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The Limits of Rationality: Suicidality, Affectivity, and the Rational

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LOYOLA UNIVERSITY CHICAGO

THE LIMITS OF RATIONALITY:
RATIONALITY, SUICIDALITY, AND AFFECTIVITY

A DISSERTATION SUBMITTED TO
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ABSTRACT

In this project, I expose conceptual and moral difficulties with the concept of rational suicide. After offering a comprehensive list of criteria used to define rationality in the bioethics literature, I turn to the scholarship of Susan Sherwin, Susan Wolf, Rosemarie Tong, Lisa Ikemoto and others to apply feminist critiques regarding the privileging of the liberal individual and claims of value neutrality in bioethics generally to the rational suicide literature specifically. Further, using the work of Genevieve Lloyd, I argue that just as definitions of rationality have been used to marginalize vulnerable populations (e.g., women and minorities), a similar marginalization of suiciders occurs in the rational suicide literature. In order to rectify this marginalization, I call on Jean Améry’s account of his own suicidality, and through exegesis of On Suicide: A Discourse on Voluntary Death, I argue that Améry’s account reveals that suicidality is neither rational nor irrational, but arational. Given that in some instances of the lived experience of suicidality, discussions of rationality are not applicable, I question the efficacy of “rational suicide” as the concept upon which to ground arguments for the moral permissibility of suicide and assisted suicide. Finally, having established both conceptual and moral difficulties with the concept of rational suicide, I argue for a new concept upon which to base arguments for the moral permissibility of suicide, appropriate death.
INTRODUCTION

When considered in the abstract, suicide is undoubtedly ontologically interesting. Human beings are the only creatures that not only can question life and its purpose, but that may also choose to self-annihilate. What does it say about the human condition that one million people a year worldwide take their own lives (that is, approximately one person every 40 seconds) and that up to 20 times more individuals attempt to do so? (World Health Organization 2014).

Yet considering suicide in this abstract way misses something. It is the undeniably complicated nature of suicide and the lived experience of suicidality that originally alerted me to an oddity in the bioethics literature on rational suicide. Much of Western bioethical thought on physician assisted suicide is devoted to establishing the possibility of rational suicide and to establishing its moral permissibility. It is widely held by bioethicists that if circumstances can be found in which suicide could be rational, then there is neither moral reason to prohibit a person from committing suicide, nor to prohibit another person from providing the means by which that person might commit suicide. In other words, a considerable number of bioethicists assert that establishing the rationality of suicide is the first and best step to arguing for the moral permissibility of assisted suicide.

But there is something intuitively odd about the phrase “rational suicide.” For those who have first-hand experience with the suicidal, pairing the world “rational” with “suicide,” an act that can seem impossible to justify and hard to contain, may be an af-
front. For those with experience of suicidal persons, or who are themselves suicidal, the phrase seems cold, without empathy, and lacking all nuance.

To introduce the complexities of a suicidal individual’s situation, consider the following case study:

“Cathy,” a 59-year-old woman, was hospitalized for her first suicide attempt at 15. Although her doctors suggested therapy, Cathy came from a blue-collar family who did not believe in “head doctors.” Cathy’s physically and emotionally abusive mother suffered from undiagnosed bipolar and borderline personality disorder, and insisted her daughter’s suicide attempt was an attempt to get back at her, refusing to recognize the sincerity of her daughter’s attempt. This young woman was released to her parents, and she continued to live with them until she was 21. She experienced bouts of what would later be recognized as clinical depression and mania, with recurrent suicidal ideation, but did not attempt suicide again while living with her parents.

At the age of 26, Cathy married, and she had children when she was 28 and 30. She started making non-lethal suicidal gestures again in her mid-thirties, and exhibited symptoms of both borderline personality and bipolar disorder. She was formally diagnosed as borderline and bipolar at 50. From the age of 45 until the present day, she has attempted suicide no fewer than six times. At 52, Cathy’s sister took over her power of attorney and became her legal guardian. Two of her suicide attempts, made at 55 and 57, were severe enough that she was admitted to the critical care unit at her local hospital. At 56, Cathy was diagnosed as paranoid schizophrenic, and she continued to have recurring bouts of delusional thinking. In addition to suffering from mental illnesses, she had COPD which causes acute bronchitis and pneumonia, frequent debilitating migraines,
diabetes, as well as several other physical ailments that required occasional surgeries and hospitalizations. She lived alone and received in home care every day of the week.

Cathy had a do not resuscitate order (DNR) and an advanced directive (AD) that specified no extraordinary measures be taken to save her life (including the express refusal of the use of ventilators, and defibrillators). Although both documents were endorsed by her primary psychiatrist and her legal guardian as required by the laws of the state in which she resided, during all of the hospitalizations for her suicide attempts, her DNR and AD were ignored.

Cathy now comes to her psychiatrist and explains that she wants to kill herself with help from her doctor. She is lucid (not experiencing a schizophrenic episode), her bipolar and borderline are currently well regulated by medication, and she expresses this wish articulately. This is not the first time she has expressed a desire to kill herself when lucid and when her bipolar is well controlled. She is afraid that like the last few times she attempted suicide, her caretakers will intervene, so she wants her doctor to prescribe her medications that will quickly and painlessly kill her. Although the correct combination of the psychiatric medications she currently takes could do this, her sister keeps her medications for her, and gives her only two days of medication at a time. Furthermore, Cathy does not have the knowledge to figure out lethal dosing. She has known her doctor for almost 20 years: this doctor is acutely aware of the daily suffering Cathy experiences, and knows her well enough to know when her suicidality is directly tied to her bipolar, borderline personality disorder, or schizophrenia. He also knows her family has suffered alongside Cathy for years, and is in support of her DNR and AD. The doctor is inclined
to prescribe her the drugs. Putting aside legal considerations, what should the doctor do?

This case highlights the potential complexity of individual cases of suicidality and is the kind of situation that motivates this dissertation. There are many details in this case that might affect one’s moral reasoning about the decision with which the doctor is faced. Although the question at hand is a moral question and sets aside legal problems, the moral framework with which one starts will determine what facts “matter.” Moreover, the opinions about suicide with which one starts will lead to very certain conclusions. The vast majority of the rational suicide literature does not address cases like this, and as I will argue, the criteria for rational suicide would not permit such a case to be considered for assisted suicide. The purpose of this dissertation is to bring more nuance to the discussion of suicidality in the philosophical bioethics literature on suicide and assisted suicide in order to allow for serious consideration of situations faced by individuals like Cathy.

This is not to say that the rational suicide literature purposefully lacks empathy for suiciders. In fact, as will be explained in this dissertation, one can understand the rational suicide literature as an attempt to explain how suicide can be a good death for a particular population of people, specifically, those faced with terminal illness. The suffering of the terminally ill demands a response. The response offered by those writing on rational suicide is to argue for the moral permissibility of suicide and assistance in suicide by appealing to reason and rationality, foundational concepts in philosophy with which philosophers are often very comfortable. Yet however noble the motivation may be, there
are considerable problems with speaking about suicidality and suicide in terms of rationality. This dissertation will examine those problems.

Before giving an overview of what will be explored in the coming chapters, some brief terminological considerations are in order. The terms I will define and use throughout this work include suicide, suicider, suicidality, assisted suicide, appropriate death, and the “good death.”

Suicide is a remarkably hard term to define. There have been entire books written on its very definition (c.f., Durkheim 1997, Fairbairn 1995, Fernandez 2001, Hill 2011, Jamison 1999, Kupfer 1990, Lebacqz and Engelhardt 1977), so while I will adopt a definition for my purposes, it is well beyond the scope of this dissertation to argue for it. I will adopt the definition offered by Gavin Fairbairn in his *Contemplating Suicide: The Language and Ethics of Self Harm*. According to Fairbairn, suicide is, “the act of deliberate, intentional and wished-for self destruction...” (Fairbairn 1995, 7). In order for an act to be considered suicide, a person must purposefully commit the act and be committed to her own death. Moreover, the death must be self-initiated and completed. That her self-destruction be “wished-for” means wishing for her death *given the circumstances at hand*. For instance, the self-destruction of a terminally ill person can be considered wished-for, even if the terminally ill person would desire to live *given different circumstances* (for example, the absence of a painful terminal illness).

The benefit of this definition is that it allows for an examination of many types of suicidality. Suicidality is the experience of the inclination to suicide (Shneidman 1996,
and it comes in varying degrees. The experience of suicidality can include suicidal gesturing (mimicking acts of suicide without the lethality of suiciding) and having suicidal thoughts and fantasies (cf. Cholbi 2011, Fairbairn 1995, Shneidman 1996). One need not attempt suicide in order to experience suicidality, or to be considered a “suicider,” but instead suiciders are “people who suicide or gesture at suicide or who otherwise deliberately act in self injurious ways that could conceivably end in their deaths” (Fairbairn 1995, xiii). This understanding of suicidality and suiciders is important for my project because, as will become evident, I will be extensively considering two very different experiences of suicidality. These experiences of suicidality exist on opposite “poles” of this concept.

The first experience of suicidality that will be at issue is the suicidality of those who are terminally ill and who wish to suicide. In some sense, those who are terminally ill, as described in the rational suicide literature, want to suicide given their circumstances, but do not want to suicide because they wish for death in and of itself. This is the person with pancreatic cancer and a terminal diagnosis who does not wish to put herself through palliative chemotherapy, but wishes instead to control the circumstances of her death. Under other circumstances, that is, if she did not have a terminal illness, she would not wish for her own self-destruction; but in such a situation her wish to suicide is a way of dealing with her circumstances as they present themselves.

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1 It is an established convention in the suicidology literature to avoid using the phrase “to commit suicide” and to use the term “to suicide” instead. The word “commit” is thought to bring with it connotations of illegal and immoral activity. Insofar as possible, many suicidologists and researchers in suicide look to use the more neutral term “to suicide” (c.f., Bolton 1987, Cholbi 2011, Clements 1986, Dunne and Dunne-Maxim 1987, Edwards 1997, Fairbairn 1995, Humphry 1986, Litman 1996, Motto 1980, Schneidman 1996). My dissertation will follow this convention.
The other sort of suicidality I will explore at length in this project is what I will call “extreme suicidality,” and is described by Jean Améry in his *On Suicide: A Discourse on Voluntary Death*. This is an experience of suicidality as a primordial conflict about a suicider’s existence in the universe. Much more detail will be offered about this experience in Chapter 3, but in brief, Améry speaks of this sort of suicidality as an inclination towards death that takes root in the suicider before all rational discourse. This sort of suicider experiences suicidality viscerally, and the pull toward death is present regardless of the circumstances. Suicidality is not situational for these sorts of suiciders, but is constitutive of their identities.

Assisted suicide occurs when the means of suicide are supplied to a person by an outside actor. Physician assisted suicide is a specific type of assisted suicide in which a physician offers these means. Usually this involves a physician prescribing a lethal drug to her patient. Several cases of non-physician assisted suicide will be considered in Chapter 2, with the prototypical case involving a loved one helping a suicider kill herself by providing the means by which to do so.

Appropriate death will be spoken of extensively in Chapter 4, but in short, an “appropriate death” is a death one might choose for himself if given the choice (Weisman 1979, 1993). It is a death that fits with the lifestyle of the person who is dying. Whereas in the philosophy literature “rational suicide” is an attempt to explain suicide as a good death for some terminally ill people, appropriate death is an attempt made by psychiatrists to offer criteria for establishing what good deaths might look like for all individuals. Appropriate death is based on two primary factors: the subjective experience of the person dying and the concrete circumstances surrounding a death. “Appropriate death” dif-
fers from “rational suicide” in a number of ways that will be discussed later on, but most importantly it is a concept that is geared toward helping anyone die a better death.

Finally, some consideration of “good death” is in order. It is well beyond the scope of this dissertation to determine absolutely the grounds for a good death, so this discussion will not be pursued at great length. The operating notion of a good death that guides my work is heavily informed by feminist and narrative ethics. Indeed, my guiding ethic behind this project is best summed up by Margarit Shildrick in her work *Leaky Bodies and Boundaries: Feminism, Postmodernism, and Bioethics*:

There is no final and absolute answer to moral dilemmas, no self-complete system which can satisfy all the demands made of it, nor which can speak with authority across time and place...the point is that a feminist ethics asks different questions of itself. It seeks to understand the specificity of meanings and the particularity of participants, with the result that its answers must always be held open to modification at least, and possible to radical change...Openness should not be interpreted as weakness, nor as indecision, but rather as the courage to refuse the comforting refuge of broad categories and fixed unidirectional vision (1997, 3).

When situations arise that call for moral resolution, one must remain sensitive to the particularities of the situation as well as to the circumstances of the individuals’ lives that are affected by the moral discussion. This is especially true in end-of-life discussions. Facing one’s own death is a point in a human life where a person is uniquely confronted with her own deep preferences, desires, and fears. Thus, attention to particularities of circumstance is essential to rich discussions of end-of-life issues. In this dissertation I will use Hilde Lindemann’s notion of counterstory to help develop this sensitivity to particularity in my discussion of suicidality. I will argue that an unintended lack of sensitivity on the part of bioethicists has created moral and conceptual problems in the bioethics literature on rational suicide. This lack of sensitivity has caused some bioethicists to deny that sui-
cide may be a good death in situations in which I argue that it could, in fact, be a good death.

The aim of my dissertation is to find ways in which the suffering of people who struggle with suicidality can be reduced. In some instances, this is going to involve granting suicidal people assistance in suicide. I will argue that it becomes morally appropriate to assist in suicide when appropriate death criteria have been met. In order for a person to live a good life, she must be able to die a good death whenever possible. The conclusion to this dissertation will argue that in some cases (like the case of Cathy that started this introduction), a good death might include suicide and a suicider might require assistance to achieve that good death.

In order to argue for the superiority of the concept of appropriate death over the concept of rational suicide for determining when suicide and assisting in suicide is morally appropriate, considerable attention must be paid to the concept of rational suicide. I have already mentioned that there is a sense in which rational suicide literature can be understood as lacking empathy, but this is a symptom of the more general foundational problems in the rational suicide literature. While the first chapter will offer an exhaustive overview of the criteria used by bioethicists to define rationality in the rational suicide literature, the bulk of this dissertation will offer specific critique of this literature.

After a thorough examination of the rational suicide literature, my second chapter will apply feminist critiques of bioethics and feminist critiques of rationality to the criteria for rationality identified in the first chapter. I will argue that the rationality literature unjustifiably privileges the concept of the liberal individual over more social conceptions of the self. It also promotes the myth of value neutrality on the part of doctors, which
negatively affects the doctor/patient relationship and allows doctors and ethicists to ignore the social realities of the medical enterprise and the ways in which these social realities change the nature of the interactions doctors have with their patients. In addition, as some feminists point out, medical training brings with it values that may run contrary to patient desires at the end of life. I will give general consideration to the way in which denial of rationality has been used to marginalize certain populations in the past, and will argue that a similar marginalization happens to suiciders in the rational suicide literature.

The third chapter will address this marginalization by bringing to bear a suicidal voice on this debate. I will offer an exegesis of Jean Améry’s On Suicide: A Discourse on Voluntary Death, which is an extended reflection on his experience of suicidality and the phenomenon of suicidality generally. I will frame this reflection in terms of Lindemann’s notion of counterstory, and present Améry’s account as a counterstory that stands opposed to the story told about the terminally ill by bioethicists in the rationality literature. While it is possible to understand bioethicists’ attempts to establish the possibility of rational suicide as trying to do the work of counterstory, ultimately this work turns into what Lindemann calls a hostage narrative, insofar as the terminal illness narrative developed by bioethicists further marginalizes the type of people who experience suicidality as Améry describes it. I will argue that as a hostage narrative, the terminal illness narrative developed by bioethicists must be rethought.

The marginalization of suiciders also causes conceptual problems. If the ethical literature written on a population does not engage with the population it purports to serve, it becomes possible that the concepts used to speak about this population are inappropriate to their lived experiences. The rational suicide literature has not actually considered
the testimony of many suiciders, and certainly not the testimony of a suicider who is not terminally ill. Since the experience of suiciders has not been given proper consideration in the development of the concept of rational suicide, bioethicists have not recognized that the ascription of rationality to suicidality is problematic. As examination of Améry’s narrative will show, extreme suicidality is rooted in an affective stance towards being in the world. This conceptual difficulty further reinforces the marginalization of certain types of suiciders.

The fourth and final chapter of this dissertation will focus on the repercussions of what was discovered in the first several chapters. Rational suicide is too problematic, both conceptually and morally, to be the base upon which arguments for the moral permissibility of assisted suicide are made. The question becomes whether there might be another concept out there that might serve as this base. I will examine a similar movement in the psychiatric literature that centers on the concept of appropriate death. I will outline what is meant by appropriate death and explain how, like rational suicide, it is an attempt to define the circumstances under which a person might die a good death. The concept and formation of appropriate death avoids the criticisms to which rational suicide falls prey. I will argue that suicide can be considered an appropriate death, and suggest that bioethicists should begin to look at appropriate death as a possible alternate foundation upon which to base arguments for the moral permissibility of assisted suicide.

This dissertation is concerned with questions of the possibility of a good death under non-ideal circumstances. It is motivated by the belief that many people can die good deaths, and that dying a good death is an important part of living a good life. Ultimately, I suggest that a vision of the good life can include the practice and social ac-
ceptance of suicidality and suicide. Anyone interested in questions surrounding the good life must deal with the fact that one choice human beings have in the face of life is to end it. It would be a hasty mistake to conclude that Cathy, in the case study above, is incapable of experiencing a good death through suicide. My dissertation will thus argue against the use of rational suicide as a guiding ethical concept in the bioethics literature, with the hope of applying the concept of “appropriate death” to help determine how the circumstances of a good death might be found for individuals like Cathy.
CHAPTER ONE

THE CONCEPT OF RATIONAL SUICIDE

There is no shortage of bioethics literature devoted to establishing the possibility of rational suicide, to defining what rational suicide is, or to establishing its moral permissibility. It is widely held that if some cases of suicide can be rational and it can be established that a rational person might want to suicide, then it is possible that there might be neither moral reason to prohibit a person from suiciding, nor to prohibit another person from providing the means by which that person might suicide. In most circumstances involving a rational adult, s/he is able to choose to act in a variety of different ways without interference from others, even if that adult’s actions would seem reckless to most other people. For instance, since I am an adult, if I want to jump out of a plane with nothing but a backpack full of silk and find licensed professionals willing to help me do so, it would not be permissible for another person to prevent me from doing so. If I want to smoke a pack of cigarettes a day, never exercise, and avoid eating any fruits or vegetables, no one has the right to force me to make other, definitely healthier, decisions. In both of these instances, my loved ones are entitled to try to persuade me to do other than I wish. My friends might remind me that I am not a fan of heights, or tell me about the number of people killed skydiving every year. They might provide me with scientific evidence of the connection between a shortened lifespan and cigarette use. They might extol the benefits of eating well and exercising. At the end of the day, however, if I want to visit the
McDonald’s drive-through while chain-smoking cigarettes on the way to a skydiving appointment, no person is morally justified in forcing me to do otherwise. In fact, my loved ones might very well run afoul of the law if they tried to force me to stop.

If the principle of non-interference holds in most circumstances, even when someone is acting as recklessly as described above, we must ask about the limits to this principle. A number of bioethicists argue for what might initially seem like an extreme limit: even in cases of suicidality, no one is justified in interfering as long as the person who is suiciding is rational and the act of suicide itself can be established as rational given the person’s specific circumstances. Much like the other circumstances described, the only justification these bioethicists see for interfering in a rational adult’s life is if her actions bring harm to those around her. Some thinkers argue that, given the right circumstances and proper planning, a person’s suicide might not bring harm to others. Moreover, if a person meets certain criteria and can be shown to be rational, others might be morally permitted (or even required) to assist in the act of another person’s suicide. There is a great volume of bioethics literature devoted to establishing the moral permissibility of suicide and assisting in suicide based on establishing that the suicider and the particular act of suicide enacted by that suicider is rational.

Yet there is something intuitively odd about the phrase “rational suicide.” For those who have had first-hand experience with suicide or the suicidal, pairing the word “rational” with “suicide,” an act that can seem impossible to justify and hard to contain, is almost an affront. This dissertation looks to explore this original intuition, and to ground and justify it. I contend that holding rationality as the foundational criterion for the moral permissibility of suicide or assistance in suicide is flawed. I believe this is the
case for three reasons. First, some of the criteria identified by bioethicists to establish rationality are flawed. Using the work of feminist thinkers, I will show how specific criteria identified in the rationality literature are problematic. Second, building off of the work of Genevieve Lloyd and others, I will argue that the application of the concept of rationality has been used to marginalize suicidal knowers and knowing in the rationality debates, much like the concept of rationality has been used to marginalize women, minorities and the disabled in other literature. Finally, even when understood in light of this historical critique, there are conceptual issues with the ascription of rationality to the act of suicide or the person who wishes to suicide. In the face of suicide, rationality is rendered meaningless.

Before expounding upon these critiques, however, we must establish how “rationality” has been defined in the literature. It is helpful to have a cursory understanding of the origins of and the motivations behind the contemporary resurgence of discussions of the possibility of “rational” suicide before defining rational suicide. Although the project of identifying rational justification for suiciding has famously been around since the ancient stoics, it is best to understand the bioethical interest in the possibility of rational suicide in terms of a reaction to two contemporary considerations.

The bioethical discussion of rational suicide in part comes about as a reaction to the scientific model of suicide that views attempting suicide or suiciding as indicative of and caused by mental illness. The creation of the “suicidology” movement in the 1950s and 1960s brought on by the research of Edwin Shneidman, Norman Farberow, and Robert Litman, among others, brought with it an increased reliance on this “mental illness model” of suicide (Litman 1996, 2). Simply put, the mental illness model of suicide holds
that suicidality is a product or symptom of mental illness. The key to understanding and treating the phenomenon of suicide is understanding and treating the mental pathology of the suicidal person (cf. Shneidman 1996 and 2004, Edwards 1997, Biggar 2004).

Although the empirical connection between mental illness and suicide cannot be denied (it has been estimated that up to 90% of suiciders were clinically depressed at the time of death, and some studies estimate that up to 10% of schizophrenics will suicide (Hewitt 2009)), many bioethicists point out that this does not exclude the possibility that some suicides are not caused by mental illness. As David M. Clarke reminds us, “the importance of these observations [that is, the observation that mental illness is very often present with suicidality] does not lie in concluding that psychiatric illness ‘causes’ suicide, but in that suicide rarely occurs in the absence of some persistent disturbance of mental functioning” (Clarke 1980, 457). Suicide, in the majority of cases, happens alongside some mental irregularity, but this is not enough to prove that suiciding is always a result of mental illness. Empirical correlation does not necessarily mean that mental illness can “explain away” all instances or types of suicide.

Even though suicides that are not directly attributable to mental illness may be rare, these sorts of suicides are possible and garner a lot of attention when they occur. For instance, a recent case in England involving David Arnold and Elizabeth Arnold has sparked much controversy. The couple entered into a suicide pact five years earlier. When Elizabeth was diagnosed with Alzheimer’s Disease and started to exhibit symptoms, the couple chose to enact their pact and overdosed on medication on July 13, 2012 (Marsden 2014). In another highly publicized story, married couple Vladimir Fiser and Marika Ferber took their lives by jumping out of the window of their apartment building.
in order to put “an end to [Ferber’s] chronic pain” (Oved 2013). This story gained much press because both Fiser and Ferber were holocaust survivors with an imagination-capturing love story. In both of these cases, the communities each couple were from reacted sympathetically, and there are no shortage of comparable stories covered in a similarly sympathetic fashion (c.f., McCormack 2013, Hughes 2014, Donaldson James 2010, Smith 2014, Chawkins 2013, Levinson 2013.) In a field that relies heavily on autonomy in its discussions of morality, stories like these, which establish that suicidality can be exhibited in persons whose judgment is not impaired by mental illness, leave room for the possibility that suiciding might be an option open to an autonomous person (cf. Barnard 1980, Cohen-Almagor 2001, Colby 2006).

The second motivating factor in the discussion of rational suicide stems from consideration of a much broader population than the mentally ill. People are living longer and under conditions that could not have been imagined fifty years ago. The need for uncovering whether there might be cases in which the act of suicide might be rational became especially pressing because of medical advancements that occurred around the same time that the mental illness model of suicide was taking hold. Advances in medical technologies in the early and mid 20th century (e.g., the cultivation of penicillin and other antibiotics, the development of artificial respirators, etc.) created a number of questions surrounding the way human beings die. An increased life span does not necessarily bring with it a similar quality of life, and worries about people being kept alive too long and under circumstances they found objectionable became an issue. There was a practical need to decide what might be considered suicide and what might not, as well as to establish whether doctor assistance in suicide might ever be permissible. Many new ethical

With these developments, determining exactly what constitutes suicide and if suicide could ever be a rational act chosen by a rational person became a timely and important project. The mental illness model of suicide justifies acting paternalistically when someone expresses the wish to suicide. However, if it can be established that suicidality is not always indicative of mental illness, that is to say that some suicidal people are not mentally ill, and if it can be established that there might be some situations in which suicide might be a rational response, many bioethicists argue that we must then take seriously the need to establish the conditions under which suiciding might be rational. Although a particular act of suicide’s being rational does not guarantee that it is moral, many thinkers hold, implicitly or explicitly, that establishing rationality is necessary in order to entertain the possibility that suiciding or assisting in suicide can be moral (cf. Battin 1980, 1998, and 1999; Beauchamp 1999; Brandt 1975; Brock 1999; Davis 1998; Diekstra 1986; Dworkin et al. 1998; Goldfarb 1983; Lebacqz and Englehardt 1977; Maris 1986; Mat-
This chapter will address the varied ways in which rationality is defined in this literature.

Margaret Battin (1982) provides a useful starting point in her *Ethical Issues in Suicide*. She explains that there are two categories under which the criteria to establish rationality in the bioethics literature fall. These categories come about as a result of “rationality” being ascribed to different parts of the issue at hand, and can be mapped onto the factors that motivated the development of this literature. The first category of criteria looks to determine the rationality of the person who wishes to suicide (Battin 1982, 132). The criteria in this category stand in direct opposition to the prevalent and influential mental illness model of suicide, and provide a foundation for establishing that not all suicidal people are irrational. Although Battin identified three criteria that fall under this grouping, my research has uncovered five criteria in the literature that fall into this category: the person looking to suicide must have the ability to reason, have a realistic worldview, be adequately informed, not display high amounts of ambivalence, and be free in the decision making process.

The second category of criteria establishes the rationality of the act of suicide. These criteria are heavily shaped by the second motivating factor in the creation of the bioethics literature. After establishing the rationality of the person who wishes to suicide, these criteria establish that the particular details of the life of the person who wishes to suicide are such that the act of suicide could be a rational act for that person (Battin 1982, 132). Again, although Battin identifies two criteria in this category, I have found five criteria in the literature that meet the stipulations for inclusion in this category: the act must not bring harm to the person who wishes to suicide, the act must be in his interest, he
must find himself in a hopeless condition, he must consider the impact of his actions on those around him, and finally, the act must be understandable according to the community in which he finds himself.

**Rationality of Person**

As noted above, the first group of criteria looks to establish the rationality of the person who wishes to suicide. These criteria show that the person has the cognitive capacities necessary for rationality, the motivation to be rational, and exists in a mental and emotional climate conducive to the exercise of rationality. Although I will discuss five separate criteria the rationality literature uses to speak to the rationality of persons, it is helpful to think of these criteria as a “breakdown” of a more colloquial understanding of what it is to be a rational person. When one says a person is rational, what one normally means by this is that the rational person is calm, is desirous of understanding the situation in which she finds herself in order to make an appropriate decision regarding the situation, and that she is not mentally impaired in any way. Many people meet this received definition much of the time. The five criteria provided by bioethicists are simply an attempt to codify this definition and show that it is possible that a person who wishes to end her life can still meet these same standards.

**Ability to Reason**

Perhaps the most common criterion in the literature used to establish rationality, and typically the one that is most associated with rationality, is the requirement that the person who wishes to suicide has the ability to reason. Against critics like Devine (1998), many bioethicists hold that the ability to reason is achievable by someone who is inclined toward death (c.f., Barry 1994; Cholbi 2011; Choron 1972; Decker 1977; Dunshee 1994;
Battin (1999) explains that, “For a person to be able to reason implies at least two distinct things: that moving from the premises from which she begins to the conclusion she reaches, she maintains good logical form (that is, does not make mistakes in logic), and that she can foresee the consequences of the positions she adopted or the actions she plans to undertake (that is, she knows what will probably happen because of what she is doing)” (13).

Following Battin (1980, 1982, 1994, 1999), other bioethicists explain the ability to reason according to her requirement that a person’s thinking “maintains good logical form.” Slater (1980) holds that we must respect someone’s decision to die when that decision “has been reached on sound principles” (200-201). Pipel and Amsel (2011) echo this when they explain that many rational suicide proponents require there to be nothing “technically wrong” with the suicidal person’s reasoning, and although the authors are critical of those thinkers who hold this criterion in itself to be sufficient for establishing the ability to reason, they recognize the importance of this criterion as a starting point in the discussion of rational suicide.

Cholbi (2011) briefly mentions the need for a person to have the “ability to reason about what she perceives, making appropriate inferences, etc...” (91). Previously in the text, however, Cholbi also implicitly expands upon this requirement by describing it negatively. He explains that many would not hold it to be morally permissible for children to
suicide because children are incapable of adult levels of rationality. He holds that children often do not have the formal reasoning abilities required to decide what is dictated by the child’s interest, and that a child’s ability to move from the consideration of her interests (premises) to a decision about the best way to achieve those interests in action (conclusion) is lacking (89).

Werth (1999) and Werth and Cobia (1995) present a particularly interesting voice in the bioethics debate on rational suicide, as they draw the criteria necessary for a suicide to be considered rational from two national studies that gathered data on how practitioners define rational suicide. One of the defining characteristics of rational suicide that remained consistent in both studies was that the person “has engaged in a sound decision-making process” (Werth 1999, 5). Although the components of this decision-making process extend beyond the simple ability to move from premises to conclusions soundly, that ability serves as the basis for the other components (discussed below).

Asking whether such a thing as rational suicide exists, Marker (1999) breaks this question down into four separate questions. Three of these questions he identifies explicitly speak to the suicidal person’s ability to reason, and two touch upon “reason” in terms of good logical form. Marker believes that a suicide can be rational if logical conclusions are drawn from the starting “premises” of a person’s particular situation, and that the decisions about actions based on these conclusions are “reasoned” (xxi).

Edwards (1997) lists several criteria for rationality that flesh out Battin’s understanding of the ability to reason as logical thinking, but refrains from using the phrase “ability to reason.” He writes that being labeled “rational” often requires,

...thinking logically and avoiding logically contradictory beliefs; having factual beliefs which are largely supported by empirical evidence, or at
least avoiding factual beliefs which are plainly falsified by experience; having
and being able to give reasons for one’s behavior and beliefs; thinking
clearly and intelligibly, and avoiding confusion and nonsense; having and
exhibiting a capacity for impartiality or fair-mindedness in judging and
adopting beliefs... (55).

His list of criteria is helpful. Although it moves us slightly beyond the strict logical valid-
ity Battin requires, this more common use of the term “logical” and the other criteria
listed by Edwards follows the sentiment of many of the thinkers discussed above. It is not
only the case that proper logical form in thinking must be achieved in order for a person
to be considered rational, but also that thinking is clear. Plenty of valid syllogisms could
be formed that are nonetheless unsound.

Edward’s list also begins to point us to Battin’s second explanation of the ability
to reason. Reason requires that one be able to foresee the consequences of actions. In
addition to the items on his list already presented, he also includes, “being able to distin-
guish means from ends and being able to identify processes and manifest behaviors
which likely will result in the realization of consciously envisioned goals” as necessary to
establish a person’s rationality (55). While this is certainly more extensive a requirement
than merely being able to predict possible consequences of actions, the spirit is similar.
Part of foreseeing consequences involves being able to distinguish between the actions
designed to bring about an event or state of affairs (means), and the event or state of af-
fairs desired (ends/consequences). Blending means and ends can be indicative of magical
thinking.

Marker (1999) echoes Battin closely when she explains that rational suicide
would require that a person has, “reasonably considered current and probable future con-
ditions...” and “...considered the impact that such action would have on one’s self and
others” (xxi). “Foreseeing” consequences here is broken down into two steps: consideration of possibilities of different conditions that might affect decisions and consequences, and consideration of the impact of the decisions when made.

Prado (2010) requires that a very particular consequence be foreseen. “I make clear that to be rational, reasoning and enactment of suicide must be done in full understanding that death may be and most likely is personal annihilation” (10). He requires a very specific understanding of the relationship between action and consequences based on skepticism about the afterlife and a restriction of reasoning to that which is bound by the observable world.

A move as common as offering an explanation of what “reasonable” or “the ability to reason” means is simply listing “the ability to reason/being reasonable” among their criteria for a rational suicide without an attempt to define this criterion. Physician Richard MacDonald (1999) appeals to dictionary definitions of rationality, which usually require that an action or person, “has reasoning or understanding, and is, therefore, reasonable...” (108-109). Clarke (1999) requires that the suicidal person have “good reasons” for suiciding in order for it to be rational (458). Motto (1999) explains that for a suicide to be rational, the person suiciding must be “capable of forming reasoned judgment” (124). Choron (1972) requires that “the reasoning of the suicidal person is in no way impaired” (96-97). Prado (2010) requires that a “self-killing” be “soundly reasoned” (10). Hewitt (2010) lists the criterion of coherence in thought, which offers us a bit more information than the term “reasonable,” but not much. For many bioethicists, a person being labeled “reasonable” is self-explanatory.
Mayo (1980) expands the criteria of the ability to reason by insisting that one not only be able to reason, but that one must be committed to reasoning. Unlike Brandt (1975), who is concerned that depression might make reasonable decision making more difficult, Mayo explains that,

an integral feature of acute despair is often that such a commitment is totally lacking. The person in such a condition is one of the most obvious examples of someone for whom being reasonable may have no appeal whatsoever. Worse yet is the fact that there seem to be situations which not merely incline people to be unreasonable, but virtually require it (134).

So not only is it the case that some situations incline or require someone to be unreasonable, but that in instances of despair or acute depression, a person might abandon the desire to be reasonable. For Mayo, then, in order for the person considering suicide to be considered rational, he must want to be reasonable in addition to actually being reasonable. Motivation must be present.

Although Mayo is the only bioethicist found in this literature review to explicitly state the need for a person to be committed to being reasonable in order to be considered rational, we see a similar, although implicit, call for such a commitment in Humphry (1986). Humphry requires that a number of parameters be met in order for a suicide to be rational. Many of these parameters go above and beyond what other bioethicists require (e.g., leaving notes of apology to hotel staff if a person kills herself in a hotel room). Requiring of a suicidal person this level of attention to detail also implicitly requires a commitment to reason (173). Planning your death becomes much like planning any other major event--a wedding, a party, or a vacation. A number of other bioethicists obliquely mention this requirement (e.g., Werth 1999, Clarke 1999, Goldblatt 1999, Jamison 1995, Siegel 1986, Diekstra 1986, Mayo 1993, Prado 1990).
Rationality also includes a “negative” requirement closely connected to the positive ability to reason. A person must be free from illness, disability, or even strong emotion, that would affect her ability to engage in a sound decision making process. Jerome Motto (1999) calls this “a clear sensorium,” which, “implies that any cognitive deficit present...does not interfere with perception or reasoning” (124). A suicidal person cannot have any mental impairment that would affect her ability to engage in a clear reasoning process.

A great deal of the literature requires that no mental illness be present in a person who wishes to suicide in order for that person and her request to be considered rational. Most bioethicists only list mental illness or psychological disorders as their concern, but some forms of specific illness are considered. Widiger and Rinaldi (1983) are particularly concerned with the presence of psychotic disorders. Several thinkers are concerned specifically with depression and the effects it has on a person’s ability to reason. Brandt (1975) famously claims that a person’s suffering from depression rules out the possibility that she can rationally choose to suicide because depression “primitivizes” mental capacities and makes it difficult to reason about probabilities (5).

Many more thinkers mention the absence of general mental illness as a requirement for the possibility of rationality. Goldblatt (1999) questions the possibility of rational suicide because he claims that mental illness is present in “nearly all cases of suicide” (115). Jamison (1999) argues that a “person’s mental health treatment history, including prior diagnoses for depression and other conditions” as well as that person’s “response to treatment recommendations” need to be evaluated before a person can be declared rational (134).
Some thinkers’ requirements for a “clear sensorium” are even more stringent than the absence of mental illness or a history of mental illness. In an early paper, Motto (1980) proposed what many would consider an extreme criterion. He claims that all “intense emotional conflicts” would conflict with a person’s ability to reason and that one cannot consider a person with intense emotional conflicts to be rational (216).

Cholbi (2011) echoes Motto’s concerns about strong emotion. He writes,

A second worry is that suicidal thinking is sometimes triggered by crises or stressful situations that tend to distort our thinking. For some suicidal individuals, their preoccupation with dying is sparked by a specific stressor, such as a professional setback, the end of a romantic relationship, or the death of a loved one. Such evidence produces powerful emotions, including grief, loneliness, or anger (93).

The connection between the ability to reason and the absence of strong emotion is seen clearly when considered along with the fact that some bioethicists require a commitment to reason. In the moments a person experiences intense emotion, such commitments are often forgotten (on absence of mental illness and strong emotion, also see Barry 1994; Battin 1982; Choron 1972; Clements 1980; Decker 1977; Diekstra 1986; Dunshee 1994; Francis 1980; Kjervik 1984; Lebacqz and Engelhardt 1979; Mayo 1993; Motto 1983 and 1994; and Sullivan 1980).

Realistic Worldview


Other thinkers spend considerable time defining what they mean by “realistic” and specifying what is captured in a “worldview.” One might think that because of the assumption of the transparency of this criterion by a large number of bioethicists, those thinkers who chose to define what they mean by realistic worldview would offer definitions that are quite similar. This is not the case, however. In the thinkers who do work to establish the defining characteristics of this criterion, the realistic worldview criterion contains both weak and strong versions, from very lax ideas on what is required for a person to have a realistic worldview to very rigid ideas.

One of the most extreme versions of an “unrealistic worldview” criterion is the worldview of a schizophrenic. Battin (1999) writes, “Most extreme is that of the person with schizophrenia, based on the bizarre beliefs about the nature of the world” (15). Belief in hallucinations or paranoid thoughts about the world makes it impossible for a (currently psychotic) schizophrenic to be expected to perceive the world realistically enough to be able to make assessments about her current life circumstances and her place in the world, and then to render a judgment about whether she should kill herself. There would
be too much risk that she would be making the decision to suicide based on an understanding of her world that is incorrect (i.e., based on a paranoid delusion).

That the worldview of a schizophrenic is unrealistic is not a remarkable view to hold, though calling a worldview realistic based solely on the absence of positive schizophrenic symptoms is. More than the absence of delusions and hallucinations is needed to establish that a person has a “realistic” worldview. On the opposite extreme of the definitions of “realistic,” we find very strict and demanding versions of a realistic worldview. For instance, as mentioned above, Prado (2010) takes a strong approach to what it means to have a “realistic” worldview. He explains that, “…suicide must be done in full understanding that death may be and most likely is personal annihilation,” in order for it to be considered rational (10). According to Prado, then, in order for a person to have a realistic worldview (and a realistic view on suicide), she must hold very particular metaphysical beliefs, or at least be willing to renounce the beliefs she does hold. A religious person who believes in the afterlife who was unwilling to deny this belief, or at least write it off as unlikely, would not meet Prado’s standards for having a realistic worldview, and thus be too irrational to meet the standards of a rational suicide. Given how common religious faiths are that bring with them a belief in an afterlife, this requirement effectively bans a significant portion of the living from meeting the standards of rationality in place for rational suicide.

Prado exemplifies an extreme view, however. Most philosophers walk a much more culturally sensitive line. When talking about religious suicides, Battin (1982) explains that,
In order that a suicide to count as rational, it is only necessary that it be based on a worldview which is consonant with the surrounding culture; we do not consider whether the worldview of the culture as a whole is realistic or not. There may of course be considerable variation in world views within a culture; contemporary western culture, for instance, includes both those whose view of the universe is materialistic and those whose view includes spiritual entities; individuals of neither sort would be counted irrational in a suicide predicated upon such beliefs, though adherents of the opposite view would surely regard them as foolish (136-137).

According to Battin, then, in order to decide that a person’s worldview is realistic, one must take into account the cultures and subcultures in which that person finds herself, even if the person considering suicide happens to be part of the same dominant culture as oneself. For example, one would have to account for religious diversity among the members of their culture. Although I might be an atheist materialist, this would not mean that I could label a Christian who believes in the afterlife irrational, especially if the way she conducts her daily life shows she is rational. For example, a Christian suffering from terminal cancer who wanted to save her family the expense of further treatment and the pain of watching her die slowly would not necessarily need to be labeled irrational, even if she was comforted by her firm belief that her death would not mean her personal annihilation.

There remains a problem, however: not all cultures have realistic worldviews, and not all people within cultures hold the beliefs of that culture in the same way. For instance, how are we to distinguish between the Branch Davidians and run-of-the-mill Protestants? These sorts of questions are especially problematic for practitioners. Motto (1980) believes psychiatrists who are trying to determine whether to provide the means by which a patient might suicide must have more specific standards than Battin’s call for cultural sensitivity would allow. According to Motto, the psychiatrist must make it a priority, whether or not suicide is a consideration, to determine whether a patient’s
worldview is realistic. Motto admits, however, that the only standard by which he has to judge other people’s perceptions of reality is his own.

Some persons have a view of reality so different from mine that I do not hesitate to interfere with their right to suicide. Others’ perceptions are so like mine that I cannot intercede. The big problem is that large group in between.

In the final analysis, then, when a decision has to be made, what a psychiatrist calls “realistic” is whatever looks realistic to him. At the moment of truth, that is all any person can offer. This inherent human limitation in itself is a reality that accounts for a great deal of inevitable chaos in the world; it is an article of faith that not to make such an effort would create even greater chaos... (214).

Motto is acutely aware of the fallibility that is part of human existence. As limited, perspectival creatures, it is impossible to understand the entirety of reality. In some very extreme circumstances (e.g., a schizophrenic patient), it is simple to justify calling a patient’s worldview unrealistic. In many cases concerning “that large group in between,” however, it becomes more difficult.

This “large group in between” probably constitutes a number of different sorts of cases, but Battin gives us a particularly troubling example of the sort of individuals who might fall into this group. Battin (1999) points out that, “an individual may have a relatively realistic picture of the world as a whole but fail to have a realistic conception of his own life situation, including his identity, position in the world, and on his particular talents, abilities, and disabilities” (15). This is the distorted “worldview” of the egomaniac or the person who suffers from crippling low self-esteem. Although these sorts of people may have a realistic view of the outside world (e.g., they do not believe the President of the United States is secretly an alien), their self-conceptions and understandings of the places they occupy in that realistic world are so skewed, that it distorts their understanding of the network of relationships which make up the world. For example, a lonely per-
son suffering with the effects of chronically low self-esteem might be aware of the avenues by which she could make friends (karate class, church group, hanging out in the dog park) and even be aware that other people are actively seeking friends, but because of how she views herself, she might believe any attempt to make friends would be futile.

Adequate Information

Many bioethicists require that the person looking to rational suicide be adequately informed (c.f., Battin 1980, 1982, and 1999; Brandt 1975; Cholbi 2011; Clarke 1999; Decker 1977; Devine 1980 and 1998; Dunshee 1994; Edwards 1997; Humphry 1986; Jamison 1995 and 1999; Kjervik 1984; MacDonald 1999; Maltsberger 1994; Marker 1999; Motto 1981; Nelson 1984; Prado 2010; Sullivan 1980; Werth 1996). This criterion walks the line between specifying that a person have particular internal capacities and requiring something of the factual situation of the person. As such, we can understand being adequately informed in two ways. First, there is the actual state of being adequately informed. Being adequately informed happens when a person has the information they need to make a decision. Second, there is the desire and the requisite effort that goes into becoming adequately informed. An example might be helpful here.

About a year ago, when I was visiting faculty at a small school in the South, I made the move from faculty housing into an apartment not owned by the college in order to save money. I decided to plan this move at the end of my first semester, which required me to conduct the apartment search while I was teaching full-time for the first time. Salem, Virginia was not a renter’s market, so my options were limited. When I visited the apartment I eventually ended up moving into, it seemed to suit my needs well. It was small, cheap, bright, and less than a mile from campus. It just so happened, however,
that when I went to visit the apartment, all of the windows were open. Although I asked the questions I was used to asking of the building managers who had shown me my apartments in the past, and I looked at every nook and cranny of the apartment, when I moved in, I was shocked to discover it reeked of stale cigarette smoke. The temperature had dropped twenty degrees and the windows were closed. Having just moved six months before from a city in which it was exceedingly rare to find an apartment building that allowed smoking indoors, and where all leases I had ever signed stipulated smoking was forbidden, I did not think about the reality of moving to a new, southern, small town without a real rental market, and I paid the price. By my understanding of the situation, I paid this price, not because I did not want to be adequately informed, but because I happened to lack an important piece of information about which I did not know I needed to ask. I had done what I thought was an adequate amount of research, and what certainly would have been an adequate amount of research in Chicago. Despite my desire, however, I lacked information necessary to make a totally rational (that is, adequately informed) decision. I did not, however, lack the brute reasoning skills necessary for rationality.

There is a second read of this event, however, given to me by a close friend. While I was complaining to her about my situation, she asked me a very pointed question: did I “miss” the smell because some part of me did not want to find anything wrong with the apartment? I was tired and stressed during my apartment search, hoping to move with little fuss. Was it possible that I did not actually want to be adequately informed? This question gave me pause. It is possible that I ignored certain facts (namely, the cigarette hanging out of my building manager’s mouth as I walked up to visit the apartment for the first time) in order to paint a picture of the apartment I wanted. I admit I may not
have wanted to be adequately informed, nor did I realize how much my desire to save money outweighed my desire to avoid living in a dumpy apartment. As mentioned above, one way of understanding being adequately informed is having all information pertinent to a situation. Although it is not common to see it listed explicitly, some bioethicists do expressly require that a person be adequately informed about her own desires and how they affect her understanding of a situation (e.g., how my desire to save money would affect my first visit to the apartment), in addition to being adequately informed of the facts of a situation.

The most well known expression of the first of these requirements, that a person be adequately informed about her own desires, comes in Brandt (1975):

> The basic question a person must answer, in order to determine which world-course is best or rational for him to choose, is which he would choose under conditions of optimal use of information, when all of his desires are taken into account (4).

A person must be aware of the desires she has regarding all facets of her life in order to make a rational decision about something that would impact the fulfillment of desires in all areas of her life, and the decision to suicide is perhaps the extreme example of this sort of decision. Suiciding cuts off all future possibilities—it renders all future world-courses null because it is an action taken to eliminate the possibility of a future. Even if the requirement that a subject be informed about her own desires is not explicitly mentioned by other thinkers, a case could be made that this is assumed given the extremeness of the consequences brought about by this sort of decision. This is especially true for those thinkers who also require that in order for an act to be rational, it must work for the fulfillment of the desires and interests of the person who acts (discussed below). For instance, Battin (1999) explains that the rationality of a person’s choices regarding suicide
requires that a person be aware of “likely reactions to deprivations and losses” (18). Being able to gauge reactions to what is lost during illness or because of reduced functioning implies that a person knows how she would like her future world to unfold (the desires she has for the world she lives in) and that she be able to reasonably assess how she might react to the thwarting of those desires brought on by illness.

This awareness of subjective desires and how the thwarting of these desires might affect a subject points to the much more common way in which a person is required to be adequately informed in order to be considered rational. To understand one’s desires, if those desires are to realistically reflect the subject’s current situation, also necessitates adequate information regarding the facts of the particular state a person finds herself in at present, as well as adequate information about how her situation might change and what opportunities might be open or closed to her in the future because of these changes. In the case of the apartment example, in order to be adequately informed, I would have needed to have asked and have had answers to all relevant questions about the terms of my lease. Even if none of my neighbors currently smoked, the fact that they were allowed to do so because the lease did not prohibit it should have been factored into my decision. A person must be adequately informed about the current reality of her situation, as well as potential future outcomes of her situation.

The need to be adequately informed about present circumstances is of vital, real-world importance in the case of suicide. Given that several people suicide every year who believe they have a terminal illness, but are posthumously shown not to not be ill, the importance of being adequately informed about the basic facts of the situation in which a person finds himself cannot be overestimated (Battin 1982, 137). Edwards (1997) ex-
plains that rationality involves “having factual beliefs which are adequately supported by empirical evidence” (55). If a person believes that he has terminal cancer, but does not have that suspicion confirmed by a doctor, any decision he makes based on the mistaken belief he has cancer is not a rational decision.

Moreover, a person must be adequately informed about not only big-picture considerations regarding present circumstances, such as whether he has the disease he assumes he has, but also the details of that situation. In the case of a person with a terminal illness who is considering suicide, she must know what disease she has, the current treatments and technologies used to combat that illness, and perhaps the status of her financial situation. As Motto (1999) writes, in order for a suicide decision to be rational, it must be, “based on a thorough understanding and realistic assessment of all of the available and pertinent facts” (124). This sentiment is echoed by many other bioethicists (c.f., Battin 1980, 1982 and 1999; Brandt 1975; Clarke 1999; Devine 1980 and 1998; Edwards 1997; Humphry 1986; Jamison 1995 and 1999; Kjervik 1984; MacDonald 1999; Marker 1999; Motto 1981; Nelson 1984).

Additionally, a person must make attempts to become informed about how her current situation might change. Marker (1999) explains that a person must have “reasonably considered current and probable future conditions” (xxi) for her suicide to be labeled “rational.” Clarke (1999) speaks of this requirement as “‘imagining’ all possible consequences” (458), and thus adds an active, imaginative element to the task. Motto (1999) requires not only that a person consider future alternatives, but also that they consider the effect of “temporizing” (124). That is to say, a person must consider not only what her
future might look like, but also what effect time might have on the seeing or imagining itself.

Even more common than the (explicit) requirements that a person be adequately informed about her own desires and the present situation in which she finds herself is the requirement that she be aware of alternatives regarding possible future actions and the outcomes of those actions. Brandt (1975) labels these possible “future world-courses.”

The person who is contemplating suicide is obviously making a choice between future world-courses: the world-course that includes his demise, say, an hour from now, and several possible ones that contain his demise at a later point. One cannot have precise knowledge about many features of the later group of world-courses, but it is certain that they will all end with death some (possibly short) time from now (4).

In order to choose suicide as a rational alternative to life, one must consider the possible paths (the possible “future world-courses”) one’s life might take. Even if he has a terminal illness, if a person kills himself without taking into account that the last few months of his life might allow him to mend rifts with loved ones or to finish a project he had been working on for years, this would not be considered rational suicide.

Some bioethicists explicitly require that a suicidal person speak with a physician about future possibilities. For instance, Jamison (1999) requires that the,

person’s understanding and response to his or her condition, diagnosis, and prognosis, including efforts to obtain a confirming medical opinion, and to discuss with his or her physician unresolved symptoms and discomfort, quality of life concerns, and treatment options and alternatives (134).

This sort of information-gathering requirement is often also accompanied by a requirement that alternatives to suicide are considered. Nelson (1984) writes that only “after a thorough and concerned search for life-enhancing alternatives” can a person say that they have nothing for which to live and thus be in a position to consider suicide rationally.

There can be a difference between having a conversation with a physician and becoming adequately informed, however. Every day, people have conversations with their physicians that they do not understand. Anyone who has been friends with a physician knows that they sometimes speak their own expert language. Cholbi (2011) brings to the fore the difficulty non-experts might face in becoming adequately informed about certain situations. He provides us with helpful analogies by which to understand the difference between being adequately informed and merely gathering information. He distinguishes between knowing and appreciating the facts of a situation, and offers another level of nuance to the requirement that a person be adequately informed in order to be considered rational. As he claims:

To know a fact is to stand in a particular cognitive relationship to it, to acknowledge or recognize its truth. But to appreciate a fact is to stand in a particular evaluative relationship to the fact, to know why that fact is important and to utilize that fact appropriately in her subsequent thinking. Thus, a person can often be said to know a certain fact without actually appreciating it. For example, I may tell a friend that I received a 1952 Willie Mays baseball card as a birthday gift. After I relate that fact to my friend, he knows it. But he may not appreciate it because he does not know other facts which, if known, would convey the significance of this fact. He may not know, for instance, that Mays is my favorite player or that the 1952 card, being his rookie card, is rare and expensive. He knows that I received the card, but he does not fully appreciate the significance of that fact. This example suggests that appreciating a fact, as contrasted with merely knowing it, can involve knowing other facts with which it is logically related and which explain the significance of that fact. In other instances, lack of relevant experience can block appreciation of a fact. Suppose that my neighbor is a renowned connoisseur of fine wine and tells me that he recently tried a vintage whose nose reminded him of Beluga caviar. I have never tried Beluga caviar, and in fact have almost no experience with the taste of caviar. For me, the comparison of the wine's nose to Beluga caviar simply fails to register. Since I trust my neighbor's expertise in wine tasting, I could be said to know that the wine's nose suggests Beluga
caviar. Yet I do not appreciate that fact, for I do not quite know what it is that I
know. My own lack of experience with the relevant facts precludes my
understanding of the significance of the comparison. Hence, we can fail to
appreciate a fact when our inexperience blocks an understanding of that
fact’s significance (94-95).

These examples make clear what is at stake. In the first example, a friend might need to
do a little bit of work to do more than simply know that his friend has a baseball card. He
must become adequately informed to appreciate the true nature of his birthday friend’s
windfall. In this case, it requires some knowledge of Willie Mays’ career, the baseball
card market, as well as particular information about the card his friend received as a gift.
It also requires that he become more informed about his friend, as well. He must learn
something about his friend’s “relationship” with Mays to fully appreciate the significance
of his receiving the card. Even in this simple example, multiple types of information are
necessary to adequately appreciate the significance of what could be understood as a
small piece of cardboard.

The second example makes the requirement of adequate information about a par-
ticular, present situation even more stringent. In order to really appreciate something like
a fine wine, considerable experience, and perhaps expertise, is necessary. A glass of wine
is not an object that stands on its own for an expert. It hails from a particular region, it
resembles other wines, and it may have a peculiar history. Additionally, in the tasting, the
connoisseur has access to different dimensions of taste, as well as the words by which to
label them. Although a wine expert might tell me why the particular glass I am drinking
is of high quality, all I will be capable of saying is whether I like it. Not only must I be
adequately informed of my desires regarding drinking wine and know what wine I am
drinking and some basic facts about the wine (the region from which it comes, or its vin-
tage, for example), but I must also have the knowledge necessary to appreciate the wine. Just as a chess master sees a chessboard differently than a novice (she sees the trajectories and outcomes of hundreds of important games, as well as famous strategies), so the wine connoisseur tastes the wine differently.

Must I then be an expert to be considered adequately informed about a situation? Would a suicide only be considered rational if and only if the person deciding to suicide had the expertise of a doctor or thanatologist? Perhaps not. Perhaps Cholbi’s example points to the need not to only possess information, but the need of the suicidal person to reach out to those around her and actively seek out the information and analyze the information gathered. A person must not only be technically informed (i.e., be able to repeat back information), but display a commitment to becoming appreciative of what the facts they know mean. A person who wishes to rationally suicide must make a substantial attempt to become adequately informed and assured that the information she gathers is accurate and that she understands, insofar as she is able, the situation in which she finds herself. This may include talking with multiple healthcare professionals, attorneys, other people who have suffered through (or are suffering through) a similar situation, and her loved ones. A person must use the faculties she has to engage with others and inform herself. But this still leaves us with the question of how to respond to the example of Cholbi’s expert.

Our answer might come from an unlikely source. Devine (1980, 1998) famously argues that speaking of suicide in terms of rational choice is misleading, because normally when a choice is considered “rational,” the person choosing has knowledge of the alternatives presented by the choice. This cannot be the case for suicide, however, since
death is “logically opaque” (Devine 1980, 140). Not only do we have no witness testimony telling a person what it is like to be dead, but our own deaths present us with the most extreme limit of our possibilities. My death is the boundary of my thought, and while I might be able to think up to that boundary, I cannot think through or past that boundary. Yet Devine offers a solution to resolve the dilemma presented by Cholbi’s wine expert example. As he explains, “We are dealing, that is, not with a situation concerning which rational men will exhibit a range of estimates, but with a situation in which one man’s estimate is as good as another, because what is being done is a comparison with an unknown quality” (1980, 139-140). Perhaps no one can be an expert in situations involving a particular, individual end of life. Even a thanatologist would not be able to make an informed decision about her own death to the extent a chess master would make an informed decision about a particular chess move, since there is no way for a person to become informed about her own death. The best we can do in these situations, then, is desire to gather the information we can, work towards gathering it, and then make a decision. This is, after all, how we make many important decisions. We have no guarantees that the person we marry will remain the same thirty years into a marriage; we do not know how a change in career will turn out. Most of our important decisions involve less than perfect information and we make those decisions without the appreciation of an expert. The requirement that one must have expertise in order to be adequately informed is too high for most people to meet in most situations. Nonetheless, Cholbi’s distinction does bring to light the need for a certain, if not expert, appreciation of the facts of a situation in order to make a rational decision.
Non-Ambivalent and Free

The last two principles that fall under the “rationality of person” group of criteria for establishing rationality are less prevalent in the literature, but important nonetheless. These criteria are related to the first three insofar as they speak to the quality of the decision made by the person who suicides. The rationality of the person, then, is premised upon her decision-making capabilities, as well as her ability to gather and weigh information, have a realistic view of the world, and have the cognitive capacity necessary to reason.

The first of these criteria requires that the person wishing to suicide should not be ambivalent about her decision to die, or at least display a minimal level of ambivalence (c.f., Clarke 1999; Martin 1980; Motto 1972; Werth 1999; Widiger and Rinaldi 1983). This criterion is spoken of in two ways, either explicitly in terms of ambivalence, or in terms of a persistent wish to die. Motto (1972) requires that the “degree of ambivalence regarding the act must be minimal” (195). As a psychiatrist, Motto believes that a person seeking his help regarding suicide indicates ambivalence. Clarke (1999) agrees with Motto (1980) (458), noting that a lack of ambivalence is a criterion for rational suicide.¹

Another requirement is that a person’s wish to die be persistent and expressed consistently over time (c.f., Diekstra 1986; Humphry 1986; Lebacqz and Engelhardt 1977; Motto 1972, 1980; Werth 1995). For instance, while Diekstra (1986) does not

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¹ Another reason that lack of ambivalence is an important criterion to mention is because it is a response, wittingly or unwittingly, to the American suicidology movement. Many suicidologists, especially Edwin Schneidman, reject the possibility of rational suicide in large part because of the claim that all suicidal people who have not yet killed themselves are ambivalent. The basic argument asserts that if suicidal people were not ambivalent about dying, they would kill themselves. No discussions would be necessary, and they would never come to the attention of a doctor. Thus, part of the suicidal person wants to live, even if part of the suicidal person desires to die. As a result, preference must be given to the part of the suicidal person who wants to live (see, for instance, The Suicidal Mind (1996)).
speak in terms of ambivalence, he does require that the person’s wish to die should be “enduring” (14-15). Humphry (1986) expands on this notion by requiring that a considerable amount of time (six months) exists between the person’s expressed wish to die and her acting on said wish.

The final criterion for the achievement of the label of “rationality of the person” also revolves around decision quality. Many bioethicists claim that a person’s decision must be freely made (c.f., Barry 1994; Battin 1982, 1994; Diekstra 1986; Francis 1980; Lebacqz and Engelhardt 1977; Mayo 1983; Motto 1981; Prado 2010; Sullivan 1980). This requirement is expressed using both positive and negative language in the literature. The positive expression speaks of freely made decisions. Marker (1999) explains that a “decision [being] freely made” is required for it to be rational (xxi). Similarly, Diekstra (1986) requires that a decision is made of a person’s “own ‘free-will’” (14). Werth (1995) walks the line between the positive and negative versions of this requirement. He explains that the person making the choice to suicide, “makes the decision as a free choice (i.e., is not pressured by others to choose suicide)” (62). This criterion is expressed negatively, though to the same effect, in the insistence that the decision to suicide is made without coercion. Motto (1999) explains that in order for any decision to be considered rational, “no external coercion is present” (124).

**Rationality of Act**

As mentioned above, there is a second set of criteria found in the literature. These criteria look to establish the rationality of a particular act of suicide. That is to say, they do not establish whether suicide, as a general act, is rational, but rather determine the circumstances that might make a particular act of suicide performed by a specific person
rational. There are five criteria in the literature that contribute to establishing the rationality of suicide as an act. The first requires that suiciding does not do harm to the actor, or at least does less harm than other actions might. The second is that suiciding is in the interest of the actor. The third criterion relates closely to and explains how the first two principles can be met in the case of suicide. It requires that the person wishing to suicide find herself in a hopeless condition. The fourth criterion requires that persons looking to suicide consider the impact of the act on the significant people in their lives. The last criterion requires that the suicidal person’s community is understanding of the act of suicide.

Harm

One of the most common means for establishing the rationality of suicide is that suicide does not do more harm to the suicider than the harm that would come to the person if she continued to live (c.f., Battin 1980, 1982, 1999, and 2005; Bogen 1980; Cholbi 2011; Choron 1972; Davis 1998; Decker 1977; Dunshee 1994; Francis 1980; Hewitt 2010; Humphry 1987; Jamison 1999; Lebacqz and Engelhardt 1977; Marker 1999; Maltsberger 1994; Motto 1980, 1994; Nelson 1984; Slater 1980; Werth 1999). As stated at the beginning of this chapter, in most circumstances interfering with a rational adult’s actions that bring no direct harm to others takes considerable justification. This is true even if the act brings harm to the actor. That does not mean, however, that those actions that bring harm to the actor would be considered rational. As Hewitt (2010) explains, “Irrationality is evidenced through incongruence and/or behaviors which are self-defeating or self-harming” (64). Work must be done, then, to show how killing oneself might not
bring (additional) harm, despite killing normally serving as the prototypical example of bringing harm.

The skydiver example at the beginning of this chapter involves a number of irrational actions done by someone who might otherwise show all signs of having the cognitive capacity for rationality. Eating a steady diet of junk food, taking up smoking, and jumping out of a plane can all be construed as self-harming. These actions are easily understood as irrational according to Hewitt’s definition. Yet, there is also a case to be made for understanding these actions as self-preserving, rather than self-harming. For instance, if no healthier food was available, and the skydiver found himself locked in the Cheetos factory for weeks, it would not be irrational to eat Cheetos, and only Cheetos, in order to stay alive. Similarly, one might argue that skydiving is a life-affirming exercise, and that the “rush” experienced during skydiving represents living life to the fullest. There might be a way to similarly understand suicide. If it can be established that in some instances, suicide would bring a person less harm than continuing to live, then an act of suicide might not be irrational.

At first glance, the claim that suiciding would cause someone less harm than staying alive seems entirely counterintuitive. How could an actor bringing about her own death not be bringing harm to herself, and in fact, not be bringing the most grievous harm possible? Would not suicide-- the possibility of an actor bringing to end the possibility of all future action (action by which she could gain goods)-- be inherently harmful? After all, it cuts off the possibility of any future goods at all. Some bioethicists respond to these questions negatively, arguing that suiciding might allow someone to avoid harm. According to the literature, there are two different ways that this is the case.
The most common way of understanding the avoidance of harm is the avoidance of inflicting pain and suffering. If a person finds herself in a situation that causes much pain and suffering, it is possible that a quick end to life might cause her less harm than continuing to live. An extreme example might be helpful here. Imagine a captured spy with a cyanide capsule hidden in a fake tooth. She knows that if she chooses to stay alive, she will be brutally tortured and beaten for information. Even if there is a chance that she might survive interrogation and eventually escape or be rescued, very few people would label the spy irrational if she chose to use the cyanide.

But now let us assume that the spy is never captured. Instead, she lives a long life, retires to the shore with three dogs and her husband and at 67, she is diagnosed with late-stage pancreatic cancer. Her doctor tells her that she will deteriorate quickly and that there will be pain. Instead of a capturing enemy, that which holds her captive and threatens her with torture is her own body. Could we not similarly label the action of taking her life in this situation rational? Several bioethicists think so, and list severe pain and suffering as justification for labeling a particular act of suicide as being rational.

Jamison (1999) explains that, “the amount of intolerable, irreversible physiological suffering” (134) must be taken into consideration when deciding on the rationality of suicide. Jamison also speaks of the need to consider other forms of suffering outside of the physical (such as emotional, psychological, etc.), as well as “social factors [and] quality of life concerns” more broadly (134). Being diagnosed with a painful and degenerative illness comes with social side effects, which can cause much harm and suffering. Moreover, having a painful and degenerative terminal illness can dramatically impact a person’s quality of life and her ability to work towards a better quality of life.
The infliction of pain and suffering is not the only way in which harm is discussed in the literature, however. Harm is also conceptualized in terms of deprivation. In “Can Suicide Be Rational? Yes, Sometimes,” (1999), Battin extends the definition of harm past bodily suffering and injury, and explains that we also must understand harm, “…in terms of deprivation of pleasures, satisfactions, and other goods, or what we call the prae minimum vitae” (18). Harm, then, is not only caused by an infliction of pain, but also by deprivation of the things that make life good. This is closely connected to quality of life issues. It is not only that particular situations will inflict suffering on a person (e.g., the pain that comes to a person who sees how much her spouse is suffering seeing her dying), but also that some situations make it impossible for a person to maintain the type of life she is used to living. If a person lives her life deprived of the basic things that make it worthwhile (relationships, pleasure, etc.), then she is being harmed.

Cholbi (2011) adds a temporizing element to the discussion of harm and suicide. He expands on this aspect of the harm of living outweighing the harm of suicide outweigh by explaining,

This condition [suicide being less harmful for a person than continuing to live] being met thus hinges not only on how harmful it would be for the person to continue to live (how much suffering, hardship, etc. her future life would portend), but also how painful her death would be and the benefits she would enjoy in her future life. A young person could fail to meet this condition if, for instance, she was suffering from a painful but treatable medical condition and had a long, worthwhile life to look forward to should she continue to live (91).

The amount of harm done to a person, then, cannot only be assessed by looking at the pain and suffering a person is currently experiencing, but must also include an assessment of future circumstances which weighs potential goods (time with family, possibility of recovery, finding meaning in suffering) against the harm an illness brings with it. If it can
be established that the harm caused by a particular situation outweighs current and potential goods, suicide may be rational.

**Interest**

Closely connected to the harm criterion is the requirement that suicide be in the interests of the person who wants to suicide (c.f., Barry 1994; Battin 1980, 1982, 1994, 1999, 2005; Boer 2007; Brandt 1975; Cholbi 2011; Clarke 1999; Cowley 2006; Edwards 1997; Hewitt 2010; Humphry 1999; Jamison 1995, 1999; Kjervik 1984; Marker 1999; Martin 1980; Mayo 1983, 1993; Motto 1972, 1981, 1983, and 1994; Nelson 1984; Pipel and Amsel 2011; Prado 1990; Werth 1996, 1999; Widiger and Rinaldi 1983). Much like the harm criterion, the “interest” principle seems counterintuitive. How could an action that eliminates all possibility of an actor meeting any future interests be in her best interests? In fact, paternalistic intervention into a suicider’s life is often justified by the claim that death cannot be in the interest of suicidal persons and that the suicidal are actually unable to determine their own interests. Many suicidologists, most notably, Edwin Shneidman (1996), believe that suicidality is always accompanied by ambivalence, that is, experienced as conflicting interests and desires. According to Shneidman, suicidal people feel equally compelled to both to suicide and to continue living (55). Shneidman argues that if a suicidal person has two sets of conflicting interests that are equally weighted in her mind, there is no way she can determine which set of conflicting interests is worth satisfying. Thus, we are justified in intervening with her attempts to kill herself because we, the non-suicidal, are capable of identifying the life-affirming interests.

As Martin (1980) points out, however, there is at least one problem with asserting that such an intervention is justified: the assumption undergirding the intervention (144).
As the first example in this chapter indicated, it is difficult to justify interfering with an adult’s decisions, even if they will result in a lower quality of life. We can see how a person’s interests can be thwarted by a lifestyle that involves needless risk taking and unhealthy habits, but no one would be justified (or legally permitted) to force an adult into living otherwise without substantial efforts to prove that the adult in question was incapable of making decisions on her own.²

There is an additional problem when we root justification of intervention in ambivalence: the moment a person chooses to kill herself, her desires are no longer competing (Martin, 1980, 146). Moreover, even if some ambivalence remains, we still might not be justified in intervening. Many of our most important decisions are colored by ambivalence. For instance, when I made the decision at twenty-one to pursue my doctorate in philosophy, I was certainly ambivalent. I knew I would be giving up some very particular life paths if I chose to do doctoral work. I knew I would work as hard as or even harder than my friends who went into the workforce, and that I would not be equally compensated for it. I knew pursuing an advanced degree of this sort might require me to put certain social goals on hold. I was not entirely sure I wanted to make those sacrifices. Does this mean someone should have intervened and forced me to do otherwise, or that members of my family, who wholeheartedly disagreed with my decision to pursue the degree, would have been justified in trying to coerce me to choose to do otherwise?³

² Moreover, many of the habits described in this example can accompany depression, but still, more than the presence of depression would be needed to justify the forceful intervention often used to prevent suicides.

³ Martin goes on to argue that it is precisely because suicide eliminates the possibility of a future for the suicidal person that we are not justified in intervening. A person’s interests are determined by looking at her future and whether an action works in accordance with those future interests and her ability to pursue
Most bioethicists discuss determining interests under the assumption that it is possible for (at least some) people who want to suicide to determine their own interests. As Cholbi (2011) explains, “the rationality, and perhaps the moral permissibility, of suicide might hinge on a person having sufficient knowledge of her own interests to know that suicide is in her interest” (84). Battin echoes this sentiment in several works (e.g., 1980, 1996, 2005). She writes,

The rationality or irrationality of a given choice of suicide is in part a function of the individual’s circumstances: his health, his living conditions, the degree of comfort or discomfort his daily life involves, his political environment, his opportunities for enjoyable and fulfilling activities and work, and so forth. Thus, when a person’s circumstances change, so does the rationality or irrationality of his committing suicide: what may have been an unsound choice becomes, in the fact of permanently worsened circumstances (say, a confirmed diagnosis of painful and incurable deteriorative illness) a reasonable one (1980, 171).

Battin’s point is that determining one’s “interests” is a complex process that involves intimate knowledge of both the “big” and “little” parts of a person’s life. Generally, then, the person best equipped to judge her interests is the person who knows best the particular circumstances of that individual’s life. Usually, this is the person living that life. In another article, Battin (1994) goes as far to say that some suicides might even be understood as self- and interest-preserving acts.

One might consider whether some self-deaths could not be understood paradoxically, as a kind of ‘self-preservation,’ a kind of self-respect and protection of one’s fundamental interests. ‘I am what I have been,’ suicides sometimes seem to say, ‘but cannot be any more.’ They are based, as it were, on a self-ideal: a conception of one’s value and worth, beneath which one is not willing to slip (294-295).

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those interests. Since suicide cuts off the possibility of a future, there is no way to gauge whether a person’s interests are met or not: she will simply no longer have any interests.
A person accustomed to a high level of control over her life, and whose self-identity is rooted in maintaining control, might have an interest in preserving the self-identity she had before a disease takes hold. An eminent professor diagnosed with Alzheimer’s disease might consider suicide to leave her legacy intact before the disease firmly overcomes her mind. Davis (1998) puts this far more starkly when she explains that suicide might be a rational decision to put an end to harms when, “[m]y body’s continued capacity to pump blood and oxygen is no longer a good for my life but rather a threat to my values and interests in how the final chapter of my life is written (114).” Sometimes our body’s functioning threatens the interests we hold closest. The example involving the spy above shows this.

Humphry (1999) echoes Battin’s and Davis’ points when he writes that,

Quality of life is far too intimate, too personal, and too individual for others to be involved in. It is the quintessence of the meaning of life in the human species. It is what makes our lives so varied and interesting, distinct from robots. It is far too glib to pass this factor off as ‘depression’ in the ready parlance that is so fashionable nowadays (xvii).

Although he couches this in terms of quality of life issues, we can read quality of life in terms of an actor being able to pursue and, at least to some extent, meet her interests.

Humphry looks to validate the desires experienced by a person who finds herself in circumstances that will dramatically alter her life. Quality of life issues are so fundamental and individual that we must not easily dismiss a person’s reaction to news that she may no longer be able to work towards improving or maintaining her quality of life.

It is also common in the literature to list the interest criterion without defining it. Mayo (1986) explains that one of the conditions necessary for any action to be considered rational is that it is in “keeping with one’s fundamental interests” (145). Motto (1980)

Interest considerations are also referenced in the literature on suicide in terms of having the ability to act on one’s values. The connection between values and interests is established by Battin (1999) when she writes,

In general we regard an act as rational if it is in accord with what we might call one’s ground-projects or basic interests, which themselves arise from one’s most abiding, fundamental values...An act that conflicts with the satisfaction of one’s ground-projects or fundamental interests and goals is irrational; an act intended to satisfy them is rational, in the sense that it is an attempt to achieve one’s own ends (20).

This way of defining interest renders clear what is at stake. For example, I have a number of interests: finishing my degree, developing and maintaining relationships with family and friends, eating breakfast, and attending an upcoming festival. Obviously, some of these are integral to my fundamental values, and some are not. What makes an act more or less irrational, then, is how it addresses my core interests and values. This sort of distinction must be made when we look at how actions meet the interests of a person. RL Barry (1994), Brandt (1975), Mayo (1983 and 1993), Motto (1972, 1981, 1983, and 1994), Kjervik (1984), Nelson (1984), Jamison (1999 and 1995), Hewitt (2010), Edwards (1997), and Prado (1990) likewise speak of an act allowing someone to enact her values as important for establishing the rationality of that act.

Hopeless Condition

The difficulties of understanding how suicide might not bring harm to a person and how suicide might be in someone’s interests are made less difficult when we consider a third criterion in the literature for establishing the rationality of an act of suicide: that
the person wishing to suicide must be suffering from a hopeless condition (c.f., Bogen 1980; Battin 1980, 1982, 1999, and 2005; Cholbi 2011; Choron 1972; Decker 1977; Dunshee 1994; Francis 1980; Goldfarb 1983; Hewitt 2010; Humphry 1986; Jamison 1995, 1999; Kjervik 1984; Lebacqz and Engelhardt 1977; Maltsberger 1994; Motto 1994; Marker 1999; Nelson 1984; Slater 1980; Siegel 1986; Werth 1996, 1999; Widiger and Rinaldi 1983). As Battin (1980) explains, there is one clear case that would explain how an actor would be harmed less and how her interests might be served more by killing herself than by living: “extreme and irremediable pain in terminal illness” (174). If a person is inevitably going to die of an illness, and the illness will bring with it much suffering, one can see how suiciding might help a person avoid harms (e.g., continued and protracted pain) and be in a person’s interest (e.g., financial interest, interest in maintaining a certain self-identity). The discussion of what constitutes a hopeless condition in the literature is fairly nuanced.

For the majority of thinkers, having a hopeless condition is explicitly defined in terms of having a terminal illness. For example, Dunshee (1994), the former President of the Board of Directors of Compassion in Dying, states that a person must be terminally ill, and goes as far to explain that an illness is determined to be terminal when “two physicians expect death reasonably soon, usually within 6 months” (5).

Some thinkers require that not only a terminal illness be present, but also that suffering is experienced as a result of that illness. For instance, Humphry (1987) requires that the person wishing to receive assistance to rationally suicide have an “advanced” terminal illness that causes suffering or “a grave physical handicap” (336).
Other thinkers do not require the presence of a terminal illness. Jamison (1999) includes consideration of an, “incurable illness, and the amount of intolerable, irreversible physiological suffering experienced,” among his list of criteria to establish the rationality of suicide (emphasis mine, 134).

Werth (1995) expands the definition of hopeless condition. He explains that “‘[h]opeless’ conditions include, but are not necessarily limited to, terminal illnesses, severe physical or psychological pain, physical or mental debilitation or deteriorating conditions, or a quality of life no longer acceptable to the individual” (62). Dikestra (1986) says something similar in noting that a hopeless condition entails “unbearable physical and / or emotional pain” and no hope of improvement (15). Kjervik (1984), on the other hand, focuses more on the “amount of physical or mental debilitation” a person faces in a hopeless condition (1984), but he does not specify that the person wishing to suicide necessarily be terminal. Motto (1994) requires that the person wishing to suicide have an unbearable condition, and he holds it might be rational to suicide even when one is not terminal. Nelson (1984) explains that, “the assertion of a right to die is based upon the proposition that a person should be allowed to end his or her life when a deteriorating quality of life appears to be inevitable” (1330). Note that this assertion is not based on the fact that a person’s life will end within a prescribed amount of time even if she chooses not to suicide. Cassell and Rich (2010) argue similarly about deteriorating quality of life, the complex nature of suffering, and the use of terminal sedation and physician assisted suicide. These authors offer comment on the American College of Physicians stance articulated in a 2001 position paper on physician assisted suicide. In this paper, the College distinguishes between clinical suffering and psychological and existential suffering. The
College ultimately argues that clinical suffering can offer justification for offering assistance in suicide, but other forms of suffering cannot. Cassell and Rich refute this position on the grounds that it is based on a discredited dualistic account of the human person. They write,

…suffering is a specific distress that occurs when an impending destruction of the person is perceived and continues until the threat is gone or the integrity of a person is restored. A person is an embodied, purposeful, thinking, feeling, emotional, reflective, relational human individual existing through time in a narrative sense. Generally, all of these parts are consistent and are harmoniously accordant. Suffering, in which all of these parts are affected, variously destroys the coherence, cohesiveness, and consistency of the whole. It is in this sense that the integrity of the person is threatened or destroyed (436).

Thus, although some thinkers argue that a hopeless condition must be defined by a terminal prognosis, the definition of “hopeless condition” is not uniformly based on the inevitable demise of a person in the literature (c.f., Cassell 1998, Cassell 2004).

Consideration of Loved Ones

The literature would be remarkably short sighted if it treated suicidal people as if they existed in a vacuum. The potential harm that comes from a suicidal person’s actions, as well as the interests served by those actions, do not belong solely to the suicider. While the literature does tend toward the liberal ideal of the protection of self-determination, with these last two criteria, there is a recognition that even autonomous and rational people are part of larger communities that need to be taken into account, even if the interests of those communities do not necessarily outweigh the interests of the individual looking to kill herself. In order for a suicide to be considered rational, most thinkers require that the suicider give due consideration to the significant people in her life. The details of this criterion differ somewhat from thinker to thinker, but generally, bioethicists call for the
person wishing to suicide to think about the impact of her action on those around her and to determine that the impact of his suicide is not so great as to outweigh the ways in which suicide is in the suicider’s interests.

Werth and Cobia (1995) list among the criteria compiled from two national surveys of psychologists the “consideration of the impact on significant others” (62). Jamison (1999) explains that one of the factors that distinguishes suicide from what he calls rational assisted dying is “a lengthy process of decision making involving significant others” (128). A willingness to discuss emotional concerns, as well as the decision to suicide, is essential for a suicide being considered rational, according to Jamison. He writes,

the person’s plans for suicide and efforts made to respect emotional needs of significant others and minimize the possible negative effects on others through selection of the means to die, provision of warnings, absence of efforts to coerce unwanted involvement of others in death, and attempts to prevent accidental discovery by those who might be adversely affected (134).

Not only must a person take into consideration his loved ones when deciding whether to suicide, but he must also plan the act accordingly. Not only the whether, but the what, where, how, and when must be answered about the act of suicide such that the least harm is inflicted on those surrounding the suicider. In his book written for those considering rational suicide, Jamison (1995) speaks of the importance of considering the impact on loved ones in a few ways. For instance, not only are people to consider “obligations to family and friends” (12-13) and emotional impact on their loved ones (41-42), but also the financial impact on loved ones (38). Many other thinkers proclaim not only the need to consider the impact one’s suicide might have on one’s loved ones, but also that the person considering suicide speak with those loved ones about a variety of aspects related

In addition to the need to speak with loved ones regarding his decision to suicide, some bioethicists also require the suicider to speak to his treating physician regarding his suicidal desire. For instance, Humphry (1986) writes:

…The treating physician has been informed and his response taken into account. What his response will be depends on the circumstances of course, but we advise our members that as autoeuthanasia (or rational suicide) is not a crime there is nothing a doctor can do about it. But it is best to inform him and hear his response. You might well be mistaken—perhaps you misheard or misunderstood the diagnosis. Usually you will meet a discreet silence (173).

In this instance, Humphry suggests speaking with the treating physician in order that the person wishing to suicide can confirm that he is adequately informed. This is required by a number of other thinkers as well (Dunshee 1994, Lebacqz and Engelhardt 1977, Maltzberger 1994, Maris 1986, Martin 1980, Slater 1976).

Interestingly, Jerome Motto (1981) takes the obligation to inform significant others so seriously that he extends this obligation to those treating the suicidal person. Motto argues not only that the patient has an obligation to tell his loved ones about his plans to suicide and to discuss those plans with them, but that if a physician knows the patient wishes to kill himself, and does not want to speak to his loved ones regarding that decision, then the physician has an obligation to let the patient’s family members know (204).

Understandable According to Community

Closely related to the criterion that a rational suicidal person must take into account her significant relations, is the requirement that the suicide and the context in
which it happens be understandable to the community in which the suicider finds herself (c.f., Battin 1982; Choron 1972; Edwards 1997; Matthews 1998; Motto 1999; Siegel 1986; Stack 1999; Werth 1996, 1999).

Choron (1972) writes,

Rational here implies not only that there is no psychiatric disorder but also that the reasoning of the suicidal person is in no way impaired and that his motives would seem justifiable, or at least ‘understandable,’ by the majority of his contemporaries in the same culture or social group (96-97).

Choron points to a distinction that must be made regarding “community.” There are two ways in which “community” can be understood. There is first the society-level sense of community. This is what most bioethicists mean when they use the term “community.” The community that makes laws and mandates public morality must, in some way, be on board with the circumstances surrounding a person’s decision to suicide if they are going to provide legal protection for those providing the means with which to suicide. Stack (1999) explains this clearly when he writes that,

“the term rational suicide refers to a class of suicides that receive some cultural support given the special circumstances motivating the suicide. Although a clear line cannot be drawn between rational and nonrational suicides, it is assumed that the greater the cultural support for a class of suicides (e.g., suicides in the case of terminal illness) the greater the presumed rationality of the suicides (41).

Lebacqz and Engelhardt (1997), Prado (1990), Decker (1977), and Saunders and Valente (1988) also all speak to this level of community.

The second level of “community” refers to the more immediate social circles of which the person who wishes to suicide is a part. This is community that is close to the person who wishes to suicide (family, friends, loved ones), as well as communities that might have some say in the actions of the person (church communities, educational
communities, etc.). In some ways, we can understand this as a more stringent formulation of the last criterion, which specified that the person wishing to suicide consider, and sometimes speak with, significant others when considering suicide. Not only must these others be considered and consulted, but they also must in some way find the suicidal person’s actions understandable.

Some bioethicists hold that many of those closest to the person wishing to suicide must be in agreement with the act. Dunshee (1994), for instance, contends that the suicidal person’s significant others must have accepted her decision to suicide. A suicide is “understandable according to the community” in the sense that it is consented to and supported by the community. Siegel (1986) explains that, “the motivational basis of [the suicider’s] decision would be understandable to the majority of uninvolved observers from his community or social group” (407). Edwards (1997) requires that the suicider represent “values which have been (or would be) adopted under conditions of freedom, enlightenment, and impartiality” (55). This list of conditions represents what one very specific culture has identified as rational, namely a liberal democratic culture. When bioethicists include this criterion in their list to establish rational suicide, it usually means that an act of suicide is in accordance with the values of the dominant culture of which the suicidal person (or the bioethicist) is a part.

**Conclusion**

These ten criteria detailed above represent a comprehensive list of the criteria used by bioethicists to determine whether a person wishing to suicide is rational. Although not all the criteria I outlined in this chapter are required by all bioethicists in order to establish the rationality of suicide, all the bioethicists I addressed appeal to at least
three of the criteria mentioned, and most, especially in the more recent literature, require several more.

Now that I have enumerated the criteria used to define rational suicide in the bioethics literature, I can begin to explore the deeper problems associated with its application. The phrase “rational suicide” would appear an oxymoron to anyone with any first-hand experience with suicide or the suicidal. That a suicide be “rational” seems an impossible requirement. The rationality described by bioethicists is a capacity experienced by ordinary people. Most people are rational in the ways bioethicists describe a majority of the time. Yet the phenomenon of suicidality is extreme, both ontologically and psychologically. Psychologically, a person must find himself in pretty dire or distressing circumstances to consider ending his existence. Ontologically, suicide is the most extreme reaction a human being can have toward the fact of her general existence. It is a concrete rejection of the value of existence and existence itself. Suicide is an act that guarantees the impossibility of all future action. To ask that a person determine whether a particular suicidal person or a particular act of suicide is rational, then, seems misguided.

As this chapter noted, the criteria in place for rational suicide are themselves contested and problematic. The next chapter will critique some of the individual criteria discussed in this chapter. I will examine the application of these criteria and argue that any account of suicide is deeply problematic if it does not include consultation with suiciders, the very individuals whose interests are at stake.
In her now-canonical work *Feminism and Bioethics*, Susan Wolf (1996) begins by observing that traditional bioethics has often ignored feminist observations. Although the anthology largely addresses the positive contributions feminist perspectives can bring to bioethics as a field, the introductory chapter serves as a diagnostic of what is lacking in current bioethical approaches. Wolf queries why a relatively diverse interdisciplinary field like bioethics has not taken advantage of the myriad insights provided by feminists, while other fields in the humanities and social sciences have done so. Wolf writes:

...[I]t is no accident that bioethics has largely ignored gender feminism, long after the rest of the humanities and law have found such work to be important. Nor is the explanation to be found in the demography of modern bioethics, for women have played an important part in the field from the start. Instead, the answer is to be found in the deep structure of bioethics--in its early embrace of a liberal individualism largely inattentive to social context; in its emphasis on deduction from ethical principles rather than induction from concrete cases; in its tendency to view ethical problems either dyadically as problems between individuals, or nationally as problems for the entire society, but rarely at an intermediate level attentive to the moral significance of groups; and in the failure of bioethics to be sufficiently self-critical by examining whom the field serves and how (5).

Bioethicists’ failure to take up gender feminism has involved no malicious plot: It reflects instead the dearth of disciplinary reflection. The insight Wolf provides here is critical, both because it is a needed corrective for the field of bioethics, and because it offers an understanding of the thread that runs through the feminist critiques which this chapter will explore. Wolf’s critique explores issues at the heart of the structure of bioethics and
exposes foundational blind spots. Her work brings to light the lack of consideration of the ethical commitments with which bioethicists begin, as well as a lack of reflection on methodological starting points.

These blind spots identified by feminists have done more than cause the exclusion of feminist voices from the field, though. These larger issues identified by feminists are an indictment of the field of bioethics as a whole and provide much insight into the treatment of specific debates in bioethics. These critiques show how the structure of bioethics itself can cause minority voices to be overlooked, as well as procedural issues in the consideration of particular bioethical problems. When subjected to the feminist critiques that will be outlined in this chapter, bioethical discussions of rational suicide will be shown to exhibit some of the problematic patterns identified by feminists.¹ Some of the critiques mentioned by Wolf and other feminists apply quite readily to the bioethics literature on rational suicide. Addressing the critiques provided by a number of important feminist bioethicists, this chapter will argue that these bioethical “blind spots” identified by feminists have had repercussions in the literature on rational suicide.

Thus, the fundamental goal of this chapter is to critique the concept of rationality as it has been presented in the bioethics literature on assisted suicide. In the previous chapter I established how rationality has been defined by a number of bioethicists and the lengths to which they have gone to codify this conception of rationality such that it can be

¹ Note that my goal in this chapter is not to render critique against bioethics as a field. While I will be referencing feminists who take on this larger project, my concern is limited strictly to the ways in which the specific critiques feminist thinkers make are applicable to the rational suicide literature. I am using the works of these thinkers to organize discussion of issues I have identified within the rational suicide literature, and to highlight a common thread in these issues. The goal of this chapter, therefore, is not an explicitly feminist goal. My goal is to borrow from and build off the insights feminists have explored regarding philosophical and bioethical analysis and to apply these same insights to a very particular body of literature.
used as the conceptual ground upon which to establish the moral permissibility of as-
sisted suicide. In this chapter, I will address feminist critiques of bioethics generally, as
well as feminist critiques of both the traditional conception of rationality and the ways in
which it has historically been ascribed to or denied individuals. I will argue that many of
the critiques made by feminist ethicists apply to the more specific work being done to
establish rationality. By exploring feminist critiques one begins to notice weaknesses in
the definition of rationality as it is presented by bioethicists in the literature on rational
suicide. This chapter will look at three specific feminist criticisms of bioethics, all of
which condemn the narrowness of bioethics and its failure to consider the social and po-
litical context within which bioethical analysis happens.

First, I will consider the tendency in traditional bioethics to uncritically embrace
liberal individualism, and the pride of place given to the liberal individual within bioethi-
cal discussions. Feminists and medical sociologists alike have criticized the field of bio-
ethics for wholeheartedly embracing liberal individualism, and in doing so, casting the
moral agent as an atomistic, liberal individual (c.f., DeVries and Subedi 1998; Friedman
2010; Sherwin 2005). This not only narrows the sorts of problems identified by bioethi-
cists, but it also restricts what might be considered morally relevant facts in bioethical
discussions. As Wolf indicates, it is the adoption of such a liberal framework that has al-
lowed for the dyadic understanding of the nature of bioethical problems. As I will
demonstrate, the moral landscape set up by bioethics has made it such that only people
living up to the standards set for the liberal individual are considered full moral agents.
This unthinking adoption has unjustifiably limited the sorts of persons considered to be
full moral agents and has ignored certain social realities that are at work in the issues examined by bioethicists. One can see this conception of the ideal liberal individual at work in some of the individual criteria used to define rational suicide, specifically in the criterion regarding the freedom of the person wishing to suicide. In addition to problems found in the freedom criterion, these critiques show us that bioethicists have established an understanding of the ability to reason that is entirely shaped by an overly-idealized conception of the liberal individual.

After exploring how the adoption of this liberal framework affects the enterprise of bioethics, I will explore feminist critiques of value neutrality in bioethics. It is difficult to present these critiques as totally separate from one another because together, liberal individualism and its ideal of the liberal individual lay the foundation for belief in the possibility of value neutrality. Yet for the purposes of this chapter, I will consider them separately. Feminists specifically critique the expectation on the part of doctors and bioethicists that they will enter into discussion about medical ethics as value neutral actors. The expectation is that as long as doctors and ethicists are making decisions solely with an eye to improving or maintaining a patient’s health, their personal values will not impact discussions about a patient’s situation, and that this sort of value neutrality is possible and desirable. Yet there are myriad examples of the ways in which values that may not be patient values inform and direct treatment. For instance, although there is no medical benefit derived from regular ultrasounds during pregnancy, regular ultrasounds have become part of prenatal care. This is one small way in which medical values (e.g., emphasizing the collection of data over avoidance of unnecessary medical intervention) have shaped a practice thought to be value neutral (Kukla 2005). Feminists claim that not
only is neutrality with regard to values impossible because the understanding and judgments of individuals are inherently perspectival, but also that claims of value neutrality are potentially harmful because they run the risk of obscuring the value-ladeness of the bioethical system as a whole (c.f., Ainsworth-Vaughn 1992; Baier 2005; Davis 1991; Kukla 2005; Roberts 1996; Sherwin 1992; Shim 2010; Tsai 2014; Wolf 1996). I will argue in what follows that it is impossible to achieve value neutrality when it comes to establishing rationality. This becomes clear in considering the harm and interest criteria in the rational suicide literature. Moreover, the requirement that the suicider have a “realistic” worldview can in no way be established without reference to some set(s) of values.

My third and final critique in this chapter concerns the feminist critique of the historical application of rationality. Feminists point out that the labels of “rational” and “irrational” have been used in the past to marginalize certain types of knowers and knowing. Feminist thinkers demonstrate that historically, women have tended to be viewed as irrational as a class, or at least to have access to a more emotional, less stable form of rationality (c.f., Anderson 1995; Antony and Witt 1993; Bordo 1986; Code 1991; Harding 1982; Lloyd 1983, 1984, 1989; Nagl-Docekal 1999; Rooney 1991; Walker 1992). Men used this claim that women were less rational or differently rational to justify depriving women of rights and to claim that women were incapable of performing certain societal roles, while never reflecting on who was defining rationality (or the personality characteristics associated with rationality) and what ends this definition served. A parallel movement can be seen in the rational suicide literature. Something similar has happened regarding suicidal “knowing” in the bioethics debates on rational suicide. Although I do not claim the suicidal have been oppressed in the same ways or at the same level as the wom-
en and minorities of which feminists speak, I will argue that suicidal people, because of the way rationality is described and demanded by bioethicists, have been excluded from conversation about the moral permissibility of assisted suicide. In some sense, researchers have been talking about rational “suicide,” while also excluding those who are most clearly suicidal. How can a thorough and exacting discussion about a phenomenon occur if those who most clearly embody or live that phenomenon are excluded from the conversation?

**Liberal Individualism**

Perhaps it is the unreflective adoption of liberal individualism by bioethicists that most clearly testifies to the lack of reflection that Wolf identifies. The central role of the liberal individual in ethical calculations in much of bioethical thinking has led to the consideration of bioethical problems in terms of abstract rights and competing moral theories, and this has had considerable effect on the ways in which bioethicists conceptualize moral relationships and the self that enters into moral relationships. When one starts from the presumption that the most ethically important “unit” is the rights bearing individual, one ends up working within a very particular moral landscape in which public relationships are understood in terms of individuals who enter into (mostly) contractual relationships. It is a landscape where moral debate is cast in terms of the conflicting rights of individuals (or societies made up of rights bearing individuals). There is a lack of attentiveness to differences between individuals or communities that make up nations and to nuances in types of relationship.

Feminists critique not only the unthinking embrace of liberal individualism, but also the effects this embrace has had on moral debate in bioethics. I will outline three of
these effects. First, it leads to a misunderstanding and misrepresentation of the therapeutic relationship. Second, it allows bioethicists and doctors to ignore the social reality of institutional authority, the cultural capital held by doctors, and how these realities affect medical relationships and decision making within these relationships. Finally, there is a fundamental anthropological misstep made by bioethicists that undergirds the first two effects: persons are cast as atomistic individual rights-bearers and the social reality of the self is denied or not noticed.

Distortion of the Relationship between Doctor and Patient

Feminists contend that when bioethicists unreflectively operate within a framework of liberal individualism, they run the risk of distorting the relationships considered in bioethical reasoning. Of specific interest is the doctor-patient relationship. As Susan Sherwin writes, “In the bioethics literature this classic power struggle between patients and their physicians is defined as a moral conflict between the patient’s right to autonomy and the physician’s responsibility for paternalism” (1992, 137). Someone who begins from liberal principles sees interpersonal interactions in one of two ways. Either the therapeutic relationship involves the meeting of two fully realized, autonomous individuals who have come to discuss the issues at hand and struggle for the ability to fully exercise their autonomy, or it involves meeting of one fully realized liberal individual who needs to take care of another individual until that individual is capable of fully exercising autonomy. In order for this conceptualization of the doctor-patient relationship to work, the patient has to remain “perceived as separate, independent, and fully rational” (Sherwin 1992, 137) or be understood as in need of a paternalistic overseer.

When the relationship between doctor and patient is cast in either of these ways,
the understanding of the relationship, what happens in that relationship, and the possibilities of that relationship are fundamentally distorted. When a paternalistic understanding of the relationship is adopted, a patient is cast as unable to make informed decisions about her care. This is usually justified by claims that patients, because of illness and lack of technological medical training, are weak, afraid, and unable to make rational (unemotional and distanced) decisions. Sherwin continues,

Because physicians are well-informed on medical matters and because they are obliged by their professional code to act beneficently toward their patients, they are commonly thought to be well-qualified to make medical decisions on their patients’ behalf. Patients’ need for care, however, can leave them particularly vulnerable to excessive degrees of paternalism; illness (or the threat of illness) sometimes leads to patients’ loss of rightful authority, by making them too weak or too frightened to protest against unjustified interference (Sherwin 1992, 139).

Although the view of doctor as benevolent overseer and as the person best able to make treatment decisions for his patients is common and not always inappropriate, deference to this view is problematic. Casting the therapeutic relationship in terms of a benevolent paternalism runs the risk of fundamentally undermining a patient’s ability to exercise her will. This casting also runs the risk of operating within too simple an understanding of a patient’s abilities to make decisions on her own, and a doctor overestimating his need to make decisions for patients.

Legal scholar Lisa Ikemoto (1992) explores the other side of the coin. She critiques the view of the therapeutic relationship in terms of an interaction between fully autonomous individuals. In her article “Furthering The Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women” she explains the standard narrative regarding what happens when people make medical decisions and enter into medical rela-
tionships, and how this narrative draws from the larger political narrative of the liberal, rights bearing individual. She writes,

The standard legal story acknowledges a conflict between certain individuals and formal government. The story’s beginning, the individual right to choose the course of one’s medical treatment, describes society as a stronghold of individuals. The invocation of compelling state interests describes a society in which there is significant consensus (512).

Ikemoto explains that this language and this conception of how medical relationships are constituted are problematic. The demand that a patient be autonomous and maintain real independence in this relationship is a fiction. The effects that this understanding has on the treatment of minorities and women (or anyone with interests that compete with either doctors’ or the state’s and who belongs to classes who have often been denied full standing as autonomous, liberal individuals) can be devastating. Ikemoto is particularly concerned with pregnant women of color and considers the rise of legal court battles as an extreme consequence of casting this relationship in terms of two actors competing for ascendancy. She documents numerous cases in which forced medical intervention has been ordered by the courts to protect state or “fetal” interests (c.f. Annas 1986, Andrews 1986, Duden 1993, Hartouni 1997, Kukla 2005, Roberts 1997). Only because the relationship is initially cast in terms of autonomous moral actors can medical decisions be thought justly and appropriately made by legal judges. Given the fact that incredibly intimate and life-altering personal decisions are made in the context of a therapeutic relationship, legal intervention to settle conflicts in that relationship should give us pause. When the doctor-patient relationship is cast in terms of two moral actors with equal access to resources and similar capacities for navigation of the relationship, the reality of the relationship is obscured. Doctors come to this relationship with years of training, so-
cial status, access to resources a patient has no access to, and likely a history of relatively compliant patients. Most patients have none of this. The claim that a working class, single mother who graduated high school can enter into a non-hierarchical relationship with a doctor who carries with him the authority his medical position and social class offer him is a difficult one to make (c.f., Ainsworth-Vaughn 1992, 1994, and 1995; Davis 1991; Fisher 1986; Friedman 1991; Hunter 1996; Scritchfield 1987; Shim 2010; Tsai 2014). Ethical dilemmas in the context of this relationship run the risk of being posed in terms of how far a physician is obliged to go in order to fulfill the requests of her patient or how a physician can avoid infringing on the rights of her patient. Thus, on a liberal individual model, settling questions of medical treatment in the courts becomes an appropriate recourse.

Social Reality

Ikemoto points out another issue at hand in the legal cases she addresses: the crystallization of power and authority. This issue helps explain how some of the distorting of the doctor-patient relationship happens, and addresses a second effect of the unthinking adoption of liberal individualism by bioethics. Ikemoto writes,

This depiction [of the doctor-patient relationship as the meeting of autonomous actors] ignores institutionalized authority or authority to which we defer because of a reputational status not based on any one individual and whose sway is greater than the combined weight of the individuals who form the institution. Medicine has become an institutional authority presumed to be a source of valuable knowledge and truth. And it is an institution of privileged knowledge; doctors, the institutional representatives, are presumed to know best. Medicine is also hierarchical. Patients are expected to defer to the greater authority of the doctor. In addition, it reflects the dominant culture in that the privileged few in medicine generally come from the privileged tier of society; it is largely white and male (512-513).

Any talk about doctors and patients as two autonomous actors thus misunderstands the
social reality at play in this relationship. There is not only considerable authority granted to individual doctors, but also to the medical institution generally. One would be remiss, then, if one did not take into account that having the label “doctor” attached to one’s person entails a certain amount of authority and cultural capital. There is a reverence around the label “medical doctor” that extends beyond simple respect for the training a doctor has, and the idea that a patient can always fight against that reverence and assert her autonomy when making decisions ignores multiple levels of social reality. A doctor is more than someone who enters into a contractual relationship with an equal. If researchers do not take into account the physician’s cultural capital, gained largely because of the authoritative position he occupies (in addition to his training), researchers risk fundamentally obscuring the reality of the relationship between patients and physicians. One only need think of the infamous Milgram experiment (Milgram 1963) to understand the power of an individual in a lab coat, even if he does not claim to be a doctor. Similar studies have shown deference to people who are assumed to be in positions of medical authority (c.f. Blass 1999, Burger 2009, Hofflin 1966, Shim 2010). This is not to deny the importance of the specialized knowledge and specialized training had by doctors, but merely to point out that doctors have a very particular power that comes to them by virtue of more than just the knowledge they accumulated in training.

Moreover, this conception of the doctor-patient relationship ignores the fact that the institution of technological medicine itself wields institutional power, and that by being a gatekeeper to that institution’s services, and by being part of (and implicitly supported by) a community that exercises the sort of influence the medical institution does, the doctor is in a position of immense power. There is an expectation that the medical
field brings knowledge and truth and that doctors are the bearers of this knowledge and truth; doctors become the holders of knowledge that brings life, or secular priests (Sherwin 1992, 5). In some sense, then, when a doctor presents treatment options and offers his patient an opinion on how best to proceed when making a medical decision (or, worse, when he simply insists that one option, without presentation of others is the best way to proceed), this situation cannot be compared to other sorts of situations in which an expert in another field presents an opinion. The sheer power of the institutional authority granted to doctors because of their standing in the medical field prevents this analogizing. Deference to medical authority and the knowledge and truth held by doctors is often the unexamined norm. To cast a “layperson's” relationship to her doctor in terms of two people exercising individual autonomy is a fiction that ignores the impact of the power a doctor has simply by virtue of occupying the role of doctor and holding the place she does within the medical institution. When a doctor speaks with her patients, she brings with her the full weight of her field. She speaks not only with her own authority, but with the authority of a (secularly) divine institution, with the presumed consensus of experts much like her, even if no explicit consensus has been garnered.

Ikemoto points to the ways that the deference to institutional power and institutional authority bestowed upon doctors restricts the patient’s supposed ability to exercise her autonomy. She explains the dangers of self-privileging institutional authority when she writes:

[B]y its status as a source of knowledge, medicine creates a presumption that there is a better choice to be made--the one that conforms with reasonable medical practice standards. The presumption raises doubt about the authority of the person who chooses otherwise. It changes the decision
making process from an opportunity for self-definition to an obligation to meet other-defined expectations. The absence of a presumption would leave more room to understand the person’s choice as a moment of self-actualization, rather than as evidence of unfitness. Second, by its disproportional influence, if it does not actually coerce widespread consensus, it gives the appearance of consensus. Thus, the dominant culture, constituted largely of institutions, is largely authoritarian. Deference to authority, institutional or other, is expected. It has become a cultural practice (513).

In order for its effects to be mitigated, doctors need to be aware of the existence of institutional authority and the self-privileging nature of that authority. Without this awareness, writing off patients who do not defer to this authority as noncompliant, irrational, or hysterical can become standard procedure. Medicine and the medical knowledge doctors yield becomes the unacknowledged standard by which to judge the decisions made about a patient’s treatment, despite that patient’s individual circumstances and preferences. This standard is built into the foundations of the patient-physician relationship. If a patient refuses or requests treatment on the basis of factors other than those defined by medicine as relevant, then it becomes easy to cast the patient as somehow lacking autonomy. Anyone who resists medical advice, unless they do so for reasons recognized as relevant by the medical establishment itself, risks being considered incapable of fully entering into the therapeutic relationship.

Social Conception of the Self

The adoption of liberal individualism carries even more serious problems than the misconstrual of the therapeutic relationship or the failure to recognize institutional authority. In fact, the other two effects I will explore belie the fact that there is a more foundational issue at play here. There is an anthropological problem that comes with the adoption of a liberal framework. The issue is not just that relationships are being misun-
derstood, nor simply that the weight of social realities is being miscalculated. The conception of the self at work in all of this is distorted. The liberal individual is a political placeholder, not a full and complete description of personhood, and though bioethicists have filled in some of this conception of personhood by focusing on the exercise of autonomy and the ability of a person to meet her interests, this understanding of personhood is too simplistic an understanding in light of the complex moral issues at play in bioethics. For the most part, persons do not function as atomistic individuals who weigh out how best to achieve and exercise their rights, especially when making decisions about their health and overall well-being.

As Rosemarie Tong (1997) points out, feminists, “do not limit themselves to one ontology (i.e., to a single conception of the self and the self’s relationships to others)” (81), and likewise I will not attempt to choose or create a “correct” conception of the self here. I will look to one conception of a more social, less atomistic understanding of selfhood, however, which might illuminate some of the problems with the abstracted and isolated notion of persons at work in the bioethics literature. Again, this is not the strong claim that a conception of self that best describes the reality of the nature of selfhood has been found, but merely that a conception of selfhood has been found that might offer a much needed corrective to the hollow liberal individual spoken of by bioethicists.²

Marilyn Friedman (1991) offers clues about what has been overlooked in the flattening of subjectivity in bioethics, and offers us characteristics of a “self” that are im-

² There are a number of theories of what Tong (1997) calls “ontology” and what I would refer to as philosophical anthropology, that I could draw from here (e.g., postmodern feminism, ecological feminism, psychoanalytic feminism, etc.). This dissertation draws heavily on Friedman’s social conception of the self not because it represents the best possible description of the human person, but because it is a helpful construct against which to juxtapose the liberal individual used by bioethicists.
important to consider when considering the moral issues at stake in (bio)ethical debates.

Friedman argues for a social conception of the self which takes seriously the fact that selves are always in community, and that a person’s identity and interests are influenced by this fact. She writes, “In [the self’s] identity, character, interests, and preferences, it is constituted by, and in the course of, relationships to particular others, including the network of relationships that locate it as a member of certain communities or social groups. This is the social conception of the self” (164). When bioethicists “view ethical problems either dyadically as problems between individuals, or nationally as problems for the entire society,” they run the risk of ignoring the ways in which the individuals spoken about either as individual moral actors or citizens are formed by more intermediate communities and various interpersonal relationships (Wolf 1996, 5). Too much focus on creating the conditions in which a self can exercise its individual will overlooks the important fact that the self learned to make decisions based on values and decision-making criterion learned from social formation.

The social self identifies herself, at least in part, by her relationships to others, including the social groups of which she is a part. She is, for example, someone's daughter, someone's sister, someone's aunt, she is Black, she is heterosexual, she is middle class, she's a Hoosier. Doubtless, she understands those relationships in terms of whatever, if any, social norms and conventions govern them (171).

A person’s decisions cannot be understood as totally removed from the influence of the communities that formed her. Without attention to this fact, bioethicists run the risk of forgetting that communities make selves. Relevant considerations in most processes of moral decision making, such as it’s effects on one’s significant others, the significant others’ feelings about decisions, and the impact of decisions on a person’s standing in a

**Rationality Criteria Critiqued: Ability to Reason and Freedom**

The very premise upon which rational suicide rests— that is, the idea that if a person and an act that person wishes to commit can be shown to be rational, then there is no moral reason to prevent that person from committing that act—requires that researchers understand the issue in terms of whether a rights bearing individual is entitled to receive assistance from another individual in procuring the means for his own death. Yet this wrongly assumes the very asocial, non-contextual self of which feminists like Friedman are critical. The debate traditionally hinges on the suitability of an individual’s desire to receive assistance in suicide, and this suitability is determined by criteria that are conditioned by the liberal framework. Thus, rational suicide is constructed as a rights issue. The question is framed as being whether a patient has the right to ask a doctor for the means by which to kill herself and whether a doctor has the right to offer (or deny) the means by which a patient might kill herself. As I will argue, framing the issue in this way mistakenly overlooks the social context within which the individual is making the request.

The general issue of the framing of the literature aside, I also find many problems in the way in which the specific criteria used to define rationality are spoken of and explained. Given the feminist critique I outline above, it should come as no surprise that individual criteria used by bioethicists to establish the rationality of the person wishing to
suicide and the rationality of the act of suicide also fall under the purview of the feminist critiques I am exploring. I will examine two specific criteria in light of the sort of feminist critiques I have presented thus far: the criteria that the person looking to suicide have the ability to reason and that the decision-making process of the person wishing to suicide be free.

Ability to Reason

There are two reasons it is especially important to examine the criterion regarding a suicider’s ability to reason. First, the requirement that a person looking to receive assistance in suicide be able to reason is the most common criterion used in the literature used to establish rationality. Second, one might convincingly argue that the ability to reason is what most people mean when they speak in colloquial terms about rationality. Given the attention paid in recent years to legalized physician assisted suicide in the United States, the strong identification of rationality with the ability to reason is an important consideration.

To reiterate from Chapter 1, the ability to reason is addressed in several ways in the bioethics literature. It is understood by some bioethicists in the strict logical sense of one’s being able to move from premises to conclusions in thinking without any logical errors (Battin 1992, Pipel and Amsel 2011, Slater 1980). This strict sense of the ability to reason causes no problems in light of the critiques made by feminist bioethicists.

There is an issue, however, when bioethicists do not make explicit this logical definition or begin to deviate from logical definitions of the ability to reason. For instance, Cholbi (2011) requires that a person requesting assistance in suicide have the, “ability to reason about what she perceives, making appropriate inferences, etc...” (91). If the person
establishing whether this criterion is met knows that making appropriate inferences means something very specific to someone who has formally studied principles of reasoning, this would cause no complications. Yet to ask a doctor, who may not have any training in logic or philosophical reasoning, whether a patient is making appropriate inferences, is to ask someone who has no frame of reference other than his medical training, or worse, appeals to “common sense,” by which to make that judgment. Given what feminist bioethicists have pointed to regarding institutional authority, there is a real danger of doctors believing they have expertise in areas in which they are untrained. A doctor may judge her patient’s ability to reason as compromised simply because the patient has reached a conclusion with which the doctor disagrees, and may not take the time to understand the reasoning process behind the patient’s drawing that conclusion.

The danger of this is made clear in Werth’s (1999) and Werth and Cobia’s (1995) studies. Werth and Cobia draw the criteria necessary for establishing rational suicide from surveys on the opinions of practitioners, and not from philosophers with training that gives them the proper expertise to speak to what constitutes rationality. Both studies indicate that in order for doctors to consider granting assistance to a patient requesting assistance in suicide, that person must have, “engaged in a sound decision-making process” (Werth 1999, 5). As any logician knows, the term “sound” is used to describe a valid deductive argument with true premises. This is obviously not what these doctors mean by soundness. Without recourse to strict logical terminology, “sound” used colloquially is a nebulous term often defined by the person using it. For instance, one of my online logic students considered her decision to throw her boyfriend’s possessions in the front yard “sound” because she thought he had cheated on her, and this is how her family members
and peers had dealt with similar issues in the past. Although this is not a particularly serious example, it does make clear the tendency to default to one’s own cultural understandings of appropriate behavior and reasoning when applying the term “sound” without reference to its logical denotation.

Moreover, the components of a “reasonable decision-making process” are numerous and must be explicitly identified in order to be adequately judged. Edwards (1997), a psychiatrist who is influential in psychiatric ethics, begins to break these down. In addition to the formal components like, “avoiding logically contradictory beliefs,” Edwards lists, “having factual beliefs that are largely supported by empirical evidence, or at least avoiding factual beliefs which are plainly falsified by experience...”, “having and being able to give reasons for one’s behavior and beliefs,” “thinking clearly and intelligibly,” and “having and exhibiting a capacity for impartiality or fair-mindedness in judging and adopting beliefs” (55). Given the fact that doctors often have such different experience than their patients, and given the authority of doctors, not only because of their expertise, but because of the particular roles they occupy in the medical institution, one must examine how doctors might go about determining whether the components of a reasonable decision-making process have been achieved by their patients.

Having factual beliefs, avoiding beliefs that have been falsified by experience, and having reasons for one’s behavior and beliefs can be understood in very particular ways by doctors. The way in which facts are constituted by most people, versus how scientific facts are established, can lead to a gulf between a doctor’s and a patient’s assessment of what it is to establish facts. Additionally, thinking clearly and exhibiting a capacity for fair-mindedness can easily be understood by doctors in light of their medical train-
ing. If fair-mindedness and impartiality are judged in light of scientific training, then scientific reasoning becomes the only appropriate mode of thought. A patient who is more concerned with ethical or religious reasoning runs the risk of being labeled unable to reason, and hence irrational, only because doctors’ training does not teach them about other modes of reasoning. If these criteria are not applied by persons who understand that scientific and medical viewpoints are but particular ways to understand and approach reality, that these viewpoints are not self-justifying, and that this is a period of history in which scientific standards of truth are often accepted as the standards of truth par excellence without justifying this acceptance, then some patients will be unable to meet doctors’ standards for the ability to reason despite a demonstrable capacity to do so.

Another way that the ability to reason is spoken of by bioethicists is in terms of a person’s ability to foresee the consequences of her actions. This means considering possibilities and the conditions that might affect decisions and consequences. This is not a problem unless a doctor or an ethicist has a very particular consequence in mind. For example, Prado (2010) writes, “I make clear that to be rational, reasoning and enactment of suicide must be done in full understanding that death may be and most likely is personal annihilation” (10). In some sense, it is necessary to ensure that a patient is aware that death may be final. Asking that a patient have the ability to at least entertain the possibility that there is no afterlife is not at issue. The problem comes with Prado’s insistence that a patient admit that personal annihilation is the most likely outcome of death. How does he arrive at this belief? And what happens in the case of a patient who has strong religious belief? The belief in an afterlife, or the hopes of an afterlife, are not established by a logical reasoning process. Logic, as the study of the form of human thought and
components of reasoning, cannot be the standard used to pass judgment on principles of faith. If a doctor or ethicist is committed to an atheistic or materialistic viewpoint, then she runs the risk of allowing personal metaphysical commitments to affect her judgment of her patient’s ability to reason if she is not aware that she is not a proper authority to judge these commitments. Given what feminists have established about the self-privileging nature of institutional authority and the dangers of a lack of reflection on moral and metaphysical assumptions made by doctors and bioethicists, special attention must be paid to the ways in which the non-medical commitments of doctors and ethicists might impinge upon their abilities to judge the reasoning processes of patients (c.f. Addelson 1984; Davis 1991; Engelhart 1986; Hunter 1996; Ikemoto 1992; Wendell 1997; Tsai 2014; Zola 1972). Additionally, given the flattened conception of the self appealed to by bioethicists, religious and moral commitments and the place of a patient in moral and religious communities may be written off as medically irrelevant, and thus denied an appropriate place in the decision-making process.

Even more concerning than specific definitions of reasoning found within the literature are the times in which “the ability to reason” is listed as a criterion for establishing rational suicide without an attempt to define the term (e.g., Clarke 1999, Choron 1972, Hewitt 2010). In one extreme instance, physician Richard MacDonald, actually uses a dictionary definition of rationality which calls on the ability to reason (1999, 109). If doctors and ethicists make no attempt to define this criterion or simply appeal to a “layperson’s” definition of reasoning, there is no longer a risk that doctors and ethicists will privilege their own reasoning processes over their patients’ reasoning processes -- they will have to do so. If all a doctor has to go on when judging the quality of a patient’s reason-
ing is that a patient give “good reasons” for decisions or “be reasonable” when making decisions, what can they do but evaluate their patients’ reasons based on their own experiences of giving good reasons? Again, given the concerns raised by feminists regarding the privileging of a very specific idea of the autonomous liberal individual, as well as the problems of unrecognized institutional authority and the undercutting of patient selfhood, there is reason to take issue with the idea that doctors can unproblematically apply this criterion to their patients (c.f., Ainsworth-Vaughn 1992 and 1995; Davis 1991; Fisher 1986; Friedman 1991; Hunter 1996; Shim 2010; Tsai 2014).

Freedom

The next criterion that this chapter will look at is the demand that a person’s choice to suicide be freely made. Very specific ideas of freedom are going to be at work within a liberal individualist framework, and the effects of these ideas within the rational suicide debate are easily seen.

The requirement that a decision to suicide be freely made is spoken of both positively and negatively. It is defined positively insofar as bioethicists require that a person’s decision be an exercise of her free will and that her decision making process be free (Marker 1999, Diekstra 1986, Werth 1995). Additionally, freedom is defined negatively: a person must not be pressured or coerced into suicide (Werth 1995, Motto 1999, Prado 2010, Lebacqz and Engelhardt 1997, Francis 1980, Motto 1981, Sullivan 1980).

3 An anecdote, but one that seems telling: I was a campaign manager for a reelection campaign to a council within the American Medical Association for a cardiothoracic surgeon a few years ago. This doctor knew of my background in philosophy and my training in ethics. When we had some downtime on “the campaign trail,” he took the opportunity to tell me that “as an ethicist” I would appreciate that he had lived a life in which he was always able to take the “moral high ground.” He proceeded to explain that he was in the “enviable” position of being able to “always” do the right thing. Again, this is entirely anecdotal, but interesting.
Both the positive and negative descriptions lack nuance, however, and run the risk of failing to take into account the social nature of the self identified by feminists. Ideas about what it is for a person to make a decision freely vary widely depending on communal standards. If it is assumed that in order to be free, a liberal individual must have considerable liberty to exercise her interests, then a loved one’s insistence on being included in that individual’s deliberative process might be construed as coercive, especially if that loved one is upset about the individual’s desire to suicide. Given that one of the components of the ability to reason spoken of by bioethicists in the rational suicide literature is freedom from intense emotion, it is not a stretch to wonder whether some of these same bioethicists would question whether a mother (or any person with strong emotional ties) could make a free decision regarding suicide.

The freedom criterion must be examined in light of both the therapeutic relationship and institutional authority. Can freedom in the sense of avoiding undue influence ever really be achieved by a person occupying the patient role? If a patient is under the care of a doctor, in reality, her freedom is curtailed. Her options for her freely made decision are limited to exercising one of the choices that her doctor presents her with and (in some cases) the refusal of treatment. In an ideal relationship between doctor and patient, the doctor works to give her patient as much freedom as possible. She presents her patient with treatment options without being overbearing and allows her patient to ask all the questions she needs to in order to be adequately informed. The doctor allows her patient time to discuss options with the patient’s significant others and offers treatment recommendations at the request of the patient. These sorts of conditions would allow a patient to make a free decision about her health and treatment options. A patient’s free decision
is hard to imagine if she is only presented with the one or two options that the doctor wants her to explore or if a doctor believes that the option proven to be most effective is the only “real” option for the patient. Bioethicists probably did not have in mind the way in which a doctor might influence a patient and were more concerned with the influence of significant others when a patient is making a decision to end her life. Yet, given the centrality of the relationship of the doctor and patient in the life of a patient who is ill enough to be considering suicide, attention needs to be paid to the ways in which institutional authority and the doctor-patient relationship might affect a patient’s decision making possibilities. If bioethicists insist on a patient meeting this freedom criterion, what must be determined is not only the extent to which a patient is influenced by significant others, but also how much the patient role affects an individual’s ability to choose freely. Given the nature of the doctor-patient relationship described by feminists, a patient engaging in a free decision making process as described by bioethicists might be difficult to imagine.

**Value Neutrality**

The next critique feminists bring against bioethical reasoning regards claims of value neutrality on the part of doctors. Feminists take issue with the claim that value neutrality is both possible and desirable. As the quote from Wolf notes above, the starting point of much bioethical reasoning is the idea that doctors and patients come (or should come) to the table as rational, free, and unencumbered agents who enter into a contractual relationship aimed towards ensuring the health of the patient. This sets up the perfect conditions for bioethicists to claim that because this relationship is geared towards only the maintenance or improvement of the patient’s health, the doctor can put aside her own
individual values and focus strictly on this mutual aim. Sherwin explains that traditional accounts of weak paternalism are often considered unproblematic because the doctor acts without self-interest. “To qualify as paternalism, the basis of the decision must be the patient’s well-being; thus it is distinguished from actions the doctor might take out of self-interest” (Sherwin 1992, 138). In the instances a doctor must “step in” and make decisions for a patient, if the doctor is looking out for patient interest, she must be able to discount her own values.

Yet even in the best cases of this sort of paternalism, ones in which doctors are wholly oriented toward the good of their patients without thought of themselves, there is a risk. Sherwin suggests, “Because paternalism aims for the patient’s good, it is recognized as well-intentioned action, but its actual achievement in bringing about the best consequences is in doubt, because it is the physician’s--rather than the patient’s--perception of the patient’s good that is decisive” (Sherwin 1992, 138). As Sherwin explains here, even when a doctor does her best to put aside her own values, the problem with this paternalistic impulse is that the patient’s vision of the good should be decisive when making treatment decisions. When she steps in for the patient, the doctor must operate from some notion of good, and if the doctor is making decisions for the patient, that notion of “good” will underlie those decisions. Most doctors are not in a position to be able to understand their patients’ notions of the good and the good life, and their training does not adequately prepare them to decide if a “good” treatment for a patient in terms of her physical health squares with the general good of the patient.

The question of the right treatment for a patient is not a question that can be wholly answered by science, because it also involves weighing the patient’s own evaluations of the risks and benefits she may experience. It is a
medical mistake to believe that science can provide all the relevant information for protecting or restoring the health of patients (Sherwin 1992, 148).

The patient’s interests are thus almost always best served if the patient is the one making decisions. Only a patient herself is able to navigate making decisions oriented toward the satisfaction of her interests and values, and to decide whether physical health is the most important of those interests and values.

There is a larger assumption being made regarding the ability of doctors to be value neutral, however. It is not just that doctors can overcome or put aside their own values and interests because their patients’ health is their primary concern, but some believe that as long as the very scientific, technical training required to become a doctor has taken root, then doctors should be able to put aside personal interest and act the part of the objective scientist. This, again, is an effect of the institutional authority of medicine identified by Ikemoto. The influence of this institutional authority extends beyond the impact it has on how the relationship between doctor and patient is understood. The self-privileging pointed out by Ikemoto also impacts the way in which the scope and power of medical training is conceptualized. The very specific training in medicine received by doctors is often assumed to make doctors capable of tremendous ethical feats. As Sherwin explains, doctors are expected to bring with them, “the uniquely ‘objective’ perspective required by this scientific enterprise” (1992, 145). Even when ethicists recognize that physicians bring with them social and cultural values (and prejudices), there is an assumption made that the physician, as an after effect of her scientific training, can somehow “overcome” this influence when dealing with her patients. Dorothy Roberts expounds on this reasoning:
Medical ethicists may recognize that doctors are influenced by social prejudices, but this is considered to be simply a distortion that should be corrected in doctors’ quests to apply the principles to their practice. ‘Physicians are subject to the same social constraints as others, but must learn from their training and experience to overcome them in the service of the sick.’ Thus, much of medical ethics proceeds by overlooking social problems and envisioning a generic physician who should resolve questions involving a generic patient by using general ethical notions (1996, 119).

The claim is that if the doctor’s goal is to heal the sick, and she has been well trained, any cultural prejudices she has are irrelevant. The primary task of the physician and her training trump cultural considerations because the doctor is trained to be an objective scientist and can apply the training in objectivity even to issues outside of the scientific, medical realm. This includes ethical decision making, despite most doctors’ lack of training in ethics.

But Sherwin points out that such claims actually ignore fundamental truths about the practice of medicine and ignore a set of values inherent in the scientific enterprise of medicine itself.

The appeal to technical measures lends an aura of objective truth to medical findings. In this way science supports physicians’ claims to dominance over other health care workers and patients. It is, however, unclear how much of their judgment really rests on a firm scientific foundation. Contemporary medical practice involves a great deal of uncertainty and intuitive reasoning, in addition to the aspects that are derived from well-defined science. In claiming authority medicine presumes a degree of certainty and authority inappropriate to its actual level of knowledge (Sherwin 1992, 147).

Not only medical training, but also claims of objective scientific training, support the institutional authority of medicine. Sherwin explains that because part of medicine is rooted in objective physical science, doctors see this scientific training as reason for claiming greater access to certainty than other healthcare workers. This claim to objective truth
also allows some doctors to ignore accounts of lived experiences of illness. Yet this claim that doctors work within the realm of objective science is problematic according to Sherwin. Medical doctors must use intuition in diagnosis and treatment. While this intuition is certainly formed and guided by intensive training, some of which is in objective science, ultimately, doctors rely as much on intuition as they do objective science. If Sherwin is right, then doctors’ claims to objectivity are deeply problematic.

This narrative of objectivity allows doctors to avoid any reflection on how their own beliefs and prejudices might impact the “private” relationships they have with their patients. It also allows doctors to avoid reflection about whether they are the best authority to judge what is best for their patients. Although their training might make them the best authority to inform patients about treatment options and to help patients evaluate these options, work must be done in order to argue that doctors are appropriate moral judges regarding the good of the patient (beyond “good” in the sense of physical health).

**Rationality Criteria Critiqued: Realistic Worldview and Harm and Interest**

Feminist critiques of the rational suicide literature are most evident in the criterion that a person wishing to suicide have a “realistic” worldview. Looking at this criterion through a feminist lens shows the inconsistency of the claims being made by bioethicists. What a “realistic worldview” is cannot be established without recourse to fundamental values. In light of the feminist critique explored above, requiring doctors to determine whether a patient’s worldview is realistic has the potential to require that doctors claim expertise where they have no specific expertise.

This criterion is quite common in the rationality literature (c.f., Decker 1977, Francis 1980, Sullivan 1980, Graeber 1981, Kjervik 1984, Siegel 1986, Barry 1994,
Werth 1999, Cholbi 2011). How such a worldview is defined varies widely, however.

As mentioned in the first chapter, some bioethicists understand a patient’s having a “realistic” worldview as simply meaning that she does not suffer the delusions or hallucinations brought about by mental illness. Requiring a patient not be schizophrenic in order to consider her worldview realistic is unproblematic. However, when doctors start demanding that their patients’ worldviews entail more specific things than the absence of delusions and hallucinations, it becomes clear that doctors are forcing their own “realistic” worldview on their patients. For example, as addressed in Chapter 1, Carlos Prado (2010) requires that a person adopt a very particular metaphysical starting point in order to have a “realistic” worldview. The person wishing to receive assistance in dying must admit that death “most likely is personal annihilation” (10). A realistic worldview in this instance is premised upon a person accepting or mimicking acceptance of a doctor’s belief regarding the non-existence of an afterlife. This requirement, however, is an overextension of Prado’s expertise. Prado, a trained philosopher, can make no absolute claims about the existence of an afterlife. How much more so is this true of a doctor? Writing off a patient’s religious beliefs and denying her access to services because of these religious beliefs is hardly a value neutral act.

Prado’s requirement is an extreme, but even with less extreme requirements, there remains the danger of doctors not taking into account the cultures and subcultures to which a patient belongs and doctors’ own lack of knowledge about cultural difference. For example, a doctor would have to account for religious diversity among members of her culture, and be open to accepting decisions based on adoption of a set of religious principles wholly other than her own. Religious considerations are not based on logic,
and there is no way to say that a fully functional, non-delusional person’s religious worldview is not realistic. Also, it is highly inconsistent to start from a liberal framework when discussing moral issues in bioethics, but then to insist that a person who lives her life based on a set of moral and religious principles should be denied her rights because the person rendering judgment on her actions thinks her starting principles inappropriate.

Some practitioners even admit that this criterion is particularly problematic. Motto writes:

Some persons have a view of reality so different from mine that I do not hesitate to interfere with their right to suicide. Others’ perceptions are so like mine that I cannot intercede. The big problem is that large group in between. In the final analysis, then, when a decision has to be made, what a psychiatrist calls “realistic” is whatever looks realistic to him (1980, 214).

The psychiatrist has to determine whether the patient’s worldview is realistic, but Motto recognizes that the only perspective from which to do so is that individual doctor’s perspective. While psychiatrists receive specific training to render judgments about how realistic the worldview of patients exhibiting certain pathologies are, any judgments about the beliefs of a patient that fall outside of the scope of the “pathological” are not appropriately judged by a psychiatrist. Not all doctors may be as aware as Motto of the ways in which their own limited perspectives affect their judgments regarding patients’ worldviews. As Sherwin explained, a doctor’s ability to put aside his own values is often assumed by patients and doctors alike. It is assumed, in part, because doctors are often understood to have undergone objective scientific training. Because of these factors, it seems possible, if not likely, that doctors may not recognize the ways in which they bring their personal values to their practice. It is even more likely that doctors do not recognize
the way in which their medical training has thoroughly enculturated them and affected their abilities to delimit the influence of the institutional authority of medicine in their own thinking.

Related to the idea that a doctor is able to determine what a realistic worldview is apart from his own views on the world is the idea that a doctor can readily establish what constitutes harm and interest in the case of an individual patient. These criteria play a pivotal role in the rational suicide literature. In order for rationality standards to be met, most bioethicists writing on rational suicide require that the act of suicide not cause more harm to the suicider than would staying alive and that the act of suicide be in the interests and/or allow the suicider to attain some of her interests. This is problematic because harm and interest are inherently subjective and must be determined from the perspective of the person who is trying to avoid harm or attain interests. In light of feminist discussions about value neutrality, and given that these harm and interest criteria must be applied by doctors to their patients, ensuring that doctors’ values do not influence the application of these criteria is of paramount importance.

The example of Donald “Dax” Cowart shows us the difficulty of this application and why applying these seemingly simple criteria is hard or impossible for doctors to do without recourse to their own values. Dax Cowart was twenty-five years old when he and his father experienced a propane explosion in his car. His father died, but Cowart survived and suffered extensive burns to 65% of his body. He spent the next fourteen months in the hospital, during which time he repeatedly refused treatment and asked to be allowed to die. Doctors and nurses treated him against his will, including daily Clorox baths that were so painful that despite his weighing only 85 pounds, it took several people

Despite Cowart’s persistent and lucid refusals of treatment and requests to be allowed to die, treatment was forced on him. His doctors claimed it was in his own interest to be kept alive because they could see an end to his treatment and claimed that he would eventually recognize that they were serving his interests. Significantly, years later Cowart still maintains that his doctors were wrong to treat him, and that despite becoming happily married and having earned a law degree since his accident, he should never have been kept alive against his will. When asked what he would say to the doctors who forced treatment on him, Cowart explains, “I would say that if they were in the bed feeling the pain I was feeling and experiencing what I was experiencing, they would understand very well. In truth, I think they did understand very well and would just not accept it” (Cowart 1994, 744).

Dax Cowart’s situation exemplifies what Sherwin, Roberts, and other feminists are concerned about (c.f., DeVries and Subedi 1998; Friedman 1987, 1991, 2005; Griffiths 1995; Grimshaw 2005; Kukla 2007; Shim 2010). His doctors felt they knew better, however, and ignored his explicit wishes. Those medical practitioners, accustomed to preserving life and often doing so at all costs, knew that they could give Cowart some quality of life and overrode his persistent wishes to be allowed to die in order that they might save him. In doing this, doctors imposed upon the patient their judgment of what constituted harm and interest.
Yet there is a more general risk. There is the risk that when speaking of interests and harm, instead of speaking to the interest and harm of a particular patient, researchers are actually preserving a moral tradition that has very distinct notions about interest and harm. There are two distinct ethics at work here--an ethic found in the medical field (an ethic of vitalism) and the ethic of the liberal framework. It is impossible to conceive of the interests of a liberal individual without that individual having life to begin with. Life is the good upon which all other values are based. The liberal individual is an individual who uses her life to maximize her interests and to avoid harm. The harm and interest criteria are thus value laden, and any patient who does not adopt these values can be written off as simply being irrational.

Application of Rationality and the Exclusion of Voices

In her book *The Man of Reason*, Genevieve Lloyd examines the way in which the concept of reason has been developed and used in philosophical history. Lloyd claims that the concept of reason, because of the way it was developed, is unnecessarily masculine. This is not to say that reason has been culturally constructed or is an entirely useless concept, but that the way in which philosophers have spoken about the concept has distorted philosophers’ understanding of reason. Philosophers have unnecessarily emphasized typically masculine traits when developing conceptions of reason, and the historical exclusion of women from philosophical discussions of reason has exacerbated the distortion. Worse, this distorted version of reason was often the very concept used to ground the justification of the explicit exclusion of women from the philosophical enterprise.

Feminist bioethicists have built upon Lloyd’s critique and applied it to specific discussions in the bioethics literature. They have noted similar ways in which the exclu-
sion of women, minority, and disabled voices from bioethical discussions have distorted ethical conversations happening in the field. The claim of this section is that a similar exclusion happens in the literature on rational suicide and that this exclusion has laid the conditions for the distortion of the very concept which the literature claims to describe. Presenting evidence for this is difficult, however, because the evidence for the claim is the lack of attention paid to accounts of the suicidal in the literature. The literature on rational suicide is almost exclusively devoted to exploring doctors’ and ethicists’ reasoning about the possibility of rational suicide. The rational suicide literature has not allowed the stories, or as Hilde Lindemann phrases it, counterstories, of the suicidal to be heard. Instead, the medical world has constructed a narrative for and about suicidal persons that ignores the narratives offered by the suicidal themselves (Lindemann Nelson 2001). My next chapter will argue for the importance of the inclusion of this counterstory and for examination of the suicidal persons’ perspectives in the rationality literature.

I am persuaded by Genevieve Lloyd’s claim that unnecessarily gendered notions of reason have been used to marginalize women in philosophical discussion. Lloyd offers an historical account of the development of the concept of reason throughout Western philosophy, starting with an explanation of reason in Plato and working through modern conceptions of reason, to show the ways in which feminine characteristics have been systematically identified with a lesser (or “complementary”) form of reason. She uses this historical exploration to argue that the concept of reason has been made unnecessarily masculine and has been put to political purposes. These political purposes have included denying women a place in philosophical discussions, as well as denying women full political rights and the recognition as full moral persons. Her concern is not the outright
claim that women are not able to reason; instead, it is the claim that women have access to a lesser form of reason and that historically, this claim has prevented women from achieving full moral personhood in the eyes of men and from being awarded full rights. Reason here is not understood simply as the cognitive capability that allows people to make judgments. Lloyd explains that bound up in most descriptions of reason are also gendered characteristics. As she states, “It is not a question simply of the applicability to women of neutrally specified ideals of rationality but rather of the genderization of the ideals themselves. An exclusion or transcending of the feminine is built into the past ideas of Reason as the sovereign human character trait” (37). It is not just that women are unable to achieve the ideal reason spoken of by philosophers, but that this ideal has been designed in such a way that anyone of a particularly “feminine” nature will not be able to achieve this ideal. Lloyd argues that philosophers have not developed a conception of human reason that captures a wide variety of human experience. Instead, the focus of Western philosophers on the perspective of white males has bound the concept of reason to that perspective; as a result, what has been presented for centuries as the universal and “objective” ideal of reason is actually a very limited and perspectival view of reason.

This masculine conception of reason has had considerable influence. Lloyd catalogues this influence and explains the way in which this deeply gendered conception of reason has impacted philosophical history. It has also had practical effects that Lloyd enumerates. She explains, for example, that it has allowed philosophers to, “believe that women are less rational than men,” and to, “formulate their ideas of rationality with male paradigms in mind” (103). Lloyd’s concern is that reason is not just the measure of true and right judgment, but also that it is incorporated into the understanding of the “proper
relations between our status as knowers and the rest of our lives” (ix). The effect gendered reason has had on the ascription of rationality and the status of certain groups of knowers is interesting for my purposes. When a person’s rational nature and status as a knower come into question, it becomes easier to justify restricting the control she has over her own life for her “own good.” If feminine personality characteristics are associated with a “diminished” form of reason and thus a lessened rationality, and many or most women display these characteristics, then barring women from certain realms (political, moral, etc.) becomes not only possible, but right.

Feminist bioethicists use Lloyd’s research to uncover and explore similar movements in the bioethical and health care fields, pointing to a marginalization that is similar to the field of philosophy (c.f., Antony and Witt 1993; Bordo 1986; Code 1991; Harding 1982; Nagl-Docekal 1999; Rooney 1991; Walker 1992). Just as a very particular perspective was privileged during the creation and development of the concept of reason, a similar privileging happens in discussions regarding issues in bioethics and there is a similar tendency to marginalize women and other underrepresented populations in those discussions.

As feminist bioethicists have indicated, in many areas of health care marginalized populations are negatively affected by a gendered conception of autonomy. For example, Roberts argues that women, and specifically pregnant women of color, have experienced dismissal as a marginalized class (1996). She writes

Judges and doctors describe women who refuse medical treatment as angry, irrational, fearful, stubborn, selfish, and uncooperative. They dismiss these women’s reasons for rejecting doctor’s recommendations, reasons which are not expressed in scientific terms, as unfounded and illegitimate (134).
In this article, Roberts catalogues legal cases in which forced medical intervention is used on pregnant women of color, and uses these cases to argue that the voices of women of color are systematically ignored and dismissed by the medical and legal establishments. The problem is not just that doctors use their cultural capital and the institutional authority of their field to dismiss the concerns and desires of individual patients and to label these patients irrational, but that there are patterns of dismissing the desires and interests of particular groups that are supported by the medical and legal establishments.

It is not only women of color whose voices are being marginalized. In her article “Deciding on Death: Conventions and Contestations in the Context of Disability,” Margrit Shildrick (2008) explains how conventional conceptions of autonomy developed by bioethicists have limited the range of disabled voices that are heard in bioethical debates, specifically in debates over physician assisted suicide. Autonomy, notably constituted by freedom and rationality according to Shildrick (2008, 210), has become the standard by which to establish that a person can fully participate in making decisions about her care. Shildrick echoes both Wolf’s and Ikemoto’s concerns about bioethics understanding moral dilemmas only in terms of conflicting rights of individuals (or individuals and the state). Resolution of moral dilemmas thus becomes premised upon maximizing a person’s ability to exercise her autonomy. Shildrick points to the fact that mainstream bioethical standards of autonomy are premised upon the assumption of atomistic individuals, and she explores how the demand for a person to meet rigorous and specific conceptions of autonomous personhood plays out in the context of end of life decision making:
In terms of the ethical delivery of health care, the multifarious variations demand on a pragmatic level sometimes more sophisticated than a single category approach can encompass. The difficulty, then, with the vigorous pursuit of any absolutist rights discourse, which inevitably speaks to a commonality of human interests, is that in the context of deciding on death, it covers over the complexity, as though everyone desires the same ends or enjoyed their form of embodiment in the same way (214).

While Ikemoto pointed out the way institutionalized medical authority constructs a fictionalized doctor-patient relationship in terms of autonomous actors, Shildrick looks more closely at the patient half of this relationship. The problem is not only that unrecognized institutional authority causes an imbalance in a relationship that is cast as a relationship between two equal actors, but that the patient role has been wrongly conceptualized to begin with. Even if the scales in this relationship were balanced somehow, and the institutional authority of the doctor could be mitigated, requiring patients to meet the standards of autonomy assumed by bioethicists is problematic.

The very specific idea of autonomy assumed by many bioethicists distorts the reality experienced by most patients, and this is especially true in the context of end of life decision making. The disabled are not able to exercise their autonomy fully because of physical limitations, and this has led to the discounting of their perspective in bioethics debates surrounding end of life issues. A particular vision of the sovereign liberal individual is put forth by philosophers and bioethicists, and a person who fulfills this vision is capable of moving herself through the world by her own power, of being embodied in a particular way. Persons with disabilities do not meet those standards, and thus are, implicitly or explicitly, denied full moral agency because they cannot exercise their autonomy fully (c.f., DeVries and Subedi 1998; Friedman 1987, 1991, 2005; Grimshaw 2005; Hollway 1998; Kukla 2007; Sherwin 2005).
Yet this is not an issue that is limited to the disabled community. As both Sherwin’s and Robert’s research show, minorities and women are often understood as incapable of meeting the standards necessary for achieving full moral recognition and are rarely heard from in bioethical debates. In addition to the lack of visibility of marginalized groups supported by sexism, racism, and ableism, there is the self-privileging and justifying nature of medical knowing to consider as well.

Significantly, either subjective experiences of illness nor health care experiences from allied professions are recognized as providing the appropriate training in the art of medicine, because neither one begins with rigorous grounding in science (Sherwin 1992, 147).

It is not only that particular groups of people are ignored, but that experiences of illness and the experiences of non-doctors are devalued. This consideration is interesting for any discussion in which a particular population is being spoken about, but is not being spoken with. How does one justify talking about, but not with, a population? As Sherwin points out, narrative accounts of illness are not considered appropriate sources of information when speaking to medical issues or developing medical knowledge. When you justify the exclusion of a minority group from discussions that impact that group, and you use a concept developed by a dominant group, there is a reasonable chance that the dominant group is privileging its own understanding of the minority group without proper justification. The institutional authority granted to medicine often allows for the unreflective self-privileging of medical knowledge.

In the case of the rational suicide literature, doctors and bioethicists not only question doctors’ willingness to aid in death, but also the conditions under which extending this service is morally justifiable. Building off of the juxtaposition explained by Sherwin,
the question of the moral permissibility of these services is seen in light of a conflict between individual rights and paternalistic impulses. The literature looks to identify the circumstances under which those wishing to receive aid in suicide can be understood as capable of exercising individual rights, that is, when a person meets the standards of full moral personhood. On the face of it, this seems unproblematic. Yet when this movement is considered next to similar movements, such as the discussion of the disabled by bioethicists without inclusion of disabled voices in that discussion, or the discussion of women and their appropriate place in political and moral spheres without the inclusion of women’s voices, a disturbing parallel is evident.

Similarly, the fact that very little, if anything at all, is heard from the suicidal in much of the rational suicide literature should at least make us cautious about conclusions drawn about the suicidal in that literature. Since doctors are being asked to provide the means of death for their patients, the need to understand doctors’ beliefs about assisted suicide is an incredibly important task when speaking to the moral permissibility of assisted suicide. Yet if the focus remains only on this “half” of the assisted suicide equation, the other half is ignored and researchers run the risk of unthinkingly marginalizing the very population the literature looks to address. Spellman and Lugones’ (1983) insistence that marginalized voices be given full audience must be taken seriously here. As they state,

To put the same point slightly differently, part of the human life, human living, is talking about it, and we can be sure that being silenced in one’s own account of one’s life is a kind of amputation that signals oppression. Another reason for not divorcing life from the telling of it or talking about it is that as humans our experiences are deeply influenced by what is said about them, by ourselves or powerful (as opposed to significant) others (573).
The next chapter will look closely at a sustained account of suicidality and will ask what this account might add to the literature on rational suicide. Any theory or account of a way of life developed without reference to the people experiencing that way of life runs the risk of misconstruing the phenomenon the account looks to describe. As Spellman and Lugones (1983) write: “No account can do this if it doesn’t get the parts right to begin with and this cannot happen if the concepts used to describe a life are utterly foreign” (578). The next chapter is dedicated to listening to a suicidal voice that offers sustained reflection on suicidality and to apply it to bioethical debates surrounding rational and assisted suicide.

What the next chapter will uncover is that in the process of trying to define rational suicide, bioethicists have focused too much on the first half of that phrase, rational, to the detriment of their understanding of the second half of that phrase, suicide. This is in part because of the exclusion of the suicidal from the rational suicide debate. Just as reason became a distorted and overly masculine concept because of the exclusion of women, the concept of rational suicide has become distorted because of the lack of attention paid to the suicidal.
CHAPTER THREE
LIVED SUICIDALITY

There is something odd about this dissertation so far. For a dissertation on suicide, I have said very little about the phenomenon of suicide itself. Suicide is arguably the most unique and extreme action a person is capable of performing. The act of suicide takes away the possibility of other acts and uses the power of the actor to destroy the possibility of power and action. Suicide cuts off all possibilities, shuts down community, and ends all projects. Given the uniquely individual nature of suicidality and the radical nature of the act of suicide, any attempt at offering a description of how suiciders should be dealt with, or moral judgments regarding the act or assisting in the act, should involve considerable attention to the individuals most affected by these discussions and judgments: the suicidal themselves.

Although suiciders have been talked about, few voices of people struggling with suicidality have been heard in the preceding chapters. The academic work addressed in this project has been written from the perspective of academics and healthcare professionals about the particular decisions and considerations clinicians must make when confronted with suicidal people. Moreover, most of this work has aimed to answer the very specific question, “What are the conditions a professional must see met by the person requesting assistance in dying in order to extend assistance in dying?” These conditions have been defined exclusively from the perspective of those who are not suicidal and
have focused on rationality as the linchpin of moral argumentation in favor of providing assistance in suicide. While the concerns of health care providers and the ethical concerns surrounding health care providers offering assistance in suicide to patients should be addressed, it is equally important that the voices of the suicidal factor into this debate. A full description and analysis of rational suicide requires that as much attention be paid to the suicidal as to healthcare professionals. Without making an attempt to understand the suicidal perspective, the ethical analysis of suicide and assisted suicide remains incomplete. As I argued in the last chapter, the rational suicide literature has marginalized suicidal knowers due to the privileging of the liberal individual, the myth of value neutrality, and the marginalization of underrepresented populations.

Yet there is a problem in the literature that runs deeper than even these, and one that finds its source in the fact that the literature, for the most part, has ignored the individual experiences of those struggling with suicidality. This chapter looks to establish the ethical and practical necessity of consideration of the lived experience of suicidality and the effects that this consideration has on the concept of “rational suicide.” I will argue that when the experience of a person struggling with suicidality is considered, it will be found that those writing on “rational suicide” have operated from an inadequate understanding of the nature of suicidality, and that “rational suicide” is conceptually problematic.

In what follows, I will present Jean Améry’s account of suicidality as offered in On Suicide: A Discourse on Voluntary Death. The importance of listening to Améry’s account of suicidality can be supported by Lindemann’s account of counterstories. Although Améry, as a white educated European male, does not come from a particular popu-
lation that Lindemann had in mind when writing about the necessity of counterstories for the empowerment of marginalized populations, a case can be made that counterstories of suiciders are needed. While Améry in many ways occupies a place of privilege, so much so that he was given the opportunity to present On Suicide as a series of lectures over south German radio, bioethicists have not listened to his story yet, and there is little acknowledgement of him in the rational suicide literature. I believe Améry’s account has not been considered in the assisted suicide literature because it takes a strange form. The description of suicidality he offers does not fit the mold of the usual stories of told about those wishing to receive assistance in suicide, and as I will suggest, his account should be understood as a counterstory.

I will offer a brief account of Hilde Lindemann’s concept of counterstory and explain the function and importance of counterstories. I will then argue that Améry’s work meets Lindemann’s definition of a counterstory and explain why understanding On Suicide as counterstory is important for its application to the rational suicide literature. After justifying On Suicide as counterstory, I will offer an exegesis of Améry’s writing in order to construct a fuller account of suicidality that references a suicider’s lived experience. Finally, I will argue that what this account demonstrates is that “rational suicide” as a concept is flawed because rationality cannot be ascribed to the lived experience of suicidality. Instead, in talking of rational suicide, bioethicists impose a narrative on suiciders as a group that is not rooted in a full understanding of suicidality generally.

Counterstory and Its Importance

In order to apply the concept of counterstory to Améry’s On Suicide: A Discourse on Voluntary Death, I will answer three questions: What is a counterstory? Why is a
counterstory important and ethically relevant? And finally, how will my reading of the rational suicide literature benefit from understanding Améry’s account of his own suicidality as a counterstory?

Lindemann gives a brief definition of counterstory in her 1995 article, “Resistance and Insubordination,” that will help orient an explanation of the concept of the counterstory.

I introduce the notion of the counterstory: a story that contributes to the moral self-definition of its teller by undermining a dominant story, undoing it and retelling it in such a way as to invite new interpretations and conclusions. Counterstories can be told anywhere, but particularly when told within chosen communities, they permit their tellers to reenter, as full citizens, the communities of place whose goods have been only imperfectly available to its marginalized members (1995, 23).

Immediately, several definitive criteria for the counterstory are seen. A counterstory must allow its teller to add to her own moral self-definition to the story. This process of self-definition must resist some other dominant narrative that has been placed upon the teller, and the teller must reinterpret that dominant narrative in light of her own counterstory. Finally, the counterstory must allow the teller to resist marginalization and to (re)enter the community she to which has been denied full access to as a result of the dominant narrative.

The first criterion a counterstory must meet to be considered a counterstory is that it must be a story. In Damaged Identities, Narrative Repair, Lindemann explains that there are four components of a story. First, it must be depictive, that is, describe human living and experience. Two, it must be selective. The teller must be particular in what she depicts and not merely chronicle all events that happen around a given topic. Third, it
must be interpretive. An author must characterize events and persons through a lens of meaning. This can also include the development of the person telling the story. Fourth, a story must be connective. Stories have to show some causal connections within the story (2001, 12-14).

Meeting the criteria necessary to be a story is not sufficient for a story to be a counterstory, though. Lindemann explains that while all counterstories are stories, not all stories are counterstories. What distinguishes counterstories from “plain” stories are the remaining criteria identified by Lindemann. A counterstory must be a story told by a person in order to offer herself moral self-definition. Lindemann appeals to Margaret Urban Walker’s definition of strong moral self definition: “It is ‘the ability of morally developed persons to install and observe precedents for themselves which are both distinct of them and binding upon them morally’ (Walker 1987, 173)” (2001, 15-16). Counterstories allow a person to take stock of her own history, determine what moral values defined her history, to reevaluate those values to determine whether she still has the same values, and to commit to a set of values for the future.

Consider, as an example, the story of a student told me about her first two years at college. She had a very different economic and cultural background from the majority of her peers. In her first two years at the college she tried to deny the differences between herself and her peers and tried to acclimate to her peers’ lifestyle. This involved a very particular way of dressing, a different speech pattern than she was used to, as well as “partying” which involved the use of drugs she would not have considered doing before coming to this institution. She sat in my office and told me this story, explaining to me, “I wanted to fit in, but I knew it wasn’t me. But this is what students who go here are like.”
When I asked her to tell me what the two years would have been like if she had been “her,” she told me a story of a studious woman who joined clubs, wore sweatpants to the cafeteria, spent more time with her family, but still went to a party every once in awhile. Through some discussion, the student admitted that what she valued was “doing right” by her family, doing well in academics, and enjoying the “college experience” in a safer way. She was a local student on scholarship and felt the “mark” of that when she was surrounded by her affluent peers. She had come to realize in her third year, however, that she had acted out of a set of values that was not entirely her own, but those she assumed she would need to adopt to be part of the college community. Telling the story of her first two years at college allowed her to realize that she wanted to work from a slightly different set of values going forward, and she did. The counterstory she told was of a different sort of student at the institution we were part of, and it allowed her to weave in elements of her moral identity, yet still remain part of the community.

An additional criterion that a story must meet in order to be a proper counterstory is that this story allows a person to confront and resist some dominant narrative. In Damaged Identities, Narrative Repair, Lindemann calls this a “master narrative.”

Master narratives are often archetypal, consisting of stock plots and readily recognizable character types, and we use them not only to make sense of our experience but also to justify what we do. As the repositories of common norms, master narratives exercise a certain authority over our moral imaginations and play a role in informing our moral institutions (Lindemann 2001, 6).

In the instance of the student above, the master narrative at work was the story of the “typical student” at the college. This master narrative is quite influential at the institution. It tells the story of a student who comes from a monied background, who cares little for
grades and academic achievement, who spends the majority of his energy on his social group at the school, and who looks to “party” as much as possible. This is a story told not only by students at the institution, but also by other members of the institution, as well as by members of the surrounding community. Although there are other characterizations of students at this college, this narrative is certainly the dominant one. My student’s reclamation of her own values in telling the story of her first two years at college, and then reinterpreting that story based on her own values and telling a new story about the sort of student she would become at that institution, is an excellent example of the way in which a counterstory can allow someone to resist a master narrative that does not align with her values. While my student did not reject the master narrative entirely -- for instance, she still wanted to go to parties and participate in college rituals -- her counterstory allowed her to be selective about the strains of the master narrative she wove into her own story and to reenter the dominant community with a sense of her moral identity intact.

Thus, counterstories are stories marginalized groups or persons tell in order to resist a master narrative and to reenter a community as full moral persons. This is of moral significance because, as Lindemann writes, “…the extent to which our moral agency is free or constrained is determined by our own--and other’s--conception of who we are” (2001, xi). Lindemann argues that personal identities are constituted in part by the stories a person tells herself about who she is, as well as the stories which are told about her. If this is the case, these stories change the scope of action available to that person and change the goods to which she has access. Lindemann appeals to Martha Minnow’s (1980) concept of the “dilemma of difference,” explaining that public policies often ig-
nlore the difference between dominant groups and less powerful groups; in so doing they “create a false neutrality that favors the dominant group: its characteristics are taken as the norm, while groups with other characteristics are marked as deviant” (1995, 28-29). This dilemma of difference, if it goes unrecognized, can create serious problems for marginalized groups and persons. It can lead to the social isolation and oppression of people and groups. If a person (or group of persons) is marked as deviant, she will not be recognized as a full moral person. A marginalized group or person might take up this identity as deviant and submoral as their own, as well. Moreover, this oppression and marginalization is not problematic simply because of social isolation, but because these groups might be denied goods, services, and the ability to exercise rights because of the way in which they are labeled deviant through the master narrative that supports public policies (Lindemann 2001, 20-21).

Telling stories about groups which display characteristics cast as “deviant” by master narratives helps call into question the privileging of the norms supported by those narratives. This begins to open up a space for those marginalized by labels of “deviant” to communicate with those who are the unknowing recipients of the privileges that come with the adoption of master narratives. Counterstories can allow marginalized groups or people to achieve recognition, to access goods which were previously denied, and, as in the case of my student, to reject the internalizing of aspects of the master narrative that do not fit with their own moral self-definition. Lindemann writes in “Sophie Doesn’t: Families and Counterstories of Self-Trust,”

To oppress a person or a group of people is precisely to force them to recognize you, but to be unwilling to extend recognition in turn. The point of many counterstories is to break up this pattern. The teller, no longer will-
ing to be complicit in the system of knowing others but never being known in return, uses the story to elicit recognition from the community that has oppressed her. To do this, her story becomes, as it were, a pair of spectacles that she extends to the inhabitants of the normal moral context who can’t see her without them (1996, 101).

Another important aspect of the counterstory, then, is that it allows the marginalized person or group a way to become seen by those who are in a dominant group. It allows those in a dominant group access to an understanding of ways of life that may initially appear deviant to them, but that are in fact merely different ways of life and different ways of navigating the world. This is an important step for avoiding and correcting the access and alienation issues mentioned above.

In some sense, the suicidal have been cast as an especially deviant group. Those who suicide reject life, and thus, reject belonging to groups and taking on societal projects entirely. One might consider suicide a kind of ontological deviance. Yet this is why it is especially important to listen to the counterstories of the suicidal. The suicidal have experienced a deprivation of opportunity because of the “deviant” label unthinkingly assigned to them. They have not had the opportunity to enter into a debate that speaks of them and greatly impacts them. The suicidal have been denied full moral recognition in the rational suicide literature insofar as bioethicists have spoken about them, but usually not with them. Lindeman writes,

Counterstories, which root out the master narratives in the tissue of stories that constitute an oppressive identity and replace them with stories that depict the person as morally worthy, supply the necessary means of resistance...Through their function of narrative repair, counterstories thus open up the possibility that the person could attain, regain, or extend her freedom of moral agency (2001, 150).
Not only must the suicidal be given a voice and the opportunity to come to the moral table to participate in discussions that directly impact them, but additionally it is equally important that those who take up the master narratives in this discussion attempt to take up the “spectacles” offered to them by the suicidal in telling their stories. Examination of Améry’s *On Suicide: A Discourse on Voluntary Death* will reveal that this essay fits the criteria and can do this work of counterstory needed desperately by the rational suicide literature.

**Améry as Counterstory**

The case can be made quite easily that Améry’s *On Suicide* meets the requirements necessary to be classified as a counterstory. Améry’s account is depictive insofar as it describes human living and experience, and a very particular sort of human experience—the experience of feeling the inclination toward death (1999, 7). He is selective in his depiction of suicidality in *On Suicide*. It is not a mere chronicle of his own experience of suicidality, and while he tells anecdotes about his personal experience, he does not list every suicidal thought he has ever had. The selective nature of *On Suicide* is further highlighted by the interpretive nature of his account of suicidality. He characterizes it through a lens that is not condemnatory by focusing on the meaning suicidality creates for those living through it. He casts the suicidal perspective as a totally “other” way of seeing the world (1999, 10). Finally, *On Suicide* is connective because causal connections are drawn between what Améry identifies as the roots of suicidality and the experiences that come with suicidality. He also draws causal connections between nonsuicidal persons’ understandings of normal or non-pathological ways of living in the world and nonsuicidal persons’ ignoring or restricting the voices of the suicidal (1999, 59).
On Suicide also contributes to Améry’s moral self-definition. There are many examples of this in the text, and the exegetical portion of this chapter will look at several of them. The most striking example deserves note here, however, in addition to being discussed later. Améry tells one particular story that allows for strong moral self-definition, the story that alerted me to problems in the bioethics literature in the first place. In this story, Améry wakes up in the hospital after his 1974 suicide attempt. He speaks of the ways in which he experienced the care provided by health care workers as degradation and the doctors’ assumptions of his gratitude as presumptuous. All Améry wanted was to be allowed to die (Améry 1999, 79). The inclination towards death that he experiences is described as an intimate, foundational part of his identity. The doctors and nurses, in assuming that he should be glad to have been “saved,” told a story that was other than Améry’s, one that was influenced by the idea of the deviant and wayward suici-der.

This text also allows resistance of a master narrative. Améry explains that suicidal people are not heard in the literature written about them. Améry speaks in this text as a suicidal person and not just about suicidal people. Immediately and repeatedly, Améry makes explicit that research on suicide speaks on behalf of a very particular population--those who research suicide and the dominant societies in which they live (c.f., 1999, 3, 5, 59, 102). These researchers start their explorations from a very particular understanding of what it is to be in the world and the value of being in the world, without recognizing the implicit values assumed by their research. Améry rejects the characterization of all who are inclined towards death as mentally ill or deviant. In one point in the text, he draws a parallel between homosexuals and suicidal people, explaining that neither are
sick, but that the orientations each of the groups experience are similarly deep. As deeply as homosexuals experience their inclination toward the same sex, so suiciders experience the inclination toward death (1999, 56).

Moreover, he very explicitly sets up a distinction between a dominant story and a nondominant story. Nonsuicidal people buy into a very particular narrative of what it is to live as a human being, and that story is dominant in society (c.f., 1999, 13, 18, 46, 57, 79). The nonsuicidal story acts as the “repository of common norms” regarding suicide and shapes many people’s moral understanding of suicidality (Lindeman 2001, 6). Améry calls this the logic of life (1999, 5). Suicidal people, however, live with a different narrative about the value of life of which Améry offers an account. In this account he resists the dominant narrative told about suicidality by those who are not suicidal and confronts the ways in which this dominant narrative has oppressed suicidal expression.

This work certainly allowed Améry to enter more fully into dominant community, not only because of the content of the text, but because of the form the expression of the text took. *On Suicide* was originally broadcast as a series of radio lectures in south Germany, and the written text has been translated into several different languages (Améry 1999, xi). Although the work itself has not been taken up at large in mainstream suicidology or bioethics literature, I will argue that the story Améry tells is one that demands to be taken seriously by both groups, as well as being a story that makes it hard to deny suicidal people a place in discussion of the morality of assisted suicide. This work should be recognized by the community of researchers of suicide, and it is the work of this chapter to bring to light the revelations it has to teach those of us who occupy this dominant community.
In this work, Améry provides a perspective anyone interested in the relationship between rationality and suicide cannot ignore. Here is a man whose life is an example of the possibilities of rationality. Améry is often called “the philosopher of Auschwitz.” His unconventional training in philosophy and literature allowed him to begin to articulate the inarticulable: how being a victim of tremendous violence and torture and how seeing others similarly victimized changes a person, and moreover, how the existence of these sorts of experiences en masse changes (or should change) intellectuals’ understandings of how the history of thought should be approached. Améry cannot be written off as irrational; his life serves as a concrete example of the pinnacle of rational discourse in the midst of that which seems beyond rationalization (c.f., Brudholm 2008, Heidelberger-Leonard 2010, McCann 2001, and Stark 2001). Améry’s life is the ultimate counterstory. He is in a unique position that renders him especially capable of offering bioethicists “spectacles.”

But there is another reason it is important to cast Améry’s *On Suicide* as counterstory. Methodologically, understanding it as counterstory offers a considerable benefit in that it offers a framework within which to make the text more approachable and more applicable to practical ethical situations. The unique form of Améry’s treatise might help explain why it has not been taken up by the literature. Like many of his other works, *On Suicide* has incredibly insightful moments, though it does not have the hallmarks of a traditional philosophical text. Because of this, it makes it hard to classify as a work, and even harder to work with in an applied way. Unlike most philosophical treatises, its goal is not to render a concept at hand as clear as possible. This is in part because Améry
thinks clarifying and attempting to universalize the concept of suicidality too much can distort the concept. As Kramer explains,

[Améry] adopted the essay as his own, thus cultivating a form that suited his aim for an interventionist thinking. The essayist, in the tradition of Montaigne, relies on the assumption that subjective experience needs to be taken as a pivotal point of reference wherever a philosopher seeks to attain novel perceptions. The essay, in the way Améry uses it, functions as a medium that remains true to the singularity of each experience but at the same time charges each with reflexivity and insight. Every thought and every concept is linked to the subjectivity of the narrator (2004, 138).

On Suicide is an essay that uses subjective exploration, description, and autobiography, and uses these as a base of non-traditional argumentation. This does justice to the subject matter of suicidality in a way that a traditional philosophical essay might not. Améry’s aim in this work is not to offer an argument for the fact that suicidality is not connected with rationality, or even an argument against preventionist measures. Instead, he offers as close a description as he is able of the lived experience of suicidality, sometimes proffering explicit philosophical analysis, other times merely reflecting on his own experience.¹ By using this form of the essay to walk the line between the researcher of a phenomenon and one of those affected by the researched phenomenon, Améry is uniquely qualified to offer comment and critique of the concept of suicidality as it is presented in research on suicidality. In doing this, he offers his reader the chance to rid herself of her own presuppositions about how it is to live as suicidal. Even if it is not possible to “think” suicide

¹ It might be tempting to refer to Améry’s work here as “phenomenological,” but Améry explicitly denies this explaining that he has, “dispensed with all concepts derived from the word logos and defined by disciplines of academic inquiry—out of modesty and with respect to positive research” (1999, xxiii). This disavowal of the phenomenological method is fitting, as he does not offer a rigorous phenomenology, but merely a thorough description that tries to approach suicidality, a way of being in the world that eludes thematicization.
directly, Améry believes persons should think “toward” it with as few presuppositions as possible, as “it plagues what are perhaps the deepest levels of our existence” and is worthy of patient consideration (1999, 28).

So the importance of understanding *On Suicide* as counterstory is not only because it allows recourse to Lindemann’s arguments regarding the ethical importance of listening to counterstories, but also because understanding Améry’s work in terms of counterstory allows researchers to pull from it information and testimony against which to test the dominant narrative they have constructed. If *On Suicide* is understood as a story that confronts a dominant narrative and does reparative work to the identity of the person telling it, then it is easier to justify why a work that seems esoteric should have bearing on an applied philosophical debate.

This is why *On Suicide* offers an appropriate and important counterstory to consider. Améry explains that researchers in suicide speak on behalf of researchers, and they speak on behalf of those who take up societal projects. They do not speak to the concerns of suiciders, and in fact, they hardly listen to the suicidal. The description of the lived experience of suicidality provided by Améry is one that challenges the belief that suicidality can be talked about in terms of rationality at all. What this counterstory will show is that suicide is neither rational nor irrational, but is arational. Using Améry’s account of his experience, I will argue that because of the primordial nature of suicidality, suicidality is arational and cannot be classified in terms of rationality. Suicidality takes root in someone before rational concerns can be considered. In restricting the stories of the suicidal to those wishing to receive assistance in dying at the end of their lives for “rational” reasons, the rational suicide literature has worked with a distorted and imbalanced concep-
tion of suicidality. Thus, the theoretical foundations upon which the rational suicide debate are built are weak because there is an insurmountable difficulty with the concept of “rational suicide” itself.

**Exegesis of Améry**

The aim of this part of this chapter is to exegete the first two sections of Améry’s *On Suicide*. Améry’s work is not just the esoteric ponderings of a public intellectual, but is in fact an oppressed person’s attempt to bring light to the story of an oppressed group to which he belongs. Since Améry’s story has been established as a counterstory, we can call on Lindemann’s reasons for the ethical necessity of those in power listening to counterstories that resist master narratives. Additionally, harkening back to Spellman and Lugones’ claim referenced at the end of the last chapter, Améry’s counterstory also has the practical effect of helping theorists avoid unrealistic depictions of the lived experience of groups to which the theorists do not belong.

In order to understand the counterstory that Améry offers, this work must be considered slowly and patiently. Although the form this work takes is not that of a traditional philosophical treatise, Améry’s work offers useful concepts and descriptions of lived experience that are applicable to the rational suicide debate. Although bringing one suicidal voice to this debate will not fully compensate for decades of ignoring these voices, it will allow some of the issues that have developed as a result of the lack of suicidal voices to come to the fore. Again, Améry is in a unique position to be this voice insofar as he has some philosophical training and considerable familiarity with suicide research. Before we discuss how the insights into suicidality Améry provides in *On Suicide* might be useful to the rational suicide debate, the text must first be examined.
Although I will look for insights that can be garnered from the work, insofar as it is possible, my exegesis will not attempt to resolve the ambiguities inherent in Améry’s essay.² He writes of the exploration of suicide:

This is an uncanny landscape I am entering when I try to substantiate this; a swampy area, a bog hung with mist, before which the essayist should protect himself. He doesn’t; he’s not accustomed to be concerned about himself. And so let’s say right here and let’s also offer a vulnerable flank to every kind of criticism: one can’t get through this with clear thinking (1999, 23).

Améry explains ambiguities are an unavoidable pitfall of research on suicidality. Given the nature of suicidality, to resolve these ambiguities would amount to being unjust to the true nature of the phenomenon in question. Non-suicidal people might be able to see the outline and limits of suicidality, but the lived experience, the content, of suicidality will remain beyond their grasp because suicidality is intimately tied to a subjective experience of suicidality (1999, 8). Moreover, for reasons that will soon become apparent, the “content” of suicidality can only be spoken of obliquely.

The “Logic” of Suicide

Améry begins On Suicide with the recognition that the distance between scientific suicidology and the world of the suicider is “measurable in light years” (1999, 23). All scientific study separates the lived experience of suicidality from the suicidal person. Scientific study of suicide, in looking to help suicidal individuals, studies them as a class. It looks for what is true of most (or all) suicidal individuals, which depersonalizes the expe-

² I follow Brudholm’s lead here. As he explains in Resentment’s Virtue, ambiguities play an important role in Améry’s work. A large part of Brudholm’s book is devoted to offering careful and thorough exegesis of Améry’s essay “Ressentiments,” and Brudholm writes: “The thorough reading has…been motivated by my observation that the ambiguities of the essay have not been sufficiently recognized and discussed by Améry’s readers. I analyze both the essay’s most enigmatic and apparently self-explanatory passages while not explaining away the genuine puzzles and ambiguities of the reasoning under scrutiny” (79).
rience of suicide. Améry goes as far to say that all research done in suicide speaks on behalf of society:

What I am aiming at is just the crucial point at which it becomes apparent that all suicide research, the psychological and sociological, speaks in the name of society—even when it most sharply criticizes the prevailing social order—instead of looking for potential suicides in the only place where they can be found: in each one’s own inalienable system (102-103).

Améry’s criticism is applicable to bioethical research in suicide, as well. Although the aim of this research is often to lessen the suffering of suicides and to determine how to respond appropriately and ethically to suicidality, it rarely includes the voices of suicides. While some research may pay lip service to the fact that suicidality isolates and individualizes the suicidal person, bioethics, in ignoring the experience of suicides, runs roughshod over a potentially fruitful interaction between researchers and individual suicidal people.

Améry explains that this sort of study is not without purpose, but that it does miss the crucial fact that there are two perspectives from which to view and understand suicidality. The separation of the suicidal person from suicide research has rendered researchers blind to the existence of a perspective other than their own. The perspective of the suicidal person, who finds himself facing an act that could separate him forever from human community, is identified by Améry as the “individual perspective.” This stands opposed to the perspective people most often understand suicide according to, what Améry calls the “societal perspective.” This is the perspective of scientists, doctors, and philosophers doing research on the suicidal, as well as anyone who thinks about the suicidal without having had experience of suicidality. These people discuss and study suicidality with very particular goals in mind, whether these goals are acknowledged or not. Each repre-
sents the interests of his or her own discipline, yet, first and foremost, as a group they look implicitly or explicitly to promote and protect the interests of the society of people who are not suicidal. The vast majority of research into suicidality searches for ways to pull back the suicidal into nonsuicidal human community (1999, 45). As such, all suicide research speaks in the name of this society.

Explaining the cause of this split in perspective regarding suicidality occupies the better portion of the first part of Améry’s essay. In order to explain how a part of the population can understand such a radical act so differently than the majority, Améry makes an equally radical claim: suicidal and nonsuicidal people live according to different “logics.” Although Améry includes formal logics under the term “logic,” Améry also uses “logic” in the loose sense of a cognitive framework that governs a human being’s ability to make inferences and move meaningfully in the world, that which gives us “laws of a life worth living” (1999, 7). These logics provide the foundational, implicit premises that guide a human being’s actions in the world. Améry is offering the theory that suicidal and nonsuicidal people are not merely different because one group is made up of members who have a desire to kill themselves, but that the cognitive framework which suicidal people use to organize their interactions with the world is fundamentally different. Améry is attempting to make explicit the implicit, primordial, pre-linguistic premises that guide both suicidal and nonsuicidal human beings’ lives (1999, 15).

The first “logic” Améry introduces is the “logic of life,” which is the logic according to which the majority function. The logic of life starts with the basic, brute fact that “I am alive.” “I therefore speak of a logic of life or a logic of being, then I mean that all logical conclusions that we draw in statements about life are constantly bound to the
fact of this life” (1999, 18). Any act a person commits, any conversation a person engages in, any study a person undertakes begins in the fact that he is alive, that he has a living body capable of doing such things. This fact is so fundamental Améry also calls it the “logic of being” (1999, 15). Allegiance to this logic often goes unnoticed, as do the ways in which everyday actions promote and preserve the logic which begins with this fact of being alive.

Although this logic of life is first grounded in the (often pre-conscious) intuition that I am alive and the actions that allow me to continue to live, this is only its most basic beginning. The logic of life is multi-leveled. Améry explains,

Because we mean by the logic of life not only the immanent logic of behavior that preserves the self and the species, to which we are tributary, but also the logic gained from this logic as an abstraction of higher order, one that weighs being against being, sets one against the other, and therefore can come to the knowledge of the logical “true” and “false,” whereby true as much as false are tacitly accepted as categories of being because there is no bridge from being to nonbeing (1999, 19-20).

The first level of this logic of life is so fundamental that Améry identifies it is a life-preserving instinct experienced by most species that compels them to seek food, to reproduce, etc. The great majority of human beings and animals experience the impulses to eat and to reproduce. They are invested in their own preservation in the very basic ways of providing the subsistence necessary to support their continued existence, and also in activities that will allow for the continuation of their genetic lines/memories/etc. through the creation of children.

The second level of the logic of life is particular to human beings, “an abstraction of higher order.” Life, as life, becomes something that is valued. It is not merely blind impulse that propels most human beings to feed themselves and reproduce. For human
beings, subsistence and reproduction are caught up in planning and meaning-creation.

Biological life is the condition for the possibility of another, more abstract and meaning-infused “life” of the human being. People build “lives” with families, careers, religious lives, etc., and then declare these lives to be good. People do not just mate to reproduce, but get married and raise children, inventing elaborate rituals to celebrate and affirm landmark moments in the life of the family. Often times, people do not just feed themselves what is necessary for basic survival, but they make meals that they share with others. Human beings are in the unique position of being able to reflect on this life-preserving instinct and the continuation of individual lives and the species generally, and then develop ways to fulfill and satisfy this instinct. This development (and the basic level of the biological that allows for this development) is then called good; people look to live the “good” life. This affirmation of the goodness of life, of the value of life qua life, is the beginning of all other values, and serves as the ground of any other project in which a human being might engage. Before a person can decide to devote her life to a cause or another person, she must live as if her life is worth living.

This particularly human dimension of the logic of life, then, is grounded on a person’s affirming this valuation. A person accepts the starting premise of this logic: “Life is a good, and life is worth living.” For the most part, the logic of life is “prescribed” for us according to Améry. The adoption of this mindset need not be explicitly known by the adoptee, and often is accepted as fact without recognition of acceptance, in large part because it is accepted by the vast majority of the human beings. He explains that this positive valuation of existence unthinkingly invades everyday language. “‘In the long run, you’ve got to live,’ people say, excusing every miserable thing they have initiated”
The idea that one must live, that one must continue to function in the face of anything, that one must cling to life (even if, in doing so, one faces an impossible moral situation), is one of the effects of this logic of life. The assumption is that with rare exception all human beings will, and should, seek to continue their existence. The great majority of human beings’ actions, whether recognized as doing so or not, promote this logic and mindset.

Even the societally approved “excusable” reasons for forfeiting one’s life actually preserve the very logic they seem to fly in the face of: the soldier who sacrifices herself for her comrades; the parent who saves his children from certain death, but only by giving his own life; the captured spy who actively takes her own life in order to stop herself from revealing secrets upon torture. All of these deaths serve to further the work of society, to save other lives. In giving up one life, the value of life-in-general and societal project are actually preserved and affirmed.

Suicide, however, stands as the ultimate insult to societal projects and the implicitly and explicitly assumed value of life qua life, and as the ultimate challenge to the logic of life that grounds these projects. The suicidal person spits in the face of the person that claims that, “One has to live, after all.” Suicide is the concrete instantiation of the failure of the logic of life to take hold. One does not have to live, and in fact, one can very easily die. The suicidal person, along with Schiller, claims that,

‘Life is not the highest good of all.’...For what is this supposed to mean? There can only be goods in life, not in the negative nonentity of death; and therefore life must be the first, last, deepest and highest of such goods. But for anyone standing before the leap, the judgment contained in Schiller’s line, absurd and to be rejected by rigorous logic, contains good sense, a sense that is of course already beyond life and its logic; beyond all reason (which is only life’s subservient spirit), beyond everything that even the
most thorough researcher in the field of suicidology is capable of bringing forth (1999, 14).

The logic of life is fundamentally incapable of offering a convincing response to the claim that “life is not the highest good of all,” and suicide is the one action that fully demonstrates this.

Yet why is it that the logic of life does not have a sufficient response to suicide? This is for two reasons. Logic, in any traditional (formal) sense, requires life as its starting point. The statements of a formal logic are empty analytic judgments that say nothing about reality, but use reality at their base.

For years, basic required reasoning on the fundamentals of logic have demonstrated conclusively, disregarding certain differences among the various camps of logicians, something that is, in my opinion, an irrefutable fact: the statements of logic are empty. They are, according to their nature, tautological; they are “analytic judgments” in Kant’s terminology, or they are rules for recasting thoughts. They express nothing about reality, or to put it another way, they never impart anything new to the knowledge of this reality. Nevertheless, reality is always their basis (1999, 18-19).

Logics, as that which outline the forms of human thought, are empty and formal. Substantive conclusions reached through formal logics are always predicated upon the facts of this life. While the premise, “Life (that which exists, that which is) is not the highest good of all,” does not take away the formal validity of conclusions reached by these logics, it does take away their substantive base. It rejects the worth of the facts of life and rejects that upon which all traditional logics are built. If one were to say that life is not the highest of all goods, that life is ultimately a contingency, and that one need not live, one makes room for the possibility that it is best not to live, to be dead. Death, not being, makes no sense in the face of the logic of life, or as Améry explains, “Formal logic must exclude death” (1999, 19). Without life, logic, the formal rules of human thought, would
not be. Without the affirmation of the value of life, logic becomes a futile exercise.

The informal logic from above (logic as that which offers a framework that allows a person to operate meaningful in the world), even more clearly requires the value of life as its starting point. A person must assume that life offers him the groundwork upon which to make or find meaning, and then want to make or find that meaning. If one were to step outside the logic of life and recognize it for what it is, a logic with a base that can only be affirmed circularly, then one might recognize that there is no way to argue against a logic that does not assert that life is the highest of all goods. One would recognize that there is no unshakeable ground from which to declare that it is best to have been born. The framework of the logic of life has no ultimate claim to be the logic that should guide a person. No one can argue with Silenus convincingly because defense of the value of life always begins with the adoption of the logic of life that finds its beings in the implicit premise, “Life is good.”

That which stands opposed to this logic of life Améry calls the logic of death. Anyone trying to describe the logic of death faces immense difficulties, in part because attempts at description (and any project undertaken with the use of reason) assumes the logic of life opposed by the logic of death. For instance, the project that I am engaging in here, a dissertation, is so caught up within the logic of life that it is outside of the reach of the logic of death. This is the case because writing this dissertation is tied to hopes and goals for the future--getting a job, moving to a city, establishing a conventional life. The hope of writing a project like this is the hope to create meaning and to enter a community of scholars. But the logic of death rejects projects like these. It rejects attempts to codify and to read meaning into anything, but suicidality and the logic of death in particular.
Moreover, the logic of death evades language, which Améry claims is caught up in the logic of life. As Améry explains, “…it is not possible to convey sufficiently with language things that per definitionem lie outside of language” (1999, 15). According to Améry, there is no way for this logic of life to “speak” to this logic of death because the logic of death is an incommunicable lived experience.

For what it comes to for them is the total and unmistakable singularity of their situation, the situation vécue, (lived situation) that can never be completely communicated, so that therefore every time someone dies by his or her own and or even just tries to die, a veil falls that no one can lift again, which in the best of cases can only be illuminated sharply enough for the eye to recognize a fleeting image (1999, 8).

This poses a particular problem when it comes to trying to exegete Améry’s writings on the logic of death. There is no way to thematize the logic of death because reason and logic are but “life’s subservient spirit[s]” (1999, 14). Saying that the logic of death “stands opposed to” or “rejects” the logic of life is not quite right. Those who experience the logic of the death feel no impulse to oppose or stand for anything at all. One who experiences the logic of death has a fundamentally different understanding of his being in the world from one who does not. Life is not necessarily good, and one does not need to be. In addition to this, one not need do anything, including justify one’s perspective. The ultimate outcome of this logic of death is the lack of the need to do or be anything, is suicide, insofar as suicide is, “the act that breaks the fetters of pure and practical reason.” (1999, 28).

Suicide as an act is not capable of being understood or contained by the terms of any logic that starts with the logic of life. This explains the difficulty someone who functions according to the logic of life has in offering a response to a suicidal person or in un-
derstanding a suicidal person’s impulse to die. The logic of life, which suicidologists ask the suicidal person to take up as her own logic, starts with the unprovable premise that life is a good. The truth of this premise cannot be proven within the logic of life, but must be accepted before one takes up the logic of life. There is a formal difficulty in asking someone who does not accept this logic of life to accept it based on a premise that she cannot affirm.

Yet this is more than a formal difficulty. In some sense, Améry only uses the term logic of death because he is trying to make clear what is totally unclear to those who are not suicidal. This logic of death is no logic at all, but is in fact an “anti-logic.” Reason as that which grounds other logics is unvalued when one suicides -- the logic of death is nonsensical. The logic of death has its own peculiar “content” that stops one who inhabits the logic of life from offering a satisfactory response to Schiller’s claim. Death is the content of this logic, and death is nonsensical. This anti-logic is not a rejection of the logic of life, but is instead itself pure negation. It concerns itself not with possibility or valuation.

The logic of death starts in the absurd, in the recognition that in the face of not being, of death, finding ultimate, grounded, unshakable meaning may be impossible.

The logic of death is not a logic in the usual sense, upholding reason alone, for it allows no conclusions other than just one, again and again and again; not is the same as not, with which the statement of every logical (that is, analytic) judgment, already in itself containing no reality, loses its last tie to reality; that tie above all in which the equation of two categories of being that are symbolically recorded as in mathematics, or are rooted in everyday language, is now related to something that is nothing and is not--a pure negation, an accursed inconceivability (1999, 19).

The ground of the (anti)logic of death, the “not is the same as not,” does not allow for rational articulation or explanation. Although it is tempting as one who takes up the logic
of life to say that the logic of death can be explained as a person’s saying “no” to the
logic of life, this is not adequate. The pure expression of the logic of death is the, “no, no,
no, no,” but these “no’s” are attached to nothing, these “no’s” deny the possibility of
comprehension and meaningful expression entirely, these “no’s” escape language and
communication (1999, 15). Death stands as the “object” of this logic, but not death as
witnessed by survivors and not death as the transition to an afterlife, but death as enigma
and oblivion. Death in this sense is not an object at all; it is unseizable and ungraspable,
yet it provides the orientation for this logic of death. Death is the unthinkable: non-being.
This logic of death is experienced viscerally by suicides. “Suicides or potential sui-
cides...beat with their heads a raging drum tattoo against the advancing walls and eventu-
ally break through the barrier with a skull beaten thin and already wounded” (1999, 8).
There are not words or reasons which explain this individual experience.

Améry explains that one cannot live fully in this logic of death. The “not is the
same as not” is impossible to bring into being, and as such, the suicider finds himself
faced with the impossible contradiction that is being alive and taking up certain projects
of living and finding himself obsessed with this anti-logic of death. Death and life cannot
coexist. He writes that the suicidal person is,

torn between the logic of life and the logic of death: in that consists the
ontically murky singularity of their situation. They know the logic of death
or the anti-logic of death, even if they have nothing to say about it even if
no room remains for them in the system of psychological concepts and ex-

As long as someone is alive, even if they are suicidal, they cannot live strictly from the
logic of death: suicidal people are those who live with a foot in both of these “logics.”
The suicidal person finds himself in an unenviable position. He is torn between one sys-
tem of valuation, one that urges him to live life and reject this other “sense” held by
him. This “no, no, no,” this “raging drum tattoo of one’s head against the wall,” exists in
tandem with the projects that the suicider takes up in his daily existence. As long as
someone is alive, even if he is suicidal, he cannot live strictly from the logic of death, but
he cannot ignore or argue himself out of this other logic, the one that tells him, “no, no,
no.”

This explains why suicidal people often seem “fine.” Before their suicides, sui-
cidal people have friends, raise families, go to work, and avoid being “caught” in their
suicidality. The suicidal person, then, is not a person who fully inhabits the logic of death.
Instead, the suicidal person is one who is not capable of fully taking on the logic of life,
of affirming the goodness of his own existence, and is one who also lives in the shadow
of the (anti)logic of death.

Affect

The logic of death is prelinguistic, cannot be described simply as opposing the
ubiquitous logic of life, and is absurd in its content. Yet if we were stuck with only this
discussion of the logic of death and Améry’s claim that psychological concepts fail to
address it, one might wonder about the usefulness of Améry’s project. Many readers
might reject the importance of talking about a phenomenon, or even call into question the
existence of a phenomenon, that is so obscure that it cannot be spoken of directly. Améry
admits as much. “Someone might wonder whether what I have been trying to say and am
about to say is logically a demonstrable piece of nonsense and empirically not true”
(1999, 27). Yet Améry stands fast to what he claimed at the very beginning of his work.
He wants to approach suicidality without forcing onto it “concepts not based on perception” (1999, 27), and uses language of obligation regarding such a venture:

Here we enter into an obligation none other than this: that under certain impossible conditions it is necessary to think ‘toward’ things that are doubly unthinkable--just as when one begins to think or be concerned about anything, one moves mentally in that direction--and that, in proceeding, something unthinkable can be represented as something partly thinkable (1999, 28).

But what recourse do the nonsuicidal have to even begin to understand suicidality? How are we supposed to represent the unthinkable as partly thinkable? Or is it the case that if one has not experienced the logic of death as Améry describes it, one will remain in the “bog”? If so, Améry’s project, his attempt to offer a window into the suicider’s world, will fail. There must be some common ground between the suicidal and the nonsuicidal, something else to which he can appeal to give nonsuicidal people more understanding of the experience of suicidality and their inability to fully appreciate what it is to live as suicidal. He begins to offer this ground in his discussion of two affects experienced by all human beings: eros and la nausée.

La nausée, one of the basic constituents of a human being. It is no more possible to ignore it than eros, with the distinction that the latter is recognized by society because it is consistent with the logic of life, while the former, la nausée, is denied by civilization’s howling rabble set on preserving the species (1999, 47).

Those who experience the logic of life privilege one particular affect, the erotic, more so than this other experienced affect, la nausée. He translates la nausée as disgust, and explains that disgust is fundamental to what it is to be a human being. This disgust is as fundamental as the experience of the erotic, but one works to preserve the logic of life, the logic taken up unthinkingly by most and supported at a society-wide level. Disgust,
however, is avoided and denied. In order to understand disgust, it will be helpful to have the erotic against which to juxtapose this avoided affect.

Améry characterizes the erotic as a fundamentally social affect. Eros is the drive to live and produce. The erotic impulse is the impulse of the lover—more life! more life! It is an impulse that more deeply entrenches a person in life and the work of life. It brings with it both work for the bettering of the life of a person and the multiplication of that person’s being, and involves a reaching out toward others. In a very basic sense, the erotic drive is the drive to fuse with others and multiply through the reproductive act. It grounds sociality because it is the beginning of the creation of future generations and because the erotic pulls us into cooperation with others.

Not only does the erotic impulse experienced as the reproductive drive go to support the first level of the logic of life discussed by Améry, but the erotic impulse also supports the second level of the logic of life, the abstraction of a higher order. The erotic brings about mating rituals, the familial life, and philosophical projects generally. Because this affect’s pull towards life, and more life, is one experienced by most people much of the time and supported by societal projects and expectations, this leads to a discounting and downplaying of another affect experienced by human beings which is, Améry claims, as fundamental to human existence.

This affect is la nausée, or disgust. It is important to speak of la nausée in terms of eros in part because the experience of eros has not only been experienced by most human beings in one form or another, but also because most human beings have recognized this experience. Since the experience of eros is a deep, visceral experience, so description of this in words falls short of completely describing the experience. Améry’s claim is the
other foundational affect, which has been denied in large part because it does not contribute to the continuation of societal projects, is felt as deeply, is as much a part of human beings’ affective experience, and is juxtaposed to the pull of the erotic. Whereas the erotic is the beckoning towards life and more life, *la nausée*, which he translates disgust, is a repulsion from life.

Améry makes clear from the start that disgust is not just *taedium vitae*, a mere weariness of existence or boredom with life (1999, 78). Disgust is one of the foundational attitudes a human being can have toward existence, despite its denial “by civilization's howling rabble set on preserving the species” (1999, 47). Although disgust is visceral and deep, because of the widespread denial of disgust, it can be harder to recognize those moments in existence. Améry spends significant time illustrating various moments of the experience of disgust that should resonate with most of his readers.

Since disgust is as foundational an affect as the erotic, it is found in many moments of human experience. The first, most basic of these moments is the hatred of the flesh, the hatred of the materiality which sustains life (1999, 46). Who has not felt uncomfortable in her body, or been frustrated with it when it was sick or injured? Disgust is the revulsion inspired by the too fat body in front of the mirror, or by the putrid body of severe illness, or the frustration felt over a simple cold. Even more than just showing up in the frustration felt toward the imperfect or ill body, disgust comes in everyday embodied moments. Améry describes the moment in which a person stands in front of a mirror and is horrified at what he sees. He explains the ego of the person falling from “crag to crag,” observing the visage of his face, and not recognizing himself in that visage. Instead, he sees a body, a body that has been there before, but in different forms, and sees that
That which should be most familiar has become alien. It is in a moment like this that the flesh is wished away, that one experiences a very visceral sense of disgust.

If one of the most common places disgust appears is alongside bodily “failings” (the sick body, the un-ideal body, the unrecognized body), other experiences of disgust are (often) much less corporeal, but also tied to failure (1999, 47). Améry distinguishes between two levels of failure when he speaks of disgust in this section: failures in life and the failure of life. The first is the failure of the person who does not pass a test or exam. People fail constantly in this first way. Confronted with the truth that many projects, big and small, will not be completed successfully at all, disgust appears. This is the disgust in the expressions of students who do not earn the grade they wanted. This disgust is felt the first time love fails or an important project stalls. The ubiquity of these failures can obscure the disgust that comes alongside them, but if a person experiences enough of these failures at once, then disgust will make itself known.

Deeper than this failure of project is the failure that is a structural part of every individual life: ultimately, surrenders to nothingness. Life will end, and in the face of death, life and the projects of life are absurd and meaningless. Améry explains this with reference to a familiar metaphor: life is a house that is ultimately doomed to collapse (1999, 51). No matter how well a house is built, no matter how well it is repaired and restored, when parts of it start to decay, a house will fall. The work of life is like the work that is put into a house. The individual projects in which people engage may or may not succeed (the basement never quite finished, the leaky taps in the sink not replaced), but eventually, decay renders the project of having projects pointless and the house collapses.
Any work done is ultimately doomed to failure, whether individual projects are successful or not. They will decay, just as the house will decay.

More disturbingly, this decay does not only apply to projects, but also to relationships. Friendships end, people die, and eventually all people will be forgotten, no matter how substantial their relationships or contributions to humanity were. Beyond eventual death, however, Améry recognizes another way in which relationships fail. There is no being totally “with” someone. Even if a person is not suicidal, his self is inalienable. There is no way to bridge the cognitive gaps between persons. These constitute the foundations of an inescapable existential loneliness that Améry points to. You cannot feel my pain or my happiness. Even before death, people are alone; people fail at being together (1999, 114-115).

This decay, this unavoidable failure built into the very structure of mortal existence renders work on/in existence absurd, that is to say, makes it impossible to offer a transcendent ground on which to base the claim that work has meaning. All work is done against the reality that one day one will cease to be, whether a person avoids that thought or not. Even for those who believe in an afterlife or place value in the memory of history, this disgust may appear. Disgust highlights the uncertainty of faith, whispers about the capriciousness of fate and memory. Moreover, no matter the strength of the belief in the afterlife or the hope in being remembered, this life will end and this life is all that is known. When this recognition of failure penetrates a person’s defenses, slithers in past the logic of life, disgust is very strong.

In some sense, suicide can be understood as adding another level to these failures. On one hand, voluntary death as a response to and consequence of the recognition of fail-
ure and disgust can be understood as another failure. When understood as a failure, voluntary death merely doubles failure, and takes away that which allows the possibility for success. The person who suicides willingly puts an end that to which an end will inevitably come anyhow. She intentionally gives up that which will allow her to correct the less profound sense of failure: failures in life. By her own hand, a person makes her own work meaningless. Loved ones’ reactions to a suicide are often plagued with a deep sense of disgust. Use of the word “suicide” is avoided, survivors deny that their loved one would have taken his own life. Suicide is often interpreted as failure and met with disgust by those left behind. Améry identifies this with the societal view that is entrenched in the logic of life (1999, 45, 51).

Seen in another light, however, the person who dies by her own hand can be understood as seizing the truth of these failures and this disgust, and as truly “belonging to herself” and restoring dignity (1999, 97). She meets the deeper failure of life, that she will die, head-on. Suicide is a way to escape failure (both failures in life and the failure of life), failures which one can only live through disgracefully (1999, 44). The understanding of suicide as a failure comes only from those who are not suicidal. For those who have one foot in the logic of death, suicide may appear as a valid recourse for escaping from failures. Suicide can be the escape from an overwhelming sense of disgust toward the world and life.

No matter the interpretation of the act of suicide, whether failure or an attempt to find freedom in failure, Améry very clearly ties the experience of disgust to the experience of failure that leads to voluntary death. “What I am driving at is simply this: that prior to the consciousness of the [failure] that leads to voluntary death...there must be the
feeling of disgust” (1999, 47). This is important because the affect of disgust is a foundational affect for human beings. Suicidality, at its beginnings, is caught up in the experience of disgust. Given this, although most nonsuicidal people flee from disgust according to Améry, the common experience of disgust might be the ground upon which those skeptical of the worth or feasibility of Améry’s project, those thoroughly caught up in the projects of society and the logic of life, can find common experience with the suicidal and the beginnings of empathy.

Importantly, Améry points out that it is only those who hold that suicide is a “failure” and who fully embrace the logic of life that attempt to impose their understanding on others. He explains that as someone who understands suicide as being other than a failure, “[m]y judgment, insofar as it does not call into question the totality of all experience, finally has to be recognized as a valid one” (1999, 57). Suicide is an instance of an individual recognizing the brute facts of his existence (disgust overwhelms the erotic and the logic of death has taken hold), and making a decision based on these facts. As an act, suicide might seem to those without a foot in the logic of death to be an affront to the logic of life and the erotic impulse, but it is not: it is ultimately an individual response to an individual life. This response is rare, but its rarity does not make it any less valid.

For the time being, we are only concerned with rehabilitating voluntary death as an act as natural or unnatural as every other kind of death. Above all socially, because death, voluntary or not, cannot be defended philosophically. I am only trying to ensure that those who try to commit suicide and those who succeed, in spite of their situation as a minority, have the rights that every minority claims for itself (1999, 52).

Although Améry does not valorize the act of killing oneself, he does argue that in the most important moments of a person’s life, that person belongs only to herself. In the
face of these moments, other people must be silent. Suicide, the voluntary ending of a life, is one of these moments. Due to the differing “proportions” of disgust and the erotic felt by different persons and the differing logic(s) persons may occupy, voluntary death is going to appear in very different ways to suicidal individuals and nonsuicidal individuals.

Recognition of the fact that voluntary death will appear very differently to different people is the beginning of stepping outside of the societal perspective. Persons who inhabit the societal perspective must understand that their particular view of voluntary death is not self-justifying. Recognizing that suicidal people start from a different logic and experience different levels of the affects fundamental to human existence is the first step in a person recognizing that her understanding of voluntary death, her recoiling from voluntary death, and her belief that suicide should be prevented at all costs, is her operating from a less than complete understanding of the phenomenon of suicidality (1999, 57).

Given their inadequate understanding of suicidality, those who occupy the social perspective must be especially careful of the ways in which they uncritically adopt the logic of life and embrace the erotic. In doing this, they privilege their own perspective over the perspective of those who are suicidal. Those who occupy the logic of life, who are immersed in the erotic impulse, have no solid, unquestionable ground from which to state, “You must stay alive. Life is better than death.” Yes, the suicidal person, standing with one foot in the logic of death, is in the minority, and that straddling of logics changes his relationship to his world. Yet this does not necessarily make him “sick” and does not justify acting paternalistically. Améry writes movingly of his own “rescue” after his first suicide attempt in 1974:

I still know very well how it was when I awoke after what was later reported to me as a thirty-hour coma. Fettered, drilled-through with tubes,
fitted on both wrists with painful devices for my artificial nourishment. Delivered and surrendered to a couple of nurses who came and went, washed me, cleaned my bed, put thermometers in my mouth, and did everything quite matter-of-factly, as if I were already a thing, un chose. The earth did not have me yet: the world had me again and I had a world in which I was to project myself in order that I would once again be all world myself. I was full of a deep bitterness against all those who meant well who had done this disgrace to me. I became aggressive. I hated. And knew, I who had previously been intimately acquainted with death and its special forms of voluntary death, I knew better than ever before that I was inclined to die. And that rescue, about which the physician boasted, belonged to the worst that had ever been done to me--and that was not little (1999, 78-79).

Though Améry feels obvious disdain for the doctors and nurses he speaks of who “saved” him after his 1974 suicide attempt, it is hard to label the intentions of the doctors and nurses bad. They were just misguided. The understanding of suicide had by the doctors and nurses was fundamentally different than Améry’s understanding. They could not understand how one might choose death over life. Suicide is such an affront to anyone who takes up the societal perspective, especially health care workers bent on preserving life, that their reaction to someone who suicides is utter denial of the validity of the suicider’s perspective (i.e., “You will thank us for saving you later when you are feeling better.”).

**Améry and Rational Suicide**

It has been established that Jean Améry provides what Lindemann would call a counterstory. The careful work of listening to that counterstory has been done. What is necessary before we draw conclusions from this listening to this story is a brief understanding of the master narrative that Améry’s work confronts. There is no doubt that Améry’s work is confronting some other narrative with which he disagrees. He writes of *On Suicide* in the preface, “What may appear to be an apologetic is only my reaction to a kind of research that pursues the subject of suicide without being acquainted with the
specific human beings in search of their own, freely chosen death” (1999, xxiv-xxv).

He says several times throughout the text that a real account of suicidality begins when suicide research is not the starting point of investigation. In order to understand the strides that Améry’s work makes in helping advance our understanding of suicidality beyond the skeletal version presented in the bioethics literature, the narrative created in the bioethics literature must be explored.

As the first half of this dissertation highlights, one of the purposes of the rational suicide literature is to establish that there are people who wish to suicide who are rational and for whom the act of suicide would be rational. If this can be shown, then “rational suicide” can be the ground upon which that the moral permissibility of assisted suicide can be established. The stories that are told in this literature follow a very similar formula, and the news stories discussed in the second chapter highlight this formula. A person is dying of a terminal illness (or, in rarer versions, has some sort of irreversible illness that will significantly diminish her capacities). She seeks assistance in dying not because of some inborn inclination toward death, but because of reasons identifiable from the societal perspective. For instance, she might look to preserve her “dignity,” to save her family from financial distress, or to maintain control of the narrative arch of her life that she has carefully constructed during her life. These reasons are all consistent with the logic of life as set out by Améry. The logic of life is used to justify the preservation of projects and the preservation of identity through almost any means necessary. She has set up her life, she has valued the way in which she has set up her life, now she looks to close her life in a way that remains consistent with her projects and values. The same thematic can be found in the sort of voluntary deaths that preserve the logic of life discussed in this chap-
ter (the foxhole jumper, the parental sacrifice). These sorts of death support societal projects.

What is strange about the bioethics narrative, however, is that it can be understood as a counterstory itself. In the rational suicide literature, bioethicists attempt to present the circumstances and characteristics of a person who might request assistance in dying, but who is not mentally ill. Bioethicists do this to explicitly combat the mental illness model of suicide presented by suicidologists. The central claim of this mental illness model of suicide is that suicide is a symptom of some sort of mental illness and a cry for help, rather than an action that can be taken by a rational individual (c.f., Biggar 2004, Edwards 1997, Litman 1996, Shneidman 1996 and 2004). Bioethicists present cases of terminally ill people who do not fit this mental illness narrative in order that these people might receive services that they were being denied (i.e., assistance in ending their lives), and to oppose a dominant characterization of those who were seeking assistance in dying. Not all suicides can be understood in terms of mental illness, thus bioethicists argue that we need to rethink the moral permissibility of assisted suicide because rational persons (i.e., a person without mental illness who meets the other criteria laid out by bioethicists) might desire such assistance. Given a liberal framework in which bioethics operates, denial of assistance of this sort to rational persons is hard to justify.

Yet there is a problem with the narrative provided by bioethicists. As Lindeman explains, a counterstory can only be a good counterstory if it does not automatically exclude another population. She calls counterstories that do this hostage stories. “[T]he hostage story unseats the master narrative at which it aims by reinforcing other oppressive master narratives” (2001, 179). Although the story told by bioethicists is a functional
counterstory for those who are looking to receive assistance in death when terminally ill, it reinforces the narrative of the mentally ill suicider. This hostage narrative has two effects. First, by restricting the group worthy to receive assistance in dying to people who meet standards of rationality, bioethicists have marginalized those who are suicidal in the way that Améry speaks of suicidality. By focusing exclusively on this subset of people, bioethicists have unwittingly excluded these sorts of suicidal people from the discussion surrounding the ethics of assisted suicide. If the person looking for assistance in suicide is cast as morally worthy only if suicide helps preserve the logic of life, then those who experience suicidality in the way described by Améry must be other than morally worthy. The story that is told is that the terminally ill should receive assistance in dying because their mental state is not “deviant” or abnormal like other sorts of suiciders, and that the terminally ill fit the mold of the rational liberal individual. This counterstory plays into the ethics of vitalism adopted by the medical community, and those who experience suicidality as Améry experiences it were disregarded and cut out of the conversation about the morality and legalization of assisted suicide.

The second effect of this hostage narrative, and a result of this exclusion, is actually a conceptual difficulty at the heart of the rational suicide literature created by this exclusion, and lies at the heart of this chapter’s critique. Bioethicists have been working with an anemic conception of suicidality in the rational suicide literature because bioethicists have not spoken with the “general” suicidal population, but have restricted their considerations to a subset of the terminally ill. If suicidality as a lived phenomenon involves someone living with the pull of the logic of death and experiencing high levels of disgust in the face of life and failures in life, then the concept of rational suicide is prob-
lematic. It is problematic because rationality, as defined by bioethicists, is inherently tied to the logic of life. If we look at the criteria for rationality in the bioethics literature, what is actually being preserved in this literature is the logic of life.

As discussed in the last chapter, it is often taken for granted that insofar as doctors are working for the preservation of their patients’ lives, they come to the table as value neutral actors. Bioethicists, in looking to preserve the autonomy of rational, liberal individuals, are likewise understood as committed to value neutrality and avoid the imposition of personal values on research. Yet as was shown in the last chapter, this is not value neutral. What was called the ethics of vitalism in the last chapter, the unthinking embrace of life and long life, can now be understood in terms of Améry’s logic of life. The logic of life is that which flows out of the unsupported claim that life is the highest of all goods. The ethics of vitalism is perhaps the pinnacle of the embrace of the logic of life, insofar as it brings to bear all available medical resources to preserving life, the highest of all goods.

The medical field is almost entirely defined by the ability to extend life and to make physical life better. Healing patients often allows patients to go back to living their lives as they would want to live them. In the vast majority of cases, the medical field as that which preserves and promotes life is helpful and exactly what best serves patients. If I have heart disease, I want my doctor to prescribe the medications that will allow me to live more comfortably and with less risk of death. If I break my leg, I want my doctor to set it and cast it so it will heal properly and I can eventually get back to my previous level of functioning.
End of life issues are more complicated, however. This is especially true with suicidality. The ethics of vitalism has caused doctors and bioethicists to think of suicide in terms of rationality, and to focus their exploration of rational suicide on rationality at the expense of a proper investigation of suicidality. When doctors, those who experience this ethics of vitalism and live out the logic of life in a very concrete way insofar as they preserve and protect patient life, and ethicists, those whose goal it is to maximize goodness in life, attempt to define the moral conditions under which suicide might be a “good,” there is an obvious conflict. Suicidality, as described by Améry, is defined by a person’s tenuous relationship with and to this logic of life. It is not as if the suicider does not embrace this logic of life at all, but there is this second logic that competes with the logic of life, that brings with it the inclination toward death, which is the hallmark of suicidality. There is a revulsion and disgust at the heart of a suicider’s experience in the world. Although doctors and ethicists as individuals might be able to empathize with this experience of disgust, as professionals who are trained in particular ways and have particular goals (heavily defined by the logic of life), the logic of death cannot be at the heart of their thinking.

Yet the problem with this is not just that the doctors are not able to remain value neutral. The application of the logic of life and an ethics of vitality to the issue of suicidality is conceptually inappropriate. Given Améry’s description of the lived experience of suicidality and its inherent tie to the logic of death, if rationality, as defined by bioethicists, can be shown to be entrenched in the logic of life and ethics of vitalism, then the applicability of the concept of rationality to suicidality comes into question. Brief examination of the ways in which bioethicists define rationality will show how several of the
criteria are tied up with the logic of life. Although many, if not all, of the criteria used to establish rationality could be shown to be grounded in the logic of life, only the four most prevalent criteria will be spoken of for the sake of brevity.

**Rationality Criteria Reexamined**

**Realistic Worldview**

The criterion that a person must have a realistic worldview in order to be rational is held by the vast majority of bioethicists concerned with establishing the possibility of rational suicide (c.f., Barry 1994; Battin 1982, 1999; Cholbi 2011; Decker 1977; Devine 1980 and 1998; Francis 1980; Graber 1981; Kjervik 1984; Martin 1980; Motto 1980, 1981, 1999; Saunders and Valente 1988; Siegel 1986; Sullivan 1980; Werth 1996, 1999). However, this criterion was shown in the last chapter to be problematic. It is difficult to establish what a realistic worldview is without imbuing the concept of “realistic” with values that often remain unrecognized and unspoken. As the feminists referenced in the last chapter point out, if doctors are not immune to social prejudices and their “technical” training is not sufficient to teach them to fully bracket their own system of values (c.f. Sherwin 1992, Roberts 1996), then value neutrality is a myth. Yet with what has been discovered in studying Améry, it has become clear that problems with claims of value neutrality run much deeper than was indicated by the feminist critiques explored in the last chapter.

Given Améry’s analysis of suicidality, in addition to questioning whether it is feasible for a doctor to take into account and bracket how her values when working with patients, a doctor must also consider her affective stance towards her world and the sort of logic(s) she adopts. Has she experienced the inclination toward death? If not, is she aware
of the ways in which this inclination can radically alter a person’s understanding of her place in the world and the value of her being in the world generally? Yet value neutrality of this sort might be too difficult a thing to ask of doctors, precisely because of their training. Doctors are indoctrinated into an ethics of vitalism. Doctors must save and repair lives, to do good for their patients in the form of offering their patients the means to the best possible physical health. The implicit premise which guides this work is what Améry claims as the starting point for the logic of life, “Life is good.” “My patient’s life is good, therefore, I must preserve that life.” This mission and its starting point cannot make room for death as a viable possibility—it can only be seen as a failure, or an inevitability, but certainly not something toward which one should be inclined toward for its own sake (“for no reason”). That doctors should accept as nonpathological the worldview of a person for whom the inclination toward death and the experience of revulsion in the face of life and being embodied are strong might seem to some like medical heresy.

The example of Dax Cowart comes to mind, once again. If health care workers, in a case where a patient was experiencing intense physical suffering because of treatments done to him, refused to accept that Cowart did not want treatment, it seems easy to imagine a doctor writing off the requests of a person who lives out suicidality in the way that Améry describes it as irrational, and thus of diminished ability to make their own decisions. The suicidal person, with one foot in the logic of life and one in the logic of death, has no recourse to make understandable to health care workers the nonsensical logic of death. If a patient was to come to a doctor and talk about the “raging drum tattoo” of his head against the wall when trying to describe what his lived experience was like, a diagnosis of some mental illness might not be far behind.
Ethicists, and philosophers generally, face a similar difficulty. The worldview of ethicists and philosophers is anything but neutral. Améry’s example of a logic professor who explains to his class that tells his students, “You can all be immortal my friends, it’s not impossible to think so,” begins to highlight this difficulty (1999, 40). For this logician, anything in thought is logically possible, any area of life capable of immense feats of imagination, including that death not be. This professor’s speech stands as an extreme example of ideas informed by the logic of life. The logical system this professor operates in allows him to deny death and proceed accordingly. This is not to say that this logician believes that he will not die, but that the discipline in which he operates allows for a bracketing of the inevitability of death.

Although not all examples of the embrace of the logic of life are this extreme in philosophy, Colleen Clements in her article, “The Ethics of Not Being: Individual Options for Suicide,” argues that as a discipline, philosophy is in a unique position when it comes to the issues of suicidality. She explains that there are pretheoretical risks in philosophers and philosophical ethicists studying suicidality. This risk is twofold.

First, Clements explains, “A philosophic analysis of suicide poses a preanalytic risk which is rarely articulated because it is so closely tied to a major primitive assumption in philosophy: that man is importantly a rational animal only” (1980, 104-105). Philosophy, with its hammer of rationality, runs the risk of seeing everything as a nail. This is true about bioethicists, as well. As was thoroughly explored in the last chapter, the rational liberal individual was taken up as the moral lynchpin of the assisted suicide debate with little reflection. What Clements argues is that suicidality is not a nail. Suicidality is not something that can be described in terms of rationality at all. Clements’ general aim
in this article is to establish that rationality is not applicable to discussions of assistance in suicide because suicide is *neither* rational nor irrational (1980, 104). Like Améry, Clements believes that suicidality is fundamentally grounded in a distinct attitude toward one’s being the world. This stance exists prior to rationality and affects a person’s relationship to rationality (1980, 107). The suicidal person says “no” to her existence (implicitly and/or explicitly, metaphorically and/or concretely) and adopts a “nay-saying” attitude, while the non-suicidal person says “yes” to her existence and adopts a “yea-saying” attitude. Clements attempts to show that the unquestioned embrace of rationality can only be taken up by someone whose primary attitude toward her world is grounded in what she terms “yea-saying,” and as such, suicidal people do not participate in rationality in the same way as non-suicidal people.

There is another risk philosophers face when studying suicidality. To do philosophy at all “implies the acceptance of cognitive values which are based on an affirmative stance” (1980, 105). Clements explains this in terms of the yea-saying attitude, but I think we can bracket “translation” issues between Clements and Améry here.³ The critiques of philosophy and ethics provided by Clements apply as well when we consider philosophy and ethics in terms of Améry’s affects and logics. As Améry explains, the work of any disciplines must take the implicit premise of, “Life is that upon which this discipline can be built,” as their starting point. Although philosophers may question whether life is good, philosophers still must start with the brute fact that they are alive and that this is the condition for them philosophizing at all. In participating in projects of philosophy, philoso-

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³ I do not wish to make the claim that Clements’ yea-saying and nay-saying attitudes are simply different ways to describe the logics and affects spoken of by Améry. Although Clements’ attitudes and Améry’s logics and affects have much in common, establishing this is not necessary for use of Clements’ more general ideas about philosophy and ethics.
phers implicitly embrace the value of life. This implicit embrace of the value of life is more clearly seen in ethical projects. Ethics, in looking for good ways of life, has to assume life is valuable, as it is the basic foundation upon which good(s) can be built.

When we are talking about a realistic worldview, if doctors, philosophers, and ethicists take up this logic of life unthinkingly, there is nothing to stop them from missing the fact that there is this other affective stance, this other logic, that can dramatically alter what is realistic for a person. Neither of these logics are self-justifying, and as such, neither has claim to reality. A realistic view of the world and the place a person has in the world has been judged according to this ethics of vitalism, which leaves no room for the logic of death and the experience of more intense feelings of disgust. Yet as Clements explains (and Améry echos), claiming the suicidal perspective is invalid based on the logics and values of these disciplines is arbitrary and circular. “In a real sense, an individual who does not value existence does not value anything at all, and to apply tools of cognitive values to this primary affect is to deny him his validity in a totally arbitrary fashion” (1980, 107). Suicide, as an act, is the absolute rejection of existence, including the need to justify decisions in light of the facts of this existence. Asking suiciders to take part in the process of giving reasons, of “rationalizing” a decision, indicates that one “buys into” the fact that one must give reasons why one decision is better than another. Rationalizing in this sense creates an implicit or explicit hierarchy of values. The “tools of cognitive values” only have value to those who believe in the necessity of valuation at all.
Harm and Interest

The harm and interest criteria are open to similar critique here as well. By way of reminder, many bioethicists require that a suicide bring to less harm to the suicider than staying alive would, and that a suicide serve the interests of the suicider in a way that staying alive would not (c.f., Bogen 1980; Battin 1980, 1982, 1999, and 2005; Cholbi 2011; Choron 1972; Davis 1998; Decker 1977; Dunshee 1994; Francis 1980; Hewitt 2010; Humphry 1987; Jamison 1999; Lebacqz and Engelhardt 1977; Marker 1999; Maltsberger 1994; Motto 1980, 1994; Nelson 1984; Slater 1980; Werth 1999.) Yet the ways in which harm and interests are defined is thoroughly informed by the logic of life. In asking a suicider to justify his suicide based on the fact that suiciding will cause him less harm than staying alive and will promote his interests more than staying alive, bioethicists ask that suicider to take part in a calculus that the logic of death cannot support. Calculating the benefits and costs of suicide is not part of suicidality. When a person does this, she operates from the logic of life. If a person wishes to receive assistance in dying because she has determined that having a terminal illness will alter the self image she has spent her life cultivating, or because the process of dying is undignified, or because she wants to protect her family’s interests, or because she wants to avoid pain, these are all reasons that start with a very particular attitude. This woman does not wish to die because she is inclined towards death, but because her love of life may be lessened if she stays alive, or because the family she has spent her life loving and protecting might be harmed, or the ideas she has had about the sort of life she has lived does not match the shape her death now takes. The harms that she is avoiding (the costs to her family, the loss of dignity, the experience of pain) and the interests she is protecting (taking care of her family,
protecting the narrative arch of her life she has spent years forming, etc.) are thoroughly caught up in the projects of life. That this woman wanted to die because she experiences “the power of emptiness” that is the inclination toward death would not be translatable into terms of harm or interest in the sense in which bioethicists talk about them (Améry 1999, 77). The suicider as characterized by Améry chooses death because of an inborn inclination toward death, because she has felt a pervasive and inescapable sense of disgust, not because she has weighed her options and has decided that there are more “checks” in the pro-suicide column. She is not interested in processes of valuation of this sort.

Understandable According to Community

One of the rationality criteria that is most problematic in light of Améry’s account of suicidality is the requirement that the act of suicide be understandable to the various communities to which a person belongs (c.f., Battin 1982; Choron 1972; Edwards 1997; Lebacqz and Englehardt 1997, Matthews 1998; Motto 19999; Prado 1990; Siegel 1986; Stack 1999; Werth 1996, 1999). Bioethicists require that the act of suicide be capable of being justified using community standards. Some even argue that the greater the cultural support given to certain suicides, the greater the presumed rationality of the act of suicide (Stack 1999, 41). The rationality of suicide hinges on members of the suicider’s community finding justification for that suicide with which many of the members of community can identify and understand.

In light of Améry’s description of the lived experience of suicidality, this might be an impossible standard. As described by Améry, suicidality is ultimately an experience radically rooted in individual subjectivity, and it cannot be understood apart from the ex-
perience of individual suicidal people. The suicider finds herself in an “absurd and paradoxical situation” that may elude translation (1999, xxv). Making her suicidality understandable to the communities to which she belongs is a difficult, if not impossible, task for a suicider who finds herself surrounded by nonsuiciders. Améry’s work is an attempt to begin to open up this sort of dialogue, to start on this translation work. His particular background and training have given him tools that may not be available to all suiciders. Even if his project is successful, however, at the heart of it lies the recognition that suicidality is not “comprehensible” to those who are not suicidal. Because of this in comprehensibility, rendering suicide understandable to a community can only take the form of the community’s recognition of the different logics and affects experienced by the suicider.

**Rationality Redux**

Once again, it has been shown that the criteria used by bioethicist to establish rationality are insufficient or problematic in some way. Again, many more of the criteria used by bioethicists to establish rationality could fall under the purview the critique regarding their foundations in the logic of life. Exploring the most common criteria in the literature has sufficiently established that these criteria are tied to the logic of life in a way that renders their applicability to suicidality generally questionable.

Although the discussion of rationality has been piecemeal in this dissertation insofar as critiques have focused on particular aspects of the definition of rationality provided by bioethicists, a general critique remains. Given Clements’ and Améry’s discussions of the beginnings of suicidality in attitudes or logics and affects, the ascription of rationality to suicidality, no matter the particularities of the definition of rationality, is questionable.
In the way in which Améry and Clements characterize it, suicidality is neither rational nor irrational, and as such rationality is not ascribable to suicidality. Améry’s discussion of the lived experience of suicidality has shown that in some instances, the phenomenon of suicidality finds its foundations in a pretheoretical worldview highly informed by a foundational affect. That a suicidal person is rational or irrational has nothing to do with his experience of suicidality generally. The question of whether a suicider should offer reasons why their suicide is rational is an inappropriate consideration. Rationality has nothing to do with this sort of suicidality itself.  

Bioethicists’ insistence on using rational suicide as the benchmark upon which to establish the moral permissibility of assisted suicide has thus committed the sin Spellman and Lugones warned theoreticians against. In trying to find a type of suicidality with which bioethicists were comfortable, they started with a concept comfortable to bioethi-

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4 A brief discussion of another conceptual difficulty in rational suicide is appropriate here. A critic of my use of Améry’s description of suicidality might claim that it is only in the case of a sort of extreme suicidality posited by Améry that rationality is not applicable. In addition to this claim requiring considerable examination of the lived experiences of different sorts of suicidality in order to be established (something bioethicists have yet to do), there another, deeper conceptual issue at the heart of the claim that rationality cannot be an appropriate descriptor of suicide or suicidality. As Améry explains, there is no bridge from being to nonbeing—because of all this, we are so helpless in thinking about death” (Améry 1999, 20). All logics assume the existence of the person using the logic, and cannot account for or handle the unknown of death. Because of the enigmatic nature of death, talking about it in terms of rationality is otiose. There are other scholars who make similar, though more philosophically oriented, arguments. For instance, Philip Devine (1980, 1998) argues that death is uncanny and cannot be chosen rationally because a precondition of rational choice is that know something about what one is choosing and the ability to compare choices. This is especially the case in the instance of one’s own death. In instances of death, Devine explains that, “We are dealing, that is, not with a situation concerning which rational men will exhibit a range of estimates, but with a situation in which one man’s estimate is as good as another, because what is being done is a comparison with an unknown quality” (1980, 139).

Christopher Cowley (2006) takes aim at the claim that if a person’s decision to suicide could be appreciated as rational by both suicider and observers, than the decision to commit suicide should be respected and it would be ethically permissible to provide assistance. Cowley argues that the concept of rationality is essentially future-oriented, and that since the suicider has no future after suicide, it makes no sense to call suicide rational or irrational (2006, 497). Additionally, Cowley argues that suicide as a phenomenon can only be fully understood as a social phenomenon, which means taking into account the reactions to suicide, as well as the suicider’s own desires and inclinations. Accounts of suicide that attempt to label a suicide rational or irrational circumvent the affective aspects of a suicide (and specifically, horror and pity felt by those who learn of the suicide) and thus offer an inadequate understanding of the concept of suicide (2006, 503).
cists. Given most bioethicists’ liberal starting point, establishing that a person is rational makes paternalism incredibly hard to justify. Therefore, so the reasoning goes, if conditions of voluntary death that meet rationality criteria can be found, these will establish the foundation upon which an ethical argument in support of assisted suicide can be made. The problem with this, however, is that “the concepts used to describe a life are utterly foreign” to that life (Spellman and Lugones 1983, 578). In considering rationality first, bioethicists did not stop to ask whether the concepts they were using to describe suicides’ lives were applicable to the experience of being suicidal.

A suicider might be able to play the part he is asked to play by bioethicists and to meet the criteria established for rationality if he denies or does not talk about his experiences of disgust and the logic of death. This suicider, however, would be recognizing the terms of the master narrative established by bioethicists, and working with a master narrative he knows misrepresents his experience of suicidality and prevents him from being honest about his experiences, so that he may receive the benefits given to those who live out this master narrative.

The next chapter will look at a possible set of different criteria that might be used to establish the moral permissibility of assisted suicide that avoids the imposition of the master narrative bioethicists have created regarding rational suicide. Instead, these new criteria encourage and make room for the hearing of the counterstories of the suicidal.
CHAPTER FOUR

APPROPRIATE DEATH

In the previous chapters I critiqued the concept of rational suicide for both its moral and conceptual failings. As I highlighted from a feminist perspective, rational suicide lacks the value neutrality to which it aspires, and it imports a liberal framework without justification; as a result, in their fervor to attain rights for terminally ill suiciders, bioethicists have thus marginalized non-terminally ill suiciders. This flawed moral framework has shaped the rational suicide literature and has limited most suiciders’ participation in the shaping of this literature.

In addition to these moral problems, I outlined conceptual difficulties with the notion of “rational suicide” that my exegesis of Jean Améry’s *On Suicide* brought to light. Améry’s explanation of the suicidal perspective indicates why reason and rationality are not an appropriate way to speak to some types of suicidality. Whether Améry’s description of suicidality is at play in the experience of terminally ill suiciders has not been established; even if his description does not apply to this group, the larger conceptual difficulty of addressing death in terms of rationality is sufficient to call into question the appropriateness of doing so.

I have argued that these moral and conceptual difficulties with the concept of rational suicide are great enough to require a new ground for establishing the moral permissibility of suicide and assistance in suicide. In this chapter, I will lay the
groundwork for a different conversation regarding suicide and assisted suicide that does not rely on rationality standards. While my work may relate to policy considerations, my primary concern in this chapter is to offer the foundations upon which a moral conversation can take place that gives consideration to all suiciders, not just those who are terminally ill and who meet the “rational suicide” criteria set forth by bioethicists and practitioners. To this end, in this chapter, I will introduce the concept of “appropriate death” originally developed by psychiatrists in the 1960s. I will offer an overview of literature on appropriate death and argue that suicide can be an appropriate death. I will review several cases that highlight the way that “appropriate death” can be applied to a wider range of suiciders, and finally, explain the advantages appropriate death has over rational suicide. One might read this project as setting the groundwork for a radically individualistic claim regarding assisted suicide (something like Thomas Szasz’s argument in Suicide Prohibition: The Shame of Western Medicine (2011)). Given Améry’s account of suicidality, it might follow that in every instance suicidal people are the best judges of whether they should receive assistance in suicide, and thus, we do not have moral reason to restrict access to assistance in suicide. Améry himself claims that in the monumental moments of a person’s life, like the moment of suicide, a person belongs only to himself, and that others must remain silent (1999, 102-103). This is not my view since, as I have argued in previous chapters, humans are deeply relational and intersubjective beings: suicide is not merely a private individual choice, but one that requires social care and concern. Améry’s project is grounded in giving an account of and for the individual suicer who experiences suicidality in the way that Améry describes it. I have explained his work as counterstory in that he wants to provide voice for the voiceless, and to make
it clear to the nonsuicidal that suicide research tends to promote societal interests, and not the interests of the suicidal. Yet as Lindemann explains, there is a need for evaluation and balance in counterstory (Lindemann 1995, 37).

The point of my project is not to argue for the privileging of the suicidal perspective over the societal perspective, nor is it to argue for a libertarian approach to end-of-life issues. Instead, I bring Améry into the rational suicide conversation in order to rectify a fundamental misstep made by bioethicists in the literature—considering only one sort of story of suicidality, that of the terminally ill person, when they approach the issue of the morality of suicide and assisted suicide. This story is an important one, but in focusing on this story and on rationality as the means by which to justify the moral permissibility of assisted suicide for this sort of suicidal person, bioethicists have ignored other sorts of suiciders. Using the work of Elizabeth Spelman and Maria Lugones, I have argued that focusing on one very particular type of suicidality, the type experienced by those who are terminally ill, is limiting and exclusionary. I have claimed that in restricting suicidality to the sort experienced by the terminally ill, bioethicists have artificially narrowed the discussion surrounding assisted suicide and done a disservice to those they claim to serve. As Spelman and Lugones point out, “part of the human life, human living, is talking about it, and we can be sure that being silenced in one’s own account of one’s life is a kind of amputation that signals oppression” (1983, 573). In not listening to the voices of different types of suiciders and considering only terminally ill suiciders, bioethicists have curtailed the participation of many other types of suiciders’ in the moral conversation.
My concluding interest in this project is to open up the moral conversation about suicide to all types of suiciders, as well as to offer a possible alternative standard by which to judge whether a person should be granted assistance in suicide. My concern here is developing a more empathetic, less individualistic approach to determining to which persons it is morally permissible to grant assistance in suicide, and an approach that does not silence the majority of the persons who might request such assistance.

In order to discover this new ground, it is useful to recall the motivation behind the development of the rationality criteria. In “Can Suicide Be a Good Death?,” psychologist David Lester offers a helpful characterization of assisted suicide discussions. In this article, Lester explains that the debate about the moral permissibility of assisted suicide has been split into two questions handled by two different camps of scholars, but that both questions are different ways of asking what might constitute a good death (Barnard 1980, Doyal 2001, Engelhardt 1989, Lester 2006). As discussed in my first chapter, in the first camp, philosophers have asked whether suicide is or can be rational, and then used the characterization of rational suicide they develop to argue for the moral permissibility of assisted suicide.

The concept of rational suicide is nothing if it is not an attempt to help people achieve good deaths. The discussions surrounding assisted suicide began because a particular problem was identified: because of rapid advances in medical technology over several decades, people were living with painful and debilitating diseases longer than they may have wanted (Battin 1982, 1994; Cholbi 2011; Fremon 1998; Kupfer 1998; Rachels 1986; Quill 2001). Rational suicide as a concept is an attempt to show that a person can meet very stringent criteria establishing autonomous rationality and that a
particular act of suicide might work to promote good and avoid harm. This is suicide as a death that promotes utility and preserves autonomy. Rationality is not the good that is pursued, but the capacity used to determine whether a person is capable of determining what her own *good* death might look like.

The second question that Lester identifies, however, has not been explored in the philosophical bioethics literature. The question is, “Can suicide be an appropriate death?” This question has mostly been discussed in psychological and psychiatric literature, and even then, such discussion is limited. In this chapter, I will argue that a modified version of this second approach described by Lester, seeking appropriate death, can offer a new ground upon which to argue for the moral permissibility of assisted suicide. I will first review the literature on the concept of appropriate death and seek to define appropriate death. I will then ask whether a death by suicide might fit the criteria for appropriate death. Having established that a suicide may be an appropriate death, I will then suggest that the concept avoids the pitfalls associated with discussions of rational suicide and is superior ground for determining the moral permissibility of assisted suicide.

**The Concept of Appropriate Death**

The concept of appropriate death is not new, but has an over forty-year history. It was originally developed by psychiatrists Avery Weisman and Thomas Hackett in a 1961 article, “Predilection to Death: Death and Dying as a Psychiatric Problem,” and further developed by Weisman throughout his career. Before looking at this concept’s historical development, let us consider some brief general descriptions of it to get a better idea of its scope and the purpose behind its development.
Weisman succinctly explains the concept of an appropriate death as putting “legs under the general notion of ‘good’” (1993, 101). He uses the concept of appropriate death to ground the colloquial understanding of a “good death.” Weisman offers another general, though more fleshed-out, description of the concept in The Realization of Death: A Guide for the Psychological Autopsy:

We take it as an ‘axiomatic truism’ that we want to live our own life. Since dying is a part of living, then we are obliged to die our own death. We can’t complain about the taboos surrounding death. Our task is to understand how a person’s characteristic life-style leads to a certain death-style. What is a ‘good death’? What kinds of death can we live with? Perhaps there are no ideal deaths, and I am reasonably sure that most people would prefer life over death. All of us fear something in dying and death. But die we must. Therefore, we want to know what kinds of death would be acceptable. Given a little choice and autonomy, what death would be best for us, the death most consistent with the values and aims we have followed throughout life? (Weisman 1974, 139).

This quote offers insight into the motivation behind the concept of appropriate death, as well as the “character” of the concept itself. Weisman begins with the simple observation that individuals want to live their lives in ways that are fitting for them. Given the fact that every person faces death, it seems reasonable to extend this desire to allow for a “fitting death.” Weisman immediately connects style of death with style of life, and asserts that fitting and good deaths cannot be determined without an examination of styles of living. He thus strongly connects the appropriateness of a death to a person’s particular lifestyle, as well as to subjective acceptability of a type of death.

In other brief descriptions he offers of the concept, Weisman connects appropriate death with an individually chosen death. As he claims, “An appropriate death, in brief, is a death that someone might choose for himself -- had he a choice” (1984, 34). In an
earlier article, he writes, “The best deaths are those that a person might have accepted and chosen, had there been a choice” (1979, 100). In both of these assertions, Weisman emphasizes the importance of the patient’s beliefs about and perceptions of his own death. In order for a death to be appropriate for an individual patient, that patient must be able to say that the death would have been one he would have chosen given the particular circumstances in which the patient finds himself.

These “brief” descriptions are a helpful place to start our discussion for two reasons. First, we see through them the catalyst of the development of the concept in general, and possibly the most important distinction between rational suicide and appropriate death as concepts. The concept of rational suicide comes about because bioethicists are looking to find a set of conditions any patient might meet such that they would feel comfortable arguing for the moral permissibility of assistance in dying. The criteria are a result of hypotheticals. “If there is a situation in which assisted suicide is permissible, then the patient would look like X, Y, and Z and the patient would want to die for A, B, and C reasons.” The development of the concept of “appropriate death” is strikingly different, however. As we found in the brief descriptions above, the concept is rooted in the desires of existing, individual patients. In all quotes above, the starting point is, “Given the life a patient has lived, what would that individual want regarding his death if given a choice?”

The concept of “appropriate death” stems from Weisman and Hackett’s direct experience with patients. They witnessed a phenomenon among a select group of surgical patients, and were struck by certain similarities among those patients’ experiences. Originally concerned with investigating the prevailing wisdom that patients who display
acute preoperative fear should be operated on as soon as possible, Weisman and Hackett noticed two seemingly similar, but actually distinct, groups of patients. The members of one group felt much fear and anxiety about their upcoming operations and facing the possibility of their own deaths, and expressed this fear and anxiety readily. Yet there was another group of patients who, while not displaying any signs of fear or anxiety, were convinced of their own impending deaths upon the operating table. The members of this group held this conviction without emotional distress. Weismann and Hackett originally built the concept of appropriate death around observations of this group of patients (1961, 232). They looked to describe a phenomenon they saw, not to create a concept that would then allow them to justify another clinical practice.

The second reason that these descriptions “in brief” are a good philosophical starting place is because one can more easily see the uniting principles under the criteria Weisman uses to determine which deaths are appropriate. The principles are simple: they must establish that deaths are “good,” and “goodness” must, in large part, be determined by the patient himself.¹ A closer look at the development of this concept will be helpful.

In the article that introduces appropriate death, Weisman and Hackett discuss five case studies, garnered over three years of psychiatric consultations in a surgery ward, in which patients were convinced that they would die after their scheduled surgeries. The article's purpose is “to call attention to a group of patients who, without open conflict, suicidal intention, profound depression, or extreme panic, correctly anticipated their own deaths” (1961, 232). These patients were convinced that death was approaching and

¹ It is important to note here that Weisman uses the words “appropriate” and “good” interchangeably. In all of the works I have encountered by him, he treats these words as synonyms. In one work, he comments that he does not mean good philosophically, but colloquially (1991, 101).
determined death was “desirable and appropriate” (1961, 232). Weisman and Hackett explore the commonalities between these patients who experience what they call the “predilection toward death,” and look to distinguish these patients from those patients who have a fear of death.

In the case studies offered by Weisman and Hackett, the circumstances leading up to the patients’ hospitalization are radically different from each other. Moreover, none of the stories told by the patients were uncommon when considered in light of the general population. The five cases involve people of different genders, ages, prognoses, temperaments, and cultural backgrounds. The ways in which they died were varied, as well (1961, 234).

What did these patients have in common, then? As these authors note, “Patients with a predilection to death are not a remarkable group, provided that a distinction is made between the fear of dying and the fact of death. It is their attitude toward death that is remarkable, not the reality of their death...Each patient shared the conviction that death was not only inevitable, but desirable” (240). These patients’ histories did not distinguish them from the general population in any particular way, and their illnesses were not rare or exotic, but their attitudes toward their own deaths were uncommon. One of the keys to understanding what makes one’s death appropriate is understanding the way in which a patient views and experiences death, and Weisman and Hackett’s original list of criteria for establishing an appropriate death reflects this:

Our hypothesis is that, whatever its content, an appropriate death must satisfy four principal requirements: (1) conflict is reduced; (2) compatibility with the ego ideal is achieved; (3) continuity of important relationships is preserved or restored; (4) consummation of a wish is brought about (248).
Note the patient-centered nature of this list. First, death has to bring along with it a reduction of tension and conflict in a patient’s life. Death resolves issues in a patient’s life, whether it is the end of intense pain caused by illness, or bringing a fitting end to personal issues. Additionally, the patient must be able to recognize a continuity between the person she believed herself to be in life, and the person she sees in the dying process. Closely connected to this is the requirement that relationships she had remain intact, and if need be, relationships be repaired before death. Finally, the patient must want something that death brings along, or desire death itself.

Over his career, Weisman continued to refine this list of principal requirements for an appropriate death, but he never strayed far from the tenor of the original list. For example, in a 1993 interview he provides a set of criteria that, at first glance, appears different, but is actually remarkably similar to the list provided by Weisman and Hackett in 1961. In this interview, Weisman explains that:

There are four major qualities of a very good or appropriate death for a specific person, since what is appropriate for one person may not be for another. An appropriate death involves 1) Awareness, 2) Acceptance, and it is 3) Timely, and 4) Propitious... Propitious means to die a death one can live with in terms of the values one has supported, and in terms of the groups whose respect and regard matter most (1993, 100).

He offers very similar lists in other works, as well (c.f. 1984, 1979). In appearance, this list is different from the list provided by Weisman and Hackett in 1961, but in application and intention, it is not. This point becomes clearer when we look at the application of the concept of appropriate death to a case study offered by Weisman in his 1979 book, The Realization of Death. As mentioned above, integral to the concept of appropriate death is that it is developed from clinical experience for clinical application.
In *The Realization of Death*, Weisman presents a case study of a middle aged recovered alcoholic who got sober through Alcoholics Anonymous. This man had a difficult childhood and adolescence, though managed some success before his alcoholism caused him to lose everything he had. This patient was diagnosed with myeloblastic leukemia in his middle age. The patient died in the hospital, alone except for the staff and some visitors from AA. He had been released briefly before his final admittance to the hospital, but was so anxious about the lack of company and a possible alcoholic relapse that he admitted himself back into the hospital. He died shortly after being readmitted (1974, 140-148). Weisman believes this man had an appropriate death.

What makes this case study interesting for our purposes, however, are not the facts of the case itself, but the way in which Weisman discusses the case. As Weisman recounts:

I’m wondering if his ‘religion,’ AA, helped him toward the end. Let’s try to piece things together; I’m trying to feel my way, too. Deciding that one death is appropriate and another not depends upon distinguishing between what would be appropriate for us and what would be appropriate for the other person. Step by step, now. Obviously, it was not an ‘ideal’ death---I don’t know what that would be. The death was expected by the patient and by the staff. It was untimely only in that he was still in middle years. But that was his life span or allotment, and we can’t do much about that. He had a lot of support, from the staff, from HSO, and from AA. In his final hours, he wept, spoke about his mother, not about anyone else. His daughters evidently belonged to a life he had already lived. He was a little afraid of dying, but had been spared the pain he feared. One day at a time. On his brief stay outside the hospital he went into a panic, and presumably now was reconciled to staying in the hospital until death. He was less alone, I think, and far more alive than he had been on that morning when he awakened on Skid Row. That would certainly have been an anonymous, John Doe death. Conquering alcoholism was a genuine victory. Like so many of our terminal patients, psychological and physical problems seem to fuse. For him, alcoholism was always a threat; he was
endangered from this and from his leukemia. And he was helpless in both instances (1974, 148).

The application of the later criteria is clear. The patient was aware of his condition, and had time to learn about his prognosis. His death was timely, insofar as it allowed him to avoid relapse and as it was an expected end. The patient was accepting of his death. Finally, his death was propitious in that the patient was able to die sober, had been able to meet with AA members before death, and had died with the support of his community (the hospital staff and AA members constituted his community by the end of his life).

This case also meets Weisman’s criteria for appropriate death as set forth in his 1961 article. Much of the recovering alcoholic's existence was directed toward staying sober and helping people through AA. Death stopped the conflict caused by addiction. His death allowed him to die sober, and sobriety was the ideal he had set for himself. This man had no significant others to consider, but the continuity of his relationships with the staff in the hospital and fellow members of AA, who had grown quite attached to him, was preserved. Finally, the patient died sober, which was his greatest wish.

Yet this case is not only interesting insofar as both sets of criteria are applicable, but also because of the sort of discussion that Weisman offers in this case. Two very important things happen in this discussion. First, Weisman distinguishes between an appropriate and an “ideal” death, and admits that he does not know what an “ideal” death would look like. It is essential to one’s understanding of the concept of appropriate death that one not imagine that it is something achievable only in an ideal world. Weisman is working to fight against the unthinking, general feeling that death is never appropriate or acceptable (1979, 98). He explains that these standards might seem too high to be
achievable, but “our preconception that death can never be appropriate may be a self-fulfilling idea” (1984, 33). Unlike ideal death, the concept of appropriate death allows the style of an individual’s life to dictate the interpretation of the criteria for appropriate death. Weisman’s concept of appropriate death recognizes that no one leads an ideal life, and as such, does not rely on defining an ideal death. He acknowledges that the death of the patient in the case study would seem a sad death to many people. Finding life satisfaction in being an active member of Alcoholics Anonymous, and experiencing death characterized by relative loneliness are things most people would seek to avoid. The issue at hand, however, is the fittingness of death, and the recognition that, “people’s attitudes toward death correspond to their attitudes toward life; how each person dies is determined by how he lives” (Weisman and Hackett 1961, 242). There is an attempt made by Weisman to incorporate the history of the patient in a substantial way into every aspect of his analysis of the situation. What constitutes an appropriate death cannot be wholly understood apart from the application of the concept itself, and this application requires coming to know the person to whom it is applied. The criteria for an appropriate death also serve as a way for a doctor to help a patient process what a fitting end might look like for him, as the criteria offer a path for achieving the best death possible within an individual’s unique circumstances. I thus argue that the concept of appropriate death is feminist in nature, as it presupposes both human relationship and knowledge of an individual's life story. What the case study shows is that clinicians without significant understanding of their patients’ subjective experiences cannot apply criteria for an appropriate death. These lists of characteristics are as much about the patient’s attitude towards his own death as they are about objective circumstances that obtain in the world.
Weisman explains why the person who is dying must play an integral role of deciding the appropriateness of her death, noting that:

Obviously, appropriate death for one person might be unsuitable for another. Finally, what might seem appropriate from the outside, might be utterly meaningless to the dying person himself. Conversely, deaths that seem unacceptable to an outsider, might be desirable from the inner viewpoint of the patient (1984, 31-32).

This is the most radical distinction between appropriate death and the concept of rational suicide. A clinician must be extremely sensitive when determining the appropriateness of a patient’s death, and must know a great deal about her patient’s life and desires. The goal of setting a list of criteria for appropriate death is to allow clinicians to determine ways to talk with patients and come to an understanding of appropriate death heavily informed by the point of view of the patient, and not to give clinicians a set of criteria to apply that requires little to no knowledge of anything beyond the patient’s diagnosis and prognosis.

That Weisman’s criteria for appropriate death change somewhat over the years is unsurprising. The criteria, like the concept, are subject to revision and reinterpretation given the need for responsiveness and flexibility. Understanding whether a patient’s death is appropriate requires thought and interpretation, as well as significant conversation with the patient. It is made clear throughout all of Weisman’s works that operational criteria are to be refined in light of a patient’s perceptions about his own death. While there may be some signs that a doctor can look for in the patient’s reporting of his experience in order to establish appropriate death, there is a level of flexibility required in interpretation. What remains constant is the responsibility of the doctor to
help a patient achieve an appropriate end, the importance of a patient’s perceptions regarding his own end, and the struggle for fittingness.

Clinicians must do more than just listen to patients, however. In his article, “Appropriate and Appropriated Death,” Weisman explains that there are clinical elements involved in appropriate death, including pain management, setting up conditions so that social isolation is avoided, and giving the patient the ability to “operate on as high and effective a level as possible” (1984, 33). Physicians have more control than anyone over many of the criteria for appropriate death, especially pain control and the ability to limit disability caused by illness.

Given the literature I have presented thus far, the following list represents a synthesis of that provided by Weisman over the years of his scholarship. In order for a death to be appropriate:

- The patient’s pain and symptoms must be well-managed.
- Social and emotional conditions must be considered and measures should be taken to limit social disability.
- The patient must collaborate in his care, or be comfortable with transferring to others his decision making power.
- The patient must be well-informed about his condition.
- The patient must seek to resolve conflicts, or see his death as resolution to conflicts.
- The patient’s death must fit with his ideas of himself and not conflict with his values.
- The patient’s attitude toward death must be one of acceptance.
- The patient must feel death is well-timed.

**Suicide as Appropriate Death**

Before fully articulating the impact of appropriate death on the moral permissibility of suicide and assisted suicide, we must address a very basic question: is the concept of appropriate death even applicable to suicide? That is to say, can suicide ever be an appropriate death?
In “Appropriate and Appropriated Death” (1984) Weisman completely rejects suicide as an appropriate death. In this work, he makes the distinction between appropriate and appropriated death. Appropriated death is one in which the patient causes his own death by suicide. The negative connotation to the word “appropriated” is intentional here. The suicidal person takes what is not hers to take. Weisman asserts that this sort of death can never be appropriate, as suicide is not only something that should not be sought, but something that cannot be autonomous. He states that “In a sense, suicide is an external agency that victimizes; the option to destroy oneself is not an expression of freedom, but one of despair” (1984, 32). Here Weisman adopts a traditional approach to suicidology: according to his view, there are no instances of suicidality that are not informed by some form of pathology. Only people with an inappropriate relationship to life would be inclined to take their own lives.

Weisman claims that suicide cannot be an appropriate death since all suicidal people are victims to the external force of despair, and insofar as they are victim to this external force, suicide cannot be an expression or extension of patients’ views of themselves. Yet again, however, this is an instance of a problem identified in the second chapter in that he has marginalized a population without justifying the reasons for that marginalization. David Lester explains this well:

Weisman is really telling us his opinion rather than arguing logically. The arbitrariness of such opinions is evidenced by the fact that some writers, such as Binswagner, believe that suicide, for example, can most certainly be an appropriate death (65).

Lester points out the contradiction involved in having criteria that allow clinicians to apply the concept of appropriate death readily to almost any situation, but then arbitrarily
restricting the application of those criteria to one form of death. It is not just
terminal ill people that Weisman believes can die appropriate deaths. He examines
cases in which non-terminal patients undergoing surgery experience a predilection toward
death.\(^2\) These patients’ calm demeanors and accepting attitudes, as well as the timing on
their deaths, cause Weisman to label these deaths as being appropriate. Yet terminal
illness is not a necessary condition for death to be considered appropriate. The
appropriate “timing” of a death has everything to do with the circumstances of a patient’s
life and how he feels about dying. Lester explains in a later article that if one suicide can
be found that meets the criteria for appropriate death, then Weisman’s insistence that
suicide cannot be appropriate cannot stand (1993, 167).

I argue that Weisman is correct that some suicides will not meet the conditions of
appropriate death. This is especially the case when depression or other sorts of mental
illness are the only factors motivating the wish to die. In these instances, suicide might
not be in keeping with the life a person has lived. If a person experiences a bout of
situational depression, for instance, or even bouts of clinical depression, if that person
experiences the desire to die only in those bouts, but also has experiences of non-
depressed states in which he wants to live and enjoy the world, then suicide would not
meet the criteria for appropriate death for this person. It would not be keeping with the
style of his life, overall.\(^3\) In these sorts of instances, a person should be treated with

\(^2\) It is of interest to note that in the original article in which the concept of appropriate death was introduced,
only in one of the five case studies was the patient diagnosed with a terminal condition (Weisman and
Hackett 1961). It is incorrect to suggest, then, that having a terminal illness is a condition of dying an ap-
propriate death.

\(^3\) This is not to say that the presence of mental illness on its own prevents a person’s death by suicide from
being considered an appropriate death. For example, in the instance of a paranoid schizophrenic who
psychotherapy and pharmacological interventions, and attempts should be made to return him to the style of life he had before he was affected by mental illness.

Yet although Weisman is correct that some cases of suicide will not be instances of appropriate death, this considerably different from the assertion that no suicide can be an appropriate death. As has been shown in the preceding chapter, exploration of suiciders’ lived experiences is absolutely essential to understanding suicidality generally. Suicidality cannot be appreciated abstractly. When speaking to the morality of suicide, individual instances of suicidality must be considered in their nuance. Moreover, the feminist concerns in this dissertation require the examination of the particularities of an individual’s life, as well as the relationships that shape that life, before engaging in moral judgment. While Weisman may have believed it sufficient to assume that in all particular instances, suicide is an inappropriate death, this is unacceptable from a feminist standpoint. His concept of appropriate death lays the groundwork to do the feminist work of exploring the particularities of cases, but his refusal to consider the cases of suiciders is wrong and is not in keeping with the tenor and purpose of the concept of appropriate death. Individual cases must be considered on their own in order to fully work out what would be an appropriate death for an individual. Also, given that appropriate death was originally developed because of doctors’ clinical experience with real patients and that a theoretical understanding of appropriate death must take into account in practical application, applying appropriate death to case studies will help enrich the discussion of the concept. With this in mind, I address some specific case studies to consider the experiences windows of lucidity during which she expresses the wish to take her own life (and perhaps even attempts to several times), one might make the argument that suicide could meet the criteria for appropriate death.
practical applicability of appropriate death, as well as to highlight the advantages of applying a concept of appropriate death rather than rational suicide.

**Case Studies**

I select the case studies below in order to address various types of suicidality. The first case I consider serves to disprove Weisman’s ungrounded assertions that suicide cannot be an appropriate death: I return to the case of Jean Améry. The second case study I address involves the other “extreme” type of suicidality looked at extensively in the bioethics literature, the suicidality of a terminally ill patient. For this, I will look to the famous case of Timothy Quill’s patient “Diane” (Quill 1991). I choose this case because it is widely cited in the rational suicide literature, and is often presented as a prototypical case of rational suicide. Diane meets all of the rational suicide criteria, and I explore this case in light of appropriate death in order to show that appropriate death will do the same moral work that rational suicide does in this case.

Finally, I will finish with two case studies that depict a more ambiguous type of suicidality. The extreme sorts of suicidality have been given considerable attention in my project, but beginning discussion of these “in between” cases is the next best step to show how the criteria for appropriate death will be useful for examining cases that exhibit different types of suicidality. For these cases I will look to the example of Dax Cowart and return to the case study that was introduced in the introduction. In neither case, is the person terminally ill, nor have they shown the extreme suicidality of Jean Améry unproblematically. Yet in both cases, these people wish to die.

What will be discovered in the study of these cases is not only the applicability of appropriate death to varied cases, but also that the criteria that define this concept allow
for different details in each of the cases to take on moral weight in a way unique to each case. Analyzing these cases in terms of appropriate death will allow me to highlight facts and relationships that are relevant for how each person lives or lived his or her life, as well as to consider what those facts and relationships meant to the person whose case is studied. The person whose death is being considered must be seen as a whole person, in the fullness of her, “identity, character, interests and preferences,” as well as in terms of her, “relations to particular others” (Friedman 1991, 164). Determining whether a death is appropriate is not to make a judgment regarding a static situation, but to attend to the nuance of lived experience.

Jean Améry

Given the time I spent on exegesis of Améry’s *On Suicide*, a brief biography will suffice. Jean Améry was born Hans Maier in Austria in 1912 to a Jewish father and Christian mother. Though little is known of his formal education after age 12, Améry was known to have attended lectures in philosophy and literature in Vienna. He was also an apprentice to a bookseller and moved in literary circles in Vienna before the war. In 1938, he fled to Belgium and joined the resistance. In 1943, he was detained by the Gestapo, tortured by the SS, and was kept for three months in solitary confinement. Eventually, he was deported to Auschwitz, transferred to other concentration camps, and ended up in Bergen-Belsen, eventually liberated by British soldiers. Améry spent almost two years in these camps. After the war, he started publishing under his pen name and gained some international renown when he wrote *At the Mind’s Limits*. *On Suicide* was offered in 1976, sandwiched between an uncompleted suicide attempt in 1974 and his completed suicide in 1978 (c.f., Brudholm 2008, Heidelberger-Leonard 2010, McCann...
2001, and Stark 2001). If it can be shown that Améry’s 1978 suicide meets the
criteria for appropriate death, then I will be positioned to reject Weisman's claim that no
suicide can represent an appropriate death.

It must first be considered whether Améry’s pain and “symptoms” were well
managed. Améry did not identify himself as suffering from a disease, and in fact, he
strongly denied that he was ill. His suicidality was a fact of his existence, something
foundational to his self-understanding. He had considered his physicians' diagnoses, as
well as psychological and psychiatric treatment options available to him (1999, 5). He
wrote a book that spent considerable space distinguishing suicidality and illness (1999,
57). As for treatment options, Améry explains that they were either not effective or so
extreme that they would fundamentally change who he was, denying him the capacity to
“be himself” (1999, 5). This total change of personality brought on by some treatment
options would contradict another of Weisman’s criterion, that the patient’s sense of self
and his values be preserved in death. Forcing Améry to live through treatment he did not
want would force him to give up his sense of self and values in life. Even in light of these
considerations, given that he underwent treatment after his 1974 suicide attempt, and he
was well informed about treatment options available to him, we can be confident that
doctors did what they could to manage Améry’s “pain” and “symptoms” (so much so that
Améry writes of his anger about such “management” in On Suicide (1999, 79)).

Related to Weisman's criterion that Améry’s symptoms be well managed is the
criterion that a patient collaborates in his own care. In some ways, Améry did collaborate
after he was “rescued” from his 1974 suicide attempt. He lived for two years longer, and
though he was angry with those who revived him after his 1974 suicide attempt, there is
no indication he did not follow doctor’s orders. Despite Améry’s protestations, to
achieve an “appropriate death” suicidal people who request assistance in dying may be
obliged to cooperate with their care providers in order to receive it. Care providers need
to be very thorough in their understanding of patients’ situations, which might require
several meetings, as well as attempts at “symptom management” before granting
assistance in dying (e.g., if the patient had not tried talk therapy or
psychopharmacological intervention, a doctor could rightfully require such interventions
in keeping with Weisman's first criterion). If the option of assistance in dying were
extended to patients, it would be very reasonable to put preconditions on that assistance
(waiting periods, required psychotherapy, or required drug therapy) in order to make sure
that the person was not just reacting to a fleeting wish. In this case, the “patient” could
collaborate with his caretakers without giving up the decision to die. In cases where
suiciders achieve their own death without assistance, such as the case of Jean Améry, it is
still possible to characterize them as “appropriate deaths.” This sort of death for someone
like Améry is in keeping with the way in which he lived his life. Améry’s insistence in
his written work that he was a being inclined toward death, that he felt the lure of death
even when engaged in the projects of living, indicates that death by his own hand was not
something he saw as surprising or unacceptable. To take his life with his own hand is that
which he was inclined to do, that which allows a “departure in freedom” for those who
are inclined toward suicide (1999, 153).

This prior treatment, as well as Améry’s own scholarly work, certainly means his
case meets the requirement that a patient be well informed. One would be hard pressed to
find a man better informed that Jean Améry. He had familiarized himself with a large
portion of the psychiatric literature and considerable philosophical literature on suicide. He was reasonable, rational, and an accomplished writer. He understood what doctors and healthcare providers told him, and he not only leveled a critique against particular facts revolving around the treatment of the suicidal, but also against the societal-wide attitudes about the suicidal and forced treatment of the suicidal.

Social and emotional conditions must also be considered when determining whether a death will be an appropriate death, and if there are any impediments to social and emotional fulfillment, attempts must be made to remove those barriers. Améry’s death meets this stipulation. There was nothing restricting his social and emotional life at the time of his death. He was not hospital bound and was actively engaged in social life up until the time of his death (West 2014).

Appropriate death also requires that a patient must seek to resolve conflicts in his life, or see his death as resolution to conflicts. Améry’s suicide notes demonstrate the fact that he thought his very being was a conflict. His death would be a resolution to that conflict, and thus, his death was appropriate. He even took steps to see that his own death brought about as little conflict as possible. He wrote letters to the staff and management of the hotel in which he killed himself and left money to cover the “inconvenience.” He wrote to his editors, his friends, and his wife. He looked to die with as little conflict as possible, and to make sure his significant others (and strangers) experienced as little conflict as possible (West 2014). The steps Améry took were prescient of requirements Humphry writes of in “The Case for Rational Suicide” (1986, 173). Humphry requires that a person engage in “acts of politeness” such as leaving notes for hotel staff in order for a suicide to be considered rational. Although I agree with the idea that in order for a
suicide to be an appropriate death one must think about the consequences for those who are left behind, I would be remiss here if I did not speak to a need to more thoroughly consider the impact one’s death might have on those around him. Although these notes and leaving money were certainly thoughtful, I think in order for a suicide to be appropriate, conflicts must not be instrumentalized and must be thought of more robustly, and that the suicider must engage in conversation with those close to him about his inclination toward death in order to resolve conflict. Améry certainly did this. These notes were the final words he spoke about his death, not all of the words he spoke about his death. It is important for a suicider not to underestimate the impact his suicide will have on those around him. Just as Améry asks nonsuiciders to recognize that the societal perspective they take up is not self-justify, we nonsuiciders can ask that the suicidal give consideration to those who their deaths with impact, and to have conversation about their deaths with significant others.

As to the other patient-centered criteria used to establish appropriate death, Améry’s death clearly meets all of these. Améry wrote an entire manuscript, which he then read over the radio in south Germany, explaining how suicide fit both with his self-image and values. It is hard to conceive of this criterion being more thoroughly, or publically, met.

Moreover, it would be hard to make a case that Améry did not accept his death. He made multiple suicide attempts, wrote a book defending and explaining those attempts, and developed an account of suicidality to attempt to help non-suicidal people gain a glimpse into an otherwise opaque way of existing in the world. Améry had accepted that suicide was an appropriate death him, and acted on that acceptance. The
timing of his death was his choice as well: Améry chose when and where to die. He had been inclined toward death for years. This condition could not be more thoroughly met.

I can only speculate what Weisman might say about a situation such as Améry’s suicide. It is hard to imagine that when confronted with someone like Améry, who was able to articulately express a history of suicidality and his own relationship to suicidality, Weisman would be able to explain why Améry’s death was not appropriate. Weisman’s repeatedly suggests that a patient’s understanding and acceptance of the fittingness of his own death are what lie at the heart of “appropriate death.” Améry had this understanding, and had been resigned to die by his own hand for years. One cannot help but think of Weisman’s concise definition of appropriate death from “Appropriate and Appropriated Death.” He writes, “An appropriate death, in brief, is a death that someone might choose for himself -- had he a choice” (1984, 34). After reading Améry’s works and his suicide notes, even Weisman would be hard pressed to explain why Améry could not be said to choose the circumstances of his own death.

“The case of “Diane”

The case of “Diane” is quite possibly the best known in the assisted suicide literature. Dr. Timothy Quill brought this case to the attention of the medical community in a 1991 article in The New England Journal of Medicine. Quill, an internist, admits in this article that Diane asked for his assistance in dying, and he granted it (Quill 1991). Diane survived early vaginal cancer and alcoholism to be diagnosed at the age of 45 with acute myelomonocytic leukemia. At the time of diagnosis, Quill had been Diane’s doctor for three years. Diane refused treatment after her oncologist explained that if a bone
marrow donor was found, she had a 25 percent chance of long-term survival following an intense, uncomfortable, and painful treatment. She came back several days later with her husband and son to discuss this decision further. Without treatment, Diane was told she would live anywhere from a few days to several months, but she remained steadfast in her decision.

A few days later, Diane asked Quill to prescribe her barbiturates for help with sleeping, but through conversation, Quill realized Diane also wanted barbiturates for purposes of suicide. Quill ruled out depression, and worried that fear about a lingering death would not allow Diane to enjoy any of the time she had left. He prescribed the drugs. About three months later, after her illness “began to dominate her life,” Diane came to see Quill one last time. Quill explains that he knew she would use the barbiturates he had prescribed. He writes,

> When we met, it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. In our tearful goodbye, she promised a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons swimming in the sunset (1991, 693).

Two days later, Diane’s husband told Quill that she had died.

What is unique about this case particularly is that Diane and her suicide would meet the rationality requirements without question, especially the criterion that it be “understandable according the community.” In fact, after the publication of his article, many wrote in support of Quill’s decision to prescribe Diane the barbiturates (c.f. Bloomstone 1991, Freer 1991, Humphry 1991, King 1991, Lynn 1991). In addition to meeting the rationality requirements, however, I argue that Diane’s case also meets the stipulations for appropriate death.
In Diane's situation, the first of Weisman’s criteria for appropriate death, that a patient’s pain and symptoms be well managed, was met. Diane had worked with Quill for years, and although she struggled with cancer during those years, there was no indication that she was not receiving proper treatment for pain, nor that her symptoms were not being managed in accordance with standards of practice (and since Quill was prosecuted for murder after publishing his article about Diane, but a grand jury did not indict him, we can be sure his records were thoroughly examined) (Pence 2004, 100). Also, the pain and symptoms she was experiencing would have been worsened had she made the decision to continue her treatment.

The social and emotional conditions Diane found herself in were such that had she lived longer than she did, they would have deteriorated considerably. In the months leading up to Diane’s death, her son left college to come live with her and her husband worked from home. Quill reports that during this time, Diane was able to spend time with her husband, son, and closest friends that had been important for her, and that this time allowed her to say things that “had not been said earlier” (1991, 692). But she also fought off infections during this time and weakness and fatigue began to impact her quality of life. Although she was not socially isolated, her dependence on her loved ones was difficult for Diane and she understood that her discomfort and her dependence would only increase. Her death by suicide allowed her to not only avoid personal pain and discomfort, but also to leave her husband and son while aware and in active relationship with them. Thus, Diane's suicide can also be seen to come from a deeply relational sensibility, which is also in keeping with my feminist concerns in this dissertation.
Diane also met the requirement that a patient must collaborate in her care. Although she could have continued treatment but decided not to do so, Diane was cooperative during the years of treatment for vaginal cancer. It was only when she was diagnosed with a particularly terminal type of leukemia that would have required painful treatment with little promise of success that she decided to discontinue treatment. Even with this decision, however, it would be hasty to say Diane did not collaborate in her care. Quill’s article makes it clear that she was involved in the decision making process, and her decision to refuse care was not made hastily, but after consideration and conversation with doctors.

There is every indication that Diane was well informed about her condition. The article written by Quill makes it apparent that Quill and Diane had a fairly close relationship and that he had been her doctor for years. Additionally, Quill details conversations he and Diane had with her oncologist.

With regard to seeing death as resolution to conflicts, the ability to take her own life gave Diane the opportunity to resolve the conflict she most feared—dying a death that was painful and prolonged. Diane saw this earlier death by suicide as the resolution of the conflict of continued dependence and further debilitation.

With regard to the more “subjective” criteria for appropriate death, these are met without question in this case. Diane requested suicide because dying slowly of a painful and debilitating terminal illness did not fit with her sense of self. She was also accepting of her death, which is demonstrated not only by taking her own life, but also by Quill’s observation that although Diane was slightly fearful of death, that fear was vastly overshadowed by the fear of the sort of death she would die if she had lived longer. As
Quill prescribed the barbiturates three months prior to Diane’s suicide, the timing of Diane’s death was chosen by her, and thus her death meets the stipulation of being well timed.

Dax Cowart

Dax Cowart was twenty-five years old when he and his father experienced a propane explosion in his car. His father died, but Cowart survived and suffered extensive burns to 65% of his body. Over the next fourteen months, he was held in the hospital where he repeatedly refused treatment and asked to be allowed to die. Doctors and nurses treated him against his will, including daily Clorox baths that were so painful that despite his mere 85 pounds, it took several people to restrain him. Cowart was left blind, unable to walk, and without most of his fingers (c.f., Arnold and Menzel 1998, Burton 1989, Gelwick 1992, Kliever 1989, and White 1975). After release from the hospital, he tried to kill himself several times (Cowart 1994, 744-745). Over twenty years later, when asked what he would say to the doctors who forced treatment on him, Cowart explains, “I would say that if they were in the bed feeling the pain I was feeling and experiencing what I was experiencing, they would understand very well. In truth, I think they did understand very well and would just not accept it” (Cowart 1994, 744).

Cowart’s case is an especially helpful one because it is perhaps the archetypal example of one of the problems with the rationality literature and the substituted judgment that can come with the application of rationality standards. As was discussed in the second chapter, Dax Cowart is still alive, and argues that he should have been allowed to die as he requested. If his doctors had let him die, or even provided him the means by which to suicide, his case would have met the standards for an appropriate
death. However, the treatment he received contradicted several of the standards for appropriate death, and displayed some of the problems with substituted judgment.\footnote{Although one might question whether Cowart’s case is applicable here because he is still alive, I believe this is exactly why his case must be discussed. In ignoring Cowart’s explicit wishes, doctors denied him the opportunity to die what would have been an appropriate death. Cowart’s case shows the danger in using (explicit or implicit) standards to determine who is qualified to direct one’s own care that do not seriously and explicitly take into account the patient’s own reports.}

Dax’s pain and symptoms were not well managed. The pain of third degree burns over sixty five percent of one’s body is hardly easily “well-managed,” but even worse are the excruciating treatments required to keep alive one burned so badly. It took months of incredibly painful clorox baths and abrading processes to keep him alive, which felt to Coward like, “being skinned alive” on a daily basis (Cowart 2002).

The social and emotional conditions he was forced to endure were horrific. He needed to be isolated in order to recover because of the risk of infection, and he was denied all autonomy. Moreover, he refused treatment and did not collaborate in his care and was not comfortable with the transfer of this decision making process. If there was a conflict to be relieved through Cowart’s death, it would have been the tremendous and overwhelming pain he felt in treatment.

Had Cowart wanted this treatment and desired to stay alive despite all of the pain his treatment caused, there would be no moral quandary to address. But since Cowart expressed the wish to die repeatedly (the first request coming moments after his accident and the others expressed throughout the remainder of treatment) and he repeatedly attempted to take his life after release from the hospital, there are tremendous ethical difficulties in this case. If appropriate death standards had been applied, it would have
been clear that allowing Cowart to die, or even providing him with the means by which to die, would have been morally acceptable.

There was no way for doctors to reasonably manage Cowart’s pain and symptoms while treating him, nor to limit social and emotional disability during treatment. Moreover, it is clear that Cowart did not collaborate in his care, and that if his wishes had been taken into consideration at all, he would not have received care. The only way in which these criteria could have been met is if palliative care was given to Cowart, instead of treatment to save his life.

The patient-centered criteria for appropriate death certainly would have been met if Cowart had been allowed to die. Cowart saw death as resolution to the conflict of his constant and excruciating pain. Death was also in keeping with his values and self-image, which he has asserted numerous times in interviews and articles since his treatment. 5 Cowart’s accepting attitude toward death and its timing is evidenced by his repeated requests to be allowed to die, as well as by the testimony he has provided in interviews and articles. Cowart's situation set the foundation for an appropriate death, a death he was denied due to the repeated and violent interventions of those who were supposed to care the most for him.

“Cathy”

Finally, I will analyze Cathy’s case, the case that started this dissertation, in light of appropriate death criteria. The case involves a 59-year-old woman who was

5 One might liken the “treatment” Cowart was given to torture, since the physical and psychic pain was extreme and the treatment was against his will. Although it is outside of the bounds of this project to make this argument, it is interesting to note that some scholars have spoken to the ways in which pain, and specifically pain through torture, radically break down the image of self a person holds (c.f., Améry 2009, Scarry 1985).
hospitalized for her first suicide attempt at 15. Although she experienced bouts of what would later be recognized as clinical depression and mania, with recurrent suicidal ideation, she did not attempt suicide again until over twenty years later. During that time, however, in addition to getting married and having children, she made suicidal gestures and experienced suicidal ideation. At 50, she was formally diagnosed with bipolar disorder and borderline personality disorder. She was diagnosed with paranoid schizophrenia at 56. From the age of 45 until the present day, she has attempted suicide at least 6 times. In addition to her mental illnesses, Cathy is frequently hospitalized for physical ailments. During several hospitalizations, doctors ignored her DNR and AD. Cathy’s sister currently has guardianship of Cathy. Cathy, during a period of lucidity, has asked that her psychiatrist of 20 years provide the means by which to kill herself.

There is no question that this Cathy’s pain and symptoms are as well managed as possible. In addition to working with her psychiatrist of almost twenty years, she has a team of doctors that worked with her on all of her physical ailments as well. As difficult as it is to manage the symptoms of the mental illnesses and chronic illnesses Cathy has, her doctors control her symptoms well.

That steps have been taken to limit social and emotional disability is also without question. In addition to receiving at home care, Cathy has been given many opportunities to participate in daily outpatient therapy, as well as in adult day care, but often quits these programs within days of joining them. Additionally, her sisters do their best to visit with her regularly, but Cathy’s mental illnesses often cause her to alienate those closest to her. The toll this caretaking has taken on her sisters is considerable, and both struggle with and are treated for depression they did not experience before they took over care of
their sister. Despite this, they still remain regular fixtures in her life. Turnover on in Cathy’s in-home care aids is frequent, as well, as she either demands new caretakers for various reasons or they quit because she is “demanding” and “rude,” but she has never been left without in-home care. Social and emotional conditions are as good as can be imagined in this particular instance.

Cathy gave over decision-making power to her elder sister several years ago, and did so readily. She also collaborates in her care to the best of her ability. That she is well informed is certainly the case. She has a team of doctors with whom she meets regularly. She also has a social worker who can explain treatment options and available therapies and programs.

The more patient-centered criteria for appropriate death are where this case becomes of great interest. That death would resolve conflict for Cathy is certainly met in this case. Before her last few suicide attempts, she wrote letters apologizing to family, but explaining that she was in immense psychological and physical pain. Death for this patient would clearly be a relief, and she has expressed this to her doctor.

That the patient sees her death as fitting with her self-image is the case. She expresses to her doctor and family her fear of episodes of psychosis and experiences of other extreme symptoms of her mental illnesses, and recognizes that years of treatment have not been able to prevent these episodes. When she is lucid, she sees the way her illnesses cause her to drive away those who are closest to her, but is unable to modify her behavior. She understands death as a way to cease alienating her loved ones, and to leave her family at a time during which she is in good relationship with those who matter most to her. As she is seeking out assistance in dying, her attitude toward death is one of
acceptance. Her repeated attempts at suicide, several of which were only non-lethal because of unexpected visitors, indicated that Cathy has not only accepted her own death, but also actively worked towards it. Finally, the criteria that her death be well-timed would be met, if given the means to kill herself, the patient were able to chose the timing of her own death. I argue that suicide is thus an appropriate death for Cathy.

**Advantages to Appropriate Death**

These case studies highlight the advantages of using “appropriate death” over the concept of rational suicide in discussions about the moral permissibility of suicide or assisted suicide. They make immediately clear one of the most important advantages appropriate death has over rational suicide -- appropriate death criteria allow for discussion of a much greater variety of cases with more sensitivity to case details. There are other advantages at work here as well. In the final section of this chapter, I will discuss the advantages of appropriate death more fully. Briefly, the advantages that come from the use of appropriate death are the ability to consider a wider variety of cases, the operational nature of the criteria for appropriate death, an increased focus on patient experience, an increased focus on doctor experience, an acknowledgement of the social nature of the self, and finally, the concept's applicability to death and the dying process.

**Consideration of All Patients**

One of the first advantages of appropriate death highlighted by these case studies is that this concept allows for the consideration of all patients. Appropriate death is a concept applicable to all persons, since it is a way of defining a good death. Because anyone can die an appropriate death, this concept can be used to evaluate the ways in which any person dies. One immediate advantage is that conversations about appropriate
death might lead to richer social and individual conversations about end of life issues, and make for a more comfortable discussion of how a patient envisions her best death.

Also, since appropriate death is a concept that can be applied to all patients, and in some instances, suicide can be a good death, this allows for serious consideration of a patient’s request to suicide. We can see the potential effects of this consideration in the cases above. In the case of Dax Cowart, if appropriate death had been the concept used to determine Cowart’s course of treatment, it is hard to imagine that he would not have been allowed to die or have been granted assistance in dying. It is unclear whether assisted suicide would have been necessary given the extent of Cowart’s injuries and the medical problems he was facing, or whether palliative care would have sufficed, but Cowart’s death would have been appropriate in either instance. Cowart was accepting (and wishing for) his own death, and his death at that point would have met all of the criteria for appropriate death, whether he took his own life or not. The discussion of how to die an appropriate death, if it was to become a standard way of talking about end of life decision making, would require much more weight be given to patient perceptions of the sort of life they wish to live and the deaths they wish to die. This is especially true when cases involve patients requesting to be allowed to die or requesting assistance suicide.

In the case of Cathy, appealing to appropriate death means that her case would receive consideration, which, given the patient's history of mental illnesses, would not otherwise be the case on a “rational suicide” approach. “Appropriate death” requires that even those who believe that the (severely) mentally ill are globally irrational would need to consider Cathy’s request for assistance in suicide. This has a distinct benefit, even if a patient is ultimately denied assistance. In cases where a mentally ill patient might
approach her doctor about the possibility of suicide being an appropriate death, the discussion of appropriate death would be intimately tied to what her vision of the good life might look like. It allows for a conversation about what improvements in quality of life might make suicide seem like a less attractive option. In the particular case of the woman above, suicide would be an appropriate death, but even in cases in which it was not, speaking to appropriate death might make for conversations in which the full weight of a person’s suffering is acknowledged. Moreover, this consideration of all patients prevents the marginalization of people like Améry. If suicide is considered an appropriate death in some cases (granted, a very small percentage of cases), patient’s stories must be listened to and discussions must be had when patients request assistance in suicide.

Operational Nature of the Criteria

The second advantage of using appropriate death to evaluate whether a suicide or assistance in suicide might be ethical is the “operational” nature of the criteria of appropriate death (Weisman 1974, 151). These criteria were developed in clinical practice, and determination of good living and dying for individual patients is at the heart of this concept (Weisman 1984, 33). Weisman calls these “operational criteria” because the criteria for appropriate death were developed with an eye to their application, and with an awareness of the relational nature of many of the criteria. It is impossible to understand these criteria without understanding the purpose of these criteria -- that is, to

6 If appropriate death was adopted as the moral touchstone regarding assistance in suicide, I wonder if it might have an unintended consequence. Shneidman, the founding father of the suicidology movement in America, has cited ambivalence in suicides as one of the preeminent reasons for the institution of preventionist measures (1996, 2004). I wonder if some of these “ambivalent” suicides would be more likely to visit doctors if they thought these doctors might take their requests as more than just a cry for help. Although in many, if not most, of these cases, suicide would not be an appropriate death, the potential promise of their suicidality being understood through their eyes, rather than immediately in terms of pathology, might make visiting a doctor more attractive.
help patients in the process of determining what it is for them to live better lives and
die better deaths. These criteria do not allow a doctor to make detached judgments about
a patient’s good without some awareness of how the patient defines her or his good. This
leads to a fuller, thicker understanding of the individuals involved.

The effects of the operational nature of the criteria are seen in the cases I
addressed above. In Diane’s case, establishing rationality would be relatively easy, but
only because Quill was in relationship with Diane was it possible to know that the
appropriate death criteria had been met. Quill spent a considerable amount of time with
Diane, and his presentation of the case touches on the criteria of appropriate death, even
if he does not directly reference the concept. Establishing that Diane’s suicide had been
rational would have required much less detail, and much less understanding of her
situation and her person. Because of the operational nature of the criteria, it is more
difficult to establish what an appropriate death is, but this difficulty reflects the complex
nature of end of life issues that the concept of rational suicide tends to overlook. Améry’s
suicidality could have been written off as irrational or a “cry for help.” Yet if one of
Améry’s doctors had been working with the concept of appropriate death, the fuller
conversation that came from its application might have lead to a better understanding of
the nature of the suicidality he experienced. Améry might have been given a chance to
explain to a doctor the way in which the unacknowledged pull of the societal perspective
shaped the way she treated him. Although this may not have lead to her assisting with his
suicide, at least she would have had a better understanding of the man she was treating. It
also would have forced a conversation about ways to improve quality of life.
The operational nature of these criteria allow for the consideration of a person’s lived experience that concerns Maria Lugones and Elizabeth Spelman (1983). Cowart’s case shows the extremes of what is possible when a patient’s experience is ignored: his caretakers completely ignored his lived experience, despite the fact that what they were forcing on him was tantamount to torture. The same can be said of Cathy: the appropriate death approach requires that her whole life be taken into consideration, not just a particular time slice. This includes her internal torment, which can be understood as equally painful as Cowart’s treatment, but not as tangible or easily witnessed.

Increased Focus on the Patient

Increased focus on the patient is perhaps the very heart of the concept of appropriate death. Weisman makes it clear that the accounts given by a patient must be taken seriously. This makes a difference in the way in which all of the cases above are analyzed and in what gets to “count” as morally relevant. The focus on the patient allows for better navigation of the power dynamics in the doctor/patient relationship, as well as a check on the way in which an ethics of vitalism guides much of medical thought. Medical knowledge is still extremely important for establishing appropriate death, but it must be balanced by a patient’s self-knowledge. Although Timothy Quill does not initially support Diane’s decision to refuse treatment, he recognizes after conversation that he must respect her wishes. He does not substitute his judgment for her own, paternalistically claiming that at the end of all the treatment, she will have been glad to have undergone treatment. Instead, he recognizes the legitimacy of her stance and concerns.
Given the details of Cowart’s case and his testimony about his treatment, there is little doubt that a severe paternalistic stance informed the way his doctors determined his treatment. The effects of an unacknowledged ethics of vitalism are also clear. If appropriate death standards had been applied, the outcome of Cowart’s case may have been very different, and he may not have needed to endure what he steadfastly claims he should never have had to endure.

In the case of Améry, appropriate death allows for the recognition of a fundamentally different worldview. Those who evaluate suicide’s moral permissibility in terms of rational suicide do not have a conceptual ground upon which to understand the claims made by Améry. As a concept, appropriate death at least leaves room for these sorts of revelations because of the way in which several of the criteria focus on the patient.

Finally, for Cathy, appropriate death gives a doctor an opportunity to give substantial weight to the patient’s account of her suffering in his moral deliberations. The mental anguish of Cathy is able to be considered in discussions of appropriate death in a way it may not be considered in discussions of rational suicide. Even if a doctor believes in the global irrationality of those with severe mental illness, which the doctor in this case does not, a patient’s severe suffering might be of greater moral significance than determinations of her rationality.

Increased Focus on the Doctor

Another advantage of the appropriate death criteria is the way doctors were included as the concept was developed. As Weisman writes, “But as we go on, comparing the better with the worse, choices become more uncertain and dependent on
the values we hold. What ‘quality of life’ means and is measured against as a general proposition remains elusive” (Weisman 1979, 123). Appropriate death is geared towards allowing patients to achieve a good death that is in keeping with their own vision of the “good life” (or death). He recognizes, however, that “quality of life” considerations are elusive and the understanding a person has of quality of life is dependent on the values he or she holds (1979, 123). Because of this focus on fittingness of death for the individual patient according to the sort of life the patient lives, a doctor’s determination about the good life might be very different from his patient’s. Weisman stresses the importance of doctors recognizing the values they bring to the table when discussing appropriate death with patients. Dying is one of the most radical experiences in a human life, and as such, personal values are inherently caught up in any examination of dying.

The way in which personal values can affect determinations surrounding dying is seen in Cowart’s case. His doctors assumed that being alive was better than being dead. There was little consideration given to quality of life, and they believed they knew Cowart would be better alive than dead. This is a remarkable, and remarkably cruel, display of the unthinking ethics of vitalism. Keeping a person alive no matter the cost to that person, whether it be physical pain, mental anguish, and/or a complete loss of autonomy, because a doctor is trained to keep a patient alive, is wrong. I assert that an appropriate death standard would simply not allow for this.

Relatedly, much more emphasis is placed on a doctor’s duty to listen to patient reports. How a patient perceives his own treatment, his prognosis, and his death are important sources of information for determining whether a death is appropriate. Development of the “spectacles” Lindemann speaks to is encouraged by this duty. These
criteria set up the conditions under which a doctor might see the situation through a different set of lenses – those of the patient herself. It is this development of empathy that will help doctors begin to better understand their patients. A self-inventory of values on the part of doctors might be a good place to start this work, but ultimately, conversation with different others is going to be what allows a doctor to understand and respect the particularities of his patients’ lives.

The case of Cathy is a case in which these “spectacles” are of the utmost importance. Life is prized above good life by some doctors, but appropriate death standards must lead doctors to question when it is appropriate to allow a patient to determine when the cost of living is too high. This is not to say that a mentally ill person should be allowed to suicide whenever she wishes because her immediate desire is to do so, but instead a recognition that in some very rare and difficult cases, suicide is appropriate. Appropriate death criteria do not allow for the abandonment of these patients, but instead foster the sort of conversation and relationship between patients and doctors in which empathetic listening can flourish. This flourishing can only happen if doctors adopt the role required by appropriate death.

Complex Conception of Self

All of the advantages spoken to so far point to one of the most beneficial advantages of appropriate death. A more complex vision of the self is allowed to surface and be at work in discussions of appropriate death than in discussions of rational suicide. People are no longer most importantly rational animals, but complex social beings. There is more consideration of relationship, more acknowledgment of the varied particularities of individual lives, more opportunities for these particularities to be considered and
understood as morally relevant, and finally, there is a different relationship between
death and an individual’s life at play in this concept. Consideration of death and the dying
process is seen as an important way to understand what the good life is for someone.
Death is not to be avoided at all costs, but is to be understood in terms of the arc of a
person’s life in total. This more complex vision of self, as well as this different attitude
towards death, leads to an understanding that deaths can be better and worse and that a
good death is worth striving for.

This more complex vision of self can be seen above in the cases, specifically in
the details that count as worthy of consideration. In the case of Cowart, doctors' values
are brought to light and shown to affect the case. With regard to Améry, his philosophical
understanding of suicidality and his understanding of his own history become morally
appropriate to discuss. With Diane, the timing of her death becomes germane. That how
she feels about her own death becomes morally relevant to this situation is an important
step forward from rational suicide considerations. For Cathy, the lack of her doctors’
ability to totally control her symptoms and the devastating effects these symptoms have
on her life are recognized fully, as is the fact that dying well might bend the arc of
Cathy’s life for the better.

Conclusion

In this chapter, I have argued that appropriate death, unlike rational suicide, is the
best ground by which to establish a “good death.” I have further claimed that, in some
cases, suicide can be an appropriate death. As a concept, its application permits
subjective experience to be taken into account without advocating a reckless and cold
radical individualism. Appropriate death also leaves room for consideration of the impact


of social realities on end of life considerations, including the impact of the particular values of individual doctors and the values inherent in medical training, as well as patient values. Finally, appropriate death criteria give license to all patients to discuss with their doctor, as well as require doctors to listen to, a patient’s account of his understanding of what a good death might look like for him.

Moreover, beyond my more narrow concern regarding how suicide is presented and spoken of in the bioethics literature, the adoption of appropriate death criteria for discussions at end of life also has larger cultural ramifications. Considerations of appropriate death force citizens to rethink cultural attitudes toward death and dying, and they offer a conceptual framework that allows for discussion of end of life issues. If this concept was to become more common in end of life discussions, towns like La Crosse, Wisconsin, where 96% of residents have advanced directives or similar documentation, might become more common (Joffe-Walt 2014). Appropriate death as a concept opens up conversations about living and dying well, and could render such discussions less threatening to both patients and their caregivers. It forces the recognition that there are better and worse ways to die. As I have suggested in this dissertation, part of living a good life is dying a good death, and that is a social—not just a personal—issue.
CONCLUSION

Despite the demonstrated oddity of the term “rational suicide,” bioethics literature uses it as the guiding concept for establishing the moral permissibility of committing suicide or assisting in suicide. In this dissertation, I have developed an argument against the use of this concept. As my dissertation has shown, rational suicide is a problematic concept that requires more scholarly consideration and critique.

After offering an overview of the criteria bioethicists used to define rational suicide, my second chapter began the critical work of my project. Through the scholarship of Susan Sherwin, Susan Wolf, Rosemarie Tong, Lisa Ikemoto, and others, I outlined general feminist critiques of bioethics and applied them to the rational suicide literature. These critiques address the uncritical embrace of a liberal framework in bioethics and the assumption of physicians’ value neutrality. These assumptions have distinctly informed and directed writings in bioethics. The uncritical embrace of liberal individualism causes distortions in the understanding of the doctor/patient relationship. It allows bioethicists to ignore certain social realities, including the cultural capital given to doctors by virtue of their social and educational position and the effects of the institutional authority of medicine generally. Furthermore, this embrace of liberal individualism causes many bioethicists to miss the more social nature of the self at play in medical relationships. I explored the impact of this uncritical embrace of liberal individualism and the three effects caused
by it in my discussion of the “ability to reason” and the “freedom” criteria in the rational suicide literature.

I also explored feminist critiques of how the bioethics literature assumes value neutrality on the part of doctors. This assumption veils their social biases and obscures the impact medical training has on their social, cultural, and ethical values. I addressed the effects these assumptions have on the rational suicide literature by considering the criteria that a patient must have a “realistic worldview,” as well as the “harm” and “interest” criteria currently used to determine rationality in suicide decisions.

At the close of chapter two, relying especially on the work of Genevieve Lloyd, I looked at feminist explorations of the ways in which rationality has been used to marginalize certain vulnerable populations, including women and minorities. I argued that a similar marginalization occurs in the rational suicide literature and that rationality has been used to marginalize certain types of suiciders and to exclude them from discussions on suicide.

In the third chapter, I addressed this marginalization by looking to Jean Améry’s account of what I called “extreme suicidality.” Through an exegesis of Améry’s *On Suicide*, I discovered that one possible version of the lived experience of suicidality cannot be discussed in terms of rationality because it is premised upon an affective stance toward a suicider’s being in the world that takes hold before rational deliberation even begins. People are either yea-saying or nay-saying in light of the fact of their existence, and extreme suiciders are fundamentally nay-saying. The application of the concept of rationality to suicide, and to death generally, has been shown to be problematic, because as Amé-
ry points out, “there is no bridge from being to nonbeing--because of all this, we are so helpless in thinking about death” (Améry 1999, 20). All logics assume the existence of the person using the logic, and cannot account for, or handle, the unknown of death. Because of the enigmatic nature of death, talking about it in terms of rationality is otiose.

Finally, in my last chapter, I suggested “appropriate death” as a possible new concept to establish the moral permissibility of suicide using different criteria to determine to whom it is morally permissible to grant assistance in suicide. I argued that the concept of appropriate death avoids the moral problems to which the concept of rational suicide falls prey. I also argued that appropriate death avoids the conceptual errors committed by a notion of rational suicide. Furthermore, there is an added benefit in that appropriate death can be applied to all sorts of deaths, and not just to cases of suicide. Enlarging the conversation around assistance in suicide to consider the appropriateness of someone’s death allows for open conversation about what an appropriate death might look like, even if the conclusion to that conversation is that suicide itself would not be appropriate. While the concept of appropriate death should include a wider range of individuals in the conversation about assisted suicide, it would not necessarily increase the number of people who are granted assistance with their deaths.

My research immediately brings into question the supremacy of rational suicide. Given how much of the assisted suicide literature references rationality as the benchmark for requesting assistance in suicide, I hope that my research will also impact future bioethics literature on assisted suicide. As I pointed out, it is often assumed that if it can be shown that a rational person might want to suicide and that the circumstances surround-
ing a suicide might be rational, then there is neither moral reason to prohibit someone from suiciding, nor to prohibit someone from assisting in someone’s suicide. If rational suicide is not an appropriate concept morally or conceptually, this assumption that conditions much of the assisted suicide literature needs to be reviewed.

My dissertation also addresses the limited group of suiciders that are considered in the rational suicide literature. I deny that only those suiciders who meet the rationality criteria should be considered as worthy candidates for receiving assistance in death. If instead of the rationality criteria, the concept of appropriate death is used to determine when suicide is morally appropriate, then suiciders other than the terminally ill who wish to end their lives need to be considered. It may be the case that for some individuals struggling with chronic physical or mental illness or even extreme suicidality, suicide may be an appropriate death.

My dissertation has brought the concept of appropriate death further into philosophical conversation. This opens new ground upon which to talk about the moral permissibility of assisted suicide. My discussion of appropriate death has given philosophers additional ways to approach moral discussions regarding suicidal persons. Moreover, appropriate death might be a new way to generally address end of life considerations in bioethics.

Finally, my research reinforces the importance of including individuals’ lived experiences when one is talking about it for purposes of moral theory. While the rational suicide literature does discuss some cases, awareness of the ways in which case studies are chosen and the limited groups from which they are chosen is important for suicide
research. Without conversation with a wide variety of those who experience suicidality, and not simply those who experience suicidality in a very particular instance, the marginalization of suiciders will continue to occur and conceptual issues will be left unacknowledged and unresolved.

In terms of future research, a project that might be taken up regards the effects my research might have on policy considerations regarding assisted suicide. One would need to do work on establishing the relationship of the rationality literature to written policy and then begin to untangle what this means for policies. Given the recent legalization of physician assisted suicide in Vermont, and the push to legalize assisted suicide in other states, this is certainly timely work.

In addition to investigating these applications to policy, I am interested in taking my future research in a few directions. For example, I would like to further explore what research on the lived experience of suicidality might tell us about the limits and contours of the concept of suicide. There are a number of questions about this brought up in my dissertation, but which I was unable to explore in full detail. Though Améry’s counterstory has done a lot to fill in some holes in the bioethics literature, more work should be done with the “in between” cases spoken of in the introduction and chapter four of my dissertation. A thorough conceptual analysis of suicide and suicidality grounded in an exploration of the lived experiences of suicidality would do much to help orient the moral discussions surrounding suicide and assisted suicide.

Furthermore, I would like to develop the concept of appropriate death. I believe that narrative ethics and virtue ethics could be used to flesh out the concept of appropriate
death in a more philosophically grounded way than Weisman was able to do as a psycholog-ist. Again, one of the benefits of appropriate death is that it was developed for clinical use, but it has not been explored rigorously as an ethical concept beyond practice. Although Weisman speaks to the fact that appropriate death gives “legs” to the notion of a good death, there is little ethical theory involved in his development of appropriate death. Offering a more stable theoretical grounding for the concept could be interesting theoretically and useful clinically.

Finally, my immediate future research interests are inspired by the cultivation of an understanding of the social nature of suicide and assisted suicide. My research has indirectly suggested that suicide cannot be understood in terms of an isolated, rational actor taking his life. There is a social component to all suicidality, even for the most socially isolated of human beings. I am interested not only in the experience of suiciders, but also of those who survive their significant others’ suicidality and their suicides. It is my belief that a thorough understanding of both these “primary” and “secondary” experiences will add to the moral conversation around, as well as to conceptual understanding of, suicidality. I hope my research will contribute to both the bioethical and “popular” suicidology spheres to offer a more thorough conceptual grounding to the literature in suicidology.
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