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The right to life in a suicidal state

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ABSTRACT

This paper considers when the State must take positive steps to protect the right to life of a suicidal patient. Using recent developments across the Council of Europe which challenge the traditional 'ugly Samaritan' approach of many common law systems, it contends that whenever and wherever public authorities know or ought to know of a real and immediate risk to the life of an identifiable person, they must take reasonable precautions to minimise it. Even J. S. Mill's approach to liberty, it is suggested, would tolerate this limited degree of State interference. However, notions of autonomy and dignity, the unpredictability of human behaviour, and the need to avoid unduly burdening the State must influence what it means to act reasonably.

1. Introduction

Suicide prevention may be a key national priority in many countries, but the common law of negligence has traditionally been reluctant to oblige the State and its citizens to prevent others from taking their own life. An individualist philosophy dissuades us from being our brother's keeper, preferring us to look after *our*selves and to take responsibility for *our* actions. Whilst legislation promotes good Samaritanism in certain parts of the world, the common law of negligence positively discourages it in others by rendering rescuers liable for bungling an intervention, despite their best of intentions.

Recent developments in human rights law are slowly realigning historically divergent legal and moral obligations towards those in a suicidal state of mind. This article will focus on the circumstances in which a suicidist's right to life may trump the law regarding omissions by positively requiring the State to intervene to preserve life. After analysing the concept of an "autonomous suicide" and its ethical boundaries, the civil liability for acts and omissions in the face of suicide shall be outlined and the 'ugly Samaritan' exposed. Attention will then shift to the interlocking human rights which bear upon notions of respect for physical and moral integrity, a dignified death, and the right to life. When must the State intervene to frustrate the intentions of an identified individual desirous of death in light of those competing principles?

The central thesis will be that whenever and wherever public authorities know or ought to know of a real and immediate risk to life to an identifiable person, they must take reasonable precautions to minimise it. In deciding what is reasonable and what precautions should be taken, the law must ensure that a disproportionate burden is not placed upon the State. Moreover, when the person is intent on suicide, precautionary reasonableness will also be heavily dependent upon the counterbalancing notions of autonomy and dignity. Some final thoughts will then be given to the difficulties arising from this positive operational duty and its future relationship with the law of negligence.

2. Are there limits to an "autonomous suicide"?

At common law, people are generally entitled to act as they please, even if death will inevitably result.[1] So competent adults have an absolute right to fatally refuse medical treatment[2] (Wicks, 2010) or to jump to their death.[3] Unless Parliament decrees otherwise, to compel us to live for longer than we wish will usually be a criminal and civil assault.[4] This stark legal position mirrors the libertarian ethical principle of non-interference. In legal terms, according to Justice Cardozo, 'every human being of adult years and sound mind has a right to determine what shall be done with his own body'.[5] Whilst in ethical terms, according to John Stuart Mill, '[o]ver himself, over his own body and mind, the individual is sovereign' and our 'own good, either physical

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[1] *Reeves v. Commissioner of Police of the Metropolis* [2000] 1 AC 360, at 379–380.
[2] *Airedale NHS Trust v. Bland* [1993] AC 789, at 865; *Re T* (*Adult: Refusal of Medical Treatment*) [1993] Fam 95, at 102; *In Re MB* (*medical treatment*) [1997] 2 FLR 426, at 432. Different considerations apply to minors.
[3] Suicide Act 1961 Section 1 (England and Wales) decriminalised the act of suicide: 'The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.' Whether this thereby created a 'right to die' is considered below.
[4] *St George's Healthcare NHS Trust v. S* [1999] Fam 26, at 62. Conversely, whilst a patient may refuse treatment, they cannot demand it: *R (on the application of Burke) v. General Medical Council* [2005] EWCA Civ 1003, at [50].
[5] *Schloendorff v. Society of New York Hospital* (1914) 211 NY 125, at 128.

or moral, is not a sufficient warrant' for intervention (Mill, 1859, p. 22). These often-cited legal and ethical perspectives sit comfortably side by side and portray the traditional notion of individual autonomy.

The consequences of respecting an autonomous decision are clearly gravest when people wish to suicide, whether by refusing life-saving treatment or by some other means.[6] But that gravity does not undermine the force of the principle: autonomy will hold firm. Arguably a fatal decision is when the principle is needed most. Ronald Dworkin, for example, described how '[w]e allow someone to choose death over radical amputation or a blood transfusion, if that is his informed wish, because we acknowledge his right to a life structured by his own values' (Dworkin, 1993, p. 239). Therein lies autonomy's intrinsic value. The Supreme Court of the United Kingdom has recognised the dominance of autonomy in death decisions: '[a]utonomous individuals have a right to take their own lives if that is what they truly want.'[7] Indeed, perhaps human freedom demands nothing less. Otherwise the very concept of human freedom is at risk of becoming merely illusory. This virtuous stance is of course heavily premised, both in law and in ethics, with at least four notes of caution: mental capacity, emergencies, harm to others and the competing bioethical principles.

First, mental capacity. The approach to autonomy of both Cardozo J. and Mill is premised upon the person having the mental capacity, or 'the ordinary amount of understanding' (Mill, 1859, p. 84), to make the fatal decision. However, opinions differ as to whether there can even be such a concept as an "autonomous suicide". Is suicidal ideation necessarily indicative of mental ill health? Or can a person competently decide to want to end their life? Ethical, psychiatric and legal views abound and space permits merely the briefest of insights into the debate. A standard reading of Immanuel Kant, for example, suggests that suicide is always irrational and unethical (Kant, 1964).[8] Whereas Thomas Schramme argues that suicide is not an immoral act and the desire to die may be rational when the person does not see a meaning in life (Schramme, 2013). In psychiatric circles, Beauchamp and Childress note that 'many persons who commit suicide are mentally ill, clinically depressed, or destabilized by a crisis and are, therefore, not acting autonomously' (Beauchamp & Childress, 2001, p. 189). Whereas Jeanette Hewitt contends that rational suicide may be a justifiable option for those with mental illness (Hewitt, 2013).

No doubt many who have suicidal intent are mentally unwell and in crisis. But many are not. Some people want to end their life prematurely – or shorten their prolonged death – for all sorts of reasons. Their state of mind should not *inevitably* be labelled as 'mentally disordered'. And those with a psychiatric diagnosis should not *inevitably* be assumed to lack the capacity to decide to suicide. The issue is, are they able to make that decision? Aside from mental disorder, all sorts of internal and external pressures may or may not influence one's ability to decide. Emotions, experiences, and environments may come to bear. But what matters is whether the person can decide *in spite of* those influences. The Death with Dignity Act 1997 in Oregon, for example, acknowledges that mental disorder may not automatically impair suicidal decision-making abilities but its presence may call for increased vigilance, routine psychiatric assessment and counselling before the person is assisted to implement their final decision.

The common law similarly recognises that the mentally ill are able to retain the ability to decide on matters of life and death.[9] The High Court of Australia, for example, noted that '[w]hile attempted suicide may be indicative of mental illness, it is not necessarily so'.[10] The Supreme Court in the United Kingdom has similarly acknowledged the wriggle room for autonomy between a psychiatric diagnosis and a capacitous suicidal decision: 'In the case of the suicide of a psychiatric patient, the *likelihood* is that, given the patient's mental disorder, her capacity to make a rational decision to end her life will be *to some degree* impaired'.[11] It shall therefore be taken as read that the concept of an "autonomous suicide" does exist, at least in legal if not also in ethical terms, for those with or without a psychiatric diagnosis.

The second note of caution surrounding the respecting of fatal decisions concerns emergency situations. Mill's liberal philosophy recognises that temporary intervention is justified in order to ascertain whether a person is acting autonomously. Drawing on his wayfarer example, if someone is about to jump from a cliff edge, Mill would no doubt permit a bystander to intervene to see whether the jumper has the 'ordinary amount of understanding' and to warn them of their impending peril. Even if they are acting autonomously, according to Mill '[t]here are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him' (Mill, 1859, p. 22). A useful legal illustration of this moral stance involved Mrs Z. She had an incurable degenerative brain disease. Her husband informed their local authority of her plan to travel to Zurich for suicide assistance. The High Court temporarily interfered by way of an interim injunction restraining him from removing his wife from the country whilst expert evidence was sought regarding her capacity to make the fatal decision. The day before the trip, the uncontested evidence was that she had 'all the requisite attributes necessary to establish legal capacity to make her own decisions'; the decision was entirely uninfluenced by outside considerations; and it was long-held and in the face of the contrary wishes of her family. The injunction was therefore lifted and Dignitas assisted her suicide. Reinforcing the individualist philosophy of the common law, the Judge held: 'This case simply illustrates that a competent person is entitled to take their own decisions on these matters and that that person alone bears responsibility for any decision so taken.'[12]

The third limit to the principle of non-interference is the recognition that power can be rightfully exercised over an autonomous person against their will in order to prevent harm to others. In particular, Mill accepted that if the person's actions violated 'a distinct and assignable obligation to any other person or persons, the case is taken out of the self-regarding class, and becomes amenable to moral disapprobation' (Mill, 1859, p. 145). This obligation to others need not be legal in nature; it could be moral. So Mill gives the example of a man who, having undertaken the moral responsibility of a family, becomes incapable of supporting them through intemperance or extravagance. The breaching of his moral duty towards his family and financial creditors, rather than the extravagance itself, would warrant interference with his autonomy. How might this relate to suicide? Clearly 'no person is an entirely isolated being' (Mill, 1859, p. 143) and an autonomous suicide is rarely an isolated act, immune from harmful repercussions. Others experience its aftermath. Emotional or psychological harm may be felt by family, friends, the community, and, let us not forget, those health and social care professionals with whom the person comes into contact. As with Mill's example, financial harm may also be caused to the suicidist's dependents and creditors. Such harmful ripples are readily foreseeable from the decisional epicentre of someone contemplating the taking of their own life. But do they give rise to a 'distinct and assignable obligation' that would justify suicide prevention?

Margot Brazier makes a strong case that patients owe ethical duties to others, including doctors: '[i]t is empowerment of patients which brings responsibilities' (Brazier, 2006, p. 401). Recognising these

[6] The courts tend to distinguish treatment refusals from suicide: *Airedale NHS Trust v. Bland* [1993] AC 789, at 864. Owing to its artificiality, no such distinction is drawn here where a treatment refusal results in immediate death: e.g. see *B v. An NHS Hospital Trust* [2002] EWHC 429 (Fam) where the patient made a competent request to have her ventilator switched off.

[7] *Rabone v. Pennine Care NHS Foundation Trust* [2012] UKSC 2.

[8] For an alternative understanding, see Cooley, D.R., 'A Kantian care ethics suicide duty' (2013) *International Journal of Law and Psychiatry*.

[9] Re C *(Adult Refusal of Treatment)* [1994] 1 All ER 819.

[10] *Stuart v. Kirkland-Veenstra* [2009] HCA 15, at [5].

[11] *Rabone v. Pennine Care NHS Foundation Trust* [2012] UKSC 2, at [30] (Lord Dyson) (emphasis added). Similarly, at [106] Lady Hale noted, '[Melanie's] mental disorder meant that she *might well* lack the capacity to make an autonomous decision to take her own life' (emphasis added).

[12] *A Local Authority v. Z* [2004] EWHC 2817 (Fam) at [21].