Susan Stefan

Rational Suicide, Irrational Laws

Examining Current Approaches to Suicide in Policy and Law

AMERICAN PSYCHOLOGY-LAW SOCIETY SERIES

Rational Suicide, Irrational Laws

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Estragon: I can't go on like this.

Vladimir: That's what you think.

—Samuel Becket (*Waiting for Godot*, 1954)

To my mother, Gabrielle Stefan (June 13, 1917–August 20, 2006):

I told you that I could not live without you, and I was right.

For more than three thousand days now, I have been unable to live without you.

To my husband Wes, my best friend Jamie, and my sister Didi:

In the darkness, you have always been the lights along the shore.

And to all the people reading this who cannot go on living, and do,

Especially to the people kind enough to share their stories with me:

I hope that this book does you the justice you deserve. I am glad you are still here.

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Series Foreword

This book series is sponsored by the American Psychology-Law Society (APLS). APLS is an interdisciplinary organization devoted to scholarship, practice, and public service in psychology and law. Its goals include advancing the contributions of psychology to the understanding of law and legal institutions through basic and applied research; promoting the education of psychologists in matters of law and the education of legal personnel in matters of psychology; and informing the psychological and legal communities and the general public of current research, educational, and service activities in the field of psychology and law. APLS membership includes psychologists from the academic, research, and clinical practice communities as well as members of the legal community. Research and practice is represented in both the civil and criminal legal arenas. APLS has chosen Oxford University Press as a strategic partner because of its commitment to scholarship, quality, and the international dissemination of ideas. These strengths will help APLS reach its goal of educating the psychology and legal professions and the general public about important developments in psychology and law. The focus of the book series reflects the diversity of the field of psychology and law, as we publish books on a broad range of topics.

In the latest book in the series, *Rational Suicide, Irrational Laws*, Susan Stefan, a legal scholar, takes the approach of an investigative journalist and interviews individuals who had attempted suicide in order to reflect on and represent various views with respect to the issues of suicide and attempted suicide. Stefan's approach was not one of research per se; that is, she did not

survey and interview individuals with the objective of representing these data as contributing to generalizable knowledge but, rather, with the intent of bringing to life the voices of those who had been affected by the very issues that Stefan addresses in this book. The purpose of this book, as Stefan writes in her introduction, is to examine and evaluate many of the legal doctrines and policy decisions across the varied areas where law and policy must respond to suicide and attempted suicide and to attempt to suggest a more consistent and helpful approach to these issues. Indeed, Stefan has done just that. Over the course of ten chapters, Stefan brings to life the legal and policy implications of various topics related to suicide and assisted suicide, including: the law of competence; the right to die, involuntary commitment, and the Constitution; assisted suicide in the United States; international perspectives on assisted suicide and euthanasia; assisted suicide and the medical profession; mental health professionals and suicide; types of suicide; discrimination on the basis of suicidality; policy and legal barriers to suicide prevention and treatment; and assisted suicide among those with psychiatric diagnoses. Stefan also includes model statutes with respect to civil commitment and provider immunity as well as for assisted suicide.

Rational Suicide, Irrational Laws presents a comprehensive and detailed analysis of these issues in a readable and relatable way, highlighted by and punctuated throughout with interviews of those who have been affected by these issues. Scholars, researchers, policymakers, and practitioners will undoubtedly find that this book has the potential to help shape the future of interactions with policy and the legal system.

Patricia A. Zapf
Series Editor

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My editors at Oxford University Press, Sarah Harrington and Andrea Zekus, held my hand, responded promptly to my emails, and were everything editors should be. I am deeply grateful to them.

Introduction: The Message from the Front Lines

> I would not tell anyone else that he or she should choose death with dignity. My question is: Who has the right to tell me that I don't deserve this choice?
>
> —Brittany Maynard

> It's not a psychiatric illness to take a look at your life and think this is never going to get better.
>
> —"Kara"

> What is scary is the level of distress. I felt very trapped, not so much that I wanted to die, as that I didn't want to live the life that I was living, and I just wanted a way out.
>
> —Leah Harris

> What we did is not against the law, and all our rights are taken away from us, we have fewer rights than prisoners.
>
> —Josh Sebastian

Suicide. Is it a public health scourge or a basic civil right? Should it always be prevented, with state intervention if necessary, as Justice Antonin Scalia and many mental health professionals believe? Is it a fundamental right that the state cannot interfere with, as the American Civil Liberties Union (ACLU) and Dr. Thomas Szasz believe? The rest of us struggle in the murky middle, gray areas

and inconsistent and contradictory reactions. And our policies and laws reflect this: they are inconsistent and contradictory. The purpose of this book is to examine and evaluate many of the legal doctrines and policy decisions across the varied areas where law and policy must respond to suicide and attempted suicide, and try to suggest an approach that will be more consistent and helpful to us all.

Each year, the Gallup poll asks Americans whether suicide is morally acceptable. An overwhelming number say no. They are asked in the same poll whether physician-assisted suicide is morally acceptable. It's been divided at a close 50-50 for almost a decade.[1] Over the years, physicians have also been asked their opinions about suicide and physician-assisted suicide.[2] Every year, conferences and colloquia are held to discuss new treatments and screening tools for suicidal people and trends in suicide prevention.

Until very recently, no one has asked people who have attempted suicide for their opinions about much of anything. This is beginning to change. In 2014, the American Association of Suicidology for the first time added a new section specifically for suicide attempt survivors, and its annual conference featured a panel of people who had attempted suicide.[3] This was spurred in large part by the efforts of talented and courageous people such as Cara Anna,[4] Dese'Rae Stage,[5] Will Hall,[6] and Leah Harris.[7] In July 2014, the National Alliance for Suicide Prevention published the first guide to suicide prevention by people who had attempted suicide.[8]

Attending to the perspectives and opinions of people who have attempted suicide is still so new that its very nomenclature is in dispute. For years, "suicide survivors" was the term designating the family and loved ones of people who had ended their lives,[9] rather than people who had survived suicide

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[1] See Chapter 3.

[2] See Chapters 3 and 5.

[3] This presentation can be accessed on YouTube.

[4] Cara Anna, *What Happens Now?* Attempt Survivors.com Blog, Jan. 5, 2015, www.attemptsurvivors.com.

[5] Associated Press, *Collection of Photos and Survival Stories of Attempted Suicides Curated by Brooklyn Photographer Offer Hope and Insight*, Daily News, Apr. 14, 2013, http://www.nydailynews.com/life-style/health/suicide-survivors-speak-prevention-efforts-article-1.1316461.

[6] Will Hall, *Living with Suicidal Feelings*, Beyond Meds: Alternatives to Psychiatry, Apr. 24, 2013, www.beyondmeds.com/2013/4/24/living-with-suicidal-feelings.

[7] Leah Harris, *Twenty Years Since My Last Suicide Attempt: Reflections*, Mad in America, Oct. 7, 2013, www.madinamerica.com/2013/10/twenty-years-last-suicide-attempt-reflections/.

[8] National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience (2014), http://action-allianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf.

[9] George Howe Colt, The Enigma of Suicide (1991).

attempts. Those latter survivors were pretty much erased by the stigma and shame of having attempted suicide. Now sometimes people who have attempted suicide are called "suicide attempt survivors," and people whose loved ones have committed suicide are called "loss survivors." Battles over language are a staple of suicide law and policy, from the insistence on "aid in dying" to designate assisted suicide to controversy over the term "parasuicide" to designate nonsuicidal self-injury.[10]

People who have attempted suicide have only recently begun to talk about it. As Eileen MacNamara, columnist for the *Boston Globe*, wrote, "Suicide remains the sorrow that still struggles to speak its name."[11] But they have so much to offer us. When I write books, I have always thought that the first order of business is to consult the people who are primarily affected by the policies and laws I am discussing, especially when the policies and laws are ostensibly intended to benefit them. So I read as many online stories from suicidal people as I could find—and there are many.[12] I created an online survey for people who had attempted suicide and was surprised when hundreds of people responded.[13] And I had in-depth interviews with almost a hundred people who had made serious suicide attempts.

I also think it's important to talk to people who have to implement policies and laws on the front lines, in order to chart the deep and painful chasm between the intent underlying policies and laws and how they actually play out in practice. So I interviewed not only people who had survived suicide attempts but people whose loved ones had killed themselves, emergency department physicians, emergency medical technicians (EMTs) and paramedics, civil rights and malpractice attorneys, psychiatrists, psychologists,

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[10] Proponents of physician-assisted suicide bitterly oppose the inclusion of the word "suicide" in describing the proposals they favor. People who self-injure strongly reject the term "parasuicide" to describe what they do, since they have no desire to commit suicide, but rather to stay alive. Since I think the word suicide refers to a person intentionally taking affirmative steps that will inevitably end his or her own life, I support the term "assisted suicide" and oppose the term "parasuicide."

[11] The quotation is from 2007, quoted in Massachusetts Coalition for Suicide Prevention, Massachusetts Strategic Plan for Suicide Prevention Plan (2009), http://www.mass.gov/eohhs/docs/dph/com-health/injury/suicide-strategic-plan.pdf.

[12] See notes 3–6; see also *Talking with Janice Sorenson*, Talking About Suicide, Nov. 5, 2012, http://talkingaboutsuicide.com/2012/11/05/talking-with-janice-sorensen/; *More from Canada, Part 2: Listening to Wendy Matthews*, Talking About Suicide, Oct. 22, 2012, www.talkingaboutsuicide.com/2012/10/22/more-from-Canada-part-2-listening-to-Wendy-Matthews/; Laura Delano, *On the Urge to Take My Life, and My Decision to Take It Back from the "Mental Health" System Instead*, Mad in America, Sept. 9, 2013, www.madinamerica.com/2013/09/urge-take-life-decision-take-back-mental-health-system-instead/.

[13] The survey and its results are available in Appendix B.

nurses, peer counselors, and social workers. My interviews with people about their professional experiences almost invariably were diverted by stories about mothers, fathers, sisters, brothers, school friends, roommates, and work colleagues who had killed themselves.

I also read about and, in some cases, interviewed, a sample of the interesting intersection: people who have attempted suicide and who are now implementing programs, policies, and laws relating to suicide prevention and treatment. Marsha Linehan, who developed dialectic behavior therapy, the most successful treatment approach for suicidality to date, was herself suicidal.[14] So was Kay Redfield Jamison, the best-selling author and expert on bipolar disorder.[15] So—by definition—are the people who run peer groups and crisis centers for people who are suicidal.

I make no claim that my surveys or interviews are scientific or random; as is always the case with surveys and interviews, only the people who want to respond do so. The survey was anonymous and did not ask for age, gender, or ethnicity. I did make a concerted effort to interview men who had attempted suicide; perhaps tellingly, two-thirds of the people who were lost to follow-up when I sought permission to use quotations from their interviews were men. The voices of the people I interviewed will be heard throughout this book, but I wanted to begin with the news they bring from their own experiences. Suicide survivors have all sorts of different perspectives, of course, and the very differences in their stories serves as a caution to those who would generalize about suicide. Marsha Linehan and Kay Redfield Jamison drew extremely different conclusions from their experiences. But they shared one thing in common: fear and shame at disclosing their histories,[16] requiring decades of professional success and acceptance to even contemplate the possibility.

I learned from my survey and interviews that people want to talk—desperately want to be heard—but are still afraid to do so publicly. More than half of my interviewees requested that I use pseudonyms when quoting them, especially among the younger people. And they have so much to tell us. We will hear their different stories throughout this book, but I will begin with the aggregate: the results of the survey.

Two hundred and forty people who had attempted suicide responded to the survey. Just under 40% had attempted suicide only once. Forty-five percent had attempted suicide between two and five times and 18% had attempted suicide more than five times. For the purposes of the survey,

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[14] Benedict Carey, *Expert on Mental Illness Reveals Her Own Fight*, N. Y. Times, June 23, 2011, http://www.nytimes.com/2011/06/23/health/23lives.html?pagewanted=all&_r=0.

[15] Kay Redfield Jamison, Night Falls Fast (paperback, 2000).

[16] "I cannot die a coward," said Linehan, see note 13. Jamison writes, "I have had many concerns about writing a book that so explicitly describes my own attacks of mania, depression, and psychosis," An Unquiet Mind (1997).

I asked them to answer questions about their first suicide attempt. Sixteen percent of them wished they had succeeded that first time, and about 37% were glad they failed. The highest response—just under 50%—were ambivalent, unsure about whether they were glad to have survived.

When asked to choose among three popular explanations for suicide: "powerless or hopelessness of changing circumstances," "despair or feeling of meaninglessness," and "sadness or grief at loss or anticipated loss," more than half picked "powerlessness or hopelessness" as their first choice.[17] This would suggest that policies to prevent suicide and help people who are suicidal should focus on supporting and increasing feelings of power, agency, control, and hope. By the same token, policies and laws that add to feelings of powerlessness and hopelessness may deepen and exacerbate suicidality over the long term.

After their first suicide attempt, 50% of my respondents were hospitalized on a psychiatric unit (27.5% involuntarily and the rest voluntarily) and 50% were not. I asked the people who were hospitalized to list which treatments were helpful, providing the choices of therapy, medication, the hospitalization itself, or "other." People choosing "other" were given the opportunity to explain their answer. Almost 50% of the respondents, who had been specifically guided by the question to focus on helpful aspects of their hospitalization, checked "other" to tell me in no uncertain terms that nothing about the hospitalization helped at all, and to detail all the damage that hospitalization created in their lives. For some people, it was the conditions of the hospital. One person said she wanted policymakers to know:

> Don't underestimate the importance of clean, well-maintained, well-lit facilities in the healing process. Leave me in a dark, moldy, filthy shithole with crumbling walls for two weeks and I'm not going to stop feeling like shit.[18]

For others, it was the treatment they received, especially seclusion: "People need human contact after an attempt; isolation on suicide watch makes things worse;"[19] "after my suicide attempt I was locked in a quiet room . . . not allowed to bathe or brush my teeth. I was also not allowed to have my eyeglasses."[20] For some people, the entire idea that they should be hospitalized with people who were mentally ill just because they had attempted suicide did not make sense:

> It is not helpful to be in a mental ward with seriously mentally ill patients or drug addicts after a suicide attempt. I know we get

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[17] Grief at loss or anticipated loss was the first choice of barely 10% of respondents. This is interesting when compared to a survey of people who used May House, a voluntary homelike residence in England for people who were suicidal, where "grief" was highest on the list of reasons for being suicidal.

[18] Survey No. 223.

[19] Survey No. 236.

[20] Survey No. 193.

> locked up for our own safety, but being in such a sterile and noisy environment does not make any of us feel better about our place in life and basically we all do our best to get out as fast as possible. The others I have met in mental wards that are suicide attempters have been professionals, nurses and of course, drug addicts—but most of us tried to end our lives because of the overwhelming despair and hurts and wounding of living in this world, not because we are crazy, but because of our awareness of life traumas.

But the rejection of hospitalization included people who believed that the cause of their suicidality was a biological illness. Even people who believe that they have a mental illness, and who credit medications for keeping their suicidality at bay, felt fundamentally alienated in a hospital filled with people whose problems, they felt, bore no resemblance to their own.

Some people did think the hospitalization itself had helped, and in a few of my interviews, some people said it helped a lot. But they were in the minority, and they were all people who had hospitalized themselves voluntarily. Ironically, when people *sought* hospitalization, many reported a difficult time being admitted:

> I know of at least one psych hospital that will not admit anyone not willing or able to express a very firm and detailed plan to act. In my own case, being turned away when I approached this facility BEFORE I went so far as to settle on a plan furthered my frustration with carrying on and led me to attempt again in private. Only after again failing in my desire to die was I admitted.[21]

Other people who thought hospitalization might be helpful were frustrated with the short-term nature of hospitalization and lack of in-depth treatment.

Paradoxically, people also couldn't get help in the community. One person reported that "I was kicked out of an outpatient program for being suicidal,"[22] another that the $40 copayment for each therapy session put therapy out of reach,[23] and many people reported that they couldn't get help at all until and unless they were deep in suicidal crisis:

> Access to continued treatment is so important. I'm barely keeping my rent paid and don't have the money for extravagant psychiatrist copays (which are considered specialist treatment) upfront every 2–4 weeks. . . It can be attractive to do something drastic because you know you'll either get help or you won't have to worry about it anymore.[24]

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[21] Survey No. 227.
[22] Survey No. 179.
[23] Survey No. 193.
[24] Survey No. 102.

Thus, our policies and practices regarding suicide create an irrational incentive structure where people understand they have to attempt suicide to get help, help which is of questionable utility, while community-based approaches that are less expensive and work are underfunded. We have a system that doesn't work for anyone—neither the people who are supposed to be providing help, nor the people who are supposed to be receiving it.

Mental health professionals in my interviews also sounded powerless and hopeless: asked to do the impossible with ever-dwindling resources, profoundly anxious about liability, genuinely baffled about how to help some of their patients, plagued by insurance demands and paperwork. I was told by a hospital social worker that staff members focused on stabilization rather than suicidality because insurance-authorized hospital stays were so short that hospital staff figured patients would do the long-term work on suicidality in the community. A few weeks later a community mental health professional told me that the authorized fifty-minute appointments every two weeks were nowhere near enough to provide the intensive help that suicidal people needed; that was what hospitalization was for.

Thus, in our current system, some people who are actually suicidal lie to avoid hospitalization; some people who are not suicidal lie to access hospital beds, but almost no one gets help specifically targeted at suicidality. Some clinicians who determine a person does not need hospitalization admit the person anyway to avoid potential liability, and some clinicians who determine hospitalization would be appropriate don't admit the person because there are insufficient inpatient beds available. And there is no solid basis in research or in the reports of people who have attempted suicide to think that hospitalization helps most people very much or at all.[25]

We have some idea what helps, and so do the people who answered my survey: community public health support programs, such as those used by the Air Force,[26] dialectical behavior therapy,[27] and peer supports.[28] Many survey respondents and interviewees mentioned spiritual faith, meditation, and other forms of mindfulness. I suspect personal care assistants (PCAs) would help too.[29] So we do have some idea what works, but little concerted effort is made to ensure that suicidal people can actually have access to these less expensive and less traumatic community resources.

And even those programs don't begin to tackle the upstream problem: what caused the person to become so miserable in the first place? It is

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[25] See Chapters 2, 6, and 9.
[26] See Chapter 8.
[27] See Chapter 9.
[28] See Chapter 9.
[29] See Chapter 10.

this upstream landscape that is missing from the downstream emergency department or crisis evaluation, as one of my survey respondents noted:

> Urbanization and the accompanying break-down of community that causes social isolation is a major contributor to mental health problems. Mental health professionals encounter people in a moment of crisis; the person may have no way to explain what's going on with them and the professionals have no way to judge accurately what's going on. Many people lack problem solving skills and survival skills and have been under great stress in a near crisis state for a long time, perhaps since childhood. Building healthy communities would be a pro-active way to prevent these problems from developing into grave crises.[30]

This comment resonated with me as I conducted my in-depth interviews. Although every person I interviewed had a unique story to tell, the most striking impression that emerged from my interviews was a sense of two very different groups of suicidal people. One group had histories of extremely traumatic childhoods, filled with violence, abuse, chaos, and often unfathomable cruelty. Many of those people began wishing they were dead when they were very, very young. They had multiple suicide attempts and lives filled with loss:

> My mother certainly must have known I was using drugs because I was using her drugs. She had speed. She had five kids and I took her drugs. The school people had to know because I passed out on the way to school. In true addict style, I took two while I was sitting in the guidance counselor's office. . . . I was born of incest . . . I was the reminder every time my mother looked at me of what had happened . . . She couldn't stand me. I knew I was the problem and if I wasn't there, her life would be better. When *Roe v. Wade* got passed, she said, "I am so glad that got passed, I went to get an abortion with you, I am so glad it's legal, because I was so scared I couldn't go through with it, what do you want for dinner tonight?" My grandmother said, "I remember the day you were born, it was the worst day of my life." My grandfather sexually abused me. The first time I tried to kill myself, I was eight years old.[31]

Another woman told me:

> I was violently sexually abused by a neighbor who was also a law enforcement officer. When I say violent, I mean just that,

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[30] Survey No. 216.

[31] Interview with Lynn Legere (Dec. 16, 2013).

> not fondling, not just sex, gun held to my head, ages 4–8, burned, whipped, handcuffed, real sadistic stuff that kind of murders innocence very early on. Because the neighbor was law enforcement, I didn't report.[32]

Nevertheless, these people hung on stubbornly through miserable lives, grasping at the tiniest straws of kindness and hope, and showed an empathy and depth that humbled me. Many became human service workers: peer counselors, therapists, and social workers, or advocates for others who were vulnerable and needed protection. For some of the people who came from the greatest abyss of misery, faith and spirituality almost literally raised them from the dead.

The other group had relatively intact and supportive families, who provided at least some financial, emotional, and practical support. These were the kinds of families that kept people alive, even when they were hesitating on the brink of suicide:

> [One] morning I couldn't sleep and at 5:30 I wandered out on the unit and [an older male patient] was reading the Bible. He was there because he was suicidal. He had no prior mental health problems but his adult daughter had killed herself five years ago and since then he's been struggling with depression. I have this crazy soft spot for my dad, I love my dad, and that made it real to me, what it would do to my parents. I was so stuck in my head and the cognitive disorder that in reality people would be better off without me and it would affect them but not that much and in any event I wouldn't be here to deal with it. But after that I couldn't consider suicide to be a valid option, because I love my dad too much.[33]

These families were not unproblematic. Many of my interviewees felt driven to be perfect—straight A, hyperaccomplished people who never felt good enough on the inside. Their suicidality often emerged around the time they started applying to college, in college, or in the context of jobs or marriages where they felt they were failures. While the people with trauma histories often had concurrent substance abuse, the people in this group were more likely to struggle with eating disorders.

For many people who didn't have histories of childhood trauma, and whose suicidality emerged later in life, suicidal feelings were alien and frightening, and were more often identified as part of an illness, to which they readily looked to mental health professionals for help. For people with trauma histories, whose families frequently included suicides, the thought of death and

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[32] Interview with Jenn Hurtado (Dec. 16, 2013).
[33] Interview with Carli Whitchurch (Apr. 18, 2014).

suicide was pretty much a constant from childhood on, and sometimes felt comforting: a potential escape route from an unbearable life. Rather than feeling threatened by suicidal feelings, many regarded suicide as an option that gave them the strength to make it through another day. Of course, even people with supportive parents can have trauma histories. One woman told me that

> I was diagnosed with PTSD. . . when I was 14, years ago, my 19 year old neighbor shot himself in the head after I threatened to tell his parents and my parents that he had been sexually abusing me since I was six. I am not sure they knew he was abusing me. I was walking back to my house I heard the gun go off. I didn't realize that had an effect on me until after therapy.[34]

The people with extensive childhood histories of trauma generally were damaged rather than helped by the current mental health framework, with its omnipresent shadow of involuntary detention, restraint, and seclusion, and diagnoses that don't begin to helpfully describe what these people have been through. As one respondent said, "The suicide attempt is not the crisis in one's life. There are precipitating events that lead up to it that are the crisis."[35] This is a core and crucial insight, which should inform policy;[36] it already informs some of the most successful treatment approaches, including those that centrally focus on narrative.[37]

And certainly, the mental health framework itself is only one way of conceptualizing responses to suicide, and a relatively modern one at that. It is considered a reform from the times when suicide was a sin or a crime. For some, including a number of my survey respondents, the decision to end one's life, like decisions to refuse treatment or decisions about reproduction, is a civil right, a fundamental liberty interest, a personal, intimate, and private decision that belongs to the person alone, which should not be the subject of state intervention.[38]

The increasing number of states and countries around the world enacting physician-assisted suicide laws also operate on the assumption that at least some people who want to control the timing of their deaths are behaving understandably and should be supported in their wishes. Some of the people I interviewed and who responded to the survey had been in enormous emotional pain and suicidal for a long, long time, and nothing had ever helped them. Just what are our rights over our bodies, over treatment refusal, over how long we live with relentless pain? Is suicide, like abortion

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[34] Interview with Christine O'Hagan (Nov. 21, 2013).

[35] Survey No. 66.

[36] See Chapter 9 for an explanation of why this is so difficult.

[37] See Konrad A. Michel & David A. Jobes, eds. Building a Therapeutic Alliance with the Suicidal Patient (2011).

[38] Survey Nos. 203 & 120.

and homosexuality, a moral and social issue that ultimately boils down to individual rights? A plurality of my survey respondents supported extending assisted suicide to people with emotional problems.

Certainly, it's no good to say people should be prevented from killing themselves at all costs, because "all costs" is precisely what our society is unwilling to pay to prevent suicide, from gun control to easy access to effective community support. Is it unconstitutional to exclude a deeply suffering person from assisted suicide if society is unwilling to provide the means to alleviate that suffering? At least one Supreme Court justice suggested this might be the case.[39] Is it hypocrisy to exclude people from assisted suicide in a country that has made clear that suicide prevention is a low priority, where even basic healthcare is a matter of titanic political and judicial controversy? Or is assisted suicide just an easy out for a society that owes its citizens a lot more than abandonment disguised as autonomy?

These are extraordinarily difficult questions of law and social policy, which will be addressed in this book. My great ambition was to develop a "unified field theory" that encompassed suicide in this country—both the kind we want to assist and the kind we want to prevent. But these questions are only the beginning of the situations in which law and policy must respond to issues involving suicide. Most people are at least familiar in passing with legal issues such as whether people should have a constitutional right to die, or whether a psychiatrist should be liable if his or her patient commits suicide. But there are many other questions: Is firing an employee for attempting suicide disability discrimination? Can a college exclude a student who attempted suicide from returning to its dorms? Are the police ever responsible in a case of "suicide by cop," and if so, when? Do the operators of the Golden Gate Bridge have a legal responsibility to put up barriers to prevent people from jumping off? Is the survivor of a suicide pact criminally responsible for assisting a suicide? Should the do not resuscitate (DNR) order of a person who attempted to kill himself be honored? Should a person who attempted suicide lose her parental rights?

All of these are issues that arise in law and policy every day, and which have been answered in conflicting ways over time, by different courts in different states, and sometimes by different courts in the same state. Many of them have implications for people who have attempted suicide and who are trying to get on with their lives. Some of my interviewees had questions for me about their legal rights, laws they found confusing, situations that seemed wrong: After I tell my university health service staff members in confidence that I am suicidal, can they really send uniformed security to escort me out of my dorm and forbid me from coming back? Does being picked up by the police for being suicidal really mean I will have a police record? Was the hospital staff member telling the truth when she said, "You have to take medicine or your insurance won't pay for the stay"?

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[39] See Chapter 2.

This book is an attempt to survey law and policy about suicide generally, and especially law and policy relating to medical and mental health professionals, assisted suicide, discrimination, and what works to help people. There are certain major subjects I do not cover in the book. Suicide in jails and prisons is an incredibly important topic. I could not readily interview people who had attempted suicide in prison and jails to hear their stories, and I try not to write about subjects unless I have talked to and surveyed the people affected by the laws and policies I am discussing. I am not confident I could do justice to this topic and have omitted it.[40]

In my survey, I asked, "If you could tell suicide prevention policymakers and mental health professionals three things, what would they be?" There was one message that was by far the most common. Sometimes it was delivered concisely. "Listen," said Wyatt Ferrara, his message echoed by many people who longed to share what they had learned at such cost: "Listen to we who have traveled that path and lived to talk about what helped."[41] "DON'T put someone in a ward full of other people in emotional distress, treat them as if they are annoying and difficult, and pump them full of drugs. LISTEN for God's sake."[42] "Don't come from a place of preventing—come from a place of connecting . . . Most importantly be present and LISTEN."[43] "Listen, listen, listen. Listen with your whole being."[44] "Be kind. Be understanding. Listen with your heart."[45]

In writing this book, I have tried to fulfill the trust that people placed in me by telling me their stories. Obviously, my opinions are my own, and my mistakes even more so. There is something cloying about calling people inspirational, but I was humbled by my conversations with many of my interviewees. I have tried very hard not to let my affection and admiration for the many people who spoke to me, and my fear and grief for several people who had vanished by the time I asked for permission to use quotes from their interviews, affect my analysis of these issues. But, to everyone who spoke to me: even talking to you for an hour or an hour and a half made me so glad you were alive. So, all of you who spoke to me, it was an honor, and, even when your stories haunted me, I learned a lot. Thank you.

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[40] But see Lindsay M. Hayes & National Institute of Corrections, Prison Suicide: An Overview and Guide to Prevention (2012); and, more generally Thomas J. Fagan & Robert K. Ax, eds., Correctional Mental Health Handbook (2002), and Terry Kupers, Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It (1999).

[41] Survey No. 237.

[42] Survey No. 40.

[43] Survey No. 75.

[44] Survey No. 93.

[45] Survey No. 209.

Rational Suicide, Irrational Laws

1

"Sane" and "Insane" Suicide: The Law of Competence

> "Any human being has the potential to become suicidal—the problem doesn't lie in the person's brain."
>
> —Laura Delano, interviewee

Introduction: The Case of Josh Sebastian

Most of us don't want to die. Some of us do. This book is about how our policy and law respond to people who want to die, especially those who try to kill themselves. This chapter concerns the distinction between people who are incompetent or lack capacity, and those who do have competence or capacity. This is a crucial first inquiry, because people who lack capacity in our society lose the right to make decisions, as a matter of law, including decisions about their own bodies and lives. "Thus, competence and liberty are inextricably interwoven."[1]

The first and most important distinction all societies have made throughout time in responding to people who attempted suicide was to differentiate between people who were responsible, competent, sane, rational (or whatever words were in vogue at the time), and those who, depending on the era, were "furiously mad," not responsible, incompetent, insane, lacking capacity, or irrational.[2]

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[1] George J. Annas & Joan E. Densberger, *Competence to Refuse Medical Treatment: Autonomy vs. Paternalism*, 15 Tol. L. Rev. 561 (1984).

[2] I do not mean to suggest that all these terms are completely synonymous: competence, properly understood, involves primarily cognitive abilities, whereas insanity has sometimes involved volitional abilities. Some have argued for "affective incompetence," a minority position that I address later in this chapter.

For most of the history of Western civilization, the first group has been understood to constitute, by far, the vast majority of people who contemplate, attempt, and complete suicide. They have been treated as despicable, criminals, heretics, and cowards, but they have not been treated as lacking capacity or moral agency. Only in the last century have some mental health professionals attempted to draw all suicidal people into their diagnostic embrace, insisting that suicidality is usually the product of mental illness and (less frequently) equating suicidality with lack of capacity. Of course, the more that mental health professionals insist that suicidality is the result of mental illness that they can treat, or that it reflects incompetence or incapacity, the more they create social expectations and corresponding legal responsibilities relating to their suicidal patients that they cannot meet and should not bear.

There is an alternative model, and the story of Josh Sebastian embodies it.

In the summer of 2012, a medical ethics committee sat around a table in Wisconsin. The committee members included several psychiatrists and other physicians, nurses, social workers, and (of course) legal counsel to the committee, a health lawyer. For a third of the meeting, they permitted the patient they were discussing, Josh Sebastian, to address them.

Josh Sebastian was a 44-year-old man who was consistently and determinedly suicidal. He had been hospitalized six months earlier, after barely surviving an extremely serious suicide attempt. He had shot himself in the abdomen, fracturing his spine. He had planned this attempt in minute detail, including ensuring that his body would not be discovered by people to whom it would cause pain and distress.

After medical treatment and surgery for his injuries, Mr. Sebastian was committed involuntarily to a psychiatric institution. This did not mean that he was not legally competent. Wisconsin law explicitly insists that people who are committed to a mental institution retain their competence. Most people who are involuntarily civilly committed *are* competent. The relevant standard for involuntary civil commitment in Wisconsin requires a person to be "mentally ill," "a proper subject for treatment," and "dangerous."[3] Each of these terms is specifically defined through statutes, regulations, and case law, which we will discuss later.

Mr. Sebastian's six-month inpatient commitment was about to expire. Although he had received various medications and therapies, he remained determined to kill himself. By itself, this was not unusual—psychiatric hospitalization often has no effect on a patient's suicidality, and sometimes makes it worse.[4] But Josh Sebastian refused to engage in the time-honored

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[3] Wisc. Stat. § 51.20(1).

[4] Joel Paris, Half in Love with Death: Managing the Chronically Suicidal Patient (2006); David Dawson & Harriet MacMillan, Relationship Management of the Borderline Patient: From Understanding to Treatment (1993); Doug Jacobs et al., Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Ideation (American Psychiatric Association 2003).

pretextual rituals (recognized as such by both patients and mental health professionals) of earnestly denying that he had any intent to kill himself and signing whatever contracts for safety his keepers required as the price of his freedom. He said, calmly and bluntly, that he still very much wanted to die.

The question before the ethics committee was whether the hospital should petition to continue his involuntary commitment. Sebastian was clearly and explicitly dangerous to himself, but the psychiatrists who had been treating him had the honesty to acknowledge that they doubted that he was mentally ill as defined by the statute and regulations. Even if he was mentally ill, they were even more dubious that he was a proper subject for treatment under the statute.

The Wisconsin involuntary commitment statute defines "mental illness" as "a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism."[5] Mr. Sebastian was certainly not psychotic. He gave a lucid and articulate account of why he wanted to kill himself, a desire that had persisted for many years despite many efforts at treatment.

The fact that his suicidality had persisted for more than twenty years despite many efforts at treatment particularly troubled committee members, because of the law's requirement that Mr. Sebastian be a "proper subject for treatment."[6] Court cases have defined this term to mean that treatment must be "likely to improve or control the symptoms" of the individual with mental illness. If treatment is unlikely to help, then involuntary detention amounts to custodial control, which the legislature decided was not a sufficient reason to involuntarily detain a person for the rest of his life. If there was no available effective treatment, in other words, simply keeping a person alive is an insufficient reason for involuntary commitment.

Josh Sebastian had tried many avenues of treatment for years, to no avail. The committee felt that personal therapy around issues of abandonment might have helped if he had been motivated, but he didn't want to talk about abandonment. Sebastian's therapist suggested cognitive behavioral therapy (CBT), a therapy oriented to solving problems in the present, but Sebastian didn't want to solve his problems. He no longer hoped or even wanted to get

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[5] Wisc. Stat. § 51.01(13)(b) (2013).

[6] Other states have similar requirements, including Arizona, Connecticut, Missouri, Ohio, South Dakota, and Utah: Ariz. Rev. Stat. § 36-501-32(c); Conn. Gen. Stat. Ann. § 17a-495(a) ("hospital treatment is necessary and available"); Mo. Ann. Stat. § 632.350(5) (a condition of commitment is that "a program appropriate to handle the respondent's condition has agreed to accept him"); Ohio Rev. Code Ann. § 5122.01(B)(4) ("would benefit from treatment in a hospital for his mental illness"); S.D. Codified Laws § 27A-1-2(3) ("the individual needs and is likely to benefit from treatment"); Utah Code Ann. § 62A-15-631(10)(e) ("the local mental health authority can provide the individual with treatment that is adequate and appropriate to his conditions and needs").

better. He just wanted to be dead. Many mental health professionals might argue that Mr. Sebastian needed medication to help with these motivational issues, but he had conscientiously tried every medication that had ever been suggested to him. None of them helped. As one person present at the committee meeting said,

> He doesn't want his life to have any meaning. Is that part of his illness? Maybe, but the treatment that would lead to recovery from his illness has to be both voluntary and participatory. There are different models of treatment—one is a more mechanical model. You drop your car off at the garage and say "fix it"—surgery is a little like that. Psychiatric treatment involves a model of collaborative engagement, which is different—we're going to collaborate and I am going to be your advocate . . . I need your active participation in this process. In [Sebastian's] case, medication did not work. In some cases it would. Psychotherapy might help, but he doesn't want it. Could someone have seduced him into life? Maybe, but we can't force him to be motivated for treatment.[7]

The deliberations of the Ethics Committee were unusual in the case of a consistently suicidal man who had just spent six months in a psychiatric facility. They took the commitment law seriously, including the requirements that in order to detain Sebastian involuntarily, he had to be mentally ill and they had to be able to offer him genuine benefit. They took Sebastian seriously and respected his account of his own life. It helped that Sebastian was articulate, intellectual, and middle class. It helped even more that he had been an uncomplaining and compliant patient for his six-month commitment. When he addressed the committee, he did so calmly and eloquently. Neither voluntary nor involuntary treatment had budged Sebastian's determination to end his life. Unlike some, his close brush with death had not altered its allure.

Sebastian also achieved a remarkable feat. The committee member I interviewed added, "He presented a very compelling case for not wanting to live." What could that be, I wondered? How could an otherwise physically healthy person (except for the spinal issues connected with his suicide attempt) make a compelling case for not wanting to live? We are accustomed to thinking of people with compelling reasons for not wanting to live as those in the last stages of terminal cancer, or who have amyotrophic lateral sclerosis (ALS; also called *Lou Gehrig's disease*). In those cases, the actual decision as to whether to live or die has effectively been wrested from an individual. The person is more like a captured resistance fighter, doomed to torture and execution by the enemy. We condone taking the cyanide pill as

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[7] This is from an interview with a member of the Ethics Committee. (This interview was conducted with explicit written consent from Sebastian, the subject of the Ethics Committee review.)

a final act of autonomy and defiance by someone who otherwise would have embraced life. In the same way, we generally assume that people who want to die because of psychiatric or emotional conditions are essentially defectors, quislings whose desire to die constitutes a kind of betrayal of the rest of us, their comrades in the struggle against the troubles life brings.

I was especially curious as to what kind of person could make a compelling case for "suicide" to a mental health professional, because that is a profession often inclined to obstruct suicide at all costs. Did Sebastian have the psychological equivalent of the torment of brain cancer or ALS? Or is a psychiatric presentation of this kind of pain and misery completely different?

I decided to try to speak to Sebastian myself. He proved to be gracious and willing to talk to me. And the conversation with him was quite unlike most of the other people I interviewed for this book who had made serious suicide attempts. I expected an individual wracked by torments of untreatable psychiatric disability, or sucked under by the thick dark muck of depression. Instead I spoke to a person who was simply profoundly tired of living and indifferent to hope. He agreed that he was depressed:

> My depression stems from the fact that I really don't want to be here. I can laugh and joke and have a good time, but it's mostly a façade, a way to dissociate myself from who I am, which is a person who doesn't really want to be here.

His previous attempts at voluntary treatment—therapy and medication—hadn't helped. Being involuntarily hospitalized was even less helpful:

> When I woke up, I couldn't believe I was alive. They sent me to the psych ward, where I had no rights at all. It felt as though I broke the law, no outside contact, my friends couldn't visit me, the environment itself is not conducive for any therapeutic effects. You're put in a place with a lot of different people with a lot of different issues. It was awful, people are screaming; staff have no idea how to help people with mental illnesses. For me to see how staff members treat other individuals was horrific in and of itself. I was treated like a child. I wasn't treated as bad as others because I was more lucid. I understood where I was at, I didn't really say much when I was there, I was quiet and peaceful so no one had to interact with me.

Sebastian seemed much less emotional than other suicidal individuals I interviewed for this book. At least his tone of voice (what psychiatrists would call his "affect") was far more muted. His account of his own emotions seemed disconnected from them. He described his pain in a dispassionate way. Yet he also described himself (as the committee member had not) as very angry:

> From the very earliest of when I was a child, when I was very young, I was very angry and I wanted to end my own life. A lot of

> people I know who have been truly suicidal, we are very angry, but we don't take it out on others. I don't want others to feel my pain. I know the pain that I go through every day and I don't want my anger to affect anyone else. I am angry at a lot of the circumstances that I was put in as a child and I am angry that I let those circumstances define me, and I am angry that I am angry. I am angry that I haven't fulfilled my potential, I am angry that I haven't killed myself; I have been a failure at suicide.

But he didn't sound angry at all. He just sounded very tired.

Sebastian couldn't remember ever being more than fleetingly happy. He had gone to college, gotten a job, been briefly married, and then in a long-term relationship for more than seven years. He had been employed, taking care of men with mental disabilities. Nothing seemed to give his life purpose or meaning. Mr. Sebastian felt that there was no meaning to his life. He had gained an education and employment, had been involved in relationships, tried therapy and medication, and had read a lot of books. Nothing worked. He believed that he had tried everything to ameliorate his condition. He excelled at caring for the mentally disabled men in his charge. He had developed relationships with them and with their parents. He had made a lot of different efforts for a long time in many ways to find meaning and purpose in life, and he was done with it. He was tired.

Mr. Sebastian's account would have been familiar to the Greeks and Romans, and to the early Christian church, but it is a foreign story in modern America. Emile Durkheim, the first great scholar of suicide, might have classified Mr. Sebastian as prone to "egoistic" suicide, when an individual feels his life is meaningless or purposeless.[8] The early church would have called it "acedia" or despair, a condition that modern folk often confuse with depression, but is actually quite different from it.[9] The Puritans would have considered Sebastian's despair and hopelessness simply his cross to bear, and any attempt to avoid it through suicide would be the gravest of sins, an affront to God. Throughout hundreds and even thousands of years, Mr. Sebastian's condition would have been instantly recognizable, and throughout history, it would have been clearly distinguished from insanity, mental illness, or madness. Although all societies at all times have recognized that suicide in a minority of cases results from "madness," "furious madness," or "insanity," only in our most recent history would Mr. Sebastian have been grouped together with people suffering from madness simply because he wanted to commit suicide.

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[8] Emile Durkheim, Suicide (Routledge Classics, 2d ed. 2002) (1897). Durkheim posited four different kinds of suicide: egoistic, altruistic, fatalistic, and anomic. See more on this in Chapter 7.

[9] See Kathleen Norris, Acedia and Me: A Marriage, Monks, and a Writer's Life (2010) for an extensive exploration of the difference between acedia and depression.

No one on the committee doubted that Mr. Sebastian was competent. How could they? They had engaged in an extended discussion with him about his situation and his perspective. I have talked to this man: he is intelligent, thoughtful, and reflective. The question never arose. The committee did debate whether Sebastian could ethically be committed involuntarily under the statute and concluded that Mr. Sebastian was probably not mentally ill as defined by the Wisconsin commitment law. He certainly was not a fit subject for treatment. No one held out much hope that treatment would alleviate his condition after twenty years of trying.

Nevertheless, in a spirit of caution, the committee proposed a compromise to Sebastian: the hospital would forego its right to petition for a one-year involuntary commitment, if he agreed to an extension of his commitment for six months in the community. He would be free to live in the community, under court order to try one more round of therapy and one more round of medication. If it didn't work, no matter how suicidal he was, there would be no further petitions for commitment, and Mr. Sebastian would be free to do as he pleased. Sebastian completed the six months (he ceased the therapy early). Nothing helped. He was freed of all legal supervision and constraint, able to commit suicide as he chose. As of this writing, he is still alive.

Many would disagree with the committee's compromise proposal. Some ex-patient activists (and Josh Sebastian himself) contend that the state should never have had power over him in the first place. Some mental health professionals argue that his bald statement of continued suicidality was an obvious sign of depression and a cry for help, and he should remain involuntarily institutionalized as long as he remained (at least outwardly) suicidal.

However, the research and interviews I conducted for this book suggest that the committee's approach was legally required, ethically sound, and clinically astute. Mr. Sebastian obviously had not been and was unlikely to be helped by an involuntary, coercive approach. Maybe nothing will ever be able to help him, as he asserts. Maybe there is hope he cannot as yet discern. What is clearly true is that coercive and involuntary approaches are not only futile, but actually harmful to any small chance remaining for him. Mr. Sebastian could not be bullied into living. What the Ethics Committee proposed was to continue the conversation, to continue the engagement in this most profound discussion, while explicitly acknowledging that the ultimate choice would be up to Sebastian.

Of course the Ethics Committee could not have known that Mr. Sebastian would live, or how long. They took a risk. One of the central themes of this book is that good patient care, adherence to the requirements of law, and effective suicide prevention requires more risk-taking by mental health professionals than is currently the norm. This may seem paradoxical. I hope to show that recognizing the autonomy and responsibility of individuals such as Josh Sebastian and seeking to help them rather than control them will both save more lives and add to the quality of the lives that are saved.

Sharing risk with people suffering so much that they want to end their lives is only possible with competent people. No one can (or should try) to share risk with someone who is extremely intoxicated or floridly psychotic. No one can (or should) share risk with a child ("mature minors" present a more complicated issue). No one can (or should) try to share risk with a person suffering from delirium or dementia.

Yet many mental health professionals equate suicidality itself with incompetence.[10] The rest of this chapter will be devoted to the argument that this is a mistaken and harmful view, and that the vast majority of suicidal people are, in fact, competent.[11] In addition, the majority of people who have diagnoses of mental illness and are suicidal are also competent, whether they are suicidal because they are terminally ill or because they are in chronic and untreatable psychic pain, or because, like Sebastian, they are profoundly exhausted with the unrewarding task of trying to live.

To concede that suicidal people are competent does not, of course, answer the question of whether, how, and when the State ought to prevent these people from committing suicide, any more than it was the complete answer to the Ethics Committee's discussion about Josh Sebastian. The State has been constraining competent people's choices about suicide for more than a thousand years. Historically, both suicide and suicide attempts were criminalized. These days, attempted suicide often leads to voluntary or involuntary commitment to a psychiatric hospital. As Wisconsin and many other states explicitly provide, being committable is not, however, the same as being incompetent to make healthcare decisions.[12] Whether, when, and how

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[10] J. Spike, *Physician's Responsibilities in the Case of Suicidal Patients: Three Case Studies*, 9 J. Clin. Ethics 311 (1998); State v. C.R., 173 P.3d 836, 837–838 (Or. App. 2007) (psychiatrist in civil commitment hearing testified, "Her denial and pleasant manner make it difficult to say she is psychotic, but in my judgment, suicidal thinking is psychotic"). In Sebastian's case, more sophisticated proponents of this theory might argue that he had *affective incompetence*, in which cognitive skills are unimpaired, but the individual's mood disorder renders the individual (according to these professionals) incompetent to make decisions. I address this argument later in the chapter.

[11] Competence is a legal construct; it is often used interchangeably with the clinical concept of lack of capacity. Paul Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 New Eng. J. Med. 1834 (2007); National Bioethics Advisory Commission, Research Involving Persons with Mental Disorders that may Affect Decisionmaking Capacity, ch.1 n.4 (1998). My argument applies to both the legal framework, which is more fixed and rigid, and the clinical construct, which is more fluid and dynamic.

[12] For example, Alaska, Myers v. Alaska Psychiatric Institute, 138 P.3d 238, 242–43 (Alaska 2006); California Welfare and Institutions Code § 5325.1 and Riese v. St. Mary's Hospital, 271 Cal. Rptr. 199, 206 (Cal. App. 1987); Florida, § 394.459(1) and (3); Minnesota, Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988); New York, M.H.L. § 29.03 and Rivers v. Katz, 67 N.Y.S.2d 485, 493–94 (1986).

the State can or should prevent competent people from committing suicide, when they should be strong-armed rather than seduced into life, is the topic of Chapter 2. Chapters 3 and 4 will look at assisted suicide laws and policies in the United States and around the world, and examine how very different frameworks operate and the results they produce. Chapters 5 and 6 will look at the powerful role played by medical and mental health professionals as gatekeepers of suicide in this country, and propose changes to reduce the burdens and distortions that law places on doctor–patient relationships in the context of suicide.

My argument in this chapter is relatively simple: the very small minority of truly incompetent people who try to kill themselves ought to be prevented from doing so. But the vast majority of people who are thinking about suicide, attempting suicide, and committing suicide are nowhere close to incompetent under our current legal standards. The best clinical and sociological research supports this assertion, and the law insists on it. Treating suicidal people as per se incompetent makes bad law and interferes with good clinical practice. Treating people as incompetent shuts down conversation at the very point when conversation is most needed. The intent to commit suicide, or a suicide attempt, does not, standing alone, constitute incompetence. The determination that a patient is competent is not the conversation: it is the threshold determination that precedes the conversation.

The fact that suicidal people are competent does not mean that they cannot be prevented from trying to commit suicide. But if you can hold a conversation with an adult about his or her desire to commit suicide, if you can have a discussion, if you think the person may be persuadable and would not question this person's consent if he or she decided to try treatment, then the individual is competent to make the decision to end his or her life.[13] I understand that many clinically depressed people fit this standard; I agree with the research that shows depression generally does not rob people of capacity.[14] A determination of competence does not depend on whether suicide would be a grievous and tragic error. Specific standards of competence to end one's life will be discussed in more detail toward the end of this chapter.

The law is on my side. The law assumes that individuals can be competent and suicidal across a wide range of situations. Four states have legalized assisted suicide, underscoring the default assumption that terminally ill people who want to end their lives are presumed competent unless determined

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[13] Although competence varies from context to context, people who are not competent to decide to kill themselves may well not be competent in other contexts. See, e.g., *In re* A.M. 332 P.3d 263 (Mont. 2014) (man who consumed all his medications in an attempt at "rebirth" did not competently waive his right to civil commitment hearing).

[14] I disagree with the theory of affective incompetence, which will be discussed later in the chapter.

otherwise.[15] But there is more: we permit competent suicidal death row prisoners to abandon appeals that might well save their lives and will certainly delay their deaths.[16] Insurance law contains hundreds, if not thousands, of decisions, including many Supreme Court decisions,[17] distinguishing "sane" suicides from "insane" suicides for purposes of life insurance.[18]

Understanding that some people can competently consider suicide and/or attempt to kill themselves has a number of consequences. First of all, it preserves the integrity of the concept of competence, which is about the process of decision making rather than the decision made.[19] Second, it accurately reflects the thoughtful and reflective struggles and pain of millions of people throughout history, including Nobel Prize winners[20] and feminist icons,[21]

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[15] The process and results of these efforts are discussed at length in Chapter 3.

[16] See discussion at pp. 20–21 infra.

[17] See, e.g., Life Ins. Co. v. Terry, 82 U.S. 580, 15 Wall 580 (1872) (exclusion of suicide from life insurance policy only applies when person takes his life while in possession of his faculties); Knights Templar and Masons Life Ins. Co. v. Jarman, 187 U.S. 197 (1902) ("suicide is not used in its technical and legal sense of self-destruction by a sane person, but according to its popular meaning of death by one's own hand, irrespective of the mental condition of the person committing the act"); Ritter v. Mutual Life Ins. Co., 169 U.S. 139, 154 (1898) (life insurance policy that paid if someone committed suicide while of sound mind would be against public policy and sound morality)

[18] Although *insane* is different from *incompetent* in criminal law, for purposes of deciding whether a person should be held responsible for his or her suicide in the context of insurance law, the definitions of insane and incompetent are similar, see, e.g., Robert I. Simon, James L. Levenson, & Daniel W. Shuman, *On Sound and Unsound Mind: The Role of Suicide in Tort and Insurance Litigation*, 33 J. Am. Acad. Psychiatry L. 176 (June 2005) (analyzing "sane/insane" and "sound/unsound mind" for insurance purposes in terms of capacity).

[19] See Chapter 2.

[20] Christian de Duve, Belgian Nobel Prize winner in Medicine, used assisted suicide to die; see, Denise Gellene, *Christian De Duve, 95, Dies; Nobel-Winning Biochemist*, N. Y. Times, May 6, 2013. Although the only Nobel Prize winner to use assisted suicide, he was hardly the only Nobel Prize winner to commit suicide, and not just the usual suspects, the Literature Prize winners (Ernest Hemingway in 1961 and Yasunari Kawabata in 1968), but many scientists, such as Emil Fischer, who won for chemistry in 1902 and killed himself in 1910; Hans Fischer (no relation), who won in 1930 and killed himself in 1945; and Percy Bridgman, who won the Nobel Prize in physics in 1946 and shot himself in 1961.

[21] Charlotte Perkins Gilman, see infra at 57; Virginia Woolf is probably the best-known feminist suicide (Virginia Woolf's Suicide Note, *Woolf, Creativity, and Madness: From Freud to fMRI*, www.smith.edu/woolf/suicidewithtranscript.php) but, more to the point, Caroline Heilbrun, in October 2003, see Vannessa Grigoriadis, *A Death of One's Own*, N. Y. Mag., Dec. 8, 2003, http://nymag.com/nymetro/news/people/n_9589/. I say "more to the point" because Gilman was

philosophers,[22] and the hundreds of people I interviewed for this book. Third, the kinds of risk-sharing with suicidal patients I propose in this book can only be contemplated with competent people.

It is important to define some of the terms I will use throughout this book:

Competence is a word that appears in statutes, regulations, and case law. Under our law, people who lack competence must have a guardian or guardian ad litem appointed to make legally binding decisions on their behalf, or, more recently, assistance and support in making decisions. *Capacity* is a medical term more often used to relate to a person's ability to make medical decisions at the moment of assessment. Some of the best scholars on competence and capacity use the terms interchangeably, especially in healthcare scholarship.

The Development of Concepts of Competence in Different Areas of the Law

The law presumes that all adults are competent.[23] Competence obviously means very different things in different contexts: competence to handle one's assets may be very different from competence to vote.[24] In this chapter, we will focus on competence to make decisions to die or hasten one's death, to exercise control over the timing and manner of one's death: in other words, competence to commit suicide. There is no current legal test for competence to commit suicide,[25] although there are proposals discussed later in this

mortally ill with cancer, and Woolf had well-known emotional problems, but Heilbrun, by all accounts, just decided it was the right time.

[22] Albert Camus and Bertrand Russell are only the most recent philosophers to wrestle with the problem of suicide, see Albert Camus, The Myth of Sisyphus (Justin O'Brien trans., Vintage 1955) and Peter Hanks, *What Made Russell Feel Ready for Suicide?* OUP Blog, June 7, 2015, at blog.oup.com/2015/06/bertrand-russell-suicide/

[23] See, e.g., National Conference of Commissioners on Uniform State Laws, Uniform Health-Care Decisions Act, Section 11(b) (1994). The law also presumes that virtually all people younger than certain arbitrary ages are not competent. It is important to discuss children and suicidality: virtually all of the dozens of people who have attempted suicide that I interviewed began contemplating suicide as children, including Josh Sebastian. A substantial number of the people I interviewed made their first suicide attempt as children. In many cases adults never knew or thought it was an accident. I take it as an article of faith that children should be prevented from committing suicide, although how to go about this may generate some controversy and will be discussed in Chapter 7.

[24] M. D. Green's famous article about the chaos of law governing wills and contracts also makes the point that competence is interpreted differently even in the same legal contexts, M. D. Green, *Proof of Mental Incompetence and the Unexpressed Major Premise*, 53 Yale L.J. 271 (1944).

[25] James L. Werth Jr., Rational Suicide? Implications for Mental Health Professionals (1996); Darien S. Fenn & Linda Ganzini, *Attitudes of Oregon*

chapter and plenty of standards for competence to make a decision that will inevitably lead to one's death.

The law deals with suicide in a multitude of areas. Cases vary from whether an ex-husband breached his child-support contract by committing suicide (he did not)[26] to whether a newspaper's false report that a man died by suicide is slander (it isn't because you can't slander dead people)[27] to whether a person who died by self-strangulation he engaged in for autoerotic purposes committed suicide (he didn't because he did not intend to die)[28] and whether the military may order a soldier accused of a crime into pretrial confinement solely for the purpose of preventing him from committing suicide (it can't).[29] Other interesting questions include whether a personal property gift made contingent on suicide is enforceable (sometimes yes, sometimes no).[30] Can suicide be considered an act of negligence?[31] Most cases involving suicide, however, also involve competence, and fall in one of six major areas: criminal law, tort law, insurance law, wills and probate, constitutional law, and healthcare law.

Three things are clear from hundreds of years and thousands of legal opinions about suicide. First, the law is internally contradictory and conflicting about suicide, in theory and in practice. Across areas of law, and within them, inconsistencies occur well beyond the normal, expected variations in any area of law. For example, for many years, suicide was decriminalized in many states, which continued to criminalize attempted suicide, even though throughout most of the law, it is impossible to criminalize attempting to do something that is not itself criminal. Children who would not be permitted under state law to make their own healthcare decisions have been held in tort cases to have made an independent and voluntary decision to kill themselves,[32] and in constitutional law cases to have the right to refuse life-saving treatment. People who literally murder their spouses, children, or parents are acquitted if those family members are suffering from a (sometimes not so) terminal illness or disability. Jurors have, for hundreds of years, consistently ignored instructions about the law in many cases involving suicide.

The second fact is that amid all these confusions, one clear and basic consistency does emerge. The law has always assumed that people are legally

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Psychologists Toward Physician-Assisted Suicide and the Oregon Death with Dignity Act, 30 Prof. Psychol. Res. Prac. 235 (1999).

[26] Wilmington Trust Co. v. Clark, 424 A.2d 744 (Md. 1981).

[27] Lee v. Weston, 402 N.E.2d 23 (Ind. App. 1980).

[28] Padfield v. AIG, 290 F.3d 1121 (5th Cir. 2002).

[29] U.S. v. Doane, 54 M.J. 978 (A.F. Ct. Crim. App. 2001).

[30] For *a lot* of information about this topic, see Adam J. McLeod, *A Gift Worth Dying For?: Debating the Volitional Nature of Suicide in the Law of Personal Property*, 45 Idaho L. Rev. 93 (2008).

[31] Yes, but I think that's a mistaken formulation of law, see Chapter 6.

[32] Logarta v. Gustafson, 998 F.Supp. 998 (E.D. Wisc. 1998).

responsible for their suicides and suicide attempts, and the burden of proof lies with those who claim that a person who committed suicide was not responsible, competent, or sane. The name of this exception has varied over time, and across different areas of law, but the fundamental truth—that the vast majority of suicidal people are competent in the eyes of the law—has never changed. Attempting or completing suicide has never, in and of itself, been sufficient in any branch of law to determine that an individual was incompetent or lacked capacity.

Finally, for most of history, the determination of whether someone was sane or of sound mind at the time of suicide or a suicide attempt, has been a question of fact entrusted to laypeople without the need for assistance from experts. With the rise of insurance and worker's compensation, which took place concurrently with the rise and professionalization of the fields of both law and mental health, these questions, while remaining questions of fact for the jury to decide, were increasingly considered complex subjects that jurors or judges could not decide without expert opinions by physicians and psychiatrists. Yet the culture, assumptions, and standards of medicine and mental health, in those days as in the present, were often far removed from the culture, values, and standards of law. This is hardly breaking news, but it has major implications for the social, legal, and policy treatment of suicide.

The Capacity to Choose Suicide and the Criminal Law

The law has always started with the assumption that suicidal people are competent, in the sense of being responsible for their actions. This stems from the fact that, until quite recently, suicide was a crime. In Western culture, the perception that suicide was a sin began with the writings of Augustine (prior to Augustine, suicide was sometimes celebrated by Christians, especially the suicides of women to preserve their chastity). With the intertwining of church and state, suicide also became a crime across Europe, known as *felo de se* or self-murder. In 967, King Edgar of England decreed that all the worldly goods and possessions of a person who committed suicide must be forfeit to the crown (as well as forfeiture of a Christian burial, and burial at a crossroads with a stake through the body).[33]

Suicide was considered the worst of all crimes because, as the famed legal commentator Blackstone wrote, quoting a 1562 case, "the suicide is guilty of a double offense; one spiritual, in invading the prerogative of the Almighty and rushing into His immediate presence uncalled for, the other temporal, against the King, who hath an interest in the preservation of his subjects."[34]

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[33] Howard Kushner, American Suicide 17–18 (1991).

[34] Hales v. Petit, 1 Plowden 253, 75 Eng. Rep. 387 (Q.B. 1562); William Blackstone, Commentaries, ch.14, p.189 (8th ed. 1778).

As a crime, suicide was tried in a court, to a jury, and the elements of the crime had to be proven. One of the necessary elements of the crime (in addition to being an adult) was that a person must be of "sound mind."[35] In fact, according to the English commentator Matthew Hale, suicide by definition required the individual to be *compos mentis*.[36] If a person killed himself or herself in the throes of madness, it was *not* suicide or *felo de se*; it was neither a crime nor a sin.[37] Thus, if a person who killed himself or herself was found by the jury to be insane, the family got to keep the individual's land and goods. Whether or not the person who killed himself or herself had an unsound mind was not considered a medical issue in any way and no expert testimony was required. But suicide while of unsound mind was initially understood to be a rare case, an exception to the rule of sane suicides. Suicide was not necessarily associated with madness any more than we currently associate murder with madness just because we have an insanity defense.

Because the penalty for suicide was total forfeiture of goods and properties, it is not surprising that juries, who generally knew the families, stretched circumstances very far to find that suicide was the result of insanity. Thus began, more than five hundred years ago, a long tradition of juries ignoring, nullifying, and distorting the law relating to suicide and assisted suicide because it simply made no sense to them. As we will see, that tradition continues to this day.

Jurors who decided whether someone was sane or insane at the time of suicide were not given definitions or much in the way of jury instructions. They listened to family and friends and neighbors and drew their own conclusions. But scholars, including legal scholars, had definitions: Robert Burton, author of *The Anatomy of Melancholy* argued that "such as are mad" "know not what they do, deprived of reason."[38] Because suicide was a crime—the murder of self—the standard for insanity that excused the offense was sometimes seen as the same standard as that which excused murder: the individual "did not know the nature and quality of the act, or does not know the act was wrong."[39]

Ultimately, the standard did not matter. The willingness of jurors to find that a person who committed suicide was insane became such a problem that Blackstone complained that juries carried the excuse to an extreme, finding

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[35] William Blackstone, 4 Commentaries on the Laws of England 195 (5th ed. 1836).

[36] Matthew Hale, Pleas of the Crown, i, 411 (1800).

[37] As Blackstone wrote, "The party must be of years of discretion, and in his senses, else it is no crime." Robert Malcolm Kerr, The Student's Blackstone 485 (1877).

[38] Robert Burton, Anatomy of Melancholy 2784 (1621) (page number in the Google Books edition, https://books.google.com/books?id=-wEvBwAAQBAJ&printsec=frontcover#v=onepage&q&f=false.

[39] M'Naghten's Case, 8 Eng. Rep. 718 (H.L. 1843).

that "the very act of suicide is evidence of insanity; as if every man who acted contrary to reason, had no reason at all." He flatly rejected this theory: "The law rationally judges that every melancholy or hypochondriac fit does not deprive one of the capacity of discerning right and wrong." He worried that "the same argument would prove every other criminal *non compos,* as well as the self-murderer."[40]

The insanity defense for suicide (or self-murder, as it was then called) in fact preceded and perhaps led to the use of the insanity defense for murder. And just as in modern times, when a claim of not guilty by reason of insanity is often met with skepticism, the attribution of suicide to mental illness was regarded by many as an outrageous manipulation of the law.

These English customs, practices, attitudes, and laws came to America with European settlers. The Puritans, in particular, were vehemently against suicide. Increase Mather preached a scathing and widely republished sermon about suicide: *A Call to the Tempted: A Sermon on the Horrid Crime of Self-Murder.*[41] In America, however, juries and others continued to stretch circumstances to find that a person—especially a prominent person—had committed suicide while insane. When he was drafting statutes for Virginia to decriminalize suicide, Thomas Jefferson pointed to the prevalent practice of jury nullification when the crime of suicide was prosecuted: "That men in general too disapprove of this severity [of forfeiture as a sanction for suicide] is apparent from the constant practice of juries finding the suicide in a state of insanity; because they have no other way of saving the forfeiture."[42] Some states in the new United States of America began decriminalizing suicide around the time of the Revolution. Others continued to consider it a crime, while removing forfeiture as a punishment.

The dichotomy between suicide as either a crime or the behavior of a madman became quite awkward in England in 1822 when the distinguished Foreign Secretary and member of the aristocracy, Viscount Castlereagh, slit his throat. If he were deemed a felon, he could not be buried in Westminster Abbey. The alternative that would permit his burial in Westminster required accepting that Great Britain had a madman running its foreign affairs. The jury neatly solved this dilemma by finding that he had been temporarily insane at the time of his suicide, and he was buried at Westminster Abbey. As in almost all findings that temporary insanity excuses a criminal act, there was a furious public backlash. Lord Byron noted sarcastically that

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[40] *Id*. at 27.

[41] Although the entire text of the sermon has not survived, fragments of it are reprinted in Increase Mather, *A Call to the Tempted: A Sermon on the Horrid Crime of Self Murder* (Ann Arbor, MI: Text Creation Partnership) available at http://quod.lib.umich.edu/e/evans/N02155.0001.001/1:2?rgn=div1;view=fulltext

[42] Thomas Jefferson, Plan Agreed Upon by the Committee of Revisors at Fredericksburg, 13 January 1777, *in* 2 Papers of Thomas Jefferson 325, quoted in Kushner, American Suicide, n.33, p.30.

> Of the manner of his death little need be said, except that if a poor radical had cut his throat, he would have been buried in a cross-road, with the usual appurtenances of the stake and mallet. But the minister was an elegant lunatic—a sentimental suicide—he merely cut the "carotid artery," (blessings on their learning!) and lo! The pageant, and the Abbey! and "the syllables of dolour yelled forth" by the newspapers—and the harangue of the Coroner in the eulogy over the bleeding body of the deceased—(an Anthony worthy of such a Caesar)—and the nauseous and atrocious cant of a degraded crew of conspirators against all that is sincere and honourable. In his death he was necessarily one of two things by the law—a felon or a madman—and in either case no great subject for panegyric.[43]

The public controversy surrounding the verdict after Castlereagh's death had its effect. The inequality castigated by Byron was ended, not by toughening up the enforcement of the law as would be likely in modern times, but by abandoning the practice of burying suicides at public crossroads. The following year saw the last example of that practice, and in 1824 it was prohibited by law.[44] Confiscation of the goods of a suicide was not formally outlawed until 1870. Attempted suicide continued to be punished in England: In 1860 a man who had attempted to cut his throat was treated until he recovered and then hanged.[45] The wound in his throat reopened, and "they bound up his neck below his wound until he died."[46] Suicide was finally decriminalized in England in 1961.

In the United States, forfeiture was also abolished long before suicide was decriminalized; as the U.S. Supreme Court said, "it shows gross moral turpitude in a sane person."[47] As the New Jersey Supreme Court pointed out, "suicide is none the less criminal because no punishment can be inflicted. It may not be indictable because the dead cannot be indicted. If one kills another and then kills himself, is he any the less a murderer because he can't be punished?"[48] Some states that had decriminalized suicide continued to treat attempted suicide as a crime.[49] This led to court holdings that appeared to defy logic even as they tried to faithfully follow the law:

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[43] George Gordon, Lord Byron, Don Juan, Preface to Cantos VI–VIII, (1837), available online at http://www.online-literature.com/byron/don-juan/6/

[44] In 1824, the English Parliament's ban on the practice of burying suicides by the highway with a stake driven through the individual's heart was codified in law. The law also authorized church burial, although without religious rites and only between 9 p.m. and midnight. 4 Geo IV c. 52, s.1.

[45] J. D. Droge & A. J. Tabor, A Noble Death: Suicide and Martyrdom among Christians and Jews in Antiquity 7 (1992).

[46] *Id.*

[47] Travelers' Ins. Co. v. McConkey, 127 U.S. 661, 667 (1888).

[48] State v. Carney, 55 A. 45 (N.J. Sup. Ct. 1903).

[49] Royal Circle v. Achterrath, 204 Ill. 549, 565–66 (1903).

> [An] attempt to commit crime imports a purpose not fully accomplished to commit it. It is the attempt to commit suicide that is the crime, while the taking of one's own life is no violation of the criminal law . . . While the attempt to commit suicide is a crime, the accomplishment of the purpose to do so is not.[50]

Several decades later another court held that "though suicide itself is not punishable in this state because we have no forfeiture, the attempt to commit suicide is punishable."[51] The criminalization of attempted suicide waned at the dawn of the twentieth century. In 1906, the highest court in Maine, noting that attempted suicide was still a crime in New York, North Dakota, and South Dakota, held that it was not a crime in Maine.[52] In 1902, prosecutors in New York City attempted to criminally charge twenty-one people who had attempted suicide, and in the first half of 1903, they attempted to charge nine people who had attempted suicide.[53] Grand juries refused to return indictments in any one of these cases, showing the disinclination of juries to follow laws that make no sense to them.[54]

In England, matters were different. Both suicide and attempted suicide were officially crimes, but successful suicides were often deemed "insane," while an unsuccessful suicide was punished as a crime. This understanding was so common that it featured in Agatha Christie's 1944 detective novel, *Toward Zero*. The novel opens as a man whose attempt to kill himself by jumping off a cliff has been thwarted by landing in a tree lies in a hospital bed and thinks to himself:

> And now where was he? Lying ridiculously in a hospital bed with a broken shoulder and with the prospect of being hauled up in a police court for the crime of trying to take his own life.
>
> Curse it, it was his *own* life, wasn't it?
>
> And if he had succeeded in the job, they would have buried him piously as of unsound mind!
>
> Unsound mind, indeed! He'd never been saner! And to commit suicide was the most logical and sensible thing that could be done by a man in his position.
>
> . . . And now here he was in a ridiculous plight. He would shortly be admonished by a sanctimonious magistrate for doing

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[50] Darrow v. Family Fund Soc'y, 22 N.E. 1093 (N.Y. 1889).

[51] State v. LaFayette, 188 A. 918 (County Ct. N.J. 1937) (but dismissing the case because the court imposing the sentence did not have the authority to do so under law).

[52] May v. Pennell, 101 Me. 516 (1906).

[53] Wilbur Larremore, *Suicide and the Law*, 17 Harv. L. Rev. 331 (1903–1904).

[54] *Id*. Prof.Larremore, the law professor reporting these facts, concluded that this outcome was "entirely satisfactory."

> the common-sense thing with a commodity which belonged to him and to him only—his life.[55]

Thus, even while suicide remained a crime in the laws of England for almost two more decades after the novel was published, the pressures of social opinion had effectively decriminalized it by 1944. But, as Christie makes clear, decriminalization was not a result of England's changing values about a person's autonomy or right to commit suicide or (as in the case of homosexuality or use of marijuana in the United States) the consequence of social normalization of the conduct. Rather, successful suicides were chalked up to insanity or incompetence. Yet, as underscored by Christie's satirical comment on the subject, English society did not really believe that suicidal people were actually insane or incompetent: unsuccessful suicide attempts were punished and continued to be punished by a week to a month in prison or a fine as late as 1959.[56]

Social values shape laws about suicide, and in turn values are shaped by law. Thus, many states in the South took much longer to decriminalize suicide than those in the North; indeed some Southern states still regard suicide as a common law crime. The North Carolina Supreme Court held that a man could be criminally prosecuted for attempted suicide in 1961,[57] the same year that Great Britain decriminalized suicide. As late as 1992, the Supreme Court of Virginia reviewed a claim for psychiatric malpractice that had been dismissed by the trial court on the grounds that suicide was immoral and criminal, and therefore the widow should not profit from her husband's immoral and criminal act.[58] The Virginia Supreme Court upheld the finding that, as a matter of common law, suicide still was a crime in Virginia, but found that in order to be a crime, the suicide must be committed by a person of sound mind. The case was reversed because the husband had been of unsound mind at the time of his suicide. As I write this, the efforts of Senator Adam Ebbin and Delegate Rob Krupicka to decriminalize suicide in Virginia have failed; a Facebook petition to support this decriminalization aiming for

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[55] Agatha Christie, Toward Zero (1944).

[56] Gerry Holt, *When Suicide Was Illegal* (BBC News, Aug. 3, 2011), http://www.bbc.com/news/magazine-14374296. Christie herself makes clear her own opinion about suicide: not that it is a crime or a sign of insanity, but that it is a mistake, because we do not know what the future will hold. Thus, the failed suicide in *Toward Zero* ends the book by saving a woman from suicide.

[57] State v. Willis, 255 NC 473, 477–78, 121 S.E.2d 854 (1961) (holding that suicide was a crime that could not be punished, but attempted suicide could be punished by fine and imprisonment). North Carolina decriminalized suicide by statute in 1973, N.C. Code § 14-17.1, c. 1205 (1973).

[58] Wackwitz v. Roy, 418 S.E.2d 861 (Va. 1992). The Virginia Supreme Court found that suicide was a common law crime in Virginia, but held that, because "suicide" required a rational mind, and Wackwitz had not been rational at the time of his suicide, he had not committed a crime. This will be discussed later in this chapter.

1000 supporters received barely half this amount. As of 2015, suicide is still a crime in Virginia.

In 1996, the highest court in Mississippi rejected a jury instruction on accident when the defendant claimed that he had accidentally shot his ex-wife while he was trying to commit suicide, because the defense of accident cannot be used when the defendant is engaged in an unlawful act, and attempting suicide is an unlawful act.[59] Two years later, a federal court recognized that suicide was still a crime in Mississippi.[60] In the military, deliberate self-injury, including attempting suicide, is still a crime under some circumstances.[61]

Social values also dictate the distinction between sane and insane suicide. In the last hundred years, many courts have tried to define the distinction between sane and insane in cases of suicide where the determination was related to suicide as a crime. No one ever really believes that all suicides are the result of mental illness. We have always had beliefs that some suicides are rational or even admirable (they are often called something other than suicide). Both the Church and State endorsed suicide by saints and martyrs, including by women to preserve their chastity. These kinds of suicides were, as a court in New Jersey in 1901 put it

> . . . ethically defensible. Else, how could a man "lay down his life for his friend?" Suicide may be self-sacrifice, as when a woman slays herself to save her honor.[62] Sometimes self-destruction, humanly speaking, is excusable, as where a man curtails by weeks or months the agony of an incurable disease.[63]

The categories of suicide generally believed to be rational are a window into culture as much as its causes. They tell us about the lives we believe are not worth living: people in comas or vegetative states; people who are

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[59] Nicholson *ex rel.* Gollott v. State, 672 So.2d 744, 753 (Miss. 1996) (noting that even if it could not hold attempted suicide was an unlawful act, his "display of a pistol, and his heated request for Diane to shoot him, after his repeated threats against Diane" violated the law prohibiting assault.

[60] Shamburger v. Grand Casino of Miss. Inc. 84 F.Supp.2d 794 (S.D. Miss. 1998) (finding that casino could not be legally responsible for suicide when decedent was not acting under irresistible impulse).

[61] United States v. Caldwell, 72 M.J. 137 (C.A.A.F. 2013).

[62] That is, commits suicide to avoid being raped. This was sufficiently common that a court ruled (over two dissents) that a man could be convicted of murder for the suicide of a woman he had raped, since it was foreseeable that she would be so distracted with "pain and shame" as to react this way to his assault, Stephenson v. State, 179 N.E. 633 (1932).

[63] Campbell v. Supreme Conclave Improved Order Heptasophs, 49 A. 550, 553 (N.J. App. 1901). I am deeply grateful that this case is actually relevant, since its magnificent name would have forced me to come up with some reason to cite it.

at death's door and in a great deal of pain; people whose independence and autonomy are compromised, and people with chronic, incurable, but nonterminal disabilities. Recently, a young man who was just married and whose wife was expecting their first child fell out of a tree while hunting and was told he would be paralyzed for life. He asked that his life support be disconnected because life was not worth living as a paralyzed individual. This decision, considered competent, was honored.[64]

In an extensive and thoughtful article on the subject, Professors Simon, Levenson, and Shuman suggest using the state's applicable standard for insanity: "if suicide is criminalized, criminal responsibility criteria should apply to the determination of unsound mind in criminalized suicide cases, as it would to other criminal offenses."[65]

Those criteria generally revolve around the ability to understand and appreciate the nature and wrongfulness of the act. Simon, Levenson, and Shuman summarize that "unless a suicide is impulsive, the result of confusion or severe intoxication, or the result of a miscalculation, a patient's suicide is usually a conscious choice to end intolerable mental pain or circumstances."[66] In other words, the individual who commits suicide is usually competent or sane under the law.

This is certainly true in the case of many suicidal death row inmates who choose to withdraw appeals of their death sentences. Between 1976 and 2003, 106 of 885 people executed in this country were so-called volunteers, inmates who waived the appeals process. They did this because they wanted and intended to die, and their actions hastened their deaths by years or even decades, and also made them inevitable;[67] waiving appeal of a death sentence is thus a suicidal act. The law currently permits death row inmates to waive appeals if they have a "rational and factual understanding of the consequences of their decision," and if that decision is "knowing, intelligent, and voluntary."[68] Courts have repeatedly found that this standard is met in cases where the inmate is explicitly, overtly suicidal. Gary Gilmore, unwilling to wait for the firing squad, made a suicide attempt six days after withdrawing

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[64] Steve Almasy & Michael Martinez, *Paralyzed after Fall from Tree, Indiana Deer Hunter Opts to End Life* (CNN, Nov. 7, 2013), www.cnn.com./2013/11/06/us/paralyzed-Indiana-deer-hunter-ends-life.

[65] Simon et al., *supra* note 18, at 1179.

[66] *Id.*

[67] John H. Blume, *Killing the Willing: "Volunteers," Suicide and Competency*, 103 Mich. L. Rev. 939, 940 (2005).

[68] Interestingly, inmates only have the right to waive discretionary death penalty appeals; no matter how competent or knowing or intelligent, courts have held that inmates cannot waive mandatory appeals of their own death sentences. For an exhaustive review of the topic, see Anthony Casey, *Maintaining the Integrity of Death: An Argument for Restricting a Defendant's Right to Volunteer for Execution at Certain Stages in Capital Proceedings*, 30 Am. J. Crim. Law 75 (2002).

his appeal. David Martin Long attempted suicide the day before his execution. In both cases the men were given emergency medical treatment; Long was revived from a coma and flown back for his execution the next evening.[69] The fact that the death row inmates are suicidal, mentally ill, brain damaged, or intellectually disabled,[70] does not preclude them from being found competent to waive their appeals.[71] The reasons for waiver vary. Many of them are, like Josh Sebastian, just "tired."[72] Many cite the miserable, hellish conditions of death row. Some actually feel remorseful. Judges, lawyers, and advocates who oppose their right to waive their appeals frequently characterize the process as state-assisted suicide, which should not be granted regardless of the competence of the individual.[73] Reasonable people can debate about this: The only point I want to make here is that the U.S. Supreme Court, understanding that some of these people are suicidal, still rules that they are competent if they have a rational and factual understanding of the consequences of their decisions.[74] Under the law, suicidal people are usually competent, and death row inmates are no exception.

Furthermore, people who are charged with crimes for behavior associated with directly following suicide attempts rarely, if ever, succeed in claims that they had even "diminished" capacity at the time of the offense, let alone being found incompetent or insane.[75]

There are other issues related to criminal law and suicide, but these will be dealt with in a later chapter. Our task here is to examine how the law divides incompetent, irrational, insane suicides from those deemed to be the acts of rational and sane people. The reader may well argue that criminal law is sui generis in that it must begin with the assumption of agency and responsibility for one's actions, or else the entire foundation of the enterprise is threatened. Fair enough: we will proceed to look at other areas of the law—insurance, torts, and healthcare—for which this is not necessarily true.

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[69] *Id*. at 952–53, n.67. This also happened in 1995, when Robert Brecheen overdosed on sedatives, was revived, and then executed by lethal injection. Associated Press, *Killer Who Took Overdose Is Revived, Then Executed*, Syracuse Herald J., Aug. 11, 1995, p. A-9.

[70] Joey Miller was found competent to waive his appeals despite having "mental retardation and brain damage." Casey, *supra* note 66, at 977, n.160.

[71] Even innocent people on death row sometimes want to forego their appeals. See Blume, *supra* note 65, at n.63.

[72] *Id*. at 939.

[73] Lehnard v. Wolff, 444 U.S. 807, 815 (1979) (Marshall, J., dissenting); Kathleen Johnson, *The Death Row Right to Die: Suicide or Intimate Decision?* 54 S. Ca. L. Rev. 575, 592 (1981).

[74] Some mental health professionals have argued that these inmates are "affectively incompetent." See p. 51.

[75] State v. Pagano, 23 Conn. App. 447 (Conn. App. 1990) (man tries to kill himself and shortly thereafter assaults a police officer; court holds defendant produced *no* evidence that he lacked capacity).

Tort Law, Suicide, and the Chain of Causation

Tort law is the law that permits compensation for personal injury or death when caused by the negligence or intentional act of an individual who owed a duty to the plaintiff. Tort law also clearly distinguishes between competent people who commit suicide and those who could not be considered responsible for their actions.

Initially, tort law relied on criminal law in barring recovery in tort for the estate of someone who committed suicide. Courts held that because it was against public policy to profit from a crime, a tort recovery when a person died by suicide was impossible. This was the holding of a Virginia court as late as 1992.[76] In these cases, tort law borrowed the criminal law's formulation of insane as essentially about recognition and appreciation of the nature of the act. Under this formulation, tort recovery was possible if an individual was insane and thus not responsible for his or her death.

However, as states decriminalized suicide, tort doctrine evolved greater, rather than lesser, bars to recovery of damages when a case involved suicide. Although suicide was not criminal, if it was intentional, it broke the chain of causation between the defendant's negligence and the plaintiff's death. The cause of death was an individual's own intentional act, so that the negligent defendant could not be said to have caused the person's death. Although criminal law absolved a person who committed suicide while insane, tort law insisted that even insane people could break the chain of causation as long as the individual had the requisite intention, i.e., knew the purpose and physical effect of his or her act.

The test to preclude recovery was often formulated as "the voluntary, wilful act of suicide resulting from a moderately intelligent power of choice," even when that "choice is the product of a disordered mind."[77] Courts underscored this latter point using a variety of colorful language: recovery was barred if an individual took his or her own life, even when the individual had a "morbid mind 'unable to tolerate the pain, inconvenience and humiliation' of its particular condition."[78]

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[76] The Virginia Supreme Court allowed the suit to go forward on the grounds that the decedent had been insane at the time of the suicide, and therefore not a criminal. It upheld the designation of suicide as a crime, *Wackwitz*, supra note 58. See also Hill v. Nicodemus, 755 F.Supp. 692, 693 (W.D. Va. 1991) (suicide illegal and immoral act in Virginia and even if decedent did not have a full appreciation of the injury she would incur from her actions, her estate still cannot recover); Williamson v. Virginia Beach, 786 F.Supp. 1238 (E.D. Va. 1992); Estate of Eavey v. J. Jagan Reddy & Assoc., 27 Va. Cir. 73 (Va. 11th Jud. Circ. Jan. 22, 1992); Mea v. Spiegel, 44 Va. Cir. 122 (Va. Cir. Ct. 4th JC Dec. 4, 1997).

[77] Daniels v. New York, etc. Railroad, 183 Mass. 393, 67 N.E. 424, 426 (1903); Barber v. Indus. Comm'n, 241 Wisc. 462, 6 N.W.2d 199 (Wisc. 1942); Scoggins v. Wal-Mart Stories, Inc., 560 N.W.2d 564, 568 (Iowa 1997).

[78] *Logarta, supra* note 32, at 1005 (citations omitted).

There are only two exceptions to this rule: when the defendant has a special, often custodial, relationship with the plaintiff, or when the defendant's negligent or criminal conduct actually caused the suicide by "creat[ing] in the deceased an uncontrollable impulse, frenzy or rage, during which he commits suicide without conscious volition to produce death."[79] It is interesting that while minors are often considered not competent to make healthcare choices, a minor who commits suicide breaks the chain of causation even when the suicide would not have happened absent the actions of defendant. In *Logarta v. Gustafson*, sixteen-year-old Ronald Logarta bought a loaded gun from his sixteen-year-old friend for $5 and a credit card.[80] His friend knew that Logarta was contemplating suicide, and left him in a cornfield with the guns, "asking only that Ronald think about what he was doing." The friend returned an hour later to the cornfield, found Logarta bleeding, and told Logarta's father that his son was injured and bleeding in the cornfield. Logarta's father ran to the cornfield in time to see his son die. Logarta's parents sued the friend's parents, who owned the guns. The court held that "some moral obligations do not translate easily into legal obligations." The friend's parents had no special duty to protect Logarta, who acted not from "uncontrollable impulse or frenzy or delirium" but from "a moderately intelligent power of choice."[81] The same logic has been used to shield schools from liability for the suicide of students.

Testamentary Capacity and Suicide

For many years, wealthy people have committed suicide and disappointed would-be heirs have contested wills that omitted them on the grounds that the testator was not competent at the time the will was executed (competence at the time of death doesn't matter in these cases). As in other areas of the law, the courts have made clear that there is a vast, vast amount of room for what they variously call eccentricities, idiosyncrasies, and peculiarities before an individual would reach actual testamentary incapacity. The evidence adduced to demonstrate the incompetence of a man who worked as a senior secretary for the California Supreme Court for fifty years before he committed suicide was that (1) he was building an airplane in his attic; (2) he said there was a tunnel to Lake Merced on his property; (3) he kept loaded guns around his house; (4) he considered his property very valuable; (5) he thought he could get bargains at delinquent tax sales (this was during the Great Depression); (6) he claimed to have supernatural powers; (7) he failed to recognize friends and acquaintances; (8) he was cruel to dumb animals;

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[79] *Id.* See also Victor E. Schwartz, *Civil Liability for Causing Suicide: A Synthesis of Law and Psychiatry*, 24 Vand. L. Rev. 217 (1971).

[80] *Logarta, supra* note 32, at 1000.

[81] *Id.* at 1006.

and (9) he thought there was a valuable water supply on his property.[82] No one even mentioned the fact that he had committed suicide as a factor in determining his testamentary competence. The jury decided that the testator was incompetent and the court overrode that finding. This was appealed to the Supreme Court, which was in a difficult position: it could hardly acknowledge that it had employed an outright incompetent for years, and the entire Court couldn't recuse itself. The Court upheld the finding that the testator was competent, citing a past decision of its own (which in turn incorporated a New Jersey court decision) and summarized the law as follows:

> The abstract opinion of any witness, medical or of any other profession, is not of any importance. No judicial tribunal would be justified in deciding against the capacity of a testator upon the mere opinion of witnesses, however numerous or respectable. A man may be of unsound mind and his whole neighborhood may declare him so. But whether that unsoundness amounts to incapacity for the discharge of the important duty of making final disposal of his property, is a question which the court must determine upon its own responsibility.[83]

By 1952, the California Supreme Court was willing to acknowledge that committing suicide was "relevant" to the question of sanity, but "standing alone it is insufficient to show an insanity so complete as to destroy testamentary capacity."[84] This rule of law—that attempting or committing suicide is not sufficient to destroy the presumption of testamentary capacity—is universal in the courts,[85] and has not changed with time. What has changed is that earlier courts never bothered with any kind of psychiatric or medical testimony on testamentary competence, even when the testator had committed suicide, while now mental health professionals abound as witnesses in these kinds of cases.

There are two ways in which a person can lack testamentary capacity.[86] The first is a broad incapacity, an inability to understand the nature of one's property (or "bounty," under older legal language) and the "natural objects of

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[82] Estate of Finkler, 3 Cal.2d 584 (Ca. 1935). Although it is not mentioned in the case, there may be a connection in Finkler's mind between beliefs 2, 4, and 9.

[83] *Id*. at 594.

[84] Estate of Lingenfelter, 38 Cal.2d 571, 581 (Ca. 1952). This was followed in a case where the decedent had made multiple suicide attempts, was addicted to barbiturates, and was frequently hospitalized, Estate of Ross, 204 Cal. App. 2d 82 (Cal. App. 1962).

[85] *In re* Butler, 2012 NY Slip Op 51324 (N.Y. Surrogate's Court, Monroe Cty, July 19, 2012); Hodges v. Genzone, 724 So.2d 521 (Ala. App. 1998), aff'd 724 So.2d 524 (Ala. 1998); Breeden v. Stone, 992 P.2d 1167 (Colo. 2000).

[86] *Breeden v. Stone* contains an excellent explanation of, and distinction between, these two different forms of testamentary incapacity.

one's bounty" (generally family members) and the ability to dispose of one's property according to some plan. This does not mean the "natural objects of one's bounty" could not be disinherited, only that a person had to understand who might be expected to inherit. Even if the person understood all these things, if he or she had a fixed delusion or hallucination that affected one of these understandings, that could also result in a finding of lack of testamentary capacity.

Thus, family members who had repeatedly tried to involuntarily commit a suicidal woman "for her own good" claimed she suffered from a fixed delusion when she disinherited them, because "she could not rationally turn against her brothers and sisters who only tried to help her."[87] The trial court agreed, but the appellate court reversed. The court said,

> We believe Mrs. Bonjean's resentment of her family's attempt to force her commitment provides a rational explanation for their disinheritance . . . We find that the facts which fostered Mrs. Bonjean's hostility toward her sisters and brother have a rational basis. The hostility is not the product of a "perverted imagination." [citation omitted] Mrs. Bonjean's hostility toward her family can be rationally explained as deriving from a threat to her personal liberty associated with those same family members.[88]

Not only is the will of a person who commits suicide virtually always held to be valid, and the decedent found to be competent, but the suicide note itself has been upheld as a holographic will (even in one case where parts of the note were illegible because they were "soiled" with the blood of the testator).[89]

Worker's Compensation Law and Suicide

Worker's compensation provides income to workers whose injuries or deaths are caused by their employment. Traditionally, it barred recovery for deaths resulting from "the deliberate intention of the workman himself to produce such . . . death."[90] Thus, a suicide while sane precluded compensation for the worker's widow and family. Conversely, suicide while insane meant that a widow could receive a pension. As in the criminal law, insane was defined more and more broadly over the years, finally including "irresistible impulse, delirium caused by injury, pain from the injury or by the use of medication

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[87] *In re* Estate of Bonjean, 90 Ill. App. 3d 582, 413 N.E.2d 205 (Ill. App. 1980).

[88] *Id.* at 586.

[89] A holographic will is "a will entirely handwritten, dated and signed by the testator (the person making the will), but not signed by required witnesses" (Holographic Will, TheFreeDictionary.com, http://legal-dictionary.thefreedictionary.com/holographic+will); *In re* Marion R. Craig Trust, Nos. 307618, 307684 (Mich. App. Apr. 23, 2013).

[90] Schwab v. Dept. of Labor and Industry, 76 Wash. 2nd 784, 787 (1969).

employed in the treatment of the injury or as an uncontrollable impulse with no direction of the mind."[91]

This was interpreted, in a standard adopted from tort law, to mean "a voluntary wilful choice determined by a moderately intelligent mental power which knows the purpose and physical effect of the suicidal act."[92] Workers might commit suicide years after their injuries,[93] and their widows might be initially denied compensation, but jurors repeatedly found in favor of the widows. In an interesting reversal of modern-day efforts of assisted suicide advocates to distance themselves from the term suicide, the very word suicide was only applied to competent and rational people:

> The evidence was all but conclusive that defendant was insane; and, from the testimony given by the medical experts, it was shown that his state of mind was that of a child. If his mind was in the condition showed by the evidence, it is, of course, apparent that he could not commit suicide, as that term is usually used to indicate the action of a person who is able to weigh and appreciate the thing about to be done…[94]

Sane and Insane Suicides and Insurance Law

Criminal law goes back many centuries. Insurance law, which is easily the area of law that has been most preoccupied with suicide in the United States, goes back barely 150 years. Insurance law contains the kinds of arguments about terminology that make laypeople hate lawyers: Is "shall die by his own hand" the same as "suicide"?[95] Its focus on parsing the distinction between sane and insane suicides was the subject of a number of U.S. Supreme Court and lower court decisions. The ultimate failure to define the distinction between sane and insane, a line acknowledged by the Supreme Court to be "shadowy,"[96] led to the introduction into life insurance policies of language excluding recovery whether the individual was "sane or insane," generally

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[91] Gotterdam v. Dept. of Labor and Industry, 185 Wash. 628, 632 (1936).

[92] Schofield v. White, 250 Iowa 571 (1959); Trombley v. Coldwater State Home and Training School, 366 Mich. 649 (1962); Globe Security Systems v. WCAB, 518 Pa. 544 (1988); Friedeman v. State, 215 Neb. 413 (1983).

[93] Gotterdam v. Dept. of Labor and Industry, n. 91 at628(1936) (after injury, worker becomes addicted to morphine and kills himself four years later; verdict for widow).

[94] Hepner v. Department of Labor and Industry, 141 Wash. 55, 59 (1926).

[95] Life Ins. Co. v. Terry, 15 Wall. 580, 21 L. Ed 236 (1872) ("die by his own hand" refers to the crime of suicide and therefore is not applicable to insane persons); Bigelow v. Berkshire Life Ins. Co. 93 U.S. 284 (1876) ("shall die by his own hand" and "suicide" mean the same thing).

[96] *Bigelow, supra* note 95.

accepted as precluding any inquiry into the mental state of a person who committed suicide.

But even with this language, the estates of some people who killed themselves were allowed to recover, and it is instructive to look at the various tiers of sanity or competence as defined in these cases.

A sane suicide, as compared to an insane suicide, is "the voluntary act of an accountable moral agent."[97] An insane suicide, however, is "conscious of the physical nature, although not of the criminality, of the act, he could take his own life with a settled purpose to do so."[98] Or, to put it another way, if an insurance policy excluded the words "suicide, sane or insane," the estate of a person could not collect if the individual "was conscious of the physical nature of his act and intended by it to cause his death, although, at the time, he was incapable of judging between right and wrong, and of understanding the moral consequences of what he was doing."[99]

From this language, it seems obvious that the self-inflicted death of an individual so psychotic that he believed he could fly, or that he was incapable of dying, would not even fall under the word suicide as understood by the Supreme Court at that time. Thus, although an insane man was "unconscious of the great crime he was committing" because "[h]is darkened mind did not enable him to see or appreciate the moral character of his act," he still "knew he was taking his own life and showed sufficient intelligence to employ a loaded pistol to accomplish his purpose."[100]

Throughout the years and in many cases, the Supreme Court and other courts gave examples of the kinds of motivations a sane suicide would have: "anger, pride, jealousy, or a desire to escape from the ills of life,"[101] the desire to discharge one's debts,[102] humiliation at being arrested,[103] or in the case of a woman, the need to preserve her chastity.[104]

One principle is extremely clear from the insurance cases: sane people commit suicide. In fact, at the turn of the century, the legal rule was that a person who committed suicide was sane until proven otherwise.[105] In another case, the court approvingly quoted a jury instruction that "the presumption of sanity is not overthrown by the act of committing suicide. Suicide may be used as evidence of insanity, but standing alone it is not

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[97] *Id.* at 286.
[98] *Id.* at 287.
[99] *Id.*
[100] *Id.*
[101] *Ritter, supra* note 17.
[102] *Id.* at 146.
[103] *Campbell, supra* note 63 (finding that insurance company was not liable where Dr. Campbell was sane when he committed suicide: "Dr. Campbell doubtless took his life through overwhelming chagrin due to arrest on a criminal charge.").
[104] Stephenson v. State, note 62.
[105] Royal Circle v. Achterrath, 204 Ill. 544, 558 (Ill. 1903).

enough to establish it."[106] This principle has been repeated over and over again[107] and remains good law today.

Healthcare, Competency, and Suicide

The most commonly invoked analogue to competence to commit suicide is competence to refuse healthcare, or nutrition and hydration, which will inevitably lead to death. I left this subject to the last for a number of reasons.

First, it is by far the most recent development in the law. A person's right to refuse life-saving treatment was by no means accepted in the 1960s, especially if she was the mother of children. This was initially true even when people refused treatment because their faith demanded it.[108] Doctors who were asked to discontinue life support refused on the grounds that it would violate the most basic tenets of the medical profession, using much the same language that they now use in opposing assisted suicide.[109] In addition, some argued that they would be held liable for withdrawing life support from their patients, since they had a duty to their patients to keep them alive (see Tort Law, *supra* at 22). As we will see in the next chapter, even when doctors in the 1970s specifically disclaimed any concern about legal liability for honoring treatment refusals, the courts didn't believe them.[110]

It was only beginning in the early 1980s and 1990s when doctors had been reassured by a number of court cases and the passage of immunizing legislation[111] that they could not be successfully prosecuted or sued that the right to refuse life-sustaining treatment of a competent person began to be more or less universally respected. Until that time, there had been no need to define competence to refuse life-saving treatment, because patients neither enjoyed nor exercised those rights.[112] Yet today, one of the most fundamental and universally cited tenets of both law and medicine is that all competent individuals have the right to "decide all aspects of [their own] health care in

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[106] *Ritter, supra* note 17, at 147–48.

[107] Strasberg v. Equitable Life Assurance Soc., 281 App. Div. 9, 13 (N.Y. App. 1952) ("Insanity cannot be presumed from the mere fact of suicide for experience has shown that self-destruction is often perpetrated by the sane.").

[108] *In re* Application of the President and Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1964).

[109] Jill Lepore, The Mansion of Happiness: A History of Life and Death (2012) quotes from a copy of the transcript of the Karen Ann Quinlan trial. The doctors argued that withdrawing life support would set them down the road to the medical atrocities of the Nazi era. This is not as fanciful as it might seem: many disability rights activists oppose assisted suicide for the same reason.

[110] See discussion of Quinlan and other cases in Chapter 2.

[111] The Patient Self-Determination Act of 1990, P.L. 101-508, both immunized doctors who followed advance directives and penalized doctors who did not.

[112] See Jay Katz, The Silent World of Doctor and Patient (paperback 2002).

all circumstances, including the right to decline health care or to direct that health care be discontinued, even if death ensues."[113]

The principle that competent patients can make their own healthcare decisions, even unto death, is fundamental to our jurisprudence and social policy, and is essentially uncontested by the legal or medical professions. However, in practice, there has been continued and consistent resistance from the medical and especially the mental health profession to patients choosing death under circumstances that these professionals consider inappropriate. This has led to theories and practices that vastly and improperly expand the concept of incompetence when it comes to decisions about dying.

Let's look at the law first. While there never has been uniform agreement on a definition or measure of competence to make healthcare decisions, most state laws share many common elements. The closest thing to a universal standard in this country is the Uniform Health-Care Decisions Act, which defines capacity as "an individual's ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health care decision."[114] The Mental Capacity Act, passed by Parliament in England in 2005, finds that "a person is unable to make a decision for himself if he is unable

> (a) To understand the information relevant to a decision
> To retain that information
> To use or weigh that information as part of the process of making a decision, or
> To communicate his decision (whether by talking, sign language, or any other means).[115]

There is certainly no specific definition of competence to commit suicide, or standards to follow, even in states with assisted suicide laws.[116] It's not clear

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[113] National Conference of Commissioners on Uniform State Laws, Uniform Health-Care Decisions Act, Prefatory Note, p. 1 (1994) (adopted in five states). Shine v. Vega, 429 Mass. 456 (1999).

[114] National Conference of Commissioners on Uniform State Laws, Uniform Health-Care Decisions Act, § 1, (3) (approved by American Bar Association 1994), see n.107.

[115] Mental Capacity Act (2005), § 3(1).

[116] The Center for Ethics in Healthcare, Oregon Health and Science University, The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals (current ed. 2008), http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf Darien S. Fenn and Linda Ganzini, "Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death with Dignity Act," 30 *Professional Psychology: Research and Practice* 235 (1999); Matthew Hotopf, William Lee, & Annabel Price, *Assisted Suicide: Why Psychiatrists Should Engage in the Debate*, 198 Br. J. Psychiatry 83 (2011).

that we need a different definition of competence from the standards cited earlier. But because competent patients are understood to have complete rights of decision about matters relating to their health, the medical and mental health professions have often, as a practical matter, expanded the concept of incompetence when the patient's decision is one with which they disagree.

First, at the crudest and least sophisticated level, the question of competence in the healthcare arena generally arises only when the patient disagrees with the recommendation of the medical or mental health professional. I once served as a healthcare proxy for a hospitalized woman with serious health problems. I received a frantic telephone message to call the hospital immediately: they needed me to act as her healthcare proxy because she had decided she wanted her ventilator disconnected. When I called back, the doctor told me (using these words), "Oh, it's all right. She's regained her competence," by which he meant she had changed her mind about the ventilator. Competence in practice for some medical and mental health professionals is simply a proxy for agreeing with the doctor's view.[117]

These assumptions of competence also operate when obviously incompetent people passively comply with recommended treatment.[118] It is an open secret that incompetent assenters to treatment proliferate in the medical and mental health system. In one of the rare decisions exposing and rejecting this practice, the Supreme Court decided that failure to protect the rights of incompetent assenters can constitute a violation of their constitutional rights to due process if they are deemed to assent to commitment and medication.[119] The practice of not questioning incompetent assent to recommended treatments, however, remains widespread.[120]

Few medical and mental health professionals would actually articulate a belief that a patient who disagreed with them was automatically incompetent.[121]

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[117] In the Elizabeth Bouvia case, the chief of psychiatry at Riverside Hospital testified that Ms. Bouvia's decision to refuse food was the result of "impairment." When asked whether if she changed her mind and decided to eat, that decision would be "a competent health care decision on her part," he answered, "I think it would be." Transcript, at 590, quoted in George Annas, n. 1 p. 571. Another doctor in the case testified "When a patient agrees with me, the patient is rational. When an eighty-year-old lady refuses to have a massive resection of her bowel for widespread cancer, then I send her to a psychiatrist because she is not agreeing with me, so she is irrational." *Id*.

[118] Zinermon v. Burch, 494 U.S. 113, 110 S. Ct. 975 (1990).

[119] *Id*.

[120] Renee Sorrentino, *Performing Capacity Evaluations: What's Expected for Your Consult*, 13 Current Psychiatry 41 (2014); James L. Bernat, Ethical Issues in Neurology (1994) 28 (doctors only question the competence of patients who disagree with their treatment plans).

[121] Hotopf et al., *supra* note 112 ("Clearly it would be wrong to state that someone, by virtue of making a decision of which others disapprove, automatically lacks capacity").