Available online at www.sciencedirect.com

ScienceDirect

BIOETHICS UPdate 5 (2019) 107–120

BIOETHICS UPdate

www.elsevier.es/bioethicsupdate

Original article

A complete treatise on rational suicide

Un tratado completo sobre el suicidio racional

Al Giwa

Icahn School of Medicine at Mount Sinai, One Gustave L. Levy Place, New York, NY 10128, United States

Received 20 December 2018; accepted 27 February 2019
Available online 23 April 2019

Abstract

It was believed for a long time that people brought to the attention of healthcare and/or legal authorities with suicidality were automatically deemed to lack medical decision-making capacity or competence. This is despite many of these patients possessing the "mental ability to make a rational decision, which includes the ability to perceive, to appreciate all relevant facts and to reach a rational judgment upon such facts". Several ethical and psychiatric specialists and defenders of patient rights have criticized this traditional paternalistic approach for failing to respect the right of a competent, rational person to self-determination and autonomy.
As society increasingly recognizes patients' rights to refuse treatment, their autonomy to make decisions and the right to self-determination, the bioethical, medical and legal community must strive to identify those individuals who are not just impulsively acting and/or under the influence of factors that may hinder their capacity. As moral people who respect competent individuals who make rational decisions, regardless of whether we agree with them or not, we have a duty to respect their right to self-determination and suicide.

Keywords: Suicide; Rational suicide; Autonomy; Capacity; Competence

E-mail address: al@bema.nyc

https://doi.org/10.1016/j.bioet.2019.02.005

Resumen

Durante mucho tiempo se ha sostenido que las personas que llamaron la atención de las autoridades sanitarias y/o legales con respecto al suicidio se consideraron automáticamente como carentes de capacidad para tomar decisiones médicas. Esto ocurre a pesar de que muchos de estos pacientes realmente poseen la "capacidad mental para tomar una decisión racional, que incluye la capacidad de percibir, apreciar todos los hechos relevantes y llegar a un juicio racional sobre tales hechos". Varios especialistas en ética, psiquiatras y defensores de los derechos de los pacientes han cuestionado este enfoque paternalista tradicional al negarse a respetar el derecho de una persona racional competente a la libre determinación y la autonomía.
A medida que la sociedad reconoce cada vez más los derechos de los pacientes a rechazar el tratamiento, su autonomía para tomar decisiones y el derecho a la autodeterminación, la comunidad bioética, médica y legal debe esforzarse por identificar a aquellos individuos que no solo están actuando impulsivamente y/o bajo la influencia de factores que pueden dificultar su capacidad. Como personas morales que respetan a los individuos competentes que toman decisiones racionales, independientemente de que estemos de acuerdo con ellos o no, tenemos el deber de respetar su derecho a la autodeterminación y al suicidio.

Palabras clave: Suicidio; Suicidio racional; Autonomía; Capacidad; Competencia

Introduction and background

In contemporary western medicine, the respect for individual liberties, patients' bills of rights, and respect for self-determination and autonomy, are key to the practice paradigms that have entered clinical medicine. Although, autonomy and the resultant rights patients have been afforded have been criticized by some, they have been generally upheld by many more in the legal, ethical, and even medical communities. According to Wolpe (1998) and others, the respect for an individual's right to autonomy is here to stay in some form in the U.S. for the foreseeable future (Mackenzie, 2015). Rhodes and Holzman (2004) state "Physicians are obliged, by law and by ethics, to respect the treatment refusals of a competent patient even when the consequences will be dire and even when the physician disagrees with the choice and does not share the patient's values." Respect for autonomy and autonomous decisions, is heralded as one of the most important principles in bioethics (Bennett & Harris, 2007). Bennett and Harris (2007) state that "People are said to be autonomous to the extent to which they are able to control their lives, and to some extent their destiny, by the exercise of their own faculties".

Despite a general movement to respect an individual's autonomy, people brought to the attention of healthcare and/or legal authorities in the U.S. with suicidality are usually still assumed to lack medical decision-making capacity or competence. This is despite many of these patients possessing the "mental ability to make a rational decision, which includes the ability to perceive, to appreciate all relevant facts, and to reach a rational judgment upon such facts" (Tennessee v. Northern, 1978). Hence, a blanket statement or fixed treatment decision committing all who attempt or contemplate suicide to mental treatment against their will, seems at odds with the respect for a patient's autonomy and self-determination that has become the hallmark for ethical medical care in most developed nations. Traditionally paternalistic statements have their origins in the Hippocratic tradition, long known for its role of the physician as protector, knower, and doer for the patient, or as Wolpe (1998) says "both duty holder and decision-maker for the patient".

Suicide is a complex and often misunderstood act, that is generally defined as "the intentional termination of a person's own life", a view shared by many scholars on this subject (Degrazia et al., 2011). By way of examples, I would like to briefly illustrate some case scenarios as a form of introduction to the varied instances of suicide:

- A young woman, having just broken up with her partner, drinks a bottle of alcohol, and jumps off a skyscraper.
- An elderly man without a prior history of mental illness, takes an overdose of barbiturates, leaving a note stating he has just had enough. He has enjoyed his life thoroughly, has no more family or friends, and no longer wants to live.
- An Army officer is captured during war, and tortured to reveal potentially damaging secrets. In order to avoid the betrayal of her fellow soldiers, she hangs herself.
- A cancer patient, riddled with pain despite high dose opioid analgesics, decides he has suffered long enough, and swallows a three-month supply of painkillers.
- A peace activist against the innocent killing and raping of a minority tribe in a SE Asian nation, goes on a hunger strike for 120 days without eating or drinking, and eventually succumbs.
- An end-stage-renal-disease (ESRD) patient on dialysis, is tired of the imposition on loved ones and triweekly inconvenience, and decides to stop receiving dialysis. He tells his physician he refuses all further treatments and as a result, dies 10 days later.

All of these case examples involve the *intentional termination of a person's own life*, hence, are suicides by definition, but are they all the same? All have reasons for their actions, but are some are viewed as more acceptable and/or less morally wrong than others? Is it still suicide if one refuses life saving treatment vs. puts a gun to one's head? Like Robert Veatch (2013), I would argue that actively or passively ending one's own life is still suicide by the above provided definition, and subject to the same analysis of motivation and state of mind.

The arguments against suicide are numerous, and I will not attempt to address each of them in this paper. However, one can sum the general category of arguments against suicide as religious-based, (God would not want you to kill yourself), rationality-based (taking one's life is an irrational decision), psychiatry-based (suicidality in and of itself is a mental disorder), civil based (we owe a duty to the state or the state is responsible for the protection of its citizens against death), and of course morality-based (suicide is immoral) (Beauchamp & Childress, 2013; Clarke, 1999; Menikoff, 2008; Mill, 1859; Szasz, 1999; Veatch, 2013).

I begin by showing the interrelatedness of competence, capacity, and rationality. I will then refute the psychiatric assumptions of suicidality as automatically qualifying as a mental disorder and as compromising capacity. Additionally, I highlight key legal decisions that have favored the rights of patients to not only terminate life saving treatments, but to end their lives. Lastly, I will provide philosophical arguments strongly supporting the concept of a "rational suicide".[1]

Capacity, competence and rationality

Although any physician can (and should) make the determination of his/her patient's capacity, oftentimes psychiatrists are consulted for their expertise, especially in cases that are deemed to have high probability of legal involvement (Appelbaum, 2007). Many physicians in the U.S. still hold the paternalistic view that patients who are suicidal (whether they are depressed or not) cannot possess capacity purely on the basis of their clinical complaint, as well as the physician's need to protect patients from self-harm (Berolote & Fleischmann, 2002). This is despite many of them possessing the four essential components in determining capacity. Appelbaum (2007)

[1] It should be noted that these arguments are theoretical in nature and obviously need to be complemented by the elaboration of concrete procedures for checking the existence of the suitable condition of competence in each particular case.

cites the most commonly agreed upon definition of capacity as "the abilities to communicate a choice, to understand the relevant information, to appreciate the medical consequences of the situation, and to reason about treatment choices." This four-part requirement has become the standard capacity determinant throughout the medical and legal communities in the United States and Canada, and most of the developed world (Ho, 2014).

Competence has generally been defined in most courts in the United States as the possession of *understanding* and *appreciation* of information provided, whether it is for a procedure, medication, and/or particular treatment or action (Gert et al., 1997). As will be further described below, understanding, appreciation, communication, and reasoning are key elements in both definitions of competence and capacity. In fact, although there has been a traditional distinction made between capacity and competence, with the latter only used after a determination by a court of law, modern scholars in psychiatry, ethics, and law have argued that they are synonymous concepts and utilize the same determinant criteria, hence I will similarly use these terms interchangeably (Appelbaum, 2007; Beauchamp & Childress, 2013; Gert et al., 1997).

Competence (as is capacity) is determined on a task specific basis, i.e., one is never deemed to be "globally competent" but competent to perform specific tasks. Gert et al. (1997) expanded on this traditional definition of competence, and argue that rationality is conceptually related to competence and should be included in the determination of competency. In fact, they argue that the truest definition of competence, "in making medical decisions, is the ability to make a rational decision" (Gert et al., 1997). They judge rationality as one's historical ability to make rational choices and decisions in one's own life. Gert et al. (1997) establish that the only factors that can interfere with a person's ability to make a rational decision are:

A. *A cognitive disability that prevents the person from understanding the information relevant to making a decision of a particular kind. In the case of medical treatment decisions, this would be the lack of ability to understand the "adequate information" given during the consent process.*
B. *A cognitive disability that prevents appreciating that the relevant information in (A) does indeed apply to one in one's current situation.*
C. *A cognitive disability that prevents coordinating the information in (A) with one's personal ranking of the various goods and harms associated with the various available options, insofar as one has stable rankings which are relevant.*

D. The presence of a mental malady, such as a mood disorder or a volitional disability, that causes one to make irrational decisions.

If either (A), (B), (C), or (D) is present, then the person lacks the ability to make a rational decision of the particular kind involved, which is to say that she is not competent to make a rational decision of that kind.

Applying these criteria to the previously provided examples of suicide, it would seem that despite the limited case information, many of these acts might be rational decisions. The first example of the young lady impetuously reacting to a stressor and then taking a mood altering substance (alcohol), clearly does not satisfy Gert et al's. (1997) rationality test. One could also argue that the example of the elderly gentleman who has enjoyed life fully, and no longer wants to live, might involve a mood disorder (although Appelbaum (2007) will later show that capacity is still maintained in the majority of such cases). However, it seems the remaining examples fail to clearly demonstrate any mental maladies or cognitive disabilities, or the lack of understanding, appreciation or coordination of information.[2] Would one commit the captured Army officer to a mental institution, despite her seeming to possess understanding, appreciation and rationality to make the sacrifice to prevent revealing secrets and causing harm to others? If it can be determined that both the peace activist on a hunger strike and the ESRD patient refusing further dialysis are without any cognitive or mental disorders, and possess capacity and rationality, should we not respect their right to self-determination?

Suicide as a mental illness

Several ethicists, psychiatrists, patients' rights advocates, and courts of law in the United States have questioned paternalistic treatment of suicidal patients. Although many patients who are suicidal may in fact lack medical-decision making capacity and be irrational, and hence should be treated under appropriate psychiatric care, I

[2] It should be noted however that some authors disagree with the notion of respect for autonomy and rationality as being substantially sufficient to provide a "right to suicide". Australian Psychiatrist and Bioethicist David Clarke states, "'understandability' and 'respect' are more useful and able to provide the foundation for responding to a person expressing a wish to die."[20] I do not believe these are opposing concepts, however in a heavily litigious society like the United States, front-line decision makers will need to document more legally permissible reasons other than empathy and respect for the individual and their suicidality.

will focus my argument on those who are without any cognitive disabilities or mental maladies as described above by Gert et al. (1997).

The psychiatrist Thomas Szasz (1999) criticized psychiatry for medicalizing suicide as a mental illness or disease. He described psychiatrists as coercively gaining control over suicidal patients by taking responsibility for their lives and using suicidality to justify their involuntary hospitalization and treatment. He also disapproved of the language used to describe "self-killing", because committing suicide suggests an act of "badness or madness, akin to a crime". Appelbaum (2007) states that only 20–25% of patients admitted for depression were found to have impairment of their capacity, as compared to patients admitted for an acute exacerbation of schizophrenia (50%). Thus by his analysis, upwards of 80% of patients admitted for major depression still possess medical decision making capacity. It is presumed that most people in a modern society possess decision-making capacity, and hence should be respected as such. It is only the few whose impairment places them at the lower end on the "performance curve of rational performance" that should be considered to be incompetent. (Appelbaum, 2007) Presumably, Appelbaum (2007) acknowledges that the spectrum of behavior that is considered "rational" is vast and complex, and it is only that which is considered below standards of reasonableness that should be deemed as deviant, and hence incompetent.

To reiterate the above point, Canadian psychiatrist, Dr. Angela Onkay Ho (2014) summarized her views on being rational yet desiring to take one's own life as follows:

> A discussion on rational suicide is warranted after recognizing that mental illness does not automatically lend itself to irrationality: people without psychiatric illness can freely desire suicide or a hastened death based on carefully contemplated, logical decision-making processes. This concept is most commonly described in cases of people with terminal illness and no comorbid psychiatric disorder who wish to speed up the dying process by receiving aid in dying or by having life support withheld or withdrawn. Assuming that the decision is uninfluenced by the coercion of others, the desire for hastened death is considered a rational decision to avoid the unbearable suffering associated with terminal illness.

Lastly, a case that garnered a lot of international media attention was the death of Kerrie Wooltorton in Norfolk, England. In 2007 she consumed several glasses of antifreeze in a suicide attempt and called an ambulance. She carried a letter with

her informing doctors that she knew the consequences of her actions, wanted no life-saving treatment, and had come to the hospital only to be made comfortable, because she did not want to die alone.

> To whom this may concern, if I come into hospital regarding taking an overdose or any attempt of my life, I would like for NO lifesaving treatment to be given. I would appreciate if you could continue to give medicines to help relieve my discomfort, painkillers, oxygen etc. I would hope these wishes will be carried out without loads of questioning.
>
> Please be assured that I am 100% aware of the consequences of this and the probable outcome of drinking anti-freeze, e.g. death in 95–99% of cases and if I survive then kidney failure, I understand and accept them and will take 100% responsibility for this decision.
>
> I am aware that you may think that because I call the ambulance I therefore want treatment. THIS IS NOT THE CASE! I do however want to be comfortable as nobody wants to die alone and scared and without going into details there are loads of reasons I do not want to die at home which I realize that you will not understand and I apologize for this.
>
> Please understand that I definitely don't want any form of Ventilation, resuscitation or dialysis, these are my wishes, please respect and carry them out. (Callaghan & Ryan, 2011)

One of the takeaways from reading this letter, besides her seemingly clear rationality and capacity, is her addressing a common misconception that those who call Emergency Medical Services (EMS) are subconsciously reaching out for help. Although, she did not want to go into the details as to why she did not want to die alone, it seems clear she was aware of all of the repercussions of her actions. Her physicians determined that she was competent after much deliberation and legal consultation, and allowed her to die in the hospital two days later. Two years later, a legal inquest and autopsy performed by the Norfolk coroner exonerated the physicians and endorsed the physicians' decision to allow her to die comfortably (Szawarski, 2013).

Laws on suicide

Focusing on the legal environment in the U.S.,[3] we know the American civil rights movement of the 1960s inspired philosophers and medical ethicists to start the (bioethical) movement to respect an individual's right to autonomy and self-determination, which was articulated by Beauchamp and Childress (2013) as one of the "Four Principles" (Baker, 2013). This also coincided with a time in American history where several court cases were gaining national attention regarding the rights of individuals to refuse medical treatment even though the refusal would lead to their deaths. From 1975 with Karen Quinlan, to the landmark United States Supreme Court decision in 1990 of Nancy Cruzan, to the Terri Schiavo case which finally ended in 2005; the respect for a patient's right to die has been upheld in most courts in the U.S. (Giwa, 2018; In re Farrell, 1987; Menikoff, 2008).

Although suicide is no longer illegal in any state or jurisdiction in the U.S., most states have expressed a legal, and some argue, a moral interest in the prevention of suicide amongst its residents. States specifically have certain interests in "*the preservation of human life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession*" (Giwa, 2018; In re Farrell, 1987; Menikoff, 2008). These interests conflict with those who represent or advocate on behalf of those wanting to exercise a right to privacy and self-determination to end their lives. Pro-suicide activists often cite precedent court cases such as Union Pacific Railway Co v Botsford (1891), with the following as their rallying call:

> "No right is held more sacred or is more carefully guarded by the common law than the right of every individual to the possession and control of his own person, free from all restraint or interference of others unless by clear and unquestionable authority of law."

This "clear and unquestionable authority of the law" has been successfully challenged in several landmark cases. Elizabeth Bouvia was a 25-year-old woman almost completely paralyzed from Cerebral Palsy with debilitating painful arthritis, who had attempted suicide on a couple of occasions and finally decided she would no longer eat. She was hospitalized for several months where she maintained her desire to not

[3] The legal framework to which I base my analysis is that of the United States system of jurisprudence, and as a result I will not analyze other systems which may have opposing legal opinions and decisions on rational suicide.

live, and refused to eat. However, her psychiatrists fed her against her will prompting her to contact the American Civil Liberties Union (ACLU) and sue the hospital. An initial probate judge ruled in favor of the hospital authorizing Elizabeth to be fed against her will, despite finding her to be rational and competent. The judge stated that if he permitted her to starve herself to death, other physically handicapped persons would follow suit, the so called "Chicken Little defense"- the sky would fall if she was not force fed (Bouvia v. Glenchur, 1986; Pence, 2014). She eventually continued her fight and appealed the decision in several lower courts until eventually the California Court of Appeals ruled in her favor stating "A desire to terminate one's life is probably the ultimate exercise of one's right to privacy." (Bouvia v. Glenchur, 1986) A few years after the Bouvia case, Larry McAfee, a 29 year old man who became paralyzed (a C-2 quadriplegic) after an accident, petitioned to the federal courts to be allowed to end his life, and a decision was granted in his favor (Pence, 2014).

The crux of the legal argument for the right of autonomous individuals to take their own lives is based on competence and rationality. These and other precedent setting, right to suicide cases, have been used to successfully argue for the legal authorization of autonomous patients to end their own lives, as well as for the terminally ill in some states in the U.S., to invoke the assistance of a physician to end their lives (Giwa, 2018).

The philosophical view on suicide

Although many prominent philosophers from Plato to Kant have been against suicide, several others have supported the right to end one's life at one's own choosing. Aristotle and Plato spoke on the injury of suicide to the state or the Republic, invoking a moral responsibility more to the community than to self (Degrazia et al., 2011). I think in this era of respect for autonomy and self-determination, this is an outdated perspective. Kant's objection to suicide comes from his Categorical Imperative and theory of "self-love", and the resultant duty to self. Kant states we must always treat self (and others) as an end, and never a means, and hence suicide, which eradicates one's existence as a rational creature, is simply treating the self as a means to end one's suffering or distress (Degrazia et al., 2011).

Generally speaking, the prominent schools of thought in support of suicide are the Idealists, exemplified in the works of the Greek philosopher Herodotus and German philosopher Schopenhauer as well as the Libertarians, exemplified with psychiatrist

and philosopher, Dr. Szasz, as mentioned above, and Austrian philosopher Jean Amery. Degrazia et al. (2011) in their analysis of the philosophical literature on suicide, state,

> "Suicide is morally acceptable to the extent that it does no substantial damage to the interests of other individuals. Moreover, even in cases where suicide has some significant negative impact on others, no person is morally obliged to undergo extreme distress to prevent others from undergoing some smaller measure of discomfort, sadness, and so forth."

Brandt (1975) argues against the viewpoints that suicide is always immoral by providing multiple examples of rational, yet deliberate intentions to end one's own life that are moral. For example, a driver who avoids killing someone who has appeared suddenly in front of her by deliberately veering off the road to her death. She knows she will die at her own hand, and chooses it over killing someone else. Again, she could have chosen not to die by killing someone else, but instead she chose to sacrifice her own life. Her intentions are noble, and clearly they are not immoral. He also states the theological arguments by Aquinas and others who espoused the Natural Law or Divine Will theories of morality, are based on faulty premises and assumptions (Brandt, 1975). Divine will relies on assumptions that there is a creator, and that she in fact has "plans" for us, and hence suicide would disrupt God's plans. Natural law fails to answer why it is natural on one hand to live, yet unnatural for the same human to want to die. Is it not natural to avoid pain and suffering? Clearly, some people choose suicide as their natural way to avoid terminal suffering.

Beauchamp and Childress (2013) express an interesting viewpoint on suicide. They first assert that suicide is a moral right for an autonomous person that can only be interfered with to determine their autonomy, and what I argue is their competence and rationality. They express concern over the paternalistic interventions by police, healthcare professionals, and the state to interfere with an autonomous person's suicide. They endorse the concept of only "temporary intervention" put forth by John Stuart Mill stating

> On this account, provisional intervention is justified to ascertain whether a person is acting autonomously; further intervention is unjustified once it is clear that the person's actions are substantially autonomous. (Beauchamp & Childress, 2013)

Mill (1859) also famously articulated a "Harm Principle", which states that "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others." According to Libertarian principles, unless the taking of an individual's own life can be clearly shown to directly and significantly lead to the harm of another, there is no justified reason to impinge on that individual's liberties. Lastly, the libertarian position on minimal interference from the state, can best be summarized in the Wikipedia (2018) page on suicide,

> Liberalism asserts that a person's life belongs only to them, and no other person has the right to force their own ideals that life must be lived. Rather, only the individual involved can make such a decision, and whatever decision they make should be respected.

In summation, the philosophical arguments in support of suicide support the premise of an individual's autonomy, and reject the moral arguments against suicide. These arguments invoke liberty, autonomy, and an individual's rights to self-determination to do that which does not cause harm (significant) to others. Although the philosophical viewpoints examined do not specifically mention rationality, the focus on autonomous actions from autonomous individuals, seems to imply rationality must be possessed in these individuals.

Conclusion

In conclusion, rational suicide is a subset of suicidality by people who possess medical decision-making capacity. These cases are sometimes argued in courts of law, where it is often determined that the autonomous actions by autonomous individuals are competent and rational. Those presenting in this fashion, are not the mentally distraught and oftentimes intoxicated persons who might be reacting to a recent or series of stressors in their lives, and clearly lack decision-making capacity or competence. This is not the impetuous patient who may be "acting emotional" and/or "seeking attention" after a recent break up from their significant other. Nor is it a person who suffers from a truly volitional or cognitive disorder. My arguments focus on those people who have acted in a competent and rational manner up until the point where they decided to end their lives. They may be suffering from an incurable ailment or have emotional and/or physical pain that no medication or therapy can control, or they may just feel that they have lived long enough and

feel it is time to end their lives. These difficult decisions are hard to understand at times, but our lack of understanding should not impact on a rational and competent individual's right to self-determination, and yes, suicide. This entails, in particular, that the generally accepted principle of respecting the patient's autonomy of decision to refuse treatments applies also to cases in which such competent decision implies that the refusal of the said treatments will have as a consequence the death of the patient. In order to avoid misunderstandings, however, it must be stressed that the arguments presented in this paper have no automatic consequence on issues such as those of medically assisted suicide or euthanasia, because in such issues the point is not whether a person has the moral or legal right to end his/her own life, but whether an individual has the moral or legal right to perform actions whose intended goal is that of ending another person's life. This important difference obviously requires a much broader spectrum of arguments to be addressed.

Conflicts of interest

The authors have no conflicts of interest to declare.

References

Appelbaum, P. S. (2007). Assessment of patients' competence to consent to treatment. *New England Journal of Medicine*, *357*, 1834–1840.

Baker, R. (2013). *Before bioethics: A history of American Medical Ethics from the colonial period to the bioethics revolution*. New York, NY: Oxford University Press.

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

Bennett, R., & Harris, J. (2007). *Reproductive choice. The Blackwell guide to medical ethics*. Hoboken, NJ: Blackwell Publishing, Ltd.

Berolote, J. M., & Fleischmann, A. (2002). Suicide and psychiatric diagnosis: A worldwide perspective. *World Psychiatry*, *1*(October (3)), 181–185.

Bouvia v. Glenchur. (1986). *Los Angeles Superior Court, California Reporter 297, California Appellate 2 District*.

Brandt, R. B. (1975). *The morality and rationality of suicide. A handbook for the study of suicide*. Oxford, England: Oxford University Press, Inc.

Callaghan, S., & Ryan, C. J. (2011). Refusing medical treatment after attempted suicide: Rethinking capacity and coercive treatment in light of the Kerrie Wooltorton case. *Journal of Law and Medicine*, 811–819.

Clarke, D. M. (1999). Autonomy, rationality and the wish to die. *Journal of Medical Ethics*, *25*, 457–462.

Degrazia, D., & Mappes, T. A. (2011). *Biomedical ethics* (7th ed.). New York, NY: McGraw-Hill.

Gert, B., & Brand-Ballard, J. (1997). *Bioethics: A return to fundamentals* (1st ed.). Oxford, England: Oxford University Press.

Giwa, A. (2018). The right to die: An analysis on the current laws banning physician aid in dying statutes in New York State. *Medicine and Law Journal*, *37*(September (3)), 387–398.

Ho, A. O. (2014). Suicide: Rationality and responsibility for life. *Canadian Journal of Psychiatry*, *59*(March (3)), 141–147.

In re Farrell. (1987). *108 N.J. 335, 529 A.2d 404.*. Available at: https://law.justia.com/cases/new-jersey/supreme-court/1987/108-n-j-335-0.html

Mackenzie, C. (2015). *Autonomy. The Routledge companion to bioethics*. London, England: Routledge.

Menikoff, J. (2008). *The constitution and the right to die. Law and bioethics, an introduction*. Washington, DC: Georgetown University Press.

Mill, J. S. (1859). *On Liberty*. Oxford, England: Oxford University.

Pence, G. E. (2014). *Medical ethics: Accounts of ground breaking cases* (7th ed.). New York, NY: McGraw Hill Education.

Rhodes, R., & Holzman, I. R. (2004). The not unreasonable standard for assessment of surrogates and surrogate decisions. *Theoretical Medicine*, *25*, 367–385.

(1978). *State of Tennessee, Department of Human Services, v. Mary C. Northern. 563 S.W.2d 197*.

Szasz, T. (1999). *Fatal freedom: The ethics and politics of suicide*. Westport, CT: Praeger.

Szawarski, P. (2013). Classic cases revisited: The suicide of Kerrie Wooltorton. *Journal of the Intensive Care Society (JICS)*, *14*(July (3)), 211–214.

(1891). *Union Pacific Railway Co v Botsford. 141 U.S. 250, 251.*. Available at: https://supreme.justia.com/cases/federal/us/141/250/case.html

Veatch, R. M. (2013). *The basics of bioethics* (3rd ed.). London, England: Routledge.

Wikipedia. (2018). *Philosophy of suicide*.. Available at https://en.wikipedia.org/wiki/Philosophy_of_suicide

Wolpe, P. R. (1998). The triumph of autonomy in American Medical Ethics: A sociological view. In R. DeVries, & J. Subedi (Eds.), *Bioethics and society: Sociological investigations of the enterprise of bioethics*. New York, NY: Prentice Hall.