

Do Suicide Attempters Have a Right Not to be Stabilized in an Emergency?

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Abstract: The standard of care in the United States favors stabilizing any adult who arrives in an emergency department after a failed suicide attempt, even if he appears decisionally capacitated and refuses life-sustaining treatment. I challenge this ubiquitous practice. Emergency clinicians generally have a moral obligation to err on the side of stabilizing even suicide attempters who refuse such interventions. This obligation reflects the fact that it is typically infeasible to determine these patients' level of decisional capacitation—among other relevant information—in this unique setting. Nevertheless, I argue, stabilizing suicide attempters over their objection sometimes violates a basic yet insufficiently appreciated right of theirs—the right against bodily invasion. In such cases, it is at least *prima facie* wrong to stabilize a patient who wants to die even if they lack a contrary advance directive or medical order and suffer from no terminal physical illness.

Key words: suicide intervention, emergency medicine, forced treatment, involuntary hospitalization, respect for autonomy, bodily integrity

A Right Not to Be Stabilized in an Emergency?

The care of suicidal patients in the emergency setting raises profound and troubling moral issues. Arguably the most vexing of these concern adults who are taken to an emergency department after a failed suicide attempt and who subsequently refuse emergency stabilization.

It is a little difficult to estimate how many patients fall into this category in the United States today. In 2020, for example, 45,979 Americans died of suicide, and 1.2 million suicide attempts were reported—roughly 0.5% of the population—with over half of these (~627,000) among young adults aged 18–25¹. As far as I am aware, no full data on suicide attempts after 2020 exist. Yet according to a provisional report from the Center for Disease Control and Prevention, in 2021 the number of completed suicides increased to 47,646 people, up 4% from the previous year.² So, assuming that the rate of completed suicides to unsuccessful attempts remained roughly constant, preliminary data suggest not only that the number of people taken to an ED after a failed suicide attempt may be alarmingly high but also that it may be on the rise.

Stabilizing suicide attempters—even over their objection—is widely considered to fall within the standard of care, raising a familiar moral tension between respect for autonomy and beneficence. But this tension is even more acute in the emergency setting, perhaps the context in which the obligation to save the patient’s life most clearly appears to take precedence. My goal in this essay is to try to resolve this conflict—or, rather, to see to what extent it may be resolved.

The main question that I want to address, then, is whether suicide attempters who refuse life-sustaining treatment ever have a *right* not to be stabilized in an emergency—a right that overrides physicians’ presumptive obligation to stabilize them. Is it ever *wrong* to stabilize patients in this situation over their (apparent) objection? And if so, when and why it is wrong?

To answer these questions, I assess the merits of two views on the ethics of stabilizing suicide attempters: strong suicide interventionism and strong suicide anti-interventionism. I argue that both views ought to be rejected, proposing a moderate alternative that respects the disparate intuitions that support each. Like the strong suicide interventionist, I hold that, due to the unique epistemic barriers specific to the emergency setting, there is a strong default presumption in favor of stabilizing even suicide attempters who refuse all medical interventions, and that permissibly withholding care must meet a very high evidential bar. Yet like the strong suicide anti-interventionist, I also hold that suicide attempters have a right not to be stabilized in a range of cases that are neither purely hypothetical nor extremely unlikely to occur.

I offer an account of the grounds of this right and the conditions under which suicide attempters have it. On my own view, the right not to be stabilized in the emergency setting standardly rests not solely on the value of respect for autonomy but, rather, on the value of bodily integrity—hence, on our robust right against bodily invasion. The upshot of my discussion is that it is sometimes *prima facie* wrong to stabilize a suicide attempter even if she lacks a contrary advance directive or medical order and suffers from no terminal physical illness.

Treating Suicide Attempters over Objection in the Emergency Setting: The Moral Tension

B is a 75-year-old man who lives alone. He has no surviving family or friends. Retired for over a decade after working as a bricklayer most of his life, he initially took pleasure in refurbishing furniture. But in the last two years he has developed severe glaucoma and rheumatoid arthritis, which has left him unable to do so. He now spends his days idly watching old television shows. Severely depressed and no longer able to find meaning in his life, he decided one day to cut his left wrist with a hunting knife. He then lost consciousness for an unspecified amount of time.

He was soon found down by a neighbor, who called 911. EMS arrived to find him still actively bleeding and hypotensive, and so applied a tourniquet to control the bleed, started an IV, administered oxygen, and began monitoring his vital signs. He was subsequently taken to the emergency department at his local hospital, where clinicians packed his wound and held direct pressure. A Complete Blood Count test determined that he had lost a quarter of his total blood volume, and while he appeared anemic, he showed no clear signs of hypovolemic shock. He was given a blood transfusion to replace lost volume. After he awoke, he was alert and oriented and dispassionately refused emergency stabilization, reporting that he had no one and nothing to live for. His emergency care team believed that he had decisional capacity to refuse such treatment. Stabilizing him at this point would require surgically repairing the transected ulnar nerve along with associated blood vessels, in addition to continuing the aforementioned interventions.

Should the emergency clinicians stabilize B? On the one hand, it is standardly accepted that a decisionally capacitated patient has a strong presumptive right to have her refusals of even life-sustaining treatment heeded. This right follows from the principle of respect for autonomy, and it (almost?) always overrides clinicians' obligation to benefit their patients. Infringement of that right amounts to a violation of the foundational requirement that patients be treated only with their voluntary, informed consent. Forced treatment is thus unjustifiable paternalistic interference with a patient's private decision-making. But then it is wrong to stabilize B despite his emergent condition, in light of his (decisionally capacitated) refusal. On this view, then, which I call *strong suicide anti-interventionism*, it is wrong to stabilize a decisionally capacitated patient who has attempted suicide and who subsequently refuses emergency stabilization.

On the other hand, the principle of beneficence seems also to yield a strong obligation for emergency clinicians to stabilize suicide attempters even despite their refusals of treatment. For

while obligations of beneficence normally give way to those of respect for autonomy, it might be thought that the care of suicide attempters in the emergency setting is exceptional. It may be doubtful that such patients have decisional capacity to refuse life-sustaining treatment to begin with, and emergency clinicians may be laboring under such uncertainty, with such high stakes, as to make it reasonable for them to err on the side of providing care in any case. Thus, the obligation to respect suicide attempters' refusals of care is either inapplicable or, due to the distinctive complexion of the emergency department, eclipsed by the obligation to save their lives. If so, it is at least permissible to stabilize B over his objection; indeed, it would be wrong not to do so. On this view, which I call *strong suicide interventionism*, it is not only permissible but obligatory to stabilize all patients who attempt suicide and who then refuse such measures.

The standard of care in the U.S. today seems overwhelmingly to favor the strong suicide interventionist conviction. That conviction appears to be enshrined in the American medicolegal landscape. Not only does one the key injunctions of the Emergency Medical Treatment and Labor Act of 1986 call for the stabilization of all patients brought to an emergency department, presenting a danger to oneself—e.g., suicide attempt—is taken to justify involuntary treatment. But strong suicide interventionism is also woven into the culture of emergency medicine itself. Per Richard Heinrich and colleagues, emergency care is guided by “the doctrine of ‘implied consent in an emergency’ which holds that in an emergency, when informed consent or refusal of care cannot be obtained, one should provide emergency treatment that a reasonable person would want in the same clinical circumstances.”³ And suicide attempters are assumed to be so profoundly irrational as to be incapacitated, due to a presumed psychiatric pathology, that it is thought to be unnecessary or impossible to obtain their consent before treating them. This general presumption of emergency medicine is aptly summarized by Jay M. Brenner and

colleagues: “If a patient is suicidal, it is the provider’s primary duty to ensure their safety, including detaining the patient for psychiatric treatment. Involuntary mental health treatment is indicated for actively suicidal patients, who are presumed to lack decision making capacity.”⁴

At any rate, the moral tension in our practice of stabilizing suicide attempters over objection requires further analysis. It is disconcerting that this policy is often regarded as holy writ. Respect for patient autonomy is correctly recognized as a cornerstone of medical ethics, making the *prima facie* case for strong suicide anti-interventionism difficult to dismiss, at least. Moreover, while emergency stabilization measures may be less invasive (e.g., oxygen therapy via a canula or mask, provision of medications or other IV fluids) they can also include very invasive interventions (e.g., intubation, cardiopulmonary resuscitation, emergency surgery). There is a very real possibility, then, that the current standard of care for suicide attempters in the emergency setting is morally problematic. It is this possibility that calls for a much closer look.

I will first examine the case for strong suicide interventionism, then consider the case for strong suicide anti-interventionism. Even though these views do not exhaust the space of extant positions on the subject, we stand to learn quite a bit about the contours of the debate from exposing their strengths and weaknesses. But, first, some clarifications are necessary.

While our topic is related to the morality of euthanasia and physician-assisted suicide, I ignore these other practices for the sake of a streamlined discussion. Clinicians who honor suicide attempters’ refusals of life-sustaining treatment in the emergency setting, thereby letting these patients die, do not intentionally end their lives, nor, in my view, do they assist them in ending their own lives. Likewise, I remain silent on the question of whether such patients, once stabilized, have a right to make themselves DNR/DNI. My topic, then, is narrow: do suicide attempters who refuse care have a right not to be stabilized? Finally, I will use the term

‘emergency medical condition’ to refer to a medical condition that is reasonably expected to lead to a person’s imminently coming to severe, especially fatal, harm. Accordingly, as I will understand it, *emergency stabilization* (or ‘stabilization’, for short) is the activity of (attempting to) resolve a patient’s emergency medical condition by means of medical interventions. I largely focus on emergency stabilization techniques intended to neutralize the risk of imminent death.

The Case for Strong Interventionism: Decisional Incapacity and Permissible Paternalism

There are two main reasons for taking strong suicide interventionism to be the more credible view. The first is that patients who have attempted suicide generally lack decisional capacity to refuse life-sustaining treatment, often due to a severe underlying mental illness. But even assuming that they are decisionally capacitated, it is typically infeasible—indeed, dangerous to the patients themselves—to properly assess their level of capacitation in the emergency setting.

Although suicidal intention may not *itself* be decisive evidence of lack of decisional capacity, even vis à vis the decision to refuse life-sustaining treatment, it may constitute strong evidence of the presence of a mental illness—such as severe depression—indicative of decisional incapacitation. A systematic review, for example, discovered that people with severe depression are often unable to appreciate the significance of the consequences of accepting or refusing treatment.⁵ Specifically, as Ayesha Rachel Bhavsar has argued, depression “may severely restrict cognitively significant properties such as a person’s ability to rationally weigh information with personal values, goals, and interests,” and thus “there must be significant burden on the clinicians to evaluate and determine decisional capacity in the specific context of attempted suicide.”⁶ Similar points can be made about other severe mental illnesses, such as schizophrenia, which tends to hamper the same abilities.⁷ Moreover, even if a suicide attempter’s decisional

capacity is not compromised by severe mental illness, the effects of the trauma sustained may likewise be incapacitating. So, even if a patient is reported to be awake and alert, substantial blood loss (say) can easily lead to hypovolemic shock, engendering drowsiness and confusion in a mentally healthy patient.

Additionally, according to the sliding scale model, the stringency of evidential standards for determining decisional capacitation varies with the risk to the patient, so that a higher bar must be cleared when their refusal of treatment would present a greater risk to her.⁸ It follows that a suicide attempter refusing emergency stabilization must clear a *particularly* high evidential bar to be deemed decisionally capacitated in the relevant respect.⁹ The problem is that it is often hazardous to the patient to assess decisional capacity in the emergency setting given that she may die or severely deteriorate if care is delayed. What is more, clinicians tend to be neither confident in their ability to assess decisional capacity nor sufficiently adept at doing so.¹⁰ Thus, the high evidential standards for demonstrating decisional capacity to refuse life-sustaining care will often go unmet, giving emergency clinicians a strong reason to stabilize suicide attempters first and assess capacity later. To do otherwise is to expose the patient to unacceptably great risk.

Let us suppose, though, that it is known to the emergency care team—with a high degree of rational confidence—that the patient has relevant decisional capacity. Does that imply that it would be wrong to stabilize her over objection? We may think not, and this point brings us to the second reason for accepting strong suicide interventionism: that it is not wrongly paternalistic to stabilize patients whose suicide attempts are either impulsive or based on false information.

As background to this claim, I note that, per a study on suicide survivors, roughly 78.3% of people who attempted suicide and survived demonstrated no all-in regret about their survival, and 90% of such patients did not go on to die by suicide later on.¹¹ Moreover, there is some

evidence that those who attempt suicide do not deliberate carefully before deciding to end their lives and that they make this choice impulsively. According to a further survey of suicide survivors, for instance, 24% of respondents spent less than 5 minutes deliberating prior to their suicide attempt, while 24% spent 5–19 minutes and 23% spent 20 minutes to an hour.¹²

These data constitute only partial evidence, of course. After all, they pertain to people who have survived their suicide attempt and have retained substantial cognitive function, not to those who completed suicide or those who survived but suffered severe neurological damage. Still, these data suggest that a significant proportion of suicide attempters sometimes lack firm intentions to end their lives and that their decision is frequently made in the heat of the moment. The fact that over half of adults who attempt—but do not complete—suicide are young (i.e., 18–25) may only make it clearer that many suicide attempts are, in fact, impulsive decisions.

The typical psychological profile of people who attempt suicide is morally significant in this context. We can grant that it is wrongly paternalistic to treat a patient against her will, even if doing so is necessary for saving her life. But it might be argued that the data canvassed so far indicate that, in a significant proportion of cases, stabilizing a suicide attempter who refuses life-sustaining care may not even amount to treating her against her will, strictly speaking. For the patient's intention to end her life may be transitory and may therefore not reflect that person's deeper values, with which her will is rightly identified. And although treating a patient in contravention of her deeper values—hence, their will—is clearly wrongful, the moral objection to treating a patient in contravention of her momentary wishes is far weaker, particularly when the realizations of her wishes would inflict upon her the severe and irreversible harm of death.

In other words, it may be thought that stabilizing suicide attempters over objection constitutes *soft paternalism*: roughly, restricting a person's freedom for her own good when her

action is (for all we know) based on inadequate information or due to compulsion. Stabilization amounts to soft paternalism if the patient has attempted suicide out of a false belief that the only way to end her suffering is through death. Or it may constitute *weak paternalism*: roughly, restricting someone's freedom for her own good when her prospective choice of means would defeat her own ends. Stabilization counts as weak paternalism if the patient's suicide attempt is impulsive and may not reflect her deeper values or judgments about what is best for her. The point is that both soft and weak paternalistic interventions are far easier to justify than forms of paternalism that consist in interfering with the patient's goal *because that goal is mistaken or bad* (for her). Stabilizing suicide attempters over objection might then be morally justified in the emergency setting, particularly because the alternative to doing so is to let the patient die.

Furthermore, the factors that make assessing decisional capacity in the emergency setting infeasible apply here, too, *mutatis mutandis*: it is typically difficult or impossible to determine just how persistent a patient's intention to die is in the rush of emergency care, at least without endangering her life. As Kenneth points out, emergency clinicians often lack access to such vital data about their patients as their medical history, diagnosis for current illness, prognosis, and treatment preferences.¹³ Why, then, expect them to be in a position, generally, to know whether a suicide attempter's intention to end her own life is sufficiently persistent? So, we may think, in the absence of strong (and feasibly attainable) evidence that the patient's intention to die is enduring, it is obligatory for the emergency care team to err on the side of stabilization.

Emergency stabilization is, therefore, not wrongly paternalistic at all. Far from constituting an infringement of the patient's autonomy, in fact, stabilization measures are not only consistent with, but even expressive of, the deepest respect for her autonomy. Per strong suicide interventionism, then, it is not only permissible but obligatory for emergency clinicians

to stabilize B. Add to these considerations the fact that completed suicide devastates the victim's loved ones—often leading them to experience greater suicidal ideation, social stigma, guilt, feelings of abandonment, and “complicated grief”—and emergency clinicians' obligation to err on the side of life appears to be crystal clear.¹⁴ Rather than abandoning suicide attempters to a premature, hastily decided death, we may think that as a society we morally ought to address the social factors that heighten the risk of suicidality, such as social isolation, discrimination, reduced access to healthcare, community violence, and the widespread availability of firearms.¹⁵

The preliminary case for strong suicide interventionism is, therefore, quite robust, so it is no surprise that it is the received view in emergency medicine. Views in the general vicinity are ably defended by some bioethicists as well. According to Dieneke Hubbeling, it is permissible, even obligatory, to stabilize a patient who refuses care only if (a) they are treated on an initial basis, (b) the threat to them is severe, and (c) they retrospectively agree with the decision to treat.¹⁶ John R. Clarke and colleagues hold that it is permissible to stabilize patients who refuse care only if their refusal does not meet a reasonable person standard.¹⁷ And Richard Heinrich and colleagues argue passionately that emergency clinicians morally ought to stabilize even suicidal patients with advance directives that exclude such measures.¹⁸ If the case for strong suicide interventionism is so compelling, what reason could there be for embracing an alternative?

The Case for Strong Anti-Interventionism: Exceptional Cases and Bodily Autonomy

The argument for strong suicide anti-interventionism rests on two planks. First, there are exceptional cases in which the high evidential standards for permissibly withholding stabilization measures are either met or mooted. Second, stabilizing a decisionally capacitated patient who

refuses such care does indeed involve violating her autonomy—a wrong that is quite serious in itself but that becomes even morally worse when it prolongs unbearable, intractable suffering.

Start with the first point. We might agree that in a majority of cases it is impossible to determine two relevant facts about suicide attempters who refuse stabilization measures in the emergency setting, at least without endangering these patients: (1) whether they have decisional capacity to refuse emergency stabilization and (2) whether their suicidal intention is persistent. In such cases, it seems quite plausible that emergency clinicians ought to err on the side of stabilizing patients even over their (apparent) objection. But this policy is only a rule of thumb, to which there are fairly clear-cut—albeit probably rare—exceptions, and it is sheer rule-worship to insist on stabilizing an unfortunate patient who find herself in such an exceptional case.

Consider the following clinical case, which, I submit, constitutes just such an exception.¹⁹ C is a 60-year-old, newly incarcerated man serving twenty-five years in a high-security prison. His only living family member is his son, from whom he has been estranged for decades. He has lived with depression and PTSD since childhood, when he was sexually abused by his father.

Before his imprisonment, C found his symptoms to be relatively manageable. But in his new environment he reports feelings of intense sadness and hopelessness, as he is often the victim of violence, particularly sexual violence. He has attempted suicide eight times over the last year, sometimes stabbing himself in the abdomen with a sharpened toothbrush or shiv and other times hoarding prescribed medications for whole months and taking them all at once.

Most recently, C took a potentially fatal dose of tricyclic antidepressants. Hypotensive and presenting with ventricular tachycardia in the prison infirmary, he is promptly given a fluid bolus and sodium bicarbonate intravenously so that he can be transferred to the ED at a nearby hospital for a higher level of care. He is awake, alert, and oriented upon arrival to the ED,

although he slurs his words and appears to exhibit depressed respiration. As after past suicide attempts, he refuses all medical interventions, telling his clinicians that he wants to die. The emergency care team and consulting psychiatric team continue to agree that, despite his recurrent suicidality, he has decisional capacity to refuse life-sustaining treatment. Because C came to the ED an hour post-overdose, stabilizing him would involve providing him with activated charcoal and a high-flow nasal canula, as well as continuing bicarbonate therapy and cardiac monitoring.

Now the emergency care team is in a position to know two relevant facts about C without subjecting him to an unacceptable risk of harm. For one, they can know that C has decisional capacity to refuse life-sustaining treatment, despite his history of depression. As Brent Kious and Margaret Pabst Battin point out, we should not overestimate the incapacitating effects of mental illness, which are sometimes episodic and sometimes only affect the patient's decision-making abilities narrowly rather than globally, leaving their values and their reasoning intact.²⁰ So, even if suicidality constitutes evidence of decisional incapacity, that evidence is clearly defeasible.

Moreover, though, in light of his previous suicide attempts and the circumstances in which he lives, C's emergency care team can know that his suicidal intention is overwhelmingly persistent, not the upshot of a transitory impulse. Indeed, the emergency care team can even know that, far from being rooted in a pathological distortion of his reasoning or his values, his desire to die is, in fact, an intelligible—perhaps even reasonable or appropriate—response to circumstances that are both unbearable and highly likely to remain so going forward. Thus, in C's case, the high evidential standards for permissibly withholding care are met. Even by the lights of strong suicide interventionism, the emergency care team is permitted to withhold care.

We can imagine variations on C's case in which the evidential standards for permissibly withholding care are not met but mooted. Suppose that prior to his incarceration C had decided

to complete an advance directive ruling out emergency stabilization, or that he had managed to make himself DNR-DNI. Let's imagine that C then arrives in the emergency department with a valid advance directive or medical order specifying that he not receive the interventions that, it now turns out, are necessary for sustaining his life. In that case, it is, at least, permissible not to stabilize him. This is true regardless of his current level of decisional capacitation or the solidity of his suicidal intention. All that matters is whether he had decisional capacity when he completed the advance directive or medical order, and suicidality is not proof of incapacitation.

But a more strongly anti-interventionistic conclusion seems warranted: that stabilizing C would be *wrong*. And this brings us to the second point. It is commonly accepted that, as Julian Savulescu puts it, people “have the right... to refuse benefits or to engage in risky ventures. We do not believe that a person ought to be compelled to do what is best for himself.”²¹ This anti-paternalistic conviction is associated with John Stuart Mill, who held that “over his own body and mind, the individual is sovereign,” such that it is presumptively wrong to constrain a person's liberty in order to promote her own good or even to spare her great harm.²²

In consequence, a decisionally capacitated person has a right to settle for herself such intimate questions as whether she will continue living (particularly, perhaps, in conditions that she finds unacceptable) or whether she will die prematurely instead. It might be thought that a patient's right to refuse unwanted medical treatment is grounded in a broad right of this kind, violation of which is wrong because it is an infringement upon her protected sphere of private decision-making about her own body. If so, then stabilizing a decisionally capacitated patient who refuses all medical interventions constitutes an invasion of privacy of this kind.

Stabilizing C in particular is wrong, then. According to strong suicide anti-interventionism, indeed, it is wrong for the very same reason that it is wrong to treat a non-

suicidal patient who refuses life-sustaining care over their objection. Thus, strong suicide interventionism can be convicted of employing an illicit double standard for suicidal and non-suicidal patients, denying the former the same rights enjoyed by their non-suicidal counterparts.

Stabilizing C is wrong for an additional reason: doing so prolongs suffering that is both unbearable for him and recalcitrant to further interventions. So, not only does stabilization interfere with the patient's freedom, on a discriminatory basis, it also perpetuates harm. It is morally bad enough to curtail someone's freedom, even for her own good, but it is morally worse to thereby trap her in a condition that she finds unacceptable and, certainly, that is bad for her.

It is somewhat more difficult to find statements of strong suicide anti-interventionism in the bioethical literature, but there are some noteworthy defenses of it (or of similar views). Anne-Cathrine Naess and colleagues argue that it is wrong to stabilize a decisionally capacitated patient who refuses treatment, although they doubt that any definite set of guidelines can be produced.²³ And while Savulescu does not aim to articulate the rights of patients in the emergency setting specifically, what he does say appears to favor the position that it is wrong to stabilize patients who refuse care because doing so paternalistically interferes with their liberty.²⁴ More generally, although full-throated defenses of strong suicide anti-interventionism are rare, the view nevertheless seems to follow from anti-paternalistic convictions commonly accepted by bioethicists, along with empirical facts about the effects of suicidality on decisional capacitation.

Anchoring a Moderate Suicide Interventionism in the Right Against Bodily Invasion

Despite their merits, strong suicide interventionism and strong suicide anti-interventionism ought to be rejected. But they each hold half the truth about the ethics of emergency suicide intervention. By appreciating their flaws, we can find our way to a more plausible view that

balances a suicide attempter's claim not to receive forced treatment with their claim not to be allowed to die due to their decisional incapacity or by deference to their momentary desires.

The main flaw in strong suicide anti-interventionism is that it problematically fetishizes respect for liberty of action. It is deeply counterintuitive to think that it is wrong to stabilize any decisionally capacitated patient who refuses such measures, regardless of how short-lived or unreasonable their intention may be. Savulescu, for example, is too quick to dismiss the relevance of these considerations, as when he writes that if a suicidal patient wants to live after receiving treatment, her change of heart "does not imply that her original judgment was wrong, or that she should have been coerced out of it. It may merely show that desires can change."²⁵ There is a more accurate takeaway from at least some of these cases, however: that the patients in question may not have a stable desire to end their lives but only a momentary wish. Emergency clinicians are under no ironclad obligation to defer to such wishes.

Indeed, it is perfectly odd that the moral threshold for permissibly withholding life-sustaining care would be so low in the emergency setting when we tend to think that it is higher elsewhere. In non-emergent settings, clinicians do not unhesitatingly defer to the wishes of a patient who refuses life-sustaining care, but remain alert to signs that their refusal is rash or otherwise irrational and try to persuade them otherwise if such signs arise. Refusals of care that fail to meet a standard of minimal reasonableness may even be taken as evidence that the patient lacks decisional capacity. The strong suicide anti-interventionist ignores the matter of just how stable and reasonable the patient's suicidal intention is. Yet these facts are surely germane to the question of whether it is permissible or wrong to withhold emergency stabilization measures.

Strong suicide interventionism, on the other hand, suffers from two quite different issues. First, while in the vast majority of cases the high evidential standards for permissibly

withholding life-sustaining care in the emergency setting are not met by suicide attempters, they can be and are met in a handful of real-life cases, not just in thought experiments. Sometimes it can be known, with a sufficient degree of rational confidence and without endangering the patient, that (a) a suicidal patient has decisional capacity to refuse life-sustaining care and that (b) his suicidal intention is both stable and reasonable. Perhaps this is only true in a tiny fraction of cases encountered in clinical practice, but it is true nevertheless, as in the case of C. Generally, it is more likely to be true of patients who attempt suicide multiple times and whose medical profiles will therefore be well known to the clinicians treating them. In such cases, the strong suicide anti-interventionist is correct to insist that stabilizing over objection is wrong.

Stabilizing a suicide attempter who refuses all life-sustaining care is even more clearly unjustified when they have an advance directive or medical order ruling out such care. Thus, Richard Heinrich and colleagues are incorrect to claim that in such cases “emergency physicians should not recognize the validity of advance directives, or a patient’s previously expressed preferences to forego life sustaining treatment,” on the grounds that so recognizing them

would not serve the vast majority of suicidal patients who are treated aggressively, survive, and ultimately are grateful for receiving appropriate treatment of their depressive illness, or who are remorseful for having behaved impulsively during a situational crisis.²⁶

Suicidality does not, by itself, divest these documents of all binding force, nor does it empower well-intentioned clinicians to violate decisionally capacitated patients’ autonomy, not even to save their lives. To fail to recognize their authority is to unjustly deprive suicide attempters of

the inalienable right to refuse medical treatment. Furthermore, while such documents sometimes expose patients to an unacceptable risk of premature death, this risk may be mitigated by carefully drafting their conditions, and the significance of that risk must be assessed alongside that of the risk of forced treatment. There is no justification for a blanket policy of ignoring suicide attempter's stated treatment preferences, still less advance directives or medical orders.

Nor is stabilizing a suicide attempter always tantamount to soft or weak paternalism. In the case of C, for instance, it is a stretch, at best, to claim that stabilization was necessary to check whether his suicide attempt was voluntary, and specifically whether his wanting to end his life was based on the false belief that death was the only way to end his suffering (without unduly burdensome interventions). The tragedy of C's case, unfortunately, is that the belief in question appears to have been *true*. And he could hardly be accused of attempting suicide impulsively; indeed, he had exhibited a pattern of such attempts. Thus, stabilizing him constitutes *hard paternalism*—roughly, restricting someone's freedom for her own good even when her prospective action would be substantially voluntary—as well as *strong paternalism*—roughly, restricting someone's freedom for her own good when the goal of her prospective action is mistaken, bad, or harmful to her. Yet both hard and strong paternalistic interventions are exceedingly difficult to justify in the clinical setting, even when their aim is to prolong life.

So, the second flaw in strong suicide interventionism is that although it appreciates the moral risk of letting a patient die who is decisionally incapacitated or momentarily suicidal, it underrates the moral risk associated with stabilizing decisionally capacitated patients who reasonably refuse such care. If we take the latter risk seriously, as we ought to, we will be led to embrace a more moderate suicide interventionism. Truth be told, though, it is unclear how, exactly, to characterize the wrong of stabilizing a capacitated patient over objection. Savulescu

claims that the problem with “do-gooders” who provide suicide attempters with life-sustaining treatment against their will is that the good thereby done is “unwanted” by them.²⁷ Yet this seems like an altogether meager basis for objecting to the stabilization of suicidal patients.

According to Michael Cholbi, who defends a version of moderate suicide interventionism, the main moral objections to wrongful suicide intervention measures are the harm that they cause and the fact that they paternalistically interfere with the suicide attempter’s liberty or autonomy.²⁸ Suicide intervention, in his view, is permissible when the at-risk person is profoundly irrational (so that there is no interference with her judgment/will) and likely to severely harm herself. While Cholbi’s account is nearer to the mark than Savulescu’s, I take the main moral objection to common means of stabilizing capacitated suicide attempters against their will to be different from, but related to, paternalistic interference with their autonomy.

Consider the more straightforward case of treating a decisionally capacitated yet non-suicidal patient over their objection. What is the core wrong of such treatment? I propose that forcing treatment on a decisionally incapacitated patient is commonly wrong, first and foremost, because it is a violation of her bodily integrity, not just of her autonomy. Let me explain.

In many cases, forced treatment constitutes a *bodily invasion*: the act of crossing the material boundaries of a person’s body—her flesh—or otherwise entering the interior of her body, without her consent.²⁹ Invading a person’s body is always morally risky, indeed very often morally objectionable. In some cases, of course, forcing treatment on such a patient does not obviously involve invading her body at all, in my sense—for example, repositioning someone for airway management. If treatment of this kind is wrong, it might be wrong simply because, say, it violates the patient’s (bodily) autonomy or inflicts distress on her. My claim, though, is that whenever forcing treatment on a decisionally capacitated patient is wrongful and amounts to an

invasion of her body, then the core wrong of such treatment is *due to its constituting a bodily invasion specifically*. Forcing treatment on a decisionally capacitated patient in a way that amounts to an invasion of her body is nevertheless often wrong for other reasons as well, such as that doing so interferes with her liberty of action or causes her bodily/psychological harm.

We have a strong presumptive right against others that they not subject us to bodily invasion. It is our right not to have our body invaded that grounds the right of a decisionally capacitated patient to refuse standard forms of (even life-sustaining) medical treatment. That right is not solely grounded, I claim, in the value of autonomy generally or in decisional privacy.

So, circling back to our main topic, a person does not waive the right not to have her body invaded—hence, the right not to have treatment forced on her—just by dint of acting on a suicidal intention. A suicide attempter has a presumptive right not to be stabilized over her objection, then, particularly when stabilizing her would require invading her body—for example, providing B with a blood transfusion and operating on his wrist. Stabilizing her is wrong on much the same grounds as it would be to stabilize a decisionally capacitated yet non-suicidal patient who refused life-sustaining treatment. In this respect, the two cases are parallel.

Now the right against bodily invasion, while quite robust, is far from absolute, and it is normally curtailed by other rights of the patient's—chiefly, by her right not to be allowed to die in deference to a wish that is momentary or incapacitated. If strong suicide interventionism ignores the first right, strong suicide anti-interventionism ignores the second. Yet both rights must be taken into account. My diagnosis naturally invites the question of how a moderate suicide interventionism ought to balance these two rights, which sometimes appear to conflict.

On the moderate view that I favor, if a suicide attempter has a valid advance directive or medical order ruling out emergency stabilization measures, then it is wrong to so stabilize her,

regardless of her current level of decisional capacitation or the stability of her suicidal intention. Otherwise, it is morally obligatory to err on the side of stabilizing a suicide attempter who refuses such interventions—except when the following four conditions are met:

- (1) *Capacity Condition*: The patient has decisional capacity to refuse life-sustaining care.
- (2) *Stability Condition*: The patient's suicidal desire is (a) strong, (b) persistent, and (c) endorsed by her upon reflection—indeed, ideally, that the relevant desire accords with her deeply held values, values that shape and animate her life generally.
- (3) *Rationality Condition*: The patient's suicidal desire is a (a) rational response to circumstances that are (b) unbearable to her and (c) recalcitrant to further interventions that are themselves not unreasonably burdensome to her.
- (4) *Safety Condition*: There is strong evidence that the above conditions are met, and the evidence in question can feasibly be known to the emergency care team without endangering the patient's life or causing her severe bodily damage.

If these four conditions are met, the patient who refuses emergency stabilization has a right not to be stabilized, and it is at least *prima facie* wrong to override her refusal in an emergency.³⁰ Again, she also retains this right if she has a contrary advance directive or medical order.

The first and fourth conditions are straightforward. The second and third conditions, however, call for further commentary. Let me make two sets of points by way of clarification.

Start with the Stability Condition. Let's say that suicidal desire is *strong* if and only if it reliably disposes the patient to certain actions or attempts, (action-oriented) thoughts, and feelings—for example, attempts to try to end her own life, thoughts of bringing about her death, and feelings of distress at the prospect of continued existence. Such a desire is *persistent*, moreover, if and only if it remains within her motivational set over an extended period of time rather than just on a momentary basis. Admittedly, there is no very precise way to measure the strength and persistence of a person's suicidal desire. That said, if a patient's desire to end her life moves her to attempt suicide on multiple occasions—and, further, if it continues to be endorsed upon reflection after each such attempt—then the Stability Condition is met.

Now onto the Rationality Condition. A patient's circumstances qualify as *unbearable* if and only if it is difficult or impossible for her to tolerate them, such that those circumstances (or attempts to alter them) tend to undermine the patient's ability to engage in pursuits that she finds sufficiently satisfying or meaningful. The patient's desire to end her life constitutes a *rational* response to those circumstances, moreover, if and only if they give her sufficient reason to want to die.³¹ Finally, the patient's situation must be *recalcitrant* to further (and not unreasonably burdensome) interventions in a sufficiently broad sense. By "interventions" I have in mind medical interventions (e.g., mood-stabilizing drugs) and non-medical interventions (e.g., regular conversation with one's children), actions on the part of the care team (e.g., electroconvulsive therapy) and on the part of the patient herself (e.g., increased contact with friends). If none of these interventions is likely to alter the patient's unbearable situation—for example, if they have all been tried and have proved to be inefficacious—then the Rationality Condition is met.

All four conditions are met in C's case. Not only does he have (relevant) decisional capacity, he also has a strong, persistent, and reflectively endorsed desire to end his life—a

desire that has moved him to do so multiple times. Furthermore, in the sense just specified, this desire is a perfectly rational response to a situation that is unbearable to C and that is, unfortunately, likely to remain so despite the interventions of C himself (or others on his behalf). It follows that C has a right not to be stabilized by his emergency care team. More generally, then, it is sometimes permissible to withhold life-sustaining treatment from a suicide attempter who suffers from no terminal physical illness. Indeed, it may be seriously wrong *not* to do so.

Conclusion: Three Objections Addressed

I have recommended rejecting two radical views concerning the ethics of emergency suicide intervention: on the one hand, the view that it is always wrong to stabilize a decisionally capacitated patient who refuses such treatment after a suicide attempt, and, on the other hand, the contrary view that it is always obligatory to stabilize a patient over her objection in this situation. As against both views, I have recommended a moderate suicide interventionism. While emergency clinicians ought generally to err on the side of stabilizing even suicide attempters who refuse all (life-sustaining) medical interventions, I have argued that it is sometimes wrong to stabilize them, because doing so violates their right against bodily invasion—a core right of theirs. I have also specified four conditions that normally defeat the presumptive obligation to save these patients' lives, even in the absence of a contrary advance directive or medical order.

It should be emphasized that my view does not constitute a tidy algorithm for deciding on particular emergency suicide interventions. It yields no decision procedure that might be neatly applied to any given case to determine whether a proposed intervention is right or wrong. Matters in this corner of emergency medicine are too complex for such sleek operationalization. I have sought only to identify some of the main factors that suspend the default obligation to

stabilize suicide attempters who refuse care. Ultimately, the moral valence of particular emergency stabilization measures depends on a mosaic of considerations, including the invasiveness and riskiness of the intervention along with the prognosis of the patient.

It is also important to stress that implementing my view in clinical practice does not obviate the need for enhancing and expanding mental health services, including support for suicidal individuals in particular. Far from it. For one, on general grounds of harm-prevention, the state has an independent obligation to improve the quality of these potentially life-saving services and to increase access to them (perhaps particularly for incarcerated or otherwise marginalized people), as well as to address the various social determinants of suicide risk mentioned previously. This obligation is not undercut or weakened by recognizing a limited right not to be stabilized after a suicide attempt. Indeed, for all I have said, it may even be that recognizing such a right *strengthens* the obligation to provide greater support for people who are more likely to be suicidal, so as to reduce the risk of premature death in this already vulnerable population. My view is compatible with this stronger conclusion but does not necessarily require it. In any case, evaluating this proposal is beyond the scope of the present discussion.

In closing, I would like to address three objections to the account that I have presented.

On the first objection, moderate suicide interventionism cannot be implemented in the emergency setting, as it is incompatible with well-established protocols and entrenched cultural norms that prevail in the ED. For one, it is common to override patients' refusals in various ways in this setting, sometimes simply to gather evidence concerning the nature and severity of their medical condition—for instance, by removing their clothes to view any injuries that they might have sustained or by administering rectal exams to check for bowel injury in trauma patients. Emergency clinicians are also frequently hesitant to assess decisional capacity in the context of a

patient's refusal of life-sustaining treatment, and they may feel that it is an unreasonable burden on them to decide whether to honor such refusals, particularly in light of potential legal liability. These data suggest that moderate suicide interventionism may not be feasible in practice.³²

In reply, I want to point out that the cases that I have in mind are exceptional, not least because the usual epistemic barriers are absent. Indeed, that is why I have focused on suicide attempters who have presented to the ED after multiple suicide attempts and whose condition, though emergent, is not so life-threatening that they will die immediately without care. (On these grounds, the reasons for honoring B's refusal of care are weaker than the reasons for honoring C's.) In these cases, the emergency care team may take two steps to lessen the burden: (1) it can avail itself of the input of multidisciplinary committees before the next such attempt, which may help the team formulate a plan, and (2) because the patient will not die immediately, it can also engage a consulting psychiatrist to support the primary team's initial capacity assessment.

According to the second objection, an emergency clinician who sincerely opposes suicide is permitted to refrain from honoring a suicide attempter's refusal of emergency stabilization on grounds of conscientious objection. For if a physician with a deeply held conviction that, say, abortion is wrong is not normally obligated to provide this treatment, then, by parity of reasoning, an emergency clinician should not be obligated to withhold needed care, either. Thus, a suicide attempter who refuses life-sustaining treatment has no strong right not to be stabilized.

Cholbi responds to a similar argument by comparing two patients who refuse life-sustaining care in order to end their lives: (a) someone who severely harms herself because she is suicidal, and (b) someone who is suicidal because he has been severely harmed by accident.³³ We agree that the second patient is entitled to have his refusal of life-sustaining treatment respected by his clinicians. But then why wouldn't the first patient be similarly entitled? A

conscientious objector who denies that the first patient is places a lot of moral weight on the fact that her desire to die is the *cause* of her injury while the second patient's desire to die is the effect of his injury. Yet, Cholbi claims, that difference is arbitrary from a moral point of view.

I believe that an even stronger response to the second objection is available, however. There is a more important difference between the physician who conscientiously objects to providing an abortion and the physician who conscientiously objects to honoring a suicide attempter's refusal of care. In stabilizing the patient over objection, the second physician *invades his body*, whereas, in omitting to abort, the first physician does not. Since bodily invasion is harder to morally justify—other things being equal—than mere inaction, the moral argument for conscientious objection to honoring the suicide attempter's refusal of care is significantly weaker than the moral argument for conscientious objection to abortion. Other things being equal, then, conscientious refusals to treat are less morally egregious than conscientiously forced treatment.

A third objection relies on the link between wrongdoing and appropriate blame. If my view is correct, then emergency clinicians who stabilize suicide attempters sometimes do wrong by them—namely, when the aforementioned four conditions are met or when these patients have a contrary advance directive (or medical order). But then it follows, apparently, that it would be appropriate for those patients to blame the clinicians who had saved their lives. Surely, though, blame is entirely out of place in this context. And if blame is generally inappropriate, then it seems less plausible that stabilizing suicide attempters over their objection is ever wrong.

In response, let me just say that while some suicide attempters who are stabilized over their objection will have grounds to blame their emergency clinicians, in practice blame will almost never be appropriate. In general, blame is rarely ever in order in contexts where it is extremely difficult to discern the right course of action or even the morally relevant facts, as

when emergency clinicians must respond to suicide attempters' refusals of life-sustaining treatment. So, blame will not generally be appropriate in such situations. But this fact only shows that stabilizing suicide attempters is typically excusable, not that it is typically permissible.

Emergency clinicians caring for suicide attempters routinely labor in a high-stakes environment under conditions of profound uncertainty, to be sure. But they also face tragic dilemmas pitting two of the highest moral values in medicine against each other, and, as a result, the clinical decisions that they are forced to make in this setting may haunt them regardless of the eventual outcome. When on rare occasions emergency clinicians do wrong by their patients, then, the most humane response is typically sympathetic understanding, not censure or blame. The moral fault lies seldom with them but, rather, with the current standard of care for suicide attempters who refuse life-sustaining care in the emergency setting. It is high time to correct it.

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is due entirely to my own negligence. Finally, I would like to thank Greg Kaebnick and three anonymous referees for the *Hastings Center Report* for vastly improving the manuscript.

Notes

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- ²⁷ Savulescu, op. cit., 110.
- ²⁸ M. Cholbi, *Suicide: The Philosophical Dimensions* (Peterborough: Broadview Press, 2011).
- ²⁹ In virtue of its nonconsensual nature, the invasion of a person’s body is a particular and especially morally salient species of autonomy-violation. There are autonomy-violations that do not constitute bodily invasions, however, such as some acts of coercion or deception or certain ways of physically restraining a person against their will. (Indeed, holding a patient down to prevent them from fleeing might constitute a violation of their bodily autonomy—roughly, their right to determine what they do with their bodies, within limits—without amounting to a bodily invasion.) In fact, I believe that bodily invasions are morally worse, other things being equal, than other autonomy-violations that do not constitute bodily invasions, but I will not—and need not—defend that claim here.
- ³⁰ Thus, the four conditions just presented are sufficient conditions for possession of the right not to be stabilized, not necessary conditions.
- ³¹ Two points. First, for the purposes of this discussion, I construe reasons for wanting to end one’s life in subjective terms, in the sense that their force depends on what the patient currently, stably values or cares about. Second, although in paradigm cases, a suicide attempter will have a right partly in virtue of the unbearable circumstances that they face in the present, I also want to allow that unbearable circumstances that they will face in the future could partly ground the right in question. So, for example, a patient with advanced dementia could reasonably judge that they will lose their mental faculties and that this loss will make their future circumstances irredeemably unbearable to them. I want to thank Nada Gligorov for raising this possibility to me in conversation.
- ³² Thanks to Jacob Mago for an illuminating discussion of the culture and protocols of the ED.
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