld, is another historic case where the state has been granted the right to perform invasive procedures on a person's body without consent. Thus, the first step down the slope has already been taken.

The second step could be based on the very arguments used to affirm the morality of suicide intervention: competency and sanctity of life. It could easily be argued that a person refusing such life-extending interventions is not competent to make such a decision. This could be justified on the grounds that, as is the case in suicide intervention, the person refusing such treatment may be depressed. If they were not depressed, it could be argued, they would not want to die. This would be especially convincing in cases where the life-extending procedures would not be burdensome or would "enhance" functioning. If the desire to comment suicide by other methods is seen as enough to diagnose depression, there is no reason to expect it would not be so in this case. In fact, a doctor may simply chose to play it safe, perform the life-extending procedures without the consent of the patient, and talk about it at some other time, perhaps, when the patient is feeling less depressed. Of course, to not be considered depressed, the patient must no longer want to die and agree to have the procedure(s). Therefore, the patient enters the same vicious circle that occurs in suicide intervention.

The second justification, sanctity of life, needs little explanation. For someone who holds a strict sanctity of life view, extending human life is always the right thing to do. This is, as previously mentioned, used to justify intrusions on autonomy for those who make this argument. Thus, if suicide prevention can be justified by appeal to sanctity of life so can forceful submission to life-extending procedures.

Any of the arguments given to justify suicide intervention can also be used to justify invasive treatment to extend life. In fact, it would be inconsistent to accept the arguments and justify degradation of autonomy for suicide intervention but not for life extension. This mimics the inconsistencies pointed to between suicide intervention and the right to refuse treatment. Simply put, the arguments used for one should extend to the other. If one does not have the autonomy to decide to end their life, it should not matter which way she wishes to do so. In short, if the justifications given to reduce autonomy by suicide prevention should be accepted, to be consistent, invasive life extension should also be permissible. Therefore, if such reduction of autonomy can be justified for suicide intervention on the aforementioned arguments, we face a very slippery slope.

Of course, if interventions were set in place and would function properly, the slippery slope argument would fail. However, the opposite seems likely. In fact, although patients currently have the right in policy to refuse treatment (a right that if upheld would be an intervention to falling down the slope), in reality it is often ignored. The reasons it is ignored parallel the justifications for suicide intervention. To elaborate, consider the following, which often occurs in cases where a person has a living will. For the physician "playing it safe" ignoring a living will can be justified. The common justification is that the patient, who was not in a life-threatening situation at the time of making the will, under current circumstances, might feel differently about her future. While this may seem at least somewhat reasonable, it turns out that even if a patient can affirm in a life threatening situation that they want the will upheld, the physician "playing it safe" could still justify ignoring the will. The justification often used is that the life-threatening situation has made their patient temporary incompetent. Most frequently, depression is cited as a factor for this "incompetence." The justifications, in and of themselves, seem reasonable. It is clearly true that a patient may not know their wishes in a future situation and that certain situations, especially when one is in severe pain or has a discouraging prognosis can cloud judgments. However, when taken together, a patient's right to refuse treatment can always be justifiably ignored.[12] Again, this argument cumulates in circularity.

While the argument here is inductive (as are all slippery slope arguments) and thus circular in a fundamental way, I believe it to be more plausible than the opposing argument.[13] The simple fact that a contrary slippery slope argument can be made with at least as much strength should be enough to cast serious doubts on the argument that giving individuals control of their death will end in mass murdering. In fact, considering current trends and the fact that there are plausible interventions (and reasons why these interventions will work), there is simply no reason to accept the slippery slope argument based on the sanctity of life. There are

certainly problems with the opposing slippery slope I construct; however, I use the construction merely to show the improbability of the opposing argument. Clearly the slippery slope argument based on sanctity of life, fails to provide a strong justification for suicide intervention.

Conclusion

In conclusion, I agree with Beauchamp's assertion that "choosing how to die is part of choosing how to live" (Battin, 1998) and believe that autonomy should extend to the decision about continued life as well as other important decisions in a person's life. Not only is prolonged suicide intervention inconsistent with current values placed on autonomy, as can be seen in policies concerning the right to refuse treatment, the justifications for it are weak. This paper has examined the inconsistencies between policies on suicide intervention and refusing treatment. My argument is that, to be consistent, if one should have a right to commit suicide by refusal of treatment they should have the right to commit suicide by other methods without interference. In examining the justifications commonly used for prolonged suicide intervention, ultimately, it is my contention that these arguments are weak and/or circular. Therefore, given that a strong justification should be required for anything as disrespectful to individual autonomy as prolonged suicide intervention; it is, unjustifiable to practice such intervention. Patients should be guaranteed the right to both refuse treatment and actively end their own lives without prolonged intervention.

Notes

1. In some cases brief intervention is certainly permissible. An example of such a case is intervention in a suicide where the attempter is under the influence of strong hallucinogenic drugs.

2. For purposes of clarification I will offer the following definition of an autonomous desire: a person's desire is autonomous if she treats that desire as providing a reason to act, and if she is satisfied with this decision. In addition this desire must not have been conditioned into her by any illegitimate external method like brainwashing.

3. A group of twenty members which includes, doctors, lawyers, and philosophers

4. This only applies to adults as children are, of course, often unable to make fully informed decisions.

5. I am aware of the problems of this standard type of definition posited by Beauchamp in "Suicide." However, Beauchamp's arguments rest on a morally charged definition of suicide. This leads to his reluctance to include Socrates' death

as a suicide. This is absurd as Socrates deliberately ingested poison in a plan to bring about his death. If this action is moral or not is precisely what must be considered and using a definition which seeks to only encompass certain intentional takings is question begging. This is akin to developing a new definition of killing (perhaps a distinction between killing and letting die) to serve one's own moral theory. However, such subdivisions are often artificial and ad-hoc.

6. Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon and Judith Jarvis Thomson.

7. I am aware of arguments to the effect that one should not commit suicide because it will hurt those around them. However, I find this unconvincing. If we should always limit autonomy to keep from hurting those around us emotionally, we could justify laws against divorce, breaking someone's heart and name-calling.

8. Good, happiness, interests or needs.

9. John Finnis gives an elaborate formulation of this argument.

10. John Harris gives a plausible account of a likely intervention.

11. See the Life Extension Foundation website for information of this project as well as many more concerning new technologies aimed at extending life at http://www.lef.org.

12. I thank R. G. Frey for bringing this scenario to my attention.

13. Under David Hume's famous argument.

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