Suicide and the State: The Ethics of Involuntary Hospitalization for Suicidal Patients

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Suicide has been around for all of known human history, and organized community response to it has been around almost as long. In the past, people who were judged to be mentally unwell were thrown into insane asylums where abuses were rampant (Unzicker, n.d.). Now, there is a larger focus on therapeutic approaches within psychiatric institutions. However, the institution of involuntary commitment of a suicidal person to a psychiatric ward has remained. A person who is judged to be suicidal will, in California, be involuntarily contained in a locked psychiatric ward for three days. After the three-day hold is over, the hospital can choose to confine the patient for an additional 14 days. The patient can request a hearing in front of a judge to oppose the 14-day hold. However, the main source of evidence in this hearing is the psychiatrist, and if the patient is deemed a harm to him/herself by the psychiatrist, the 14-day hold is typically upheld (Los Angeles Superior Court, n.d.).

Involuntary commitment has a variety of consequences for the patient. The patient may realize that s/he did not, in fact, actually want to die, and may be grateful for the intervention. On the other hand, the patient may continue to feel suicidal, and may continue to desire death while the state continues to intervene to prevent this death. Additionally, the cost of an involuntary hospitalization can be a large burden for the patient and the patient's family, especially if the patient does not have health insurance or buys his/her own health insurance (private policies typically do not cover mental health services) (Shute, 2008). Patients who have been involuntarily hospitalized often feel a strong stigma associated with their hospitalization (Greenberg, 1974). Finally, philosophers do not agree about whether suicide should necessarily be prohibited, so it is unclear if involuntary hospitalization can be justified in all cases.

The issue of involuntary commitment can be broken down into three distinct moral dilemmas: 1) Does an individual have the right to commit suicide, 2) Does mental illness exist, and 3) Does the state's interest in suicide prevention allow it to intervene in any way?

In this essay, I will first present the argument that involuntary hospitalization is justified, and then I will present the view that involuntary hospitalization is never justified. Then, I will conclude that

involuntary commitment is sometimes justified, but that the rules governing the institution need to be dramatically altered.

Justification of Involuntary Hospitalization

Those who favor involuntary hospitalization would generally reject the right to suicide. The supposed right to suicide is a derivative right of the right to self-determination, but suicidal people are often irrational and therefore the right to self-determination is meaningless in this context; according to the *Stanford Encyclopedia of Philosophy*:

> Even if there is a right to self-determination which in turn implies a right to suicide, it seems to imply a right to commit suicide only when one's true self is making that determination, and there are numerous factors that may compromise a person's rational autonomy and hence make the decision to engage in suicidal behavior not a reflection of one's considered values or aims. (Cholbi, 23)

In this view, hospitalization is actually the way to uphold the right to self-determination, since preventing an individual from committing suicide likely brings the patient's actions in line with his or her true values.

The belief that suicidal behavior often goes against a person's "rational self" stems from the idea of mental illness. There are two definitions of mental illness: the strictly biological definition, and the "[More sophisticated] medical model [which] is characterized not only by organicity but also by being negatively valued by society, by 'nonvoluntariness,' thus exempting its exemplars from blame, and by the understanding that physicians are the technically competent experts to deal with its effects," (Chodoff, 1976, p. 498). Since there is currently no scientific consensus regarding a biological basis for depression (Leo & Lacasse, 2007), the second definition proves more useful in this case. Depression and suicidal tendencies are strongly linked, and depression can cause "individuals' attitudes toward their own death [to be] colored by strongly negative and occasionally distorted beliefs about their life situations (career prospects, relationships, etc.)" (Cholbi, 2009, p. 24). In the view of those who favor hospitalization, the cognitive distortions of those with depression are strong enough to constitute a self that is different than the suicidal person's true self, which in turn justifies the view that the right to suicide is not a derivative right of the right to self-determination.

Though those in favor of involuntary hospitalization would say that there is no right to suicide, it does not necessarily follow that involuntary hospitalization is right. Mill's Presupposition in Favor of Liberty (McGinn, *Liberty and J.S. Mill*, 2010) says that society must allow a person liberty unless allowing liberty clearly causes more harm than restricting liberty; therefore, society must show that the harm caused by suicide is greater than the harm caused by forced hospitalization. There are three principles of harm that apply to suicide: Mill's Harm to Others Principle, the Offense Principle, and the Legal Paternalism Principle.

The definition of Mill's Harm to Others Principle states that an action causes public harm when the action would undermine public institutions if it became prevalent (McGinn, *Liberty and J.S. Mill*, 2010); society

typically may justifiably prevent actions that cause public harm. If suicide were to become common, society as a whole, as well as many of society's institutions, would likely be undermined, as each suicide removes a potentially valuable moral actor from society and a potentially valuable worker from the market. Suicide can also cause private harm in the form of increased financial and extreme emotional suffering for surviving family members, sometimes even leading other family members to commit suicide (Teicher & Jacobs, 1966). Therefore, suicide violates Mill's Harm to Others Principle.

Suicide also violates the Offense Principle, which states that society may restrict an action that causes offense to others under certain conditions. In order for an act to be actionable under the Offense Principle, it must be non-trivial and non-transient, universally found offensive, and not reasonably avoidable (McGinn, *Lecture #5*, 2010). Almost everyone considers suicide to be non-trivial, and it is definitely non-transient (it is one of the most permanent actions one can make). In the United States, suicide is virtually universally found offensive (Ansel & McGee, 1971). Because our ubiquitous media often fervently reports suicides, hearing about a suicide may not be reasonably avoidable. Therefore, suicide is also actionable under the Offense Principle.

The Legal Paternalism Principle allows society to prevent a person from harming him/herself under certain conditions (McGinn, *The six LLPs, concluded*, 2010). One condition is that the harm a person is inflicting upon him/herself would be actionable under the Harm to Others Principle if another party were inflicting the harm upon the party in question. This condition is met because if someone else killed the suicidal person, it would typically violate his protectable interests. Another condition is that the harm a person is inflicting upon him/herself must be primarily self-regarding; if the harm is mostly harming another person then it is only actionable under the Harm to Others Principle. The action of suicide is usually primarily self-regarding. Finally, the harm a person is inflicting upon him/herself must not be fully voluntary; because of mental illness, suicide is probably not fully voluntary. Since suicide is highly actionable under several different principles, state intervention in suicides in the form of involuntary hospitalization is therefore justified according to this argument.

Argument Against Involuntary Hospitalization

Those who would eschew involuntary hospitalization altogether often begin by arguing for a right to suicide; therefore, "Attempts by the state or by the medical profession to interfere with suicidal behavior are essentially coercive attempts to pathologize morally permissible exercises of individual freedom" (Cholbi, 2009, p. 17). The right to suicide can be derived from the more fundamental right to self-determination, according to this view. This right is valid under any circumstances, because only an individual has the prerogative to decide when suicide is in his/her best

interests, but it may be subject to "bounded exceptionlessness." This is the principle that states that a certain right may apply "*without exception* inside a bounded domain, but not outside" (McGinn, *Rights (concluded)*, 2010). To exercise the right to suicide in certain locations may violate others' protectable interests; for example, committing suicide in a school may psychologically damage the students. However, involuntary hospitalization would still not be permitted in order to prevent such an act. One would be justified in removing the suicidal person from the location in which they were attempting to commit suicide if committing suicide in that place violated others' protectable interests, but one would not also be justified in attempting to prevent that person's suicide altogether. Therefore, one would not be justified in involuntarily hospitalizing a suicidal person.

The view that the right to suicide is a derivative right of the right to self-determination rests on the view that either mental illness does not exist, or that if mental illness does exist, the mentally ill person still has the right to self-determination, even if his decisions are partially derived from his mental illness. In this view, mental illness is a social construct designed to stigmatize those who do not conform to society's values. For example, almost every suicidal person would be diagnosed with some form of mental illness on the basis of his/her suicidal ideations, but this occurrence seems to reflect the negative societal stance on suicide rather than being an objective standard of illness. Suicidal thoughts or actions are a symptom of depression on most major depression scales; therefore, stating that depression and suicide are linked (with depression presumably causing suicide) can be circular logic, since they are usually linked by definition (GlaxoSmithKline, 1997). For example, Idaho "includes in its definition of mentally ill persons any person 'who is of such mental condition that he is dangerous to himself,'" (Greenberg, 1974, p. 229). Suicidal ideation was not always considered an illness:

> The majority opinion in the ancient pre-Christian world was that suicide not only was not wrong, but was a valuable manifestation of human freedom. The Epicureans believed that if life ceased to be happy the remedy for the free man was to end it, and the Stoics held that human freedom lay partly in the fact that man continued to live by his own consent. (Dardis, 1988, p. 23)

Those who are against involuntary hospitalization would still admit that suicide sometimes does cause harm, but would reject many of the claims of those who are for involuntary hospitalization. First, regarding Mill's Harm to Others Principle, those who oppose involuntary hospitalization would say that though suicide does often harm the suicidal person's family, this harm must be weighed against the emotional harm inflicted upon the suicidal person by being forced to continue living (Greenberg, 1974).

Regarding the harm to society brought about by suicide, opponents of forced hospitalization would point to the fact that individuals are not morally or legally obligated to contribute to their society. For example, an individual can renounce citizenship and emigrate from his/her country or become a hermit and thus stop participating in society, and these actions are not typically judged as a moral wrong or prevented by law. These cases are similar in most morally relevant respects (in terms of the effects on society) to an individual removing him/herself from society through suicide. Suicide may do marginally more harm because of the grief people feel after a person commits suicide, but those who are against state interference in suicides would argue that individual grief is transitory, and so the suicide is worse only by a small degree. The Formal Principle of Comparative Justice states that "cases that differ in at least one morally relevant respect must be treated *differently in direct proportion to the degree of difference between them in the relevant respects in question*" (McGinn, *Justice (concluded*), 2010). Since the suicide is only slightly worse than the person leaving society in another way, it deserves to be treated only slightly more harshly. Furthermore, since people are not punished at all for emigrating or for becoming hermits, it is doubtful that such an extreme intervention as forced hospitalization is justified for suicidal individuals.

With regard to the Offense Principle, opponents of mandatory hospitalization would favor a global, rather than a local, definition of "universality" (McGinn, *Lecture #5*, 2010). Many cultures consider suicide less offensive than the United States does. For example, Slovenians consider suicide much more justifiable than the United States does, implying that they are less offended by suicide as well (Hume, 2009). Since suicide's offensiveness may be limited to the United States and certain other countries, the Offense Principle should not apply in this case.

Opponents of involuntary hospitalization may admit that sometimes suicide does more harm (especially to the family) than good. In a cost-benefit analysis, involuntary hospitalization would be justified in these cases. However, opponents would say that the right to self-determination and the derivative right to suicide are trumping factors, so suicide cannot be prevented even when it does more harm than good.

Conclusion

The right to suicide is certainly more problematic than the view of those opposed to involuntary hospitalization would suggest. Often, suicidal people, even those who make an attempt at suicide, decide immediately after that they do not actually wish to die. Studies of suicide attempts have shown that between 85% and 95% of those who attempt suicide and fail are still alive 15 years later (Greenberg, 1974). This statistic implies that at least a significant portion of the suicide attempters did not actually wish to die, and would support the theory that allowing suicide infringes upon the

right to self-determination. On the other hand, the presupposition that all or almost all suicidal people are operating under a mindset that does not reflect their "true self" is also problematic, regardless of whether or not mental illness exists. For example, consider the case of a person who, despite seeking treatment, has been suicidal his/her whole life. Does this person have a "real self," separate from his/her suicidal self, that s/he simply has never been able to access? If, for his/her whole life, s/he is never able to access this non-suicidal self, it seems meaningless to speak of this "other self" as existing in any real sense. Therefore, since self-determination is a human right that must be extended to this life-long suicidal individual, and the only "self" that s/he possesses in any meaningful sense is his/her suicidal self, then the right to self-determination must be extended to his/her suicidal self. In a given case of a suicidal patient, it is very difficult to judge, especially at a glance, whether the "self" who is considering suicide is what society would come to consider the "true self". This ambiguity makes it difficult to decide whether to intervene in a given suicide.

The opposition's argument is also problematic because part of its foundation is the idea that mental illness does not exist as a biologically based phenomenon. Although there is currently no definitive proof for a biological basis for depression or suicidal ideation, the possibility remains that scientists may prove one in the future. This would undermine opponents' argument, because the right to suicide is based on the suicide not being the product of a mental illness. Additionally, depression and suicidal ideation, if they are illnesses, are not currently always curable: at least 30% of those treated for major depression still have symptoms after treatment (Silva & Larach, 2000). However, if suicidal ideation turns out to almost always be the product of a true mental illness, and the mental illness becomes curable, then the proponents of mandatory hospitalization will be justified in their belief that there most often exists a separate, non-suicidal self. This would make mandatory hospitalization justified in almost all cases.

Despite this hypothetical situation, with the current knowledge of suicide, it is far from clear that suicide is always irrational. Additionally, all of the liberty-limiting principles require that the intervention to prevent harm be the least coercive intervention possible. So, to protect the freedom of those who wish to rationally commit suicide, while protecting the lives of those who are irrationally considering suicide, I suggest a much stricter basis for involuntary hospitalization. Currently, the decision about whether to hospitalize a person lies almost entirely with the emergency room psychiatrist. This psychiatrist is subject to confirmation bias, and

experiments have shown that psychiatrists will often diagnose even a perfectly healthy person with a mental illness.[1]

To practically enact this moral view, the grounds for involuntary hospitalization should not be a psychiatrist's recommendation. Rather, the potential patient should be given a hearing similar to a criminal trial, but with minimal or no input from the psychiatrist. Currently the patient is allowed a trial before being put on a 14-day hold, but the criteria to hold the patient are that they are a danger to themselves, a danger to others, or gravely disabled; the evidence for these claims comes almost entirely from the psychiatrist's judgment (Los Angeles Superior Court, n.d.). These criteria clearly do not fit with my claim that some suicides are reasonable and should be allowed. Because to many patients, being in the psychiatric ward is a punishment (because of the stigma it engenders, the cost, and the confinement), a more thorough court case would be reasonable comparative retributive justice (McGinn, LLP6: *The social welfare or benefit to others principle*, 2010). In other words, since the punishments for being suicidal and committing a crime are similar, the decision processes to inflict these punishments should be equally rigorous. Most crimes more clearly violate the Harm Principle than suicide does, and criminal cases are generally designed to decide simply whether or not the defendant has committed the crime. Suicide is less clearly always harmful, so its benchmark should not be simply whether or not the person is a danger to him/herself, but whether the reasons for the person being a danger to him/herself are justifiable. Treating suicide the same way society would treat other crimes is comparatively retributively unjust, since suicide and other crimes are morally distinct.

The court case for a suicidal person should reflect the conclusions that suicide is not always wrong, but that in cases where it is not the suicidal person's "true self" making the decision, the suicide should be prevented. In the court case for a suicidal defendant, there would be a presupposition in favor of liberty. The only way the defendant could be hospitalized would be if his/her reasons for considering or attempting suicide were clearly irrational.[2] These concrete reasons, and not the psychiatrist's judgment, would be the basis for the defendant's case. Additionally, if a

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[1] In an experiment at Stanford University, researcher David Rosenhan had a group of perfectly mentally healthy people check into the psychiatric ward complaining of hearing voices. Once they were inside, they were told to say that the voices had stopped and that they felt fine, and to act normally. Doctors proceeded to diagnose every one of them with a mental illness, taking the normal behaviors that they exhibited in the hospital and unconsciously distorting them into the symptoms of a mental illness. The healthy people were kept for an average of nineteen days (and one was kept for two months), and the doctors never realized that the patients were, in fact, healthy (Gladwell, 2009).

[2] The discussion of how to decide which reasons are rational or irrational is outside the scope of this paper.

person was considering suicide and did not want to go to court, the state could provide an application for suicide non-interference.

Admittedly, the idea of a suicide application sounds strange. However, society is increasingly recognizing that the desire for death is complex and not always unjustifiable, as shown through the increasing acceptance of euthanasia. The recognition that there are other valid reasons to wish to die, coupled with the recognition that not every reason to wish to die is valid, will lead society to a more just public policy.

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