ON THE POSSIBILITY OF RATIONAL SUICIDE

Can competent, rational agents commit suicide?

Masterthesis Applied Ethics

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A B S T R A C T

Current suicide policies assume that the suicidal agent is irrational and in need of treatment. Because of the assumed irrationality of suicide, suicide policies focus on suicide prevention. In this paper, I question the assumed irrationality of suicide and incompetence of suicidal agents. This paper will argue that rational suicide by competent agents is possible, and therefore current suicide policy overlooks death deciders; a group of rational, competent suicidal agents.

I begin by offering a conception of rationality and rational suicide in chapter one. To come to a definition of rationality I discuss the positions of Richard Brandt, Michael Cholbi and Govert den Hartogh. The resulting definition of rationality involves autonomously chosen ends, proper planning and discussion with experience professionals. In chapter two, I discuss competence, based on a list provided by the KNMG (the Dutch physician association). This list will be critically reflected on with Gerald Dworkin's theory on autonomy. The resulting definition of competence involves the ability to explain yourself to others, understand what is going on and awareness of the external influences on your deliberation process. This second chapter ends with a comparison of rationality and competence and the conclusion that the suicidal rational agent and the competent agent can be one and the same. There is one important difference between the two which has to do with awareness of external influences appears to be a difference. This group will be referred to as death deciders.

Having delineated death deciders, I will turn to a discussion of suicide policies in chapter three. The irrational and/or incompetent people are of a different category than death deciders, they will not benefit from treatment and therefore need a different approach. Whereas it is necessary to protect irrational and incompetent suicidal people from harm, physically limiting the freedom of death deciders is potentially unjust. I suggest a two-phase policy approach for suicide policy. In the first phase, suicide prevention polices should apply to every suicidal agent. The second phase entails holds treatment for the irrational or incompetent people and -to be investigated- suicide managing policies for death deciders.

INTRODUCTION

Self-inflicted death has long been seen as morally wrong. Our current suicide policies are based on the assumption that the suicidal agent is mentally ill, irrational and/or incompetent to make her own decisions, and the policies are therefore preventive. A suicidal agent's mental illness warrants treatment, and sometimes physical interference. This view of suicidal people as mentally ill is broadly accepted and supported by the Dutch suicide statistics, which show that the vast majority of the suicides are committed by people with mental illnesses. The statistics show that 90-95% of the suicides is based on irrational grounds.[1] At the same time, the rationality of euthanasia is widely recognized in the Netherlands, with over four thousand euthanasia requests granted every year.[2] Euthanasia as well as suicide causes your own death, why do we see the possibility of a rational euthanasia and not of a rational suicide? In this paper, I want to explore the possibility of rational suicide.

Current research and political discussions on suicide discuss *either* the possibility of rational suicide, *or* the proffered policies surrounding suicide. In this thesis, I want to connect these two debates, and propose a missing link. A theoretical discussion of the (im)possibility of rational suicide will need to be informed by the complex and practical issues of applied ethics, and, vice versa, a practical discussion of our suicide policies will need to be informed by a fundamental philosophical analysis. In forging the connection between the theoretical and the applied aspects of suicide and suicide policy, I will argue that both approaches have missed the importance of 'competence' in their assessment of suicidal people. In overlooking the importance of competence, the debate so far has treated the group of rational suicidal people as homogenous. This, I argue, is a mistake, as it fails to recognize the rational and competent suicidal agent who decides on their own death. This group of death deciders should be acknowledged by our suicide policies.

The starting point for this thesis in the first chapter, then, is the question whether rational suicide is possible, in contrast to the current assumption in society. This is a theoretical question and needs an extensive analysis of the concept rationality in suicidal contexts. I conclude that rational suicide is possible. Rationality by itself, however, does not have immediate consequences for the way we treat suicidal people. In determining whether it is morally acceptable to forcibly treat

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[1] Govert den Hartogh, "Two Kinds of Suicide", in: *Bioethics,* 2016. pp. 672-680, p. 672.

[2] Marten van de Wier, "Trendbreuk: het aantal euthanasiegevallen daalt voor het eerst in jaren", in *Trouw*, 16 October 2018, url: https://www.trouw.nl/samenleving/trendbreuk-het-aantal-euthanasiegevallen-daalt-voor-het-eerst-in-jaren~abd64bdb/, (consulted on 5 april 2019).

or detain someone against their will, our current medical practices take people's competency as an agent as leading.[3] The second question, then, is whether it is possible to be a competent agent in a suicidal context. In chapter two, I will examine the concept of competency with a more practical approach in order to determine if and when it is morally acceptable to admit someone to a psychiatric hospital against her will. I will conclude that it is possible for a suicidal agent to be rational and competent, that is, to be a death decider. In chapter three, I discuss the implications for suicide policies.

First chapter

Is rational suicide possible? Firstly, I will take a closer look at the different theories that categorize suicide as irrational. Subsequently, in order to investigate the (imp)possibility of rational suicide I will give a definition of 'suicide' and 'rationality'. Defining 'suicide' involves a relatively brief discussion. Defining 'rationality', however is much more complex. I discuss the concepts of rationality used by Richard Brandt, Michael Cholbi and Govert den Hartogh. They all claim that rational suicide is possible, but they all have a different concept of rationality and the necessary conditions for rational suicide. Though Brandt, Cholbi and Den Hartogh do not talk about exactly the same subjects, they all bring out important points and complementary aspects of rationality. After a short elaboration on the theories of rationality I will continue with a discussion on four conflicting points: future wishes, the necessity of other people to be able to act rationally, the methods used and the degree of planning. Finally I conclude that rationality in a suicidal context involves at least a decent degree of planning, and that autonomously chosen life goals are best served with committing suicide and a form of peer-review rationality.

Second chapter

Is the suicidal rational agent competent to make her own decisions? In answering this question I will begin with a discussion of competence. This discussion will start with the list of the Dutch physician federation (KNMG) of what the competent agent should be able to do.[4] The KNMG requires, for example, that the agent is able to explain her decision and understands the information that is given to her. This list will be critically reflected on two points with the theory of Gerald Dworkin in mind. Firstly, only the ideal agent can live up to this list. Not every agent is articulate enough to be able to express themselves sufficiently.[5] Secondly, the deliberation process

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[3] Kees Blankman, Dick Willems, "De Wilsonbekwame Patiënt", in: *Basisboek Ethiek & Recht in de Gezondheidszorg*, ed. Johan Legemaate, Guy Widdershoven, (Amsterdam: Boom, 2016), pp. 67-84, p. 79-80.

[4] Blankman, Willems, p. 79-80.

[5] Gerald Dworkin , "The Nature of Autonomy", in: *Nordic Journal of Studies in Educational Policy*, 2015:2. pp, 7-14, p. 13.

can be influenced without the agent's awareness. I will argue that agents that are not aware of external influences are not competent to make their own decisions. Based on this discussion of competence, the list of the KNMG will be complemented with three additional points.

Having arrived at a more adequate definition of competency, the question is whether the rational suicidal agent and the competent suicidal agent can be one and the same person. After comparing the two lists of rationality and competence I will conclude that the rational agent is not necessarily competent and vice versa, but that it is possible to be rational, competent and suicidal at the same time. The main difference between the rational-not-competent and the rational-and-competent agent lies in their (lack of) awareness of external influences. The group of suicidal agents that rationally and competently decide to die will be referred to as 'death deciders'.

Third chapter

What are the consequences for suicide policy? The third chapter will question the current suicide prevention policies. The current policies assume that every suicidal person is a patient that needs treatment. On this view, if the suicidal agent is a threat to herself or the environment, she can be detained against her will. Drawing on Cholbi's theory of paternalism in suicidal contexts, I will argue that the moral permissibility of detaining death deciders is questionable. Cholbi argues that it is morally wrong to limit the freedom of the rational and competent agent.[6] However, Cholbi uses the argument of the finite nature of suicide to refute other theories and I will show that this argument is also applicable to his own theory. Following from this, it turns out to be impossible to have suicide prevention policies without infringing the freedom of rational and competent suicidal people. Finally, I will give an outline of a potential approach to designing a new suicide policy. There is no space to elaborate on new policy into detail, but I will give an outline of a possible train of thought. This proposed suicide policy consists of two phases. Every suicidal agent will first be met with suicide prevention policies, combined with an assessment of their rationality and competence. The second phase entails treatment for the irrational or incompetent people and suicide managing policies for death deciders.

Conclusion

I set out to explore the possibility of rational suicide. I have argued that it is possible to be a rational and competent suicidal agent, that is, to be a death decider. Recognizing that people can decide their own death rationally and competently it is time we find ways to deal with it. Both in policy and in society in general. My hope is that my discussion helps to free the public debate

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[6] Michael Cholbi, "Kantian Paternalism and Suicide Intervention", in: *Paternalism: Theory and Practice*, ed. Christian Coons, (Cambridge: Cambridge University Press, 2013), pp. 116-133, p. 118.

from the taboo on suicide. As Brandt says, the negative attitude towards suicide '*[…]stands in the way of action by those persons whose welfare really is best served by suicide and whose suicide is the best thing for everybody concerned*."[7]. As long as we refuse to see suicide as anything other than an illness that should by fixed by any means necessary, we limit our understanding of it and risk treating suicidal people in profoundly wrong ways.[8]

This paper is first and foremost written to help people with suicidal feelings. Suicidal thoughts and feelings should not be something that send you to the madhouse immediately, it should not separate you from society. Instead of being ashamed of it, it is time people dare to open up about their true feelings and help others by opening up.

[7] Richard Brandt, "The Morality and Rationality of Suicide", in *A Handbook for the Study of Suicide*, ed. Seymour Perlin, pp. 61-75, (Oxford: Oxford University Press, 1975), p. 68-69.

[8] Thomas Szasz, *Fatal Freedom: The Ethics and Politics of Suicide*, (Westport: Syracuse University Press, 2002), p. 22.

FIRST CHAPTER: RATIONAL SUICIDE

I. The (im)possibility of rational suicide?

Throughout history there have been many theories on the irrationality of suicide. Richard Brandt mentions three different kinds of arguments that reject the impossibility of rational suicide.[9] The first kind is the theological argument. It claims that suicide is irrational because God gave us a duty on earth and we should live up to that duty until God tells us otherwise.[10] The second kind of argument bases the irrationality of suicide on arguments from natural law. Every man, the idea is, naturally loves himself and therefore rational suicide should be impossible.[11] The third kind of argument is based on harm to others. The idea is that suicide is always irrational because in committing suicide, you will always harm other people, and even society as a whole. Aristotle , who gives such an argument, even claims that suicide treats the state unjustly.[12]

These three theories on the irrationality of suicide will not have a noteworthy influence on ordinary people with suicidal feelings. They do not touch upon the reality of suicide. In the practical and political debate on suicide, we find a fourth kind of argument for the irrationality of suicide that actually influences suicidal people. The core of this kind of argument is this: suicide is the result of mental illness, and we should suicidal people as severely mentally ill people who will benefit from treatment, possibly by forced hospitalization.[13] This view seems to be deeply rooted both in today's society and the medical world. The view that suicide is very likely irrational is supported by the suicide statistics. Out of all suicides, only 5 to 10% is categorized as a rational suicide.[14] Furthermore, current suicide policies assume that the suicidal agent is incompetent to make her own decisions and should therefore be protected against herself.[15] Both statistics and suicide policies confirm the assumption in society that suicide is irrational.

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[9] Brandt, p. 61-75.

[10] Brandt, p. 65.

[11] Brandt, p. 66-67.

[12] Brandt, p. 67.

[13] Susan Stefan, *Rational Suicide, Irrational Laws. Examining Current Approaches to Suicide in Policy and Law*, (Webcom: Oxford University Press, 2016), p. 272.

[14] Den Hartogh, p. 673-674.

[15] Rijksoverheid, "'Gevaar' in de zin van de Wet Bopz' in *Dwang in de zorg*, url: https://www.dwangindezorg.nl/gedwongen-opname/gevaar (consulted on 5 March 2019).

However, both Govert den Hartogh and Susan Stefan doubt the suicide statistics and the amount of rational suicides. Stefan argues:

> *"It is undeniably true that a small minority of people are found to be either insane at the time a crime was committed or incompetent to stand trial. However, that is no reason to run the entire criminal justice system as though mental illness caused all crime or all criminals lacked responsibility or capacity. It is also undeniably true that a small minority of people kill themselves while they are psychotic or otherwise clearly incompetent […]. But that is no reason to make suicide policy and laws as though they were merely a subset of the mental health system."*[16]

She claims that not all suicides are a result of mental disorders, or a moment of irresponsibility. She compares this with crimes: criminals are not all mental either so we did not design our criminal justice system on the assumption that every criminal is irrational. And yet, we have done this with suicide prevention policies.[17]

Govert den Hartogh as well claims that there are much more rational suicides than our statistics show. The 5 to 10% rational suicides from the statistics are undeniably a suicide because of their violent, impulsive nature and have a rational motive. They are only not recognized as such because of their peaceful nature and decent planning and thence categorized as natural deaths or an accident.[18]

So both Stefan and Den Hartogh claim that there are more rational suicides than statistics show, but what exactly that rational suicide defines is not explained by Stefan, and Den Hartogh's definition is matter for discussion. Den Hartogh's conception of rationality will be discussed later on in this paper, but first it is necessary to determine what we are talking about when we talk about 'suicide'. This is a relatively brief discussion. Secondly, and this is the more laborious part, I will discuss 'rationality'. When can we label a suicide as a rational one? To explore the different views on rationality I will discuss the concepts as used by Richard Brandt, Michael Cholbi and Govert den Hartogh and explain why we focus on these three authors. After determining what we understand when we talk about 'rational' and 'suicide' it is time to discuss the possibility of rational suicide and three different categories of rational suicide.

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[16] Stefan, p. 50.

[17] Stefan, p. 50.

[18] Den Hartogh, p. 672, 677.

II. What is suicide?

Let us first be clear that we are talking about suicide, not euthanasia. The most important difference is that suicide is done by one person on his own without the intervention of a doctor who does it: with suicide death is entirely self-inflicted. Euthanasia, on the other hand, always has a second and third person involved. Moreover, when someone requests euthanasia a doctor has to decide whether it is requested on rational grounds, and whether the request is based on rational grounds. Suicide, on the other hand, can be decided upon and executed by one person, regardless of whether it is careful decision. In suicide, the perpetrator and the victim are one and the same person.

At first thought, committing suicide is "terminating your own life". Whereas I believe this to be a necessary condition for suicide, I do not think it is a sufficient one: merely terminate one's own life does not yet constitute suicide. Consider, for example, Charlotte. On a hot summer day Charlotte wants to swim in the river, so she dives of the bridge. Unfortunately, there are some rocks just below the water surface that she did not notice and she does not survive the jump. By jumping off the bridge, Charlotte terminates her own life, however accidentally. I think we can all agree that someone who kills herself by accident is not a case of suicide - the agent in question is 'just unlucky'.[19] Therefore, besides causing one's own death, a second necessary condition is that the agent does so on purpose. Suicide, then, is the intentional termination of your own life.[20]

I want to add a point of clarification to what it means to intentionally terminate your own life. Firstly, we might think that intentionally terminating your own life requires that death itself is the goal of acting. However, we can speak of suicide even if your own death is not the main goal of an act. Think, for example, of someone with a chronic and painful disease for which there are no effective painkillers. The patient has decided that the only way out of this misery is dying, and commits suicide. This patient will not commit suicide because she wants to quit life, but because she wants to get away from the pain. Wanting to die is not the main reason she acts on, but intuitively we would categorize this case as suicide. Chronic pain is one kind of reason one might have for committing suicide. Another kind of reason is when a person commits suicide to save others, for example someone who kills herself to save the family's honor. In committing suicide, then, wantig to die does not have to be a reason for action. Dying does not have to be the agents main goal. But, as we saw in our earlier discussion, for a life-taking acting to be a suicide it is important that the agent knows death is a consequence of their action.

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[19] Szasz, p. 22.

[20] Brandt, p. 61.

In summary, suicide is an act in which you take your own life on purpose. An act performed to die, or an act motivated by some other reasons knowing that death would be a very likely consequence of this action. Now we have a definition of suicide, we can ask whether rational suicide is possible. In order to ask this question, I will now discuss rationality on the basis of three theories and provide a conception of rationality in suicidal contexts.

III. What is rationality according to Brandt, Cholbi and Den Hartogh?

Whereas rationality undoubtedly involves acting for reasons, there seems to be much more to rational suicide than 'having reasons to take your own life'. In getting clear on the concept of rationality in suicidal contexts we will now take a closer look at three authors: Brandt, Cholbi and Den Hartogh. Based on these authors, I will answer the question what is a rational decision is in suicidal contexts. Importantly, this discussion is one about the *rationality* of suicide, and not about its moral acceptability. I will start with Brandt, who has played a big role in shaping the debate on rational suicide. I then discuss Cholbi, one of Brandt's most comprehensive respondents. Lastly, I discuss Den Hartogh's conception of rationality. Other than Brandt and Cholbi, Den Hartogh gives a definition of rational suicide, which he uses to critique the current way of compiling rational suicide statistics. Though Brandt, Cholbi and Den Hartogh do not alk about exactly the same subjects, they all bring out important and complementary aspects of rationality. Although Cholbi responds to Brandt, he only does so on specific points. The rest of his paper emphasizes other points than Brandt does. The same applies to Den Hartogh, although he discusses rational suicide, the aim of his paper is completely different from the other two. On some critical points they disagree, but they complement each other as well on other points. Firstly, I discuss Brandt, Cholbi and Den Hartogh's theories of rationality in turn. Secondly, I synthesize their three distinct theories of rationality, highlight discussion points and suggest ways in which these thinkers can complement each other. Thirdly, I propose a list-based definition of rational suicide.

a. Richard Brandt

In a process of decision-making, an agent chooses between different possible world-courses, according to Brandt. The choice to commit suicide is one of these possible world-courses that we can choose from. He identifies two requirements for a decision in order to be rational:

Firstly, while comparing the different world-courses we need to assume that all our wishes, current and possible future wishes, are taken into account. All these different wishes should have the

same weight in the decision process.[21] Secondly, we should take other people into account. In making a choice, the rational person not only includes her own life course, but also the influence her choice has on the life course of other people. Your decision to end your life may, for example, eliminate opportunities for others. Moreover, people who are close by should receive particular attention.[22] Brandt himself applies this theory to the decision to commit suicide. He argues that the suicidal agent should imagine what the world would look like when she leaves the earth right now, or when she leaves the world in three months, in five years, or does not commit suicide at all. The best option is the one that assumes that all my wishes are taken into account and take others into consideration and provides the best outcome. The agent who acts according to this outcome is acting rationally.[23]

However, to act rationally is not that straightforward according to Brandt. Brandt identifies two threats for rational decisions in human nature. Firstly, it is demanding to give your current life wishes the same weight as the wishes you might have in the future. There is "*a reduction of motivational influence of events in the distant future*"[24]. Consequently, the agent is less motivated to do things that are good for her in the future, the agent naturally prefers acts that are good for her in the short term. Secondly, people who suffer from mental illnesses will have a hard time seeing the world clear and objectively. A depression influences your judgment of the possibilities you have, thus it is hard to determine what world-course is the best possible.[25] Whether depressed people are ever able to act rationally is not discussed by Brandt. These two problems for acting rationally are not solved easily. It is necessary that we are aware of the dangers in human nature and make adjustments in your daily life to compensate for the mistakes that you can possibly make.[26]

A few questions come up with Brandt's theory. Brandt discusses the difficulty to take the present as much into account as the future, but he does clear the air entirely. Is it really achievable to take the future into consideration as much as Brandt wants? Furthermore, Brandt does not mention others people. He seems to claim that it is possible to act rationally without other people, but is

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[21] Brandt, p. 71.

[22] Brandt, p. 72.

[23] Brandt, p. 71-73.

[24] Brandt, p. 72.

[25] Brandt, p. 72.

[26] Brandt, p. 72-74.

it? The questions Brandt's theory raises will be further elaborated on after Cholbi and Den Hartogh are discussed properly.

b. Michael Cholbi

In his paper "Kantian Paternalism and Suicide Intervention" Cholbi discusses autonomy and rationality together. In this part we will only discuss his views on rationality, Cholbi's views on autonomy will be discussed in chapter 3.

Cholbi defends that to act rationally is to act for an autonomous reason, that means you are not under influence of, for example, other people or an addiction. A rational choice is solely and completely your choice. When we are able to act for our own reasons, we can exercise self-government and self-direction and therefore we have liberty.[27] On the contrary, ignoring your goals and principles leads to irrational action.

To determine whether someone is acting rationally we look at the goals and principles the agent has *right now* because that determines your actions at this moment. The potential wishes in the future, or the principles the agent has had in the past, are not important. Both, future and past, do not have any decisive effect in how the agent will act. The only self that matters is the present self. *"Paternalistic interference therefore does not privilege the desires or reasons of some future and presumably more rational or "authentic" self against the less rational present self*."[28] Cholbi acknowledges that agents change through time, still there are so many possible changes that it is impossible to anticipate on it. Moreover, the present self is the self that actually acts rationally or irrationally and therefore the only self that is important to us.[29]

The agent's second order desires and principles are important in the process of assessing the agent's rationality. A second order desire: a desire to want to want something, *"the power to form desires about their own desires*"[30]. Second-order desires always relate to, and reflect on, first-order desires. First-order desires usually concern ordinary stuff. For example: a drug addicted wants to stop using drugs, but his addiction is too strong to stop on his own. He wants to want to stop and therefore his second-order desire is to go to rehab while his first-order desires still want

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[27] Cholbi 2013, p. 115.

[28] Cholbi 2013, p. 120.

[29] Cholbi 2013, p. 120-121.

[30] Tim Schroeder, "Desire", in: *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, url: https://plato.stanford.edu/archives/sum2017/entries/desire/ (consulted on 4 March 2019).

drugs. According to Cholbi we need to look at his second order desires, the desire to stop doing drugs, in order to see whether the agent follows the second-order desires and is rational.[31] Yet, we can only base someone's second order desires on the person they are right now.[32] When the goals, principles and actions are in accordance, the agent is acting rationally. What the agent's principles and goals should be is undetermined, Cholbi does not prescribe a conception of 'the good life'.[33] "*[…]KP [kantian paternalism, MB] remains steadfast in its neutrality amongst conceptions of the good*."[34]

The rational agent, then, acts in accordance with the second order desires and autonomously chosen life goals she has right now.

Cholbi's theory raises questions as well. Firstly, he acknowledges that people change, but because of the impossibility of prediction he stays with the present self. Yet, we know for sure that people change so why not anticipate on it? Think for example of someone who is depressed because she just lost her job. The current situation may seem hopeless, but we know for sure that it will change. For the good or the bad, but it will change. We can take the possible changes already into consideration to determine what would be best for us and whether the agent is acting rationally. Secondly, Cholbi seems to prefer the completely independent position of the rational agent. The more independent, the more rational the agent can be. However, our actions influence others and we are influences by others. Also, do not we need others sometimes in order to reflect on our line of thinking? These points will be discussed further later on. First we will discuss Govert den Hartogh's conception of rationality.

c. Govert den Hartogh

In his article "Two Kinds of Suicide" Govert den Hartogh identifies a discrepancy between society's assessment of the rationality of euthanasia and suicide. Hundreds of euthanasia requests a year are assessed as rational: *"In all cases in which a request for euthanasia has been granted, both the doctor and an independent colleague who has been consulted has judged the request to be well-considered."*[35] On the other hand, suicide rates show that only 5 to 10% of the suicides is

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[31] Schroeder.

[32] Cholbi 2013, p. 129.

[33] Cholbi 2013, p. 119.

[34] Cholbi 2013, p. 125.

[35] Den Hartogh, p. 673.

considered to be rational. Both suicide and euthanasia result in your own death on purpose.[36] In this article Den Hartogh wonders what causes this difference.

According to Den Hartogh, a significant number of rational suicides are not recognized as such exactly because of their rational character. He identifies four reasons to explain this. Firstly, people are diagnosed as mentally ill because they have suicidal thoughts. This is tautological according to Den Hartogh. If we agree on this and accept that most requests for euthanasia are rational we must doubt the suicide statistics on the small amount of rational suicide.[37] Secondly, he claims that with pathologizing suicide, the victims become more violent to themselves and less rational. They do not feel the opportunity to talk to family members or professionals about their suicidal feelings. Besides, the potential rational suicide can turn into irrational because of the taboo on suicide. Thirdly, a history of mental illness inclines doctors to assess a suicide irrational. Yet, the agent could have been mentally healthy at the moment of committing suicide. This is reinforced by the foreknowledge that someone killed herself. If you look for a mental problem to explain the suicide, you will find a mental problem. Fourthly, there are a lot of rational suicides that are not recognized as such and registered as an accident, or a murder.[38] *"In particular drownings, fallings from high places, collisions and medication poisonings are notoriously difficult to classify as either accidents or suicides (or, occasionally, murders)."*[39] As we will see further on, exactly these suicides are rational because of their non-violent nature.

So if we dare to look differently at suicides, we would see more rational suicides. But what exactly *is* a rational suicide? Den Hartogh contrasts this with irrational suicides. An irrational suicide is not thought through, not planned, violent means were used and the agent did not communicate with others. "*They tend to use means of killing themselves that happen to be at hand, and these are almost always violent means, means that cause considerable damage to their bodies, and/or some severe suffering before they actually die: drowning, shooting, hanging themselves, throwing themselves from a high building or a bridge or in front of a train. They almost never*

[36] Den Hartogh, p. 673.

[37] Den Hartogh, p. 677.

[38] Den Hartogh, p. 677.

[39] Den Hartogh, p. 677.

discuss their plans with friends or family."[40] A rational suicide on the other hand is characterized by communication with others, decent planning, peaceful means and is well thought through.[41]

I want to point out three demands for a rational suicide: methods used, planning and conversation with others. At first, the methods used. Den Hartogh makes a sharp distinction between violent, irrational methods and peaceful, rational methods. Violent methods are a sign of irrationality. Think of jumping of a building or shooting yourself. The more peaceful means are stopping eating and drinking, or poisoning yourself with a mix of medicines. With the peaceful means you cannot impulsively terminate your life, they need planning and perseverance to execute:[42]

> "*A decision to stop eating and drinking can be taken impulsively […]. But it cannot be executed impulsively. Collecting lethal drugs requires planning, in order to acquire information about efficient and safe means and ways to get and use them; and the execution of the plan requires some inventiveness and patience. It is true that the decision to use drugs can in the end still be quasi-impulsive, but this probability is low when the decision is discussed with proxies*."[43]

This also points at the second demand of decent planning. The rational, peaceful methods require planning. Without it they would not succeed.[44] Thirdly, conversations with others. As mentioned in the citation above, 'proxies' are important in the process of a rational suicide. During conversations, the 'proxy' can find out whether someone is planning to act rationally and the suicidal agent can verify whether her thoughts are consistent. These 'proxies' are people who are close to you like family members and close friends. The characteristics of a rational suicide need each other, it is not a rational suicide if one is missing.[45]

I agree with Den Hartogh that it is necessary for a rational choice to have it planned in a decent way. For big decisions like suicide, it should take longer to think it through than the decision to go to work by bike or by car. Secondly, the criterium of talking to proxies. According to Den

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[40] Den Hartogh, p. 672.

[41] Den Hartogh, p. 672-673.

[42] Den Hartogh, p. 680.

[43] Den Hartogh, p. 680.

[44] Den Hartogh, p. 680.

[45] Den Hartogh, p. 680.

Hartogh it is impossible to take this decision on your own. But is it? Others influence my process and it may be harder to stick with my own principles. Is not it more rational if I am able to make a decision on my own?

IV. Rationality in suicidal contexts

This section contains three discussion points drawn from the theoretical analyzes above, eventually I will conclude with a list-based conclusion of rationality. It is important to note that I will not offer a full conception of rationality, the final list is only applicable in suicidal contexts.

The first discussion will focus on conflicting positions of Cholbi and Brandt concerning future and present wishes and desires. The first argues that we need to look at the present self, whereas the latter claims that we need to take the present selfs into account as well. I will argue that we have to adopt Cholbi's theory, especially because of the finite nature of suicide. The second discussion is between Cholbi and Den Hartogh about the need for other people in our rational decision-making process. Den Hartogh emphasizes the importance of conversation in order to act rationally and give the other the opportunity to assess the agent's rationality. However, Cholbi argues for independence of other people, they can only be an obstacle in your autonomous decision-making process. Thirdly, I will discuss Den Hartogh's evaluation of different methods of committing suicide and the requirement of decent planning. Although this concerns two separate points, I will discuss them at once because they are interdependent. Moreover, Cholbi and Brandt do not discuss these two points. However, I think we need to reflect on them because they can specify the more abstract theories Brandt and Cholbi offer.

a. Only look at the current desires and life goals

This section contrasts Brandt and Cholbi on the importance they attach to future life goals. Brandt argues that we need to anticipate on changes agents will go through in the future and therefore take future desires and life goals into account. Cholbi does not agree with Brandt and provides two counterarguments. I argue, with Cholbi's theory and one argument of my own, that it is impossible and dangerous to rely on future desires. We should only look at the agent's current desires and life goals. I provide three arguments.

The first argument is general, it concerns the (un)predictability of a life-course. We know people change, but which changes will actually happen is impossible to predict. Cholbi even doubts whether the present and future self are the same person and can be assessed as the same. "*No doubt individuals sometimes undergo abrupt and radical revisions in their conceptions of the good, revisions of character or judgment which raise questions about whether there exists an*

identity relation across time between the earlier and the later individual."[46] The radical changes can create a whole new individual and will reshape the agent's rationally chosen goals. I agree with Cholbi. No one knows whether an individual becomes an addict, converts to a religion or gets divorced until it actually happens. Besides, there are too many possibilities in life to anticipate on all of them. In conclusion, it is impossible assess rationality based on future life goals.

Brandt would agree that it is hard to predict, but our whole life consists of uncertainties and we live with it as best as we can. "*But we always have to live by probabilities and make our estimates as best as we can*."[47] It is the way we make decisions in life and live life we want to.[48] Furthermore, in making our decisions we must assume that all our desires are taken into account. "*It is not just a question of what we prefer now, with some clarification of* all *the possibilities being considered. Our preferences change, and the preferences of tomorrow are just as legitimately taken into account in deciding what to do now as the preferences of today*."[49] So we have to make rational decisions with the best estimates we have at the moment, weighing the future as much as the present.

However, there is an important difference between suicide and other rational decisions we make. This is the second argument against Brandt's position. Most rational decisions can be adjusted when we want to refine its effect, or sometimes completely reverse it. It is always possible to review your decision. This is in contrast to suicide. A successful suicide terminates one's life and there is no way back. You cannot refine it's outcome if it is not satisfying. Because of suicide's finite nature and it's irreversibility more certainty is required. Cholbi compares suicide to overeating and obesity as a result to explain this: "*This is because the harms of overeating are importantly different from the harms of suicide. In comparison with obesity, for instance, the harms are severe, irreversible, and imminent*."[50] Obesity and the associated behaviour is difficult to change, but it can be done. Unlike suicide. Exactly because of the irreversibility of suicide only current desires are important for the assessment of rationality. The current level of rationality determines whether someone commits suicide on irrational grounds, on rational grounds or

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[46] Cholbi 2013, p. 121.

[47] Brandt, p. 70.

[48] Brandt, p. 69-71.

[49] Brandt, p, 66.

[50] Cholbi 2013, p. 130.

stays alive. It is possible that someone develops more rational grounds in the future, but that is not what you are dealing with right now and therefore is not of any interest.

Thirdly and lastly, it is impossible to commit rational suicide if we take future desires and life goals into account like Brandt wants us to do. A rational agent considered all the possible world-courses with and without her presence, takes all the people around her into consideration and so on. However, for every individual radical changes can come. Changes that no one would have thought of in advance. All these potential changes need to be taken into account if we consider possible future desires. Among those options will be one with radical changes where the agent does not want to commit suicide anymore. Hence, Brandt contradicts himself by saying that rational suicide is possible, his theory leaves no room for rational suicide.

I have provided three arguments: firstly, the impossibility of knowing future desires, secondly life goals and the irreversibility of suicide it is and thirdly the impossibility of rational suicide at all if you consider possible future desires. How do we get to know someone's desires and life goals in order to assess rationality? That is when we come to the next point of discussion.

b. The necessity of other people

This section contrasts Den Hartogh and Cholbi on their views whether we need other people in our rational decision process. Whereas Den Hartogh argues that we need to have others in the process of decision making, Cholbi fears that they negatively influence your rationality.

Den Hartogh argues that a suicide can be considered rational if and only if the agent has been talking to others about the decision. 'Others' are specifies by Den Hartogh as 'proxies'. "*It is true that the decision to use drugs can in the end still be quasi-impulsive, but this probability is low when the decision is discussed with proxies*."[51] Proxies are family members and friends, people who are close to you. Den Hartogh does not explain why we specifically need proxies and not other people, but I can imagine that they are best capable to talk with us about such emotional subjects like suicidal thoughts. They know you best, can emphasize with you and know what you have been through over the years. If you never speak out loud about your suicide plans, you can get stuck in you own head, maybe do not see the obvious solutions anymore. By expressing your

[51] Den Hartogh, p. 680.

plans out loud you may become aware of what is actually happening in your mind. The conversations will promote the suicidal agent's rationality in this way.[52]

This is in contrast to Cholbi. He argues that we need to make our own autonomous decisions in liberty, without interference of disturbing factors.[53] Other people can be a disturbing factor in this process. However, he also talks about paternalism and the right to intervene in an action when the agent is planning to act irrationally. To know whether the agent is planning to act irrationally we need to know her autonomously chosen life goals. Although he himself does not talk about it, I cannot think about a different method of getting to know these life goals than conversations. So in some way conversations and other people are necessary in Cholbi's theory but they must be as objective and independent as possible in order not to disturb the autonomous process.

These two positions seem to exclude each other at first sight, but I think they can reinforce each other. They both point out something important and can go together, depending on the type of conversation partner you choose. I will elaborate on three different types of possible conversation partners. The first one is the conversation partner Den Hartogh proposes, the second one is in line with Cholbi's theory and the third one is a mix between the first two.

Den Hartogh suggests you to talk to a proxy. This group has an advantage because they can live with you because they know you so well. However, they can complicate the process as well. If someone tells you she is struggling with suicidal thoughts you will, in all likelihood, be overwhelmed with emotions. You do not want to lose your friend. You can burden you friend with feelings of guilt because you will feel alone, or you will feel guilty because you failed 'to make your friend happy'. Furthermore, with someone who is close to you it is easy to miss important signs because you are overwhelmed with emotions. To be able to have a good conversation about this difficult topic with someone who is close to you is hard, and may for some even be impossible. Is it desirable to have such conversations with proxies if they can as easily make the process more complicated? Proxies will easily limit your rationality, exactly what Cholbi fears.

Even though Cholbi does not elaborate on conversations to assess the agent's rationality, I think he would appoint a health care professional for the conversations. They can look at the situation objectively and do not have burdensome personal emotions loved ones have. Besides, they have

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[52] Den Hartogh, p. 680.

[53] Cholbi 2013, p. 115-118.

medical knowledge and skills to help me with medication and in emergency situations. This group will not influence the rational decision making process. Yet, I think there is an important skill the medical professionals generally lack, which relatives generally have: the ability to *really* understand your situation. Of course there are some professionals who have this ability without living with you through the hard times of the past, but it is less common. Before we can determine whether someone is actually rational, a suicidal agent needs to open up to their conversation partner. It can make it easier if the other knows what you are going through and a proxy would better be able to than a health care professional.

A solution can be found in a third group of conversation partners, it finds a balance between proxies and health care professionals. There is a group of people who lived through a period of suicidal feelings and sometimes even suicide attempts.[54] They know what it is like to have a strong wish to die and they know what have helped them (and what did not help) to deal with it. We can call them 'experience professionals'. Obviously they are not fit to substitute the medical staff when they are needed, but in my opinion they are the perfect match between the necessary skills of relatives and of health care professionals. They can talk to you in the most independent way possible while on the other hand they can actually feel with you.
An opponent of the 'experience professional' can argue that this group is not as fit as it seems, they somehow lived through the hard times and are still among us. Were or are their suicidal feelings not that strong to actually do it? What advantage would they have? Obviously it is true that this group has survived the suicidal feelings and that they might not be experience professionals in the final stages a suicidal person will go through. However, I think this even may be an extra asset of this group. If someone is not that sure about their planned suicide, if someone is still in doubt, this experience professional will recognize it out of their own history. Furthermore, they will be able to help someone who do not want to continue their plans how they can get on with their life, how to build it up again. Lastly, and maybe the most important asset: they are the living example that there are more people who struggled with suicidal feelings. The experience professionals can show that your life is not finished after having feelings like this, you are not the only one. You can have a life afterwards and be part of society

In conclusion, I agree with Den Hartogh that we need other people in suicidal contexts. They are necessary to help the suicidal agent to organize her thoughts. Besides, I agree with Cholbi that we must prevent these conversation partners from burdening the autonomous process. The expe-

[54] Susan Stefan, p. 372-373.

rience professional can meet both requirements. They can help in an independent way to organize thoughts while at the same time they understand where the suicidal person is going through. Besides, this group is able to recognize, out of own experience, the doubtful or irrational person and the well organized, steadfast, rational and suicidal person. They can assess the suicidal agent's rationality. This can be seen as some kind of 'peer review rationality'.

c. Methods of committing suicide and planning

Den Hartogh categorizes suicides based on the peacefulness of the methods used and the degree of planning that is required to execute it. First I elaborate on Den Hartogh's theory. Secondly, I discuss the methods used and thirdly the requirement of decent planning.

The first group of suicides is identified by its violent, quick, and mostly impulsive nature. These suicides are not well thought through, therefore the victim chooses a method close at hand. This methods go with a lot of damage to the body, a lot of pain before death occurs and/or others who unwillingly witness the act of suicide. Think for example of jumping of a high building, shooting or hanging yourself or jumping in front of a train. These suicides are irrational according to Den Hartogh.[55] The second category of suicides uses more peaceful methods with as less as possible damage to the body, the environment and as less pain as possible. In order to make it happen, planning and perseverance are necessary. Think for example of stopping eating and drinking, or taking a poisonous mix of medicines. These methods contain moments where you can quit and decide to continue your life.[56'57] If I want to take the best mix of medicines to make sure my heart stops beating, I need to do research to what medicines I need and in what amount. I need to convince a doctor I need that kind of medication and the pharmacy need to give them to me even though it is a toxic combination. Even if you came across those obstacles, the last obstacle is the method of ingestion: when, how and in which order? A lot of thinking work is necessary to get it done. The same applies to stopping eating and drinking. There will be a lot of moments when you are yearning for a sip of water or something to eat. The more you give in to those natural desires, the longer it will take for you to actually die, this tendency must be suppressed in order for the suicide to succeed. A rational suicide, then, has two features: planning and peacefulness. First I will elaborate on the methods used, secondly I will discuss the requirement of planning.

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[55] Den Hartogh, p. 672.

[56] Den Hartogh, p. 672.

[57] Stefan, p. 352.

Firstly, a minor point: I think it is important to realize that the methods Den Hartogh mentions are not peaceful at all. Both will damage your body in a substantial way. The toxic reaction in your body of the medication will not be peaceful and the influence of starvation on your body is at least as intense. However, these two may be less damaging than other methods.

Secondly a more substantial point on the methods used. I provide three arguments against Den Hartogh's sharp distinction between peaceful and violent. I think the distinction is more ambivalent. I agree with Den Hartogh that there are certain forms of suicide that need more time and planning than other methods. However, firstly, I doubt whether we can ask this from people in the current society. It is not like we have a decent option for someone with rational suicidal thoughts to actually commit suicide in a decent way. Every decent, rational possibility is almost impossible to conduct. It is imaginable that someone, let's call her Elly, is thinking of suicide for over ten years now. She is trying to find the way to do it in the most decent and rational way, but it seems to be impossible. Collecting the right medicines becomes impossible because a doctor will not prescribe her the necessary medicines. If Elly stops drinking and eating she will be hospitalized because she is "a threat to herself".[58] Out of hopelessness Elly hangs herself after five years of trying to find another way. If we have given he a decent option to quit after years of deliberation, she would not have needed this violent way. If we compare that to Bert who is in desperate need of water. He can see a water bottle but it is locked behind a glass door. There is a keyhole in the door, and with the key Bert would not need to use violence in order to get to the water. However, the key is not available and he really needs the water in order to stay alive. Kicking the glass will hurt for a moment, but his problem will be completely resolved afterwards. After considering his options, Bert decides that it is worth the pain and a broken door. I think Den Hartogh would see breaking the glass as a rational act. It is planned, possibly discussed with proxies, and eventually the method used is violent because there was no peaceful way. So why is not Elly's suicide rational? It is understandable that a doctor will not prescribe Elly the medicines that will kill her. However, if we do not give her the opportunity to die a decent way, we force her to do it the violent, and damaging way. It would be valuable if we can call a suicide a rational one based on the methods used, but I think society is not ready for it yet. Until that moment we force people to seek for violent ways.

Secondly, as long as peaceful means are not completely secure, it is not certain that the 'peaceful means' are as peaceful as Den Hartogh claims they are: if Elly finally collected the medicine she

[58] Rijksoverheid, "'Gevaar' in de zin van de Wet Bopz' in *Dwang in de zorg*, url: https://www.dwangindezorg.nl/gedwongen-opname/gevaar (consulted on 5 March 2019).

thought she needed, but it turned out badly, she suffered a lot of pain and might even not die. Another scenario: as long as suicide is not something we can talk about with each other, Elly can use a peaceful method without noise and consequently lie in her apartment for over a week before someone misses her. I do not know if that is a more peaceful way for the family to find her than if she shot herself and was found within a short amount of time. Besides, the process of dissolution for over a week will do more damage to her body than when she hanged herself and was found within a few hours.

Finally and thirdly, what is least shocking for family members is subjective. One person can think blood is less shocking than a body marked by a chemical reaction caused by cocktail of medicines, for the other it can be the other way around.

In conclusion, I doubt whether the distinction is as sharp as Den Hartogh illustrates. Current society does not give space for the peaceful means. Thence the peaceful means does not turn out as peaceful as they can be because suicide happens in silence and the effect on the body over a longer period of time can be experienced as intense. When society is ready to give rational suicidal people a peaceful way out I think we need to reconsider to adopt 'peaceful means' as one of the requirements for a rational suicide. Right now society is not ready for it yet.

Yet, planning is not something society denies people. It is still possible to plan your suicide, make sure there are certain things organized before you step out of life. For example, your will, leaving a note, make sure that your family and pets are taken care of and ordinary stuff like the mortgage and contracts. In this sense, planning is a prerequisite for rational suicide, it gives you the ability to reconsider your decisions when you realize what the consequences are. A decent planning, then, is a requirement I would like to adopt.

d. Rationality

To conclude, someone acts rational in a suicidal context if:

1) The agent chooses the world-course, with or without her presence in the future world, which serves her current autonomously chosen life goals and principles at best,
2) The agent talks to others, preferably an experience professional on suicide, in order to organize her thoughts,
3) The suicide is planned well,
4) The 'other' can determine whether this suicidal individual meets the criteria.

Where these points come from is discussed in the sections above, but to shortly summarize where they come from: the first criterium 'autonomously' is essential because this needs to make sure that it is not coincidental that an act coincides with my life goals and desires. That it is actively and conscious chosen. The second and third criterium are indispensable because they guarantee the sustainability of a desire, to make sure the suicidal feelings are consistent. Furthermore, the second criterium is important because talking to other people helps you to organize your thoughts, become more rational *and* it is essential to fulfill the fourth point. The fourth criterium is a kind of peer review rationality. If other people can follow the agent's line of thinking and the conclusions that comes with it, it is rational.

Defining the concept of rationality in suicidal contexts was necessary to question the current views on suicide in society and in medical practice. It turned out that suicide is not necessarily committed by an irrational agent, rational suicide is possible. It is a fundamental correction of deep-rooted feelings towards suicide in society and medical practice. It was never meant to come up with a complete conception of rationality for other contexts. Rationality in this sense is a characteristic you do or do not have, it is black or white. Although there is a large gray area, we focus on the black and white cases, where it is completely clear. I am not trying to clear the gray area (even though I would want to do so). We need to draw a line somewhere in order to make it work, and this conception of rationality is an attempt to draw that clear line. The suicides that meet this list completely will be assessed as rational. Every suicide that does not meet one or more of the requirements belongs to the 'gray area'. As said before, defining suicide and rationality was needed to refute current views on suicide in society. However, as we will see in the next chapter, only proving that rational suicide is possible, is not enough to advocate changes in suicide policy. Before we can say something about how we should deal with suicidal agents we need to elaborate on competence. Competence is the necessary link between rationality and policy.

SECOND CHAPTER: COMPETENCE

In the first chapter we have established, after a theoretical discussion, that a rational suicide is possible. However, this does not have a direct impact on the practical application of the policy on forced hospitalization. Rationality is not included in the deliberation if a medical professional wants to admit a suicidal agent to a hospital against her will. What actually does have influence on the treatment of suicidal people is the degree of competence. Although I will later argue that rationality should also be taken into account when medically treating the suicidal agent or not, that is not what happens right now. The current policies allow medical professionals to admit someone to hospital against their will if and only if the agent is incompetent to make her own decisions. If it turns out that rational suicidal agents can be competent to make their own decisions, it has consequences for current policies on suicide prevention. Before we can discuss changes in policy, we need to discuss whether it is even possible to be suicidal and competent at the same time. Whereas the discussion on rationality was theoretical, this discussion will be more practical because we are looking for the practical implications of the competent suicidal agents.

To discuss this subject I will first turn to the list the KNMG, the Dutch federation for physicians, recommends to assess competence. This list will be questioned with Gerald Dworkin's theory of autonomy in mind. Dworkin talks of autonomy instead of competence, but his theoretical notion of autonomy provides insight into the understanding of competence in practice. Dworkin's theory offers valuable insights for the correction of the KNMG list on competence, but I do not have the ambition to define autonomy. Eventually the list of the KNMG will be complemented with requirements for the deliberation process and a requirement for agreement between non-verbal communication and statements. It turns out that the suicidal agent can be competent. The third section of this chapter will verify whether the rational suicidal agent can be competent. To do so I will discuss all the requirements for rationality in light of the requirements we have set for competence. We will see that it is possible to be rational, competent and suicidal all at once. However, the rational agent is not necessarily competent. It will turn out that competence requires more awareness of external influences and the psychological knowledge of the professional involved. The last and fourth part of this chapter will ask how we can recognize the competent agent.

Shortly summarized this chapter identifies a group of suicidal people that is not recognized before: the competent, rational and suicidal agent. This group will be referred to as 'death deciders'. The other suicidal agents that are irrational and/or incompetent are not a topic for discussion here.

I. What is a competent suicidal agent?

The Dutch physician federation, the KNMG, composed a list that the competent patient should meet. This list of the competent patient consists of four categories of questions that the patient needs to be able to answer in order to prove that they are competent. In the first categories belong questions like 'Can you tell me what your decision is?'. The second category contains, among other things, 'Can you tell me in your own words what I told you about possible treatments and the risks?'. The third category asks 'What do you think will happen when you do not get treated?'. The last and fourth category questions 'What were important factors in your deliberation process?'.[59] These questions out of four categories can be summarized in four criteria for the competent patient:

"*1. The patient can explain her decision,*

2. The patient understands the available and relevant information,

3. The patient can apply the information to her own situation,

4. The patient is able to use this information to choose one of the possible treatments."[60]

First I will argue why I think this list contains the necessary conditions for a competent agent, supported by a little example. Afterwards I will show why I think it does not offer sufficient conditions for the competent agent. There are a few things missing before we can assess the agent as competent. Finally the list of the KNMG will be complemented with two extra requirements.

a. Necessary conditions

This list requires that you are able to explain your decision adequately, prove that you really understand the given information and the alternatives and that you are able to take your own interest into account in a reasonable way. This list makes sure that the patient understands what is happening and what the consequences the treatment will be, or the decision not to be treated. In my opinion, understanding the consequences is one of the necessary conditions for being competent. Think for example of Matilda who was diagnosed with breast cancer a week ago. Her physician explained the possibilities and what would happen if she does not start the prescribed treatment. One necessary and life-saving step is an operation, unfortunately there are no breast-saving possibilities. One week after the diagnosis, Matilda has a new appointment with her physician to discuss the treatment plan before actually starting the process. Matilda can explain her decision to the physician, she wants to start chemotherapy, but she does not want to have the

[59] Blankman, Willems, p. 74.

[60] Blankman, Willems, p. 74. (Translated from Dutch)

operation because she does not want her breasts to be amputated. The physician asks further and it turns out that Matilda did not understand that she will die if she does not get the operation. She thought she had a choice between the operation and chemotherapy, she did not know she needed both. Maybe she was overwhelmed by emotions during the bad news talk with the physician and was not able to understand it properly, or it was too much information to process at once, or the physician used too complex language. Whatever the cause, it is clear that Matilda has no control over the information and was therefore unable to make an informed decision. Unfortunately this inability to contain the essential information happens quite often during a bad news conversations.[61] This case proves the necessity of these four criteria. Furthermore, the first criterium of explanation is important for the physician, or other professional in question. During the explanation the physician is able to check whether the patient meets the criteria, the patients' explanation seems necessary in medical contexts.

These four points are essential in assessing a patient's competence. However, understanding what will happen when you make a decision is not enough for being competent. In the next three sections I will question this list and its completeness. First I argue to replace 'patient' for 'agent'. Secondly, I ask whether everyone can live up to this list, especially the less eloquent and less educated people. This argument is supported by the theory of Gerald Dworkin. Thirdly, I criticize this list because it does not talk about the influence others can have on someone's decision process and her ability to make an autonomous decision.

b. 'Agent' instead of 'patient'

The requirements for a competent person listed above consistently speaks of 'the patient'. I would argue in favor of talking about 'the agent' instead. Speaking of a patient implies that the person can be healed, and this curability is out of the question when we talk about a rational suicidal person. When talking about 'an agent' we include both the suicidal with irrational motives, who can be healed, and the suicidal with rational motives, who is not sick and will not benefit from treatment. I can imagine that the agent who is assessed as irrational and therefore needs treatment will be labelled as a patient again.

c. Only the ideal agent can live up to this list

The first substantive element I think is missing in this list is derived from Dworkin's paper "The Nature of Autonomy". As mentioned in the introduction of this chapter, Dworkin speaks of au-

[61] Paul Serail, "Naarzegger. Het perfecte slechtnieuwsgesprek bestaat niet", in: *Quest*, April 11, 2019.

tonomy and I want to stick with competence. However, I think that the theoretical analysis Dworkin offers is valuable for the practical application of competence we want to make here.

Dworkin offers an alternative for the liberal conception of autonomy. The liberal conception cannot explain that some competent and autonomous people ask others to be limited in their liberty. To outline the problem for the liberal view Dworkin tries to refute, he describes several examples of soldiers who freely choose to be subjected to the orders of someone else. Applying for the army means that you need to obey orders from your superior. The liberal conception of autonomy cannot explain this for an autonomous agent. Dworkin on the other hand argues that you are autonomous if your second-order desires, for example, want to serve your country and therefore apply for the army. Or the Greek myth of Odysseus. *"Not wanting to be lured onto the rocks by de sirens, he [Odysseus, MB] commands his men to tie him to the mast and refuse all later orders he will give to be set free. He wants to have his freedom limited so that he can survive*."[62] Dworkin explains that Odysseus has a desire to survive and he wants that desire to be stronger than the first-order desire to sail on the cliffs he will feel in a few minutes. Therefore, he needs to make a freedom limiting decision that will make it impossible live up to the temporary first-order desires. In conclusion, autonomy is defined by Dworkin as the capacity to reflect critically upon your first-order desires and change your behaviour in accordance with your second-order desires. Autonomy has to do with who you want to be and what motivates you to act.[63] Dworkin's notion of second-order desires is important to understand his critique points on the list of the KNMG.

Dworkin also sees problems with theories of autonomy that require the agent to express herself properly. In the KNMG list it is necessary for the agent to verbally express her decisions, preferences and deliberations in such a way that we can understand it. In the first criterium this necessity is clear, the other three are not that clear but sufficient verbal skills seem necessary to assess the agent's competence properly. However, Dworkin argues that this is impossible for the average agent. *"If we think of the process of reflection and identification as being a conscious, fully articulated and explicit process, then it will appear that it is mainly professors of philosophy who exercise autonomy and that those who are less educated, or who are by nature or upbringing less reflective, are not, or not as fully, autonomous individuals*."[64] According to Dworkin, only well educated, well-spoken agents with good self-reflective skills and awareness of their own feelings

[62] Dworkin, p. 12.

[63] Dworkin, p. 14.

[64] Dworkin, p. 13.

and thoughts would be autonomous, or competent to make their own decisions because they are able to express themselves well. That would mean that, if only rational and competent people are allowed to commit suicide, only educated and eloquent people can commit suicide because they are the only competent agents. That is not a conclusion I want to accept. Think for example of a farmer who lives alone in a remote area. He only speaks to other people when he goes to the city center four times a year. He is not used to expressing his feelings verbally and justifying his decisions to others. If we wants to be seen as autonomous by a professional (for some reason), he would have a harder time than a professor of philosophy. In contrast to the professor of philosophy, he is not used to expressing his feelings. It may seem like an easy task, but if you are not used to it is tough. And on top of that you have to justify an intense and personal decision like committing suicide. The farmer may be competent, but he can lack the necessary skills and exercise to express himself properly.

If we do not want to rely completely on conversations with the agent, how do we decide whether she is competent? Dworkin identified this problem and offers a solution as well. He suggests that we need to look at the agent's behaviour, and whether the agent is able to act in accordance with her second-order desires. The agent needs to be able to adjust her first-order desires in accordance with her second-order desires and express it in her behaviour. Someone who is not autonomous or competent will act in accordance with her first-order desires. An autonomous agent, on the other hand, is self-reflective and able to adjust her behaviour if the reflection of a second-order desire requires to do so. This creates coherence between actions and statements. "*This [autonomy, MB] will be shown not by what he or she says about his or her thoughts, but in what he or she tries to change in his or her life, what he or she cricitises about others, the satisfaction he or she manifests (or fails to) in his or her work, family and community.*"[65] The agent's behaviour should reveal whether she is acting autonomously.

Still, I think that the conversations that are implied in the list from the handbook are necessary as well. To be sure the agent understands all the available information, knows her options and is able to apply the information to her own situation, she needs to talk to someone in a level within her own capabilities. However, for the majority of the agents only a talk is not enough because they are unable to express their feelings and thoughts in the right way. Furthermore, Dworkin talks about observing the agent's behaviour, but I think the non-verbal communication is even more important. Non-verbal communication still includes the agent's behaviour, but it is also

[65] Dworkin, p. 13.

important to see how confidently someone acts. Is there any doubt visible in acting? Or is the agent confident in his actions? So in the end we need to find a combination between conversations and observations of non-verbal communication. The agent's non-verbal communication reveals whether she is acting in accordance with her second-order desires and is therefore acting autonomously.

Conclusively, I suggest to refine the first criterium on the list:

1. The agent can explain her decision in a language level within her capabilities.

And we have to formulate a fifth criterium:

5. The agents' statements are in accordance with her non-verbal communication.

d. The deliberation process

There is a second thing missing in the KNMG list that I want to point out. To make it as clear as possible I will use an example. Think of Olivia who is planning to commit suicide. She was bullied when she was a little kid, but she has been in therapy to process it and it does not bother her anymore. Her current death wish has nothing to do with the former bullying, at least she thinks it does not. In a conversation with her psychiatrist she can explain her decision down to the smallest details. She knows when she wants to end her life, the method she wants to use and everything is planned and set. Olivia understands the information she got from the psychiatrist and medical staff in earlier conversations. She understands the possible treatments and what she leaves behind if she commits suicide. Lastly, it is clear that she is able to value her own interests: her goals are served best when her life ends. Olivia meets the list of competence. However, I can think of obstacles that will trouble the deliberation process and are not taken into account by the current list. There are pieces of information missing that determined the deliberation process.

What we would not know is that Olivia's role model is Joost Zwagerman, a famous writer from the Netherlands who committed suicide in 2015. Olivia always admired him, and if his life goals were best served in committing suicide, why would not she do the same?[66] Olivia thinks she made her own decision and she can explain her decision credibly without using Joost Zwagerman as an explanation. She may not even be aware of the influence it has had on her deliberation process. This external influence may have given the final push to make this decision. So should we eliminate external influences? No, Dworkin answers, that is not possible. Living without external influences is impossible. They make you to who you are, they can motivate or inspire you.

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[66] Victor Schildkamp, "Onderzoek: zelfmoord beroemdheid vaak nagevolgd", in: *AD*, 10 september 2015, url: https://www.ad.nl/binnenland/onderzoek-zelfmoord-beroemdheid-vaak-nagevolgd~a4b6f2e0/ (consulted on 1 April 2019).

Besides, it is practically impossible to live independently of other people.[67] To deal with the external influences, Dworkin argues that we need to make a distinction between influences that improve us and influences that undermine us. The negative influences are influences like "*hypnotic suggestion, manipulation, coercive persuasion, subliminal influence and so forth, and doing so in a non-ad hoc fashion*."[68] A religious environment where some topics are not negotiable and thereby some options may not even be thinkable is another example of a negative influence. Positive influences on the other hand are things like education, a good health and a safe environment. We should ban the negative influences and keep the positive ones.

I agree with Dworkin that we need to make a distinction between negative and positive influences, and I agree with him that it is impossible to live without external influences. However, it is impossible to completely ban the negative influences. To be able to ban them, you need to be aware of the external influences and you cannot ban them as easily. Therefore, I think that it is most important that the agent is aware of the external influences on her deliberation process and take these into account in the final decision.

After all, it is important that you are aware of the things that have influenced your deliberation process, with or without the influence of other people and/or the help of a guardian. This results in a sixth criterium for autonomy concerning the deliberation process:

6. The agent is aware of the positive and negative influences on her deliberation process

II. Competence is…

1. The agent can explain her decision in a language level within her capabilities,
2. The agent understands the available information,
3. The agent can apply the information to her own situation,
4. The agent is is able to reason and is capable to reasonably value her own interests,
5. The agent's statements are in accordance with her non-verbal communication,
6. The agent is aware of the positive and negative influences on her deliberation process

III. Rational and therefore competent?

I think it is wise to shortly summarize what we have done so far. Firstly, I have defined rationality in suicidal contexts in order to refute the current assumption in society that suicide is always a result of irrational acting. This part showed that a suicide is not always done by an irrational

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[67] Dworkin, p. 13.

[68] Dworkin, p. 13.

agent. On the contrary, suicide can be committed by someone who is completely rational. However, proving the rationality is not enough to draw conclusions for suicide prevention policies. The degree of rationality does not mean anything for the moral acceptability of, for example, forced hospitalization. To say anything about forced hospitalization we needed to look at the agent's competence. Is a suicidal agent able to make her own decisions? Now we have concluded that the suicidal agent can be competent, there is one step before we can discuss the policy surrounding suicide: can the suicidal rational agent be competent as well? And if so, is the rational suicidal person always competent? Of is it possible to be rational without being competent? Only when these questions have been answered we can take a critical look at the suicide policies. To make it as clear as possible, these are the concepts we are talking about:

Rationality

1. The agent chooses the world-course, with or without her, which serves her current autonomously chosen life goals and principles at best,
2. The agent talks to others, preferably an experience expert on suicide, in order to organize her thoughts,
3. The rational suicide is planned well,
4. The 'other' can determine whether this suicidal individual meets the first criterium.

Competence

1. The agent can explain her decision in a language level within her capabilities,
2. The agent understands the available information,
3. The agent can apply the information to her own situation,
4. The agent is able to reason and is capable to reasonably value her own interests,
5. The agent's statements are in accordance with her non-verbal communication,
6. The agent is aware of the positive and negative influences on her deliberation process.

As said before, we do not discuss irrational suicide, therefore it is uninteresting to take competence as a starting point: then the person can still be irrational. Therefore, the rational suicidal agent is the starting point of the discussion that follows below. To structure the discussion as best as possible, I will list the criteria for rationality and check whether they meet with the criteria of competence. Are all the criteria of competence covered by rationality? Of requires competence more, or something else, than rationality? We will see that the rational and competent agent have major resemblance. However, due to a nuance difference, not all rational agents are competent to make their own decisions. This difference has to do with awareness of external influences which is not covered by rationality. Eventually it turns out that the concepts reinforce each other.

a. World-course

The first criterium of rationality requires the agent to choose the world-course which serves her autonomously chosen life goals and principles at best. To do so, a few criteria of competence are necessary to be able to choose the best possible world-course. It is for example necessary to understand the available information, apply the information and value your own interests in order

to make a good decision. There are no contradictions on this point between rationality and competence. Competence even seems to create the conditions to be able to meet this criterium of rationality.

b. Decent planning

This is the third criterium in the list or rationality. Even though it is not explicitly mentioned in the criteria for competence, I think a decent planning is, among other things, a result of the criteria listed for competence. Understanding the available information, applying it to your own situation and value your own interests are necessary for and will result in a decent planning. More is necessary to complete the planning, but these are minimal conditions to achieve it. The conditions for competence support the requirements for rationality.

c. Talk to others and the 'other' assesses the degree of rationality

These two are the second and fourth requirements for rationality. Because they are quite similar I will discuss them together in this section. Competence explicitly requires the agent to explain her decision to other people within her capabilities. Furthermore, the concept of competence requires the agent to act and behave in accordance with her statements, this is primarily intended to give 'the other' the opportunity to assess the degree of competence. Both concepts value the judgment of others about the coherence of the suicidal agent's statements and non-verbal communication. Whereas the rationality focuses more on someone's line of thinking and competence focuses more on someone's non-verbal communication. Yet they do not exclude each other and are likely to occur in the same person.

d. Pronounced consciousness of external influences

Up to this point, competence and rationality were completely compatible and reinforcing. However, there is one point that is not covered by rationality and of main importance for the concept of competence. The pronounced awareness of external influences.

Rationality requires autonomous chosen ends and logical conclusions drawn from that. It is focussed on the agent's internal deliberation process. This requirement was drawn from Cholbi's requirement that our ends are chosen independently of others without external influences. In the theoretical discussion on rationality this was convincing. Yet, turning to the more practical discussion on competence the requirement of independence turned out to be unsound. Whereas it is impossible to live without external influences, we set the requirement that the agent needs to be aware of external influences on the agent's decision process. Whether the agent is aware of the

external influences can be assessed through outward statements and whether it is in accordance with non-verbal communication. Both measures are necessary to do the assessment properly. Rationality leaves the opportunity that you are less explicitly aware of external influences because you were never asked to speak out loud. If and only if the agent is aware of the influences and can point at them, she can act competently. Through intensive conversations to assess an agent's competence the unnoticed influences on her competence will surface.

In the end we see that it is possible to be rational, competent and suicidal all at once. However, you are not necessarily competent when you are rational. The pronounced consciousness of external influences makes the difference when assessing the competence of a rational agent. Whether it is possible that the competent agent is irrational is another interesting question, but because our interest lies with rational suicidal agents, it will therefore not be elaborated further. The group that is of interest to us is the one that is rational as well as competent. With the conclusion that it is possible for the suicidal rational agent to be competent, we have delineated a new group. This group is not yet recognized in the current suicide policies. This group has a reasonable set of options and out of these options they conclude death is preferable. They are not coerced by others, they do not 'choose' death because there is no alternative, nor because they are under the influence of a medicine or mental illness. They select death as the best option out of rational deliberation. Maybe because they are incurably ill, maybe they feel their life is complete or maybe because they do not feel at home in this world. Death is not thrown upon them by natural causes, an accident or self-caused due to mental illness, wrong beliefs or other forms of irrationality or incompetence. No matter the reason, as long as it is a rational choice made by a competent agent they belong to this category. They select death as the best option. They have a decided death wish. From now on, I will refer to this group as death deciders. Only the group of death deciders is of interest to us. How can we recognize them out in a group with suicidal agents who are rational but not competent? Or competent but not rational? In other words, how do you recognize a death decider?

IV. How to recognize a death decider?

In the first chapter we have discussed a method to recognize the rational agent. However, we cannot simply adopt this method when we want to assess the agent's competence. As seen above, the assessment of an agent's competence can be more complicated and/or needs more psychological knowledge.

The first chapter argued for experience professionals to assess the agent's rationality and help her act rationally through conversations. These experience professionals lived through suicidal thoughts themselves. This was referred to as 'peer review rationality'. Except for the requirement that the experience professional has experience with suicidal feelings and the capability to approach the case in a professional way, no requirements were set in the first chapter. However, the difference between rationality and competence has impact on the requirements for the experience professional a well. We can think of someone who is planning to commit suicide and talks to an experience professional. Her plans may be rational within the information and self-knowledge she has, and therefore it seems rational to the experience professional. The professional bases his judgement on the information he gets from the suicidal agent. However, what we do need to assess the agent's competence is a professional that is able to unravel her deliberation process much deeper than the agent herself is aware of. Think of the example of Olivia, she had therapy to process the bullying, and in her daily life it did not bother her anymore. Yet, the bullying can still unconsciously influence her.[69] Just like bullying, the loss of a loved one, poorly informed convictions, strict religious beliefs and a history of sexual abuse[70] and so on can have a decisive impact on the agent's deliberation process without the agent being aware of it. An experience professional without psychological knowledge is not able to help you bring these influences to the surface. Especially because the agent himself is not aware of the influences it has, or may be scared to talk about it. Furthermore, once the external influences came to the surface the experience professional needs carefulness, conversation skills and human knowledge to guide an agent through an intense process like this. Without those skills it would not be responsible to expose an agent in such a vulnerable position to an exploration through her deliberation process.

Competence and rationality do not always occur together and we need an experience professional with psychological knowledge to determine whether the rational agent is indeed competent. This can possibly be found in one professional, but it is imaginable that two professionals are needed to have the required expertise all together. Of course, communication between these two (or more) professionals is necessary.

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[69] Morten Birkeland Nielsen, "Does Exposure to Bullying Behaviors at the Workplace Contribute to Later Suicidal Ideation?", in *Scandinavian Journal of Work, Environment & Health*, (2016), pp. 246-250, p. 246.

[70] John N. Briere, Diana M. Elliot, "Immediate and Long-Term Impacts of Child Sexual Abuse", in *The Future of Children*, (Princeton: Princeton University, 1994), pp. 54-69, p. 54.

THIRD CHAPTER: SUICIDE (PREVENTION) POLICIES

The first discussion on rationality was completely theoretical, the second discussion on competence was more focussed on the practical implications. This third discussion on suicide policies is the most practical discussion we will have with a moral component. Even though I want to give a complete policy proposal, there is no space to discuss it as elaborately as necessary to give a complete proposal. The final result in this chapter, therefore, contains a cautious set-up for a possible new policy. Firstly, I will elaborate on the current policies. We will see that these policies are focussed on healing the suicidal patient. However, as we have seen in the previous chapters, suicidal thoughts are not always treatable. Sometimes, suicide is a rational choice of a competent agent and the current policies did not anticipate on this. The second part questions the policy of forced hospitalization and specifically the moral acceptability of it. The third, and last part of this chapter tries to make a start for new policies. This proposal consists of two phases. The first phase is for every suicidal agent and focussed on the assessment of the suicidal agent. The second phase is different for death deciders and others, depending on the assessment of the agent's competence and rationality. However, this proposal is far from concrete. The last part of this chapter only tries to provide a direction where new policy could possibly go.

I. Current policy in suicide prevention and forced hospitalization

This section focuses on the policies in the Netherlands, the policies will be different in other countries. Whether it is permitted to admit someone to a psychiatric hospital against her will is legally regulated in the 'Law special hospitalization of psychiatric hospitals'[71]. This law dictates that someone can be admitted against her will if and only if there is an emergency which can only be avoided by detention, because the patient does not want to admit voluntarily.[72] 'Danger' can be a danger to herself, the people around her, or her environment. There are different examples of 'danger'. Among other things: there is danger if someone neglects herself seriously, threatens to injure others or, the point that matters to us, threatens to kill herself. Only then a person can be admitted to a psychiatric hospital against her will.[73] A serious suicidal threat is always seen as a threat to the self that needs to be averted. When the agent is in detention, a treatment plan is mandatory for every case. In order to request a detention, the request must be approved by the mayor who will determine whether the patient meets the set of requirements. If the request is approved the patient will be picked up by the police and an ambulance, both to secure

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[71] Translated from the Dutch 'Wet bijzondere opnemingen psychiatrische ziekenhuizen (Bopz)'.

[72] Forced hospitalization is translated from the Dutch concept 'inbewaringstelling (ibs)'.

[73] Rijksoverheid, "'Gevaar' in de zin van de Wet Bopz' in *Dwang in de zorg*, url: https://www.dwangindezorg.nl/gedwongen-opname/gevaar (consulted on 5 March 2019).

the safety of everyone involved. Within 24 hours after the detention the patient will be assigned a lawyer. Finally, the mayor will ensure that all those involved are informed of the forced hospitalization. Think of the treating psychiatrist, family, the public prosecutor and the legal representative.[74] If the immediate danger is averted, forced hospitalization is no longer allowed and hospitalization is only possible if the agent complies. Preferably a shorter term, but at least within three weeks, the professional will try to get the agent to voluntary treatment or other forms.[75]

Analysis

The policy described above is applied to every suicidal agent in the Netherlands and thereby every suicidal agent is seen as (mentally) ill and therefore treatable. Every suicidal agent is assessed as irrational, no distinction is made between different suicidal agents. No distinction is made based on rationality, every suicidal agent is seen as irrational and in need of treatment. Competence on the other hand does divide suicidal agents in two groups. The group that is still competent to make her own decisions - to stay alive, and the incompetent agents - who seriously threat to kill themselves. The distinction between suicidal agents is made based on competence and following from the assessment they are admitted to a psychiatric hospital against their will, or not. I do not doubt the conclusion that the irrational and/or incompetent should be protected against herself and forced hospitalization is one of the possibilities to do so. For example someone who has suicidal thoughts caused by medication or any psychiatric disorder can be helped to get rid of those thoughts. However, we have seen that the group of death deciders exists. These people are not ill, not irrational and therefore will not benefit from any form of medical treatment. The current policies of forced hospitalization probably will not work because they are not ill. What to do with this group will be elaborated on in the last part, but more interesting at this point is a moral discussion on these policies. Are the current policies moral acceptable for death deciders? Is it morally acceptable to forcibly treat a death decider?

II. The moral dilemma of forced hospitalization

Now we have delineated the group of death deciders we need to discuss the consequences for suicide policies. The first step we need to take is questioning whether the current policies are morally acceptable for this group. Is it morally permissible to admit a death decider to a psychiatric hospital against her will? To answer this question I will look at the difference between a rational act of suicide and other forms of rational acts.

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[74] Rijksoverheid, "Beslisschema: Inbewaringstelling (GGZ)", in *Dwang in de zorg*, url: https://www.dwangindezorg.nl/gedwongen-opname/documenten/publicaties/2017/oktober/1/procedure-inbewaringstelling-ibs (consulted on 5 March 2019).

[75] Rijksoverheid, *Dwang in de zorg*, ur: www.dwangindezorg.nl, (consulted on 5 March 2019).

a. Suicide compared to other rational acts of competent agents

As seen in the discussion on the suicide prevention policies, there is a possibility of a temporary physical interference with suicidal people. I wonder if this is morally permissible for the group of death deciders. To show my doubts I will use an example.

Imagine your best friend Nina wants to sell her house and everything that belongs to her. Not because bad things happened at home, or she wants to run away from harassment. She wants to start over in a new country because she feels she would have more opportunities to flourish. It is time to leave the country she knows so well and travel to unknown places in the search for new adventures. Not knowing if it will get better than what she has got right now, but she is ready to take the chance. However, Nina is your best friend and you do not want to see her leaving. You have been friends for such a long time and it feels like she leaves you alone. Does she not like you anymore? What is wrong with the lives you both have at the moment? You are satisfied with the life you have here, so why is not she? Yet, you may not feel the way she feels and thereby do not *really* understand what she is going through, but in your discussions her thoughts are easy to follow and consistent over time. She planned everything perfectly, talked to others who made similar decisions and all in all she has come to the conclusion that this is in her best interest. Furthermore, Nina can explain her decision in detail and it is in accordance with her non-verbal communication. She knows every little aspect of information she needs to know of her new residence. Lastly she is aware of everything that influenced her decision to emigrate. In other words, we can say that Nina is a competent agent who intends to act rationally.

We can all agree that it is morally acceptable for you to talk to Nina, express your feelings concerning her plans to leave and you can make an effort to convince her to stay. Those attempts will not harm her ability to determine her own actions. The conversations will leave her competence intact. Or at least, for as long as the conversations are not too compelling and rational to some degree. Some conversations will ruin the agent's competence, but there are multiple forms of conversations that can even promote rationality. You have a lot of conversations, but she is surefooted. She is leaving. The last resort to convince her is to hold her here as long as possible. But you cannot lock Nina for as long as she is planning to leave. And even if you would lock her, it will not change anything because she made a rational decision. It is not a matter of temporary treatment because she is irrational or mentally ill. The morally acceptable method of conviction is rational conversation, and that apparently did not work before. We can agree that it is morally unacceptable to physically stop a competent agent from acting rational. This would argue to stop putting death deciders in detention. Cholbi would agree on this. What exactly does he advocate? What would the world look like when we apply his theory to practice?

b. Cholbi: only paternalism with an irrational agent

In his paper "Kantian Paternalism and Suicide Intervention", Cholbi argues on what conditions paternalism is permitted in a Kantian theory. Interferences with individual liberty do not necessarily limit someone's rational autonomy, Cholbi argues, it can even promote individual liberty. Cholbi identifies different threats to our rational autonomy, for example poor planning and weakness of will. Paternalism would help an agent to get back to the rational chosen ends she had before distorted reasoning struck her. If and only if we are able to restore the rational chosen ends in the agent through paternalism, interference in an agent's liberty is permitted. Cholbi himself describes it as *"Interference with an individual's liberty for her own sake is justified absent her actual consent only to the extent that such interference stands a reasonable chance of preventing her from exercising her liberty irrationality in light of the rationally chosen ends that constitute her conception of the good*."[76] So paternalism is focussed on restoring the agent's rational autonomy, and to do that we sometimes need to limit an agent's freedom for a while.[77] If we apply this theory to death deciders, paternalism would not be permitted. Death deciders are rational and competent to make their own decisions. There are no "*rationally chosen ends that constitute her conception of the good*"[78] to bring them back to. Paternalism would have no purpose or effect. In principle I agree with Cholbi, it was one of my arguments to doubt current suicide policies. I wonder what would happen if we hold on to Cholbi's demand? To explore this I use a thought experiment.

You can imagine a psychiatrist receiving a young suicidal man in his consultation room. They meet each other for the first time. The young man was brought here by his aunt because she worries about him. The aunt is scared that her nephew will hurt himself if he does not get help. The young man on the other hand tried to convince her that suicide is the best he can do for himself and the people around him. In the ideal world, the young man, the psychiatrist and the aunt can speak freely with each other about the situation, their feelings and the options they have. Following from that information, the psychiatrist can make his judgment whether the young man would benefit from psychiatric help to cure irrationality or incompetency or whether the young man is a death decider. If the young man is competent and/or irrational, physical interference may be necessary to keep him safe from his own harmful and suicidal decisions. However, if the young man is competent and rational, the psychiatrist may, in the ideal world, decide that he is free to go. Or

[76] Cholbi 2013, p. 118.

[77] Cholbi 2013, p. 118-121.

[78] Cholbi 2013, p. 118.

at least we must not physically limit him to act. Yet, there are at least three major problems we meet with this way of dealing with suicidal tendencies.

The first problem rises in an early stage of the meeting between the psychiatrist and the young man. To enable the psychiatrist to make the best assessment of the person sitting in front of him, his patient needs to speak freely about his feelings, thoughts and history. However, this is not as easy as it seems. Probably the patient is not used to talking about his suicidal feelings, especially not with a stranger. Besides, talking about suicidal feelings even causes discrimination, socially as well as professionally. So speaking out loud about suicidal feelings requires courage.[79] Furthermore, the psychiatrist is not familiar to the agent in question, so it may take some time before the patient can trust the psychiatrist enough to talk freely. Hence, it may take some time before the agent can open up and let the psychiatrist do his job in a decent way.

Secondly, it will take a while before the psychiatrist can judge whether he speaks to a death decider. Even if the patient is open, self-conscious and honest from the first moment on, at least a second conversation is necessary to judge, for example, the agent's consistency and whether the agent's non-verbal communication is in accordance with her statements. It is impossible to verify all the requirements for competency and rationality in one conversation. Not only because it is too much to do all at once, but also because it is important to get to know the people you are dealing with as a psychiatrist. Particularly because it is necessary to test consistency in statements and non-verbal communication of the agent. It is impossible to verify all the different requirements in one session or one week. The longer the psychiatrist works with the agent, the better he can judge the rationality and competence of the agent.

In Cholbi's ideal world, this patient lives in freedom until it is sure that the agent is irrational and paternalism will help him. However, Cholbi's own argument against Brandt is his own pitfall on this point. I briefly outline why his theory may be interesting in abstract theory, but not desirable in practice.
Cholbi responds to Brandt that we need to look at the present-self because of the irreversibility of suicide in order to assess rationality. Say the psychiatrist is still uncertain about the assessment of the young man from the example, the psychiatrist has to let him go. Freely, making his own decisions. Yet, the young man is able to harm himself badly or even commit suicide in the time he is free. Suicidal and irrational/incompetent people will die without physical interference and

[79] Stefan, p. 372-373.

the effect is irreversible. On the other hand, death deciders can be hospitalized against their will, but that decision is reversible. It is may not be morally acceptable to detain death deciders against their will, but it is even worse to let irrational/incompetent people die in order to let death deciders be. Therefore, to be as sure as possible that we can help those who are irrational and/or incompetent, it may be necessary to secure all suicidal people for a while until the professionals had a decent opportunity to assess the agent. I think we have to accept some form of physical interference with suicidal people in order to safeguard every suicidal person that is not a death decider.

The third problem rises at the end of the process described. Because the group of death decider is non-existent in the current policies, there is no policy for them. Suppose the psychiatrist is by a miracle able to judge the young man within an hour and appoints him as a death decider. What happens next? Letting him go and live his life as he wants to do, with or without suicide, is rude. For him, his loved ones and everyone accidentally around him if commits suicide. We have discussed the requirement of peaceful means in order to commit rational suicide in the first chapter. I emphasized that it is impossible in today's society to use peaceful means. So what should the death decider do? Still jump in front of the train? Of a building? Shoot herself? These methods will harm the death decider *and* the people around her more than necessary. I do not think anyone wants that and to properly guide these people we are in need of policies to care for death deciders, without harming the others.

III. Proposal for new suicide policies

As said in the introduction of this chapter, I do not strive to provide a full policy proposal. This section only tries to give an idea of one of the options one can think of when trying to design a new policy. It is one of the many options that is compatible with the conclusions we have drawn on rationality and competence with suicidal agents. What we need is a policy that guarantees everyone's safety as much as possible and at the same time does not violate the death decider's autonomy and rationality more than necessary. One of the possibilities for a new suicide policy as I would see it consists of two phases. The first phase is the same for every suicidal agent and is focussed on the assessment of the agent's rationality and competence and suicide prevention. The second phase is different, based on the assessment that was made in the first phase, either focussed on suicide prevention or managing suicide.

a. First phase

This first phase is necessarily the old-fashioned suicide prevention. It is purely focused on assessing the agent's rationality and competence. As argued in the last chapter, forced hospitalization is necessary to safeguard the irrational and incompetent suicidal persons. To make sure everyone is as safe as possible, every suicidal agent is treated as irrational and incompetent until the opposite is proven. In addition, if someone is no longer a direct danger to herself, detention is no longer allowed. This is also prescribed by the current policies. Whereas current policies require a treatment plan, I think a plan and report of the interviews for every suicidal patient is more accurate here. As seen in the discussion on how to recognize a competent agent, it is difficult or even impossible for one professional to determine whether someone meets the requirements of being a death decider. If different professionals talk to the same agent, a flawless transfer of information is necessary. Together they are responsible for someone's future, for the treatment of help the agent will get. Literally a matter of life and death. A planning and report do not imply treatment for every suicidal agent, and still care for transmission between the professionals working on one case. Therefore, a decent planning of the conversations and report should be mandatory.

b. Second phase

When the first phase is finished and the agent is assessed as irrational and/or incompetent, she turns into a patient and the focus stays at prevention and the treatment will start. This patient will get, among other things, a treatment plan and medical supervision. This group will benefit from the suicide prevention policies that are already set out in the Netherlands.

On the other hand, the group of death deciders do not have any policies to rely on because current policy assumes that every suicidal agent will benefit from treatment. The policies do not anticipate on rational and competent suicidal people. Thence, all policies are focussed on the prevention of suicide and I think it is time we start looking further than that. Detain them until they change their mind will not help, but can not just 'let them go' either. With the last option we risk that they use harmful suicide methods. Methods that are harmful to themselves and their environment. However, give them a jar filled with deadly drugs will not work either. The drugs will avert the damage to the environment as much as possible. However, the lethal combination of drugs still leaves strong marks and, maybe most importantly, you do not know whether the agent takes them in a sudden whim of irrationality. Finally, both options leave the death decider alone in the most difficult period of her life. Is that what we want? Therefore, practical guidelines are necessary to help this group and the people around them. One of the possible solutions we can

think of is a place where people are able to, after an intense period of assessing competence and rationality, commit suicide in a controlled and peaceful environment. This would diminish the damage to the death decider's body and the environment. As said before, I never tried to come up with a complete policy proposal - although I aspired it when this project started. It is just a little attempt to explore the possibilities we have to protect both death deciders as suicidal patients that need treatment.

C O N C LU S I O N

I. What we have discussed

This thesis started with the question whether rational suicide is possible. From there on followed questions about the competence of a rational suicidal agent. Eventually the consequences on the current suicide prevention policies were discussed. The goal of investigating rationality and competence was different: rationality needed elaboration to show that suicide is not always a result of mental illness or other forms of irrationality. The conclusion that suicide can be rational is a correction of the deep-rooted feeling in society that suicide is always irrational. Competence on the other hand was needed to discuss because current suicide prevention policies assess suicidal people for competence.

The first chapter focused on the definitions of suicide and rationality. In conclusion, a rational suicide is characterized by decent planning, in accordance with autonomously chosen ends, the decision is discussed with an experience expert and the experience expert assesses the planned suicide as rational. In this chapter was shown that the current opinion in society about suicide, that it is always done by someone who is irrational, is not necessarily true. Rational suicide is a possibility. However, this did not have immediate consequences for the way we treat suicidal people at the moment.

Competence was discussed in the second chapter. Whether it is accepted to hospitalize someone against her will nowadays is decided on the assessment of competence. If the agent is not competent to make her own decisions and threatening to commit suicide, forced hospitalization is permitted. So competence needed to be discussed in the second chapter. The important features of a competent agent are that she is able to explain her decision, understands the important information, her non-verbal communication is in accordance with her statements and that she is aware of the external influences on her deliberation process. The important difference between rationality and competence turned out the be the pronounced awareness of external influences. Whereas rationality theoretically requires the agent to act autonomously and independent from others, competence pointed out that it is impossible to act independent from others. The two concepts of rationality and competence do not exclude each other, they can even reinforce each other. From this point on, I referred to the competent, rational and suicidal agent as death decider. The self-inflicted death is not thrown upon them by others or mental issues. They selected death as the best option.

The third chapter discussed the suicide prevention policies. The current policies imply that the suicidal agent is always (mentally) ill, needs treatment and thereby suicide needs to be prevented. The question rose whether it is morally acceptable to hospitalize the death decider against her

will. Unfortunately, it turned out to be necessary to hospitalize every suicidal agent with a serious threat in order to save the irrational/incompetent suicidal agent. The time of forced hospitalization gives the medical professionals time to assess the suicidal agent properly. Finally, I elaborated on a new system of suicide policy. Suicide prevention still is important for the irrational/incompetent suicidal agent, but suicide managing policies should be of interest for the death deciders. The assessment of the agent's rationality and competence will happen in the first phase of suicide policies where the focus still is with suicide prevention. If we stick with current policies and let the death decider go we will leave them in the dark because there are no policies they can rely on. Current society would force death deciders to brutal ways of committing suicide, I want to prevent that from happening as much as possible. In order to help death deciders to commit suicide in a peaceful way with respect for their own bodies, their loved ones and their environment, we have to offer new policies. Eventually, this will result in some kind of suicide managing policies that will help death deciders to leave this life in a peaceful and decent way. There was not enough space to work this out properly, but hopefully this last section gave some direction for future research.

II. Future research

The elaboration on the second phase is far from finished. Future research is needed to work this out properly. One of the possibilities that will probably come up is stretching the policies on euthanasia. I think it is fine if the agent agrees with euthanasia, but if someone does not want euthanasia, I think we need to try and find policies to give the opportunity to actually commit suicide. If we do not respect the wish for suicide and force them to go with euthanasia, a whole new discussion on competence and rationality will start. So whereas smoother rules on euthanasia will help a part of the group, there will still be people who really want to commit suicide for various reasons. There are two possibilities I think are worth exploring, both require intensive psychological investigation. One possibility is to let people commit suicide in controlled circumstances, for example in a hospital situation. This would make sure no one else is hurt in the act of suicide. The second option is to prescribe some kind of medication that causes one's own death in a peaceful way. We can design this medication in such a way that it requires decent planning, that it is not done in a sudden whim. Even if the agent has been assessed as rational and competent before receiving the medication this will be necessary, as we have discussed during this project people are changing all the time, so the assessment of rationality and competence can change as well.

On a cold October morning in 2010, my father found his brother's body lying in his bed at home. He took a lethal combination of drugs. He had been dead for over five days before my father found him. My father knew his brother was planning to commit suicide - he knew all about his considerations and all the details of his suicide plans. Yet my father was not able to help him. Had the plan not been kept secret, a psychiatrist would have detained his brother and a judge would have sentenced my father. Being there for him was the only thing my father could do, and in his last moments, he could not do even that, and that must have been tough. For both of them it has been an intense period without any support and a lot o fear, pain and grief.

My uncle felt like he had to commit suicide in secret, at least five days before the scheduled day. Maybe he felt he needed to rush because he feared that his plans would leak. As a result, he was completely alone in the last moments of his life - and the short week thereafter. Unfortunately for him this project started too late, but I hope in the future that we can make life, and death, a little bit easier. A less tense public debate would be the first step, new policy would be the preferred second step.

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