8 Thoughts for the Last Days: on suicide[1]

> You got to know when to hold 'em,
> Know when to fold 'em,
> Know when to throw away,
> Know when to keep;
> Cause every hand's a winner,
> And every hand's a loser,
> And the best that you can hope for
> Is to die in your sleep.
>
> —Kenny Rogers, *You got to know when to hold 'em*

Apology

Like any other animal, I am going to die. Given my age and way of living this may be sooner rather than later. On present evidence, the most likely causes will be cardiovascular disease, lung cancer, liver failure or suicide. I cannot rank these in order of likelihood, but none would come as a huge surprise. My heart, though sound, has a discouraging family history; heart disease, respiratory disease and/or liver failure are not unlikely because of my smoking, drinking and general state of stressedness and sloth. Even the early stages of any of these diseases might well make suicide a reasonable option, if the prognosis involved major surgery or chemotherapy or radiation. Or if I were likely to suffer excessive pain, lose my ability to work, or my autonomy, my dignity (such as it is) and independence. If I were to have one heart attack or lung malignancy, it is on the cards that I would neither treat it nor allow a second. Exit is simple and quick: there is the bottle of tablets on the kitchen spice shelf, just below the basil. Even the darkest depressives often have a surprisingly light view of the future, because we know there will not necessarily be one. At least it seems this simple to me at the moment.

These facts and attitudes are all nestled in the matrix of my depression, now in remission, but waiting to surface, in who knows what form, colouring my attitudes toward everything else. And this itself may at some future time make living intolerable. It may also not, but it would be imprudent to be unprepared. The possibility that I will kill myself before anything else does the job properly is distinct if not looming. No book on mood disorder, especially one whose author has been well trained by six decades of less than optimal life, can avoid these issues of death and choice.

This chapter is personal and argumentative, an attempt at ideological persuasion and

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[1] I am grateful to Roger Melvill, Jeff Peimer, Hein Pierneef and James Temlett for discussions of some of the issues raised in this chapter, particularly from their point of view as practising physicians. Nothing I say is to be taken as implying agreement from any medical discussant. Some non-medical people have been also been particularly helpful (either by agreeing or disagreeing) in helping me establish my point of view on the difficult issues raised here: thanks especially to Debra Aarons, David Benatar, Sharon Brodovcky, Christiane Dalton-Puffer, Lara Davison, Ana Deumert, Meg Laing, Jaime Lass, Kirsten Morreira, Anette Rosenbach and Lisa Treffry-Goatley

amateur moral philosophy. I write in a state of remission, and am in no way suicidal, quite the opposite—though I am of course still me. Indeed, if I were seriously contemplating suicide, it would probably be an abuse to write on the topic: I would be too involved for clarity. I owe it to myself and my audience to look at this matter in as cold blood as my state of mind, experience and beliefs will allow.

It is obvious that I have not written just a disinterested study of a disease and the issues that surround it. Since even the more technical and philosophical parts of the book grow out of and invoke autobiography, it is a self-portrait. This chapter will be coloured, of necessity, by aspects (including ideological ones) of the self that has been portraying itself, and a fair reading will have to take some aspects of me as well as my subject into account. My tolerance for aversive experiences is low, and I am more self-absorbed and less involved with others—except a very choice few—than most other people. I am also self-willed and independent to the point of eccentricity. Perhaps it comes from the way I was brought up, without loving or probably being loved (I don't know, but I didn't detect it), and having from the beginning till I was in my twenties no very solid personal recourse or object of love. All I had that I could really trust was myself. Though now I do have some recourses—as well as responsibilities engendered by love, which have to be weighed against the rest. I am no longer a potential suicide living with a potential suicide as I was for my whole marriage, and since my wife's death I have had to do some rethinking.

There appear to be two primary issues raised by the problem of suicide, one rather abstract and philosophical (or for some theological), the other apparently more concrete and ethical or moral.

> (i) Life as a good *per se*. For some people, life itself is so precious, so self-evidently a divine gift, a good of the highest order, that it is simply impermissible to take one's own. This is so regardless of the quality of that life. Interestingly, those who hold this ideological position may well not hold the same beliefs with respect to taking the lives of others when 'necessary', e.g. in self-defence, in wartime, or through a judicial act of the state as a punishment for some classes of offense. For such people, suicide falls under various categories, depending on the underpinning beliefs: it may be a sin, a secular evil, an expression of selfishness, an intellectual error, or a challenge to the paternalist authority of the church, state or medical profession if they have decided that one's life does not 'belong to one'.
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> (ii) Suicide as an offense against others. Anybody not totally alone in the world has certain indefeasible obligations to other people. These may be dependents, non-dependent loved ones, friends, colleagues—all of whom will suffer in one way or another by his suicide. In the case of dependents, suicide may be an abdication of material responsibility (e.g. if one's life-insurance has a suicide clause and they are left unprovided for). In general it may be a source of profound loss, lasting bewilderment,

> guilt, trauma, stigma. This position raises the potential conflict between one's responsibilities to others and to oneself. Do (long- or short-term) social responsibilities in the broad sense override the right to rid oneself of a life that has become, or will become, intolerable? Do interconnections with other human beings imply an obligation to live because of the effect your death would have on them, or a right for them to pressure you to live?

My attempt at survival has left me toughened and somewhat (though now, in remission, decreasingly) reserved about personal matters, generally unwilling to drag others into my illness, or fully admit them into my world. (One might ask then why I have written this book, which seems to go against these predilections: I have no answer except that for various reasons, and because of impulses I could not dignify with that term, it seemed necessary.) My choice at the worst times has generally been—with a very few exceptions, most quite recent—neither to request nor accept help from anyone. What I cannot do myself does not get done. This detachment, compromised as it has recently become, still colours my view of (at least my own) death. No matter how attached I am to anyone, in the end my life is mine to do with as I like. And grandiose and puerile as it may sound, the most important freedom I retain is that of choosing my own time of departure. I have a principled (or mad) dislike of the idea of dying at nature's behest.

From such a perspective, attempting to stop somebody who is going to commit suicide could be seen as immoral and patronising, a rejection of their autonomy and personhood. I still believe, as deeply as I believe anything, that the ability to kill oneself in clear consciousness is a profound affirmation of personhood and liberty. Along with voluntary celibacy and non-celibate refusal to breed, it is one of the few utterly anti-Darwinian properties that distinguish humans from other animals. Or more accurately, it is one of the unique pathways our new cortical biology has given us for transcending our old brainstem and limbic biology. This is the background for the argument of this chapter.

I have certainly not been 'fair' to all points of view in this book, but have pursued a particular philosophical and theoretical line. This chapter, perhaps the most ideologically loaded of all, is a necessary part of my design, both for myself and for my readers, if they are to get some idea of where the emotional experience of depression can lead you intellectually, and the solutions that may become necessary. In one way or another the issue of Last Things is central to consideration of any chronic, incurable and disabling illness. So this is an 'apology' in the theological sense, an explanation and argument, not an excuse.

On rational suicide

> My life in the world of medicine has taught me that death is not always an enemy. Sometimes it is good medical treatment. Often death can heal what medicine cannot—it ends suffering.
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> —Christiaan Barnard, *Leef goed sterf goed* (1981)[2]

Discourse on suicide often resembles that on capital punishment: it tends to run round in circles and skip the central issue. Public discussion of the death penalty appears to be dominated by three concerns: the violation of human rights; the possibility of the innocent being executed; and the efficacy of the death penalty as a 'deterrent'. Practically (not morally) speaking, these are red herrings. Whether or not hanging or drawing and quartering or lethal injection are practical deterrents to crime is irrelevant. In contradistinction to other punishments, the result of execution is necessarily a zero recidivism rate.[3] The same logic must be part of any discussion of suicide: no suicide ever has to suffer again the conditions that provoked the act in the first place. Whatever else may be said, it is a final solution.

It does however have complex ethical spinoffs. On the personal side (which provokes a major class of moral condemnations), it is virtually impossible for a suicide not to leave a painful legacy of guilt and regret and puzzlement, scars that may never heal, great unfillable gaps in the lives of loved ones. Suicide in this light becomes not only the easing of pain for the immediate beneficiary, but the infliction of pain on others; these concerns may have to be subtly balanced in making a final moral judgement. There are also religious questions, meaningless except to believers, but strongly felt by them; the general theme appears to be that if God has given life, then it is up to Him to take it away, and a mere human arrogation to oneself of this kind of power is blasphemous and/or sinful. I will not discuss such matters, since the issues are unintelligible to me.

Suicide is not only the result of depression or other psychological disorders. It can be a rational response to purely physical conditions, even ones not currently existing. Someone suffering from a terminal or debilitating illness may of course commit suicide in the late stages, because their pain is intractable, their excessive dependency on others is unbearable, their quality of life has been degraded to the point where for the sake of dignity it is no longer worth the trouble to persevere. Or suicide may be a thoroughly rational preventive on diagnosis of a condition that *will* become unbearable if allowed to go on long enough.

Two people I know have killed themselves under conditions of this latter kind. One was

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[2] 'Live well, die well. A doctor's argument for euthanasia and suicide'. The author is the same Christiaan Barnard who did the first heart transplant.

[3] Provided of course the person you execute is the guilty one. This is a simplistic judgement of course; it may be that the practice of capital punishment has larger moral effects on a society that practices it. A death that prevents recidivism may have ripple effects among the family and friends of the executed, may do social harm in the process of doing what appears to be social good. But here I am talking on a strictly individual level.

a victim of recurrent leukaemia, who had been through several bouts of chemotherapy, and eventually found the treatment so unbearable, and the fact of its unpredictable but certain recurrence so horrible, that he killed himself while in full remission. (This as I have pointed out is not uncommon among depressives.) Another committed suicide immediately after being diagnosed with a colon cancer that required surgical treatment and had a medically 'good' prognosis, but would have necessitated a permanent colostomy. He apparently decided that this was not a condition he was prepared to tolerate, and killed himself without making any further medical appointments. Such suicides are prophylactic rather than therapeutic: the act follows an assessment of future consequences, and a *decision* not to be subject to them. In neither of these cases would it be appropriate or fair to say that the 'balance of the mind was disturbed'.[4]

Suicide raises ethical issues for people other than the suicide and his loved ones and friends. How far for instance is one obligated (or permitted) to prevent the suicide of a stranger, when it seems possible to do so? How much force or interference (if any) is permissible? Is the answer the same for all cases? Or is there perhaps a range of situations, in some of which intervention (e.g. calling the police or emergency services, taking direct physical action) is allowable or even perhaps right, and others in which the same act would grossly violate a person's autonomy or privacy? These are not easy matters.

And finally of course, since suicide is essentially self-euthanasia, I cannot avoid the question of 'assisted suicide'; nor that of euthanasia as performed by many doctors, either at the request of patients, or in some cases not at the patient's request but as a matter of medical assessment, the doctor's own (one hopes empathetic and well-informed) judgement about present quality of life and likelihood of future improvement. Ordinary suicide 'under duress', prophylactic suicide, assisted suicide, euthanasia performed by doctors at patients' request, and even euthanasia performed without the patient's request as a matter of medical judgement occur, whatever their legal status in any particular society. They all raise aspects of what to me is the central question: what rights do (or should) people have when it comes to the final disposition of their lives? Should we recognise a right to die parallel to the supposed right to live?

In 1990 the psychoanalyst Bruno Bettelheim, in advanced age and poor health, committed suicide. About a year before, he was interviewed for the *Los Angeles Times* and in the course of the interview said some wise and exceedingly humane things about suicide, which coming from a man of his profession might bear a special weight.[5]

When asked whether he is afraid of death, Bettelheim replies: 'No, I fear suffering. The older one gets, the greater the likelihood that one will be kept alive without purpose'. A bit later he remarks that his view of life is that of an 'intellectual rationalist': 'For me, death is the end of the road [...] that's it'. He brings up the example of Freud, who chose to be dispatched by

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[4] Unless you believe that anybody who attempts or commits suicide is 'sick' by definition, which some doctors do. I return to this later, and take up the problem of suicide or attempted suicide during severe disturbance or psychosis, which is not as clear-cut as it may seem.

[5] Fremon 1991.Quotations from the reprint in Donnelly 1998: 79.

lethal injection:

> [...] it's obvious that he felt he really couldn't go on with his life and still write and be productive and so on. He wanted to die with his boots on, with his mind unimpaired by sickness and old age. I think that was a rational decision. And well taken.

I take the liberty of recasting the next portion of the interview as a dramatic dialogue, omitting only the connecting material—all else is direct quotation:

> CF [author]. What keeps you from choosing your death now?
> BB. Nothing.
> CF. But here you are, still alive, still vibrant, still able to enlighten others, still full of ideas.
> BB. Yes. At great risk to myself.

Bettelheim finds nothing *outré* in the desire to die when one is still at one's best, fully functional, before retirement and inevitable decay or degenerative illness. He specifically uses the word 'rational'. How much more rational then the decision to end things when one is perhaps still functional but severely compromised by disease, or has good reason to believe that one will be. This is not the consensus, either among the general public or among doctors; but I think it is a position worth arguing. It raises some crucial questions about the role and duties of medical personnel, as well as friends and even passers-by. I begin with a sketch of my own position on the suicide of strangers and what one might conceive one's duty to be if faced by this possibility.

Responsibility, autonomy and intervention

> Suicide is a fundamental human right and ought to be a choice that is always available to the individual.
>
> —Christiaan Barnard, *Leef goed sterf goed*

You see someone standing on the parapet of a bridge, obviously preparing to jump into the dangerous-looking water below. What do you do? Go for the police? Try yourself to dissuade him with the usual platitudes ('things surely can't be *that* bad ...')? Or make sure you are unobserved, and retreat as discreetly as possible so he can get on with it? What is your obligation (if any) to attempt to save a life?

This is one of those maddening hypotheticals, and all answers are at least marginally suspect. As a committed vegetarian, I am often asked questions like: what would you do if you were stranded on a desert island whose only other inhabitant was a cow? Would you starve to death, or kill it and eat it? I know what I *hope* I would do; but not being on the island and starving, I can only give an abstract and self-interested answer. It is impossible to imagine a hypothetical stressor so clearly that your own predictions of how you would react are worth very much. But this does not stop one from having ideals, and hoping one will live up to them if the time comes.

Back to the potential jumper. If this happened in broad daylight, with traffic passing by, I might judge that it was not really a genuine suicide attempt, but a 'parasuicide', a 'cry for help'. I would make this judgement precisely because the potential jumper appeared to be calling attention to himself and what he was about to do. His behaviour could be interpreted as the result of a desperation that does not necessarily seek actual death, but raises the critical temperature as it were to the point where someone might do *something*. In this case I could well be tempted to act. Especially if the person was clearly not ready to jump immediately, and there was some ambiguity about whether his hesitation was the result of uncontrollable fear (even after having genuinely decided to die), or an attempt *in extremis* to show unwillingness actually to die, a mute request for someone to act to prevent the suicide. I *might* just possibly act, but I would never be entirely sure I was doing the right thing, and would always have a nagging moral discomfort about having acted.

But say the same scene took place in the country, at night, in a quiet area with no traffic or potential observers, and I happened upon it, with nobody there except the two of us, and me unobserved. My reaction would be different and certainly not ambivalent. These circumstances would tell me that the attempt was genuine; if the jumper was hesitating it might be a gesture of farewell and 'collection', or simply getting up enough nerve. On this assessment I would be obligated *not* to interfere in any way. I have just stumbled on a private and intimate act I have no business observing, and any interference would violate the person's right to privacy, and assault his autonomy as a human being.

Overstepping: suicide as sin, error or self-misunderstanding

> Quos Deus vult perdere, prius dementat.[6]
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> —Translation of a Fragment of Euripides, quoted in Boswell's *Life of Johnson*

In reading the literature on suicide, most of it of course anti-, I am struck by the pervasiveness of a strong and largely unargued moral (perhaps better 'moralistic') certitude. It seems customary in such discussions to adopt an Olympian perspective, often with an underlying deprecatory stance (even in people presuming to be philosophers).[7] Here is a characteristic example, more theological than philosophical, but guided by a simple elementary assumption—that there is no value higher than life (Griffiths 1981, quoted in O'Keeffe 1994):

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[6] 'Those whom God wishes to destroy, he first makes mad'.

[7] One notable exception (for the most part) is Mark Williams. In his *Cry of pain* (1997), he admits that there are good motivations for rational suicide, but in the later parts of the book he distinguishes this from suicide triggered by 'despair', which he thinks is largely treatable by 'cognitive means'. Still, this is one of the best overall surveys of suicide, from demographic, psychological, social and other points of view, and is well worth reading, even for the suicidal.

> Suicide is the paradigm of evil, the "elementary" sin. To seek death is to reject life [...] and this is fundamentally different from other futile bad strivings of a particular will [...] In all other sinning we fail to accept the world whatever it is—we would not have it as it is. In suicide we would not have it at all: we desire not merely a different meaning but no meaning: no God.

Of course this is not very compelling for atheists, most of whom probably live that way anyhow, and quite happily. But the point is that it makes suicide a moral offense under all conditions, on the essentially unargued grounds of the primacy of 'life'. But there are (at first sight) slightly more reasonable views, in which suicide under some conditions seems at first permissible, as long as the reasoning leading to it does not violate certain other apparently necessary and unarguable preconditions.

Gary is a terminal cancer patient, 'racked with pain', who decides to kill himself, even though surrounded by loving and devoted friends (Graber 1998):

> We may feel that if we were in Gary's situation, we would rather endure the pain in order to be able to continue to associate with other human beings. Nevertheless, if Gary himself is not afraid of death (with the resulting loss of human contact) and prefers it to a continuation of the pain, we have no right to impose our preferences upon him by insisting that he is not rationally justified in ending his life. On the other hand, if Gary were to say that he saw no value at all in human association, or no disvalue at all in death, *he would be mistaken, and we ought not to endorse his mistaken judgement.* (158: emphasis mine)

This is an extraordinary (and moralistically patronising) assumption. The author, on no particular argued grounds, has decided that association with other humans is a universal positive value (*per se*), and death is likewise negative. This sounds rational, or at least not religious, since it does not invoke metaphysical categories like 'sin'. But in fact it is just as metaphysical, since it invokes particular abstract values as somehow superseding all purely personal, individual considerations or preferences. On this interpretation suicide, regardless of the pressures of pain, would not be a sin but simply a *mistake*. Apparently human society and life are such self-evident goods that not having a positive attitude toward them can only be a kind of intellectual error.

But there is a worse kind of arrogance still, especially common in the health professions. Here is a particularly egregious example (Schneidman 1965):

> Individuals who are intent on killing themselves *still wish very much to be rescued or to have their deaths prevented*. Suicide prevention consists essentially in recognizing that the potential victim is "in balance" between his wishes to live and his wishes to die, then throwing one's efforts on the side of life. (177; emphasis mine)

What monstrous presumption. How can he possibly know? Is it really the case that the suicide who makes sure nobody is around and takes great precautions to make the job successful, performs it in a place where he is unlikely to be interrupted, or does it violently and quickly (e.g. with a gun or by driving off a cliff) 'wishes very much to be rescued'? If so, why the privacy, why the precautions, why not act dramatically and ostentatiously in public, where rescue is

possible? There is a total failure of imagination here, a simple inability to conceive that there are people who are different, who genuinely and sincerely do not want to live, and cannot be persuaded that life is somehow better than death. And it is disingenuous as well. The claim that there is a universal 'wish to be rescued' is belied by the usual stance of the medical professions. A striking amount of care is taken, and there is a plethora of elaborate strategies for the prevention of suicide. Surely locking someone up and watching him 24 hours a day to make sure he doesn't kill himself does not suggest that the custodians believe this at all. Here imaginative or empathetic failure is elevated arbitrarily to a general principle of universal human preference.

A similar obtuseness is often shown by psychiatrists. The chapter on suicide in McHugh & Slavney (1998) is a fine example. They claim that since the majority of suicides have a diagnosable psychiatric disorder, and suicide can be influenced by social modelling (as in copycat suicides after those of famous people), suicidality itself is a 'behaviour disorder', and anybody attempting suicide or even having suicidal ideation is 'confused'. The psychiatrist's function is to help the potential suicide see the light, since the psychiatrist's norms are unproblematic and universally binding. Theirs is the extreme paternalist position. They provide a sample interview aimed at eliciting evidence of suicidality: their recommended actions hinge on the patient's answer to the question 'Have you been feeling so bad that you've thought about ending your life?' A certain class of replies should elicit 'protective' action (246-7; bracketed comment mine):

> [...] replies, such as "Yes, I might take pills" or "I could use a gun" or even "Well, I did look into that book *Final Exit*,"[8] must be followed with some actions to protect the patient, such as discovering whether he has pills or firearms available, and beginning to involve his family members and other supporters in protecting him and appreciating the distress and dangers he faces [never mind the distress he is undergoing!]

But even this may not be enough:

> [...] this step may prompt some reassuring responses from the patient [...] but they should be followed by such questions as "have you ever tried any of these dangerous things—taken a few pills, cut yourself [...]?" Any positive answers indicate an intensity of suicidal inclination that *demands protection of the patient* and if necessary hospitalization. [emphasis mine]

This militant benevolence is extended further in standard institutional protocols for suicide prevention, and the powers arrogated to themselves by political and medical institutions to deprive the intending suicide of the most basic liberties, to allow suicide to be seen as a medical problem (narrowly conceived), rather than as a possible (and defensible) existential choice, or even a libertarian issue.

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[8] Humphry 1991. Unsurprisingly but unacademically, McHugh & Slavney do not give a precise reference to this book in their otherwise exemplary bibliography, though they do cite literature criticising it. I read it about a decade ago; just to defuse the mystique of 'that book', I bought mine for 50p off a table in the Oxford bus station. It sits on my study shelf, and I am apparently still here. But I have absorbed its lessons.

The suicide as infant and criminal

> Quis custodiet ipsos
> Custodes?
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> —Juvenal, *Satires* VI.347-8[9]

In many jurisdictions it is considered both moral and legal for a doctor to impose life-saving procedures on patients not legally 'competent'. A good example is forcing a blood transfusion on the minor child of a Jehovah's Witness family. The presumable grounds are that in case of danger to the life of a child, and parents' refusal to allow appropriate treatment, the state may come to stand *in loco parentis*. I find this at least morally ambiguous—certainly in a case where the child may be technically a minor, but is clearly old enough (and has enough knowledge of alternative views) to give or refuse 'informed consent' to a procedure.

Coercive medical treatment (including institutionalisation) may be actuated by noble motives. It also may not, as doctors and other people in authority may have (on the most charitable interpretation) implicit yearnings for power and control. But whatever the motivations, such treatment is demeaning and infantilising. A person taken into captivity 'for his own good' may be treated as a cross between a petulant and misbehaving child and a criminal. Indeed, one standard set of guidelines for treatment of the suicidal (including those who are assessed as being in danger of attempting suicide, but have not) recommends just such a regime. My text here is the Harvard Medical School's *Draft suicide assessment guidelines* (1993).I begin with a definition that sets the tone for the whole discussion:

> Suicide is a complex, multicausal phenomenon that primarily occurs as an outcome of mental illness. More than 90 percent of suicide completers suffer from psychiatric illness: primarily affective disease, alcoholism, schizophrenia, or borderline personality disorder [...]
>
> Most people who complete suicide have a combination of the well-known risk factors: psychiatric illness, male gender, disrupted social supports, previous suicide attempts, family history, and recent loss. However, most people with these risk factors do not go on to suicide. The paradox of these observations leaves the clinician who works with potentially suicidal patients in a difficult position: how to recognize which of their patients require more intense intervention.

Note the odd logic in the first paragraph: 90% of suicides suffer from psychiatric illness, but there are no figures given as to whether the illness is active at the time in any individual, or can be shown to have a causal relation to the suicide. How many depressives who commit suicide happen also to suffer from terminal cancer, end-stage Parkinson's, the early stages of dementia or some other irremediable condition? The link is simply assumed. If a diagnosed depressive commits suicide during a full remission, does this mean that the depression is causally linked to

[9] 'Who will guard the guardians themselves?'

the suicide in a direct way, and that the suicide was not 'competent' at the time, or had 'clouded judgement', that the mere existence of the diagnosis (whenever it was made) overrides the empirical evidence of remission? Or is it that by (circular) definition the remission was only 'apparent'? The aim of the Guidelines is among other things 'to provide information to be incorporated into institution-specific protocols'. What this means can be shown by some suggestions as to how a 'rescued' or (according to assessment) *potential* suicide should be treated in an institutional setting. First, the patient is assessed for indicators of danger, such as 'suicidal intent and lethality', 'dynamic meanings and motivations for suicide', 'presence of a suicidal plan', 'physiological, cognitive and affective states', and finally 'coping potential'. The assessment may provoke institutionalisation even in the absence of an overt attempt.

Once the patient is hospitalised, 'appropriate levels of observation, supervision, and privileges' must be chosen. At this point the distinction between hospital treatment and imprisonment becomes rather slippery. I will simply quote the suggestions here in full, as they give the flavour of the regime approved by a group of apparently well-meaning doctors (emphases and bracketed comments mine):

> **Choose Appropriate Levels of Observation, Supervision, and Privileges**
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> • The inpatient unit is especially effective in the treatment of acute rather than chronic suicidality. It offers safety, support, and *hope* [...] [who for – the doctor or the patient?] Inpatient treatment planning is determined on an individual basis to meet *the patient's* [or the doctor's?] need for maximal safety in the least restrictive environment. Although precautions and privileges have restrictive elements, they are applied in the context of a treatment plan that aims to enable a patient to tolerate suicidal feelings [what if the patient does not *want* to tolerate them, but get rid of them by committing suicide?].
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> •Inpatient treatment of suicidal patients relies upon a progression through a hierarchy of observation levels, supervision levels, privileges, and therapeutic passes.
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> • With clinical improvement, suicidality may still persist. Although the ultimate goal is toward a less restrictive environment, the clinical decision must be based on an assessment that there has been a reduction in suicide risk.

The fleshing out of these outline provisions I find rather chilling:

> **The Levels of Observation, Supervision, and Privileges Parallel the Patient's Potential for Suicidal Behavior**
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> • Some examples of observation levels are:
> ○ Continuous observation (1:1 or remaining in sight of staff members)
> ○ Restricting the patient to an area where he or she can be seen at all times by staff
> ○ Restricting the patient to public areas; not allowing him or her to be alone in room
> ○ Checks at intervals of 5, 15, or 30 minutes
> ○ Periodic checks at intervals greater than every 30 minutes
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> • Some examples of staff supervision include use of:

- Sharps (nail cutters, razors, scissors)
- Bathroom
- Kitchen
- Poisons (cleaning supplies)
- Occupational therapy

•Some examples of privilege levels are:
- Restricted to unit
- Accompanied off unit by staff [...]
- Accompanied off unit by non-staff (reliable family member or friend)
- Unaccompanied off unit

Aside from the fact that any clever intending suicide can easily figure out how to work such a system (and the suicidal are often very patient indeed), the philosophy implied is inappropriate in context. It appears to be identical in principle to that for assessing 'good behaviour' in a prisoner. What purports to be a medical action 'for the sake of the patient' is in fact essentially punitive. It both deprives the patient of autonomy (freedom of movement, elementary privacy) to the point of criminalising him (since the setting is totally coercive), and simultaneously infantilises him, since his movements and 'privileges' are controlled by the primitive carrot and the stick. It looks rather more like 'training' than treatment. I could see a justification for this in the case of a patient who is a serious danger to others; but if the danger (or assessed potential danger) is to the patient only, I fail to see any universal moral grounds whatever for the imposition of what is often euphemistically called 'custodial care'. Each case ought surely to be evaluated on its own merits.

'Beneficence', paternalism and autonomy

> Thou shalt not kill; but needst not strive
> Officiously to keep alive.
>
> —Arthur Hugh Clough

There is a great deal of discussion in the field of medical ethics concerned with the potential conflict between two principles: 'beneficence' and 'autonomy'.[10] Beneficence (on the part of the healer) is the Hippocratic imperative: first do no harm. Autonomy (on the part of the patient) is his right to full personhood during the course of the healer's ministrations. It is inevitable that these should come into conflict: one frequently discussed example is the dilemma of the doctor's right to withhold information that he thinks will distress the patient vs. the patient's right to know the truth about his own medical condition. If a doctor has just seen the latest CT scan of a

[10] For a lucid, humane, and detailed introduction to the minefield of medical ethics, see Beauchamp & Childress 1989. Thanks to Roger Melvill for introducing me to this book.

severely depressed or anxious patient and found a potentially fatal cancer, should he tell the patient (at the risk of provoking worse anxiety and depression), or lie? Should he 'for the patient's own good' lie to the patient but tell the family?

Nowhere do these two principles come into more striking conflict than in the case of forced hospitalisation or other restraint vs. (relative) inaction with respect to the suicidal patient; more subtly and perhaps more accurately, the suicidal person who is forced to *become* a 'patient' not of his own free will but by virtue of a physician's intervention, which so defines him. Here the provider of beneficence has to tread a subtle and difficult line between recognition of autonomy and the opposing principle of paternalism (the doctor knows best, and is entitled to perform virtually any act that will lead to the maximal expression of beneficence). In the standard view, any case of potential conflict between autonomy and paternalism requires a careful weighing of the claims of both against the overriding principle of beneficence. Beauchamp & Childress (1989: 220-1) set out the issues with admirable clarity:

> Minor paternalistic actions against the preferences of patients and careful monitoring of potentially upsetting information are common in hospitals, and when there is no reasonable alternative they are justified examples of strong paternalism. The weight of beneficence in these cases is substantial, whereas infringement of the principle of respect for autonomy is minimal. These and other paternalistic actions are appropriate in health care only if
>
> (1) a patient is at risk of injury or illness,
>
> (2) the risks of the paternalistic action (e.g., intervention or nondisclosure) to the patient are not substantial,
>
> (3) the action's projected benefits to the patient outweigh its risks,
>
> (4) there is no feasible and acceptable alternative to the paternalistic action,
>
> (5) infringement of the principle of respect for autonomy is minimal, and
>
> (6) the action involves the least infringement necessary in the circumstances.

These principles are the bases for judgement calls rather than 'hard' evidentially based criteria. They conclude this listing with an example:

> The crucial fifth condition can be satisfied only if vital autonomy interests are not at stake. For example, if a Jehovah's Witness refuses a blood transfusion because of a deeply held conviction, a vital autonomy interest is at stake. To intervene coercively by providing a transfusion would be a substantial infringement of autonomy and thus would be unjustifiable.

One of the more extreme versions of the paternalist approach is articulated in McHugh

& Slavney's rather vitriolic and dismissive chapter on suicide.[11] I quoted some of their discussion in the previous section, with respect to a patient's need for 'protection', and the rather nasty suggestion of going behind his back to the family and 'other supporters' in case 'suicidal inclination' is detected. But their attitude is actually more paternalistic than this; they deny even the theoretical possibility of rational suicide (247: emphases mine):

> The goal of self-destruction, prompted as it *may be by psychiatric states and predispositions*, is nonetheless one in which the *will* of the patient is involved. A conflict of wills over a behavior [...] is a critical issue. It emerges when the psychiatrist evaluates the patient's state of mind and impedes his or her inclinations. Just as with drug abuse, bulimia, and hysteria, the patient may offer complex justifications for their [sic] actions that take substance from the Zeitgeist. *Such comments as "whose life is it, anyway?" reflect a common thread in behavior disorders, where the physician's effort to thwart the behavior and obstruct the goal can be challenged as an arbitrary imposition of moral judgement.*

(Note how effortlessly they move from an explicit 'may be' to an implicit 'is'.) They do admit that they are making a moral judgement, but since it is based on superior knowledge it is clearly the correct one:

> Preventing suicide certainly rests on a moral judgement, as do many decisions on behavior disorders. This conflict is a regular feature of the psychiatric treatment of behaviors—a conflict that other people may try to join. Psychiatrists add to their moral judgement and act to prevent suicide because *they recognize the mental disorders confusing patients and encouraging the behavior*. In any given case, the justification for the psychiatrist's efforts emerges only after proper treatment is given to the depressive symptoms that have prompted the suicidal thoughts and actions. Then *most* patients are grateful to be alive.

So suicidality is simply a 'behavior disorder'. This is about as insightful as the bumper sticker that says 'Life is a sexually transmitted disease'. Yes, both are true; life is certainly transmitted by sex, and suicidality is a 'disorder' in the sense that it is unusual, results from and may cause distress, and is considered 'treatable'. But there is a great deal more depth and texture to both. Here the patient is granted no autonomy at all, not even the presumption of rationality. It apparently is impossible in principle that suicide could be motivated by a carefully thought out and simple desire not to be alive any more because of present or predicted conditions. Any pro-suicide sentiments on the patient's part are blandly attributed to 'confusion', which the doctor can recognise from Olympus because he is by definition clear-sighted. Note that even the question 'whose life is it, anyway?' (one that has exercised minds as cultivated as those of St Thomas Aquinas and Hume and Nietzsche—or were they also 'confused'?) is not taken seriously. The mere asking of it is attributed to suggestibility, the baneful influence of the ambient culture ('the Zeitgeist'), or disorder, and it is not even considered worthy of discussion. Once again a serious moral and existential issue is reduced to a matter of infantile 'wilfulness';

[11] I shouldn't exempt myself from the charges of vitriol and dismissiveness. Whose is more justified is for the reader to judge.

the intending suicide is perceived as a naughty child, trying to offer justifications for outrageous behaviour that the omniscient physician knows is really bad for him.

There are serious moral issues involved here, which McHugh & Slavney evade. The best discussion I know is by the philosopher David Benatar (2000); his subject is euthanasia and assisted suicide, but his arguments apply to ordinary suicide as well. Benatar sums up the intersection of rights and duties with respect to self-chosen death this way:

> To disallow others the authority to decide on when their lives are no longer in their interests is [...] to assume one's own infallibility. None of us can be so confident of our view about whether another person's continued life is in his or her interests, that we can risk the costs of our error for that person by enforcing our view on him [...] Being forced to live a life in which one is wracked by pain or which is characterized by loss of all independence, all self-control and all meaning, is a serious cost indeed. It is a cost one may not impose on another, even if one thinks for oneself that it is worth bearing. That is to say, even if one thinks that terminating one's own life in such circumstances is wrong this does not entail that we may prevent others from choosing to end their lives.

Competence and 'informed consent'

There is an attitudinal spectrum running from extreme paternalism to extreme libertarianism. I seem to be close to the anarchic end of the libertarian, in holding myself ultimately responsible only to myself, and considering my death and the manner and time of it a matter of no overriding social concern, but subject only to private decision (though of course mediated by and of concern to my loved ones).

On the other hand, the social consensus implied by the usual infantilising and punitive treatment of suicidality comes very close to the other end. How far is it from making the blanket assumption that anybody suicidal 'really wishes to live', or is by definition ill and requires involuntary hospitalisation, to the former Soviet government's incarcerating people who wished to leave the USSR in psychiatric hospitals on the grounds that such a wish is a sign of psychiatric illness? Judging by the tone of the material quoted above, I would think not very far.

The crucial issue in deciding to impose involuntary medical care on someone is an assessment of his 'competence'. If a person is adjudged incompetent, say through dementia, to manage financial affairs, there are legal procedures to assess this, which may make sense. The question really is one of agency: to what extent is a person in a given state to be adjudged not to be a rational agent, not capable of handling his own affairs, and therefore subject to deprivation of major civil liberties? What are the criteria in the case of suicide, particularly if the actor at the time is not psychotic, or even showing particular signs of mental disturbance—except for the wish to die, or more accurately, the wish not to be alive, with dying merely the means.

McHugh & Slavney simply define suicidality, whether or not there is accompanying psychosis, disorientation, delirium, dementia, or any other lack of mental clarity, as 'incompetence'. This means that under no conditions must the desire to die be allowed to be fulfilled. But many humane people with strong objections to suicide or assisted suicide feel no qualms at all

about euthanising beloved, terminally ill and suffering pets. Surely my sick and aged cat is not 'competent' to tell me whether or not he is suffering to the point where the quality of his life is no longer worth sustaining. But out of sheer humanity, *as a moral act*, I have to make the decision to end his life, and I do so on the grounds of careful observation and an attempt at empathy. Though the cat is not human, at least it is a mammal, and I make certain assumptions (perhaps slightly anthropomorphic, but still I think justified) based on that. I know from long experience what a healthy and happy cat looks and acts like, and I also take veterinary advice. If the cat is dehydrated, anorexic, indifferent, depressed, in respiratory distress, with no hope of recovery, it is generally construed as an act of mercy to end his suffering.

My decision here is similar to the one that some doctors make when confronted with patients who are clearly suffering and do not have any expectation of quality of life, but cannot make their wishes known. It is not unheard of for doctors to 'make sure' that neonates with conditions that will lead to short lives and great suffering simply fail to survive even the most heroic critical care[12]. Nor is it uncommon for doctors to invoke the 'doctrine of double effect' in treating patients with intractable terminal pain: that is, give sufficient analgesia to relieve the pain (first effect), even in the knowledge that such a dosage is likely to lead to death (second effect). This is usually legally permissible, and does not count as 'euthanasia' or 'assisted suicide'. And in the case of patients who cannot communicate their condition verbally, but are in a state similar to that of the cat mentioned above, at least some humane physicians will simply go ahead off their own bat and overdose.[13] Are we to be less humane about ending suffering for fellow humans than we are about our pets? If we can make judgements of quality of life for organisms we love but do not even share a language with, and cannot explain things to, why should we not be able to make the same judgements for ourselves? Surely we know more about how we feel and whether we want to go on living than we can know about any Other, whether human or not.

The only case I can think of where there might be a justification for the forcible prevention of a suicide is patent psychosis. But there is still a question in my mind about whether the wishes of the psychotic patient, if he is going to harm only himself, should not be regarded with some compassion, or at least not dismissed out of hand. It may very well be that under the proper medical regime the distress that is provoking suicidality will go away; but it is equally possible that it will only do so under conditions that will render his life considerably less than optimal (e.g. heavy sedation leading to confusion, the side-effects and risk of movement disorders from antipsychotic drugs: I would certainly rather be dead than tanked up on Thorazine and a Parkinsonian before my time, drooling and stumbling and confused). But even if the

[12] In such cases of course the process of care and/or withdrawal of care is undertaken in full consultation with the baby's parents.

[13] I base this assertion on numerous conversations with doctors who have told me this and given me perhaps more detail than I would like to have about their own practice. Unfortunately, even in the interests of scholarship and citation of sources I cannot name names, so the reader will have to take my word.

psychotic state is judged to be only temporary, could it not be the case that here the future (as constructed by the doctor) is not really relevant, but only relief from present distress?[14] I am not sure about this, but I think the question is worth raising even in this extreme situation. Certainly for the non-psychotic, or those whose mental state is not determinable (e.g. patients comatose or disoriented after a failed suicide attempt), there are grounds for very careful thinking about procedure, and avoiding the knee-jerk reflex of 'rescue'.[15]

The unbearable darkness of being

> The [...] pain of severe depression is quite unimaginable to those who have not suffered it, and it kills in many instances because its anguish can no longer be borne. The prevention of many suicides will continue to be hindered until there is a general awareness of the nature of this pain. Through the healing process of time – and through medical intervention or hospitalization in many cases—most people survive depression, which may be its only blessing; but to the tragic legion who are compelled to destroy themselves there should be no more reproof attached than to the victims of terminal cancer.
>
> —William Styron, *Darkness visible. A memoir of madness* (1990)

The unipolar depressive, even in remission; the manic-depressive, even in his tingliest hypomanias; such people often live perpetually *in umbra mortis*, their thoughts even at their brightest are typically shadowed, however faintly at a given time, by a muted longing for death. Thoughts of suicide are an inextricable part of life. One friend wrote to me during a very bad depression in the southern hemisphere spring:

> Yes, springtime has always been my favourite season for planning my suicides—usually at its peak around my birthday in early September. The smell of jasmine triggers it for me, and there is a great bush of it here just outside the window.

She knew we all do this: 'planning my suicides' says it with just the right touch of casualness, habitualness, and observation of the often potent effect of beauty as a trigger. The darker the mood, the more the untouched and untouchable beauty of the outside world becomes an offense;

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[14] The standard argument that the person attempting suicide will be 'grateful' for having been saved (once the 'confusion' is eliminated) is fallacious. How does one know in a given case? How many 'saved' suicides try again and again, and how many succeed? I am not sure that such a judgement is really safe, especially if the doctor(s) involved cannot think beyond a fundamentalist 'pro-life' position, which is often the case. I return to this matter at the end of the chapter.

[15] A doctor friend who often treats failed suicides tells me that the extent to which he will repair the damage done in the attempt depends on his judgement of the seriousness of the attempt, and the likelihood of an even worse quality of life due to the injuries sustained in the attempt. If he judges that the suicide was truly serious, or if the patient's quality of life will be significantly impaired if he survives, he either does not do the necessary repairs, or uses some other strategy to insure non-survival. To me this is a fine example of a doctor as a healer in the best sense, not a blind follower of the Hippocratic Oath.

nostalgia for a once-experienced (or once partly-experienced, or even just wished-for) ability to enjoy it becomes a reason for suicide. It is the mood of Housman's poem:

> Into my heart an air that kills
> From yon far country blows:
> What are those blue remembered hills,
> What spires, what farms are those?
>
> That is the land of lost content,
> I see it shining plain,
> The happy highways where I went
> And cannot come again.
>
> —*A Shropshire lad*, XL

We are, as my friend L puts it, 'high-maintenance people'. We do not live unreflectingly and easily. The very act of living takes more energy than for many others, the constant calibration of mood and avoidance of danger and fear of new episodes is fatiguing, often to the point where suicide becomes a reasonable option out of sheer tiredness, the unwillingness to face yet another day, and all the work it takes just to talk to people, be polite, live with one's own head. I speak now for perhaps a small group, but I know enough of us to believe we constitute an important minority, and like all non-criminal minorities in civilised societies we too ought to have rights—especially when these do not compromise the rights of others. One of these must surely be the right to die, when circumstances are appropriate.

Appropriateness can be judged only by the individual concerned, since no matter how articulate he may be, his private mental state is not accessible to anyone else. Though I should add that those of similar persuasions may have a special empathy, and be unsurprised by someone in a bright and sunny mood who still in the background thinks constantly of death, and even, in pure euthymia, achieves it. As I write this, for instance, I am in full remission, probably the best in over a decade. My mood is as good as I've known it; I'm working, thinking, reading, talking to people, listening to music, watching cricket and enjoying it all. But still, today as any other day when the vet provides me with a month's supply of phenobarbital for my epileptic dog, a certain number of tablets get creamed off into the family suicide-bottle. This is an act of pure and affectless routine, a kind of prudential housekeeping, taking out a death-insurance policy as neutrally as others take out life-insurance. Whatever else it may be, it is not 'confused'.

For us, life at its very best, enjoyable and productive as it may be, still carries a burden and a shadow. It is never or rarely joy uncorrupted, there is a background of unconquerable blackness, or fear of its return, and a knowledge that some day it may get too much to bear. And aside from that there are other possibilities too, terminal illness, loss of mental power ... all of them with the potential for tipping the precarious balance in favour of death, for those who are not fully in love with life.

Our background darkness and lack of unproblematic love for life often raises problems

with our non-depressed friends, who feel a sense of failure or frustration. No matter what they do, how much they extend themselves, with what sincerity and strength and love, we remain at bottom hopelessly miserable, and sometimes kill ourselves. Friends may take this almost as an insult: we have been putting ourselves out for you to the maximum, trying to be a joy in your life, and everything is thrown back in our faces. However much we strive in good faith to introduce some brightness into your life, it's as if we'd done nothing, as if we'd never existed. But we are not normally devoid of gratitude; they simply have no power to do anything because the disease allows no entry. My friend K noted in an exchange on this topic:

> It's very hard to get people to understand that it is Not Up To Them how you feel, or up to you. I suspect that no matter how much experience you've had with depressives, it's almost impossible to believe something as outlandish as the fact that sometimes we wake up wishing we were dead for no 'reason' at all, and there's nothing anyone can do.

This is one of the motivations for our strong tendency to see ourselves as a kind of separate culture, sometimes living in a separate if adjoining world. In moments of luck we can sometimes reach each other; but for much of the time, nobody from Outside can reach us. Regardless of our connections and attachments and loves, which may deep and passionate as anybody else's, to a large extent we live and die in a hermetic and impenetrable world.

Nobody who has not lived this way for decades has the authority to tell me that things will get better, or that I have an obligation to live on whether they do or not. Obligation to whom? Since I am an atheist and materialist, and do not believe in an afterlife or a 'soul', religious objections to suicide are irrelevant (if curious and historically and anthropologically interesting).

Freedom, love and the ethics of suicide

> Du bist sehr verzweigt, und nur die größten Drohungen können dich zusammenfassen.
>
> –Elias Canetti, *Die Fliegenpein* (1992)[16]

The only arguments left that could force a negative evaluation of suicide would be ethical, in a non-universal, purely interpersonal sense. If I kill myself the people whom I love and who love me will be devastated, as I would be if they did the same. But since I have lived so long with the daily thought of self-inflicted death, or death in general and its desirability, I often find it very hard indeed to put myself in the shoes of others who would be more disturbed by my topping myself than I would be sympathetic and distressed if they happened to. Here I suppose I might turn the charges of lack of empathy and imagination I have levelled at others against myself.

One of the commonest moral arguments against suicide (except for those who are totally

[16] 'You are exceedingly fragmented, and only the greatest stress can put you together'.

alone in the world, where it loses its force since it has no consequences) is the effect that such an act has on survivors: family, friends, lovers. Surely the residue of guilt and pain, and among the unenlightened, stigma, is such that suicide is a damaging, selfish and antisocial act. Mark Williams writes (1998: 225):

> Like someone trying to escape from a blazing house-fire, the suicidal person is focused on escape. He or she has tunnel vision, which prevents them imagining what the act would do to others. They are completely self-absorbed. The feelings of other people do not appear in their calculations.

He characterises this as a 'catastrophic failure of empathy, the complete breakdown in understanding how others will react'. But this is not universally true: many suicides do carefully consider such factors before making their decision, and weigh up, as well as they can, the costs to others against the benefits to themselves, and even discuss these matters in detail with the people most likely to be affected (as my wife and I did, and I have done—though with ambiguous results and considerable disagreement—with my best friends).The obverse of this coin is that the objector to the suicide displays the same failure of empathy and understanding; though in the case of partners and close friends, especially if they themselves are not or have never been seriously depressed, this may be unfair.

True, the aftermath of a suicide is often horrendous, and others may bear the scars for life, while the 'perpetrator' (on this interpretation) is happily out of it. But note the assumption behind this: the claim that your obligation to others is at least as great as, and may take priority over, your obligation to yourself. Other people's 'happiness' (the scare-quotes reflect the often nearly unbearable stress of living with a terminally ill or seriously depressed person) takes precedence over yours. But who, after all, has to *live* my life? Is martyrdom really that attractive and admirable? Merely staying alive may be the equivalent to martyrdom for the seriously depressed or terminally ill. If one does not accept the religious arguments, and is not of the totalitarian and paternalistic disposition that rejects autonomy, there is only one reasonable conclusion: *Nobody has the moral authority to compel another person to live.*[17] An individual's most central and private concern is his own life.

Why should a civilised regard for autonomy and integrity of the human being not extend to life itself under all conditions, at all ages? What do I own more than my life, which was given to me without my consenting or even being consulted?[18] Pardon the paradox: of course there was no 'me' before the act that produced me, but once I was there I was, like any organism, a potential victim. Let me quote again a passage from Bernhard's *Alte Meister*, which I used in the

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[17] Lara Davison has pointed out to me that this is distinct from the claim that other persons, e.g. your best friends, may have a 'moral interest' in your survival, and may have the right to intervene, at least up to a point, to try to make you survive. But in the end you have the countervailing right to refuse.

[18] In terms of law and the discourse of political philosophy, I do not really 'own' my life or my self, because these are not properties that can be alienated. I use the term loosely, because I cannot think of another one that carries the same force.

previous chapter in a slightly different connection. This casts what to many people is a shocking light on parenthood and the parent-child relationship; but it describes a situation that is attested over and over, and struck me with a powerful sense of rightness when I read it. This is *my* life, I thought, this is what it was really like, and to a large, but now perhaps decreasing extent still is. It may be bizarre and distressing, even 'inhuman', but it is the way things are for many, and gives some insight into why I in particular (and people with similar histories) feel rather differently about certain matters than others:[19]

> My parents made me, and when they saw what they'd made they were terrified and wished they could have unmade what they'd made. And since they couldn't stuff me in the wardrobe, they stuffed me into the dark hole of childhood, which I never escaped during their lifetime [...] To make a child and give 'the gift of life', as it's so hypocritically called, is nothing but to bring a fatal misfortune into the world [...]
>
> .
>
> To say that one had a fortunate childhood and thereby to show respect for one's parents is nothing but a sociopolitical commonplace [...] We respect our parents, instead of accusing them of the crime of procreation, he said yesterday. For thirty-five years I was imprisoned in the pit of childhood, he said. For thirty-five years they tortured me [...]They committed two crimes against me [...] they oppressed me, without asking my permission they produced me and once I had been produced and hurled into the world, they oppressed me, they committed the crimes of procreation and oppression against me. (109-11)

Note the characterisation of procreation and upbringing as 'crimes', specifically crimes against the innocent who are brought into the world through parental irresponsibility. Those who have had certain kinds of experiences (my wife's mother was a sadist and sociopath, my father was a tyrant of doubtful sanity) simply do not view procreation and 'the miracle of birth', 'the gift of life', with the same sanguine or innocent eyes as others. (There is in fact a serious philosophical argument to the effect that procreation is always at best morally dubious, from the point of view of potential infliction of harm. The nonexistent cannot be harmed by being deprived of the benefits and potential pleasures of existing; whereas the existent can always be subject to harm. For the details see Benatar 1997.)

For many chronic depressives who lived from earliest childhood under nearly unendurable stress and abuse, psychic or physical, memory and guilt are permanent toxic presences. Our childhoods (or our versions of them) are always with us; there is a sense, regardless of how well we know it to be unfounded, that we are guilty of some terrible but unspecified crime. My friend of the unconsummated September suicides wrote in another letter that what triggered many of her worst episodes was

> this long distance persecution which always works on oldest children who want to be good girls even though they know they are bad girls. It's the way Calvinism gets us all the time. I am left guessing as to my heinous crimes, so must search my soul. And you have some inkling of what's in there [...] So that's a big possibility, as is the other obvious possibility of the Jewish need to always want to go somewhere else, so

[19] This of course is a description of only one subset of depressives; I discuss this group because I belong to it and know it best. But the argument applies to all of us.

they won't get me.

This absurd but potent conviction often will not go away, and blights the rest of our lives. In our 40s, in our 60s, we are still haunted by parental monsters, the image of our childhoods, or diffuse and targetless guilt and fear.

Suicide is in a way the ultimate freedom. And acceptance of another's right to end his own life is the clearest possible recognition and granting of respect to that person, even an act of selfless love. Under certain conditions death is the most humane solution for all concerned, provided one takes a particular, perhaps radically autonomist, view of individual rights. The central point is this: officious attempts to prevent a necessary suicide show a lack of respect for the Other, a refusal to contemplate the Other as separate, autonomous, and endowed with certain 'natural rights'. These rights may not be taken as 'natural' in the legal sense, but they ought to be in the moral. What after all is moral behaviour? Is it obeying fossil codes (which may or may not have been relevant or useful ages ago), or acting at least so as to minimise harm to others? If we accept this reasonable definition, then it becomes very difficult indeed to find a true moral objection to suicide. If moral behaviour includes 'selflessness', as it appears to do for many, then trying to prevent a suicide because of *your* likely subsequent misery is at least as selfish as the suicide's insistence on escape to evade *his* misery. I am not sure that arguments from potential harm to others can get us any further than this impasse.

So in the end it seems that my self and life, however touched by the concerns of others, are still indefeasibly mine. If this is the case, then as an American citizen I can invoke the preamble to the *Declaration of independence*, which tells me that I have certain inalienable rights, one of which is the right to 'the pursuit of happiness'. If my vision of happiness should turn out to be the achievement of my own death (rather than something antisocial like paedophilia or serial murder), I see no reason why I should be prevented by anybody from pursuing it.

My ethic of self-destruction however would demand at least a dual social engagement, one part personal, and the other impersonal. I would feel obliged to discuss my intentions with those who would be most affected, listen to them, argue with them if necessary, take all they say into account, and then decide. But if the compulsion at the time should be too strong for that, the need too immediate, I still have responsibilities. Even *in extremis* I should be obliged to avoid a sickening mess and as much of the trauma of discovery as possible. Sometimes the most shocking part of a suicide for survivors is the condition in which the body is found, and it is only right to take steps to avoid that being as horrible as it can be. And finally: under no conditions is it permissible to make others, particularly strangers, the unwitting means of one's own death. It is bad enough that my loved ones will have to live with it; it would be unconscionable to inflict it as well on some unknown train-driver who will have to live the rest of his life with the image of what he has inadvertently done. The right to suicide carries with it the countervailing demand that one at least attempt to show maximal compassion toward everyone involved—ineffectual as that may be.

But what if ...? Enforced benevolence and the opaque future

> The future is dark, which is on the whole, the best thing a future can be, I think.
>
> —Virginia Woolf, *Diaries*, 16 January 1915

Despite all the fine and principled talk preceding this, I seem to have left out something crucial. I have not considered in detail the delicacies of aborting the future in the face of the impossibility of knowing it. What if the intending suicide, prevented from completion, would have had a good life later on? What if the 'doctor knows best' principle, while morally repugnant in its authoritarian shape, may encode something really important, transcending the attitudes of those for whom it is apparently more a source of power and control than an instrument of benevolence? And these are not the only people who might with some passion try to save a suicide against his will: there are caring doctors as well, whose interest is entirely focussed on the 'victim' rather than their own role in the drama.

Here is an example of the problem, from close to home. As I write this, and for some weeks preceding, I have been in quite amazingly good shape—for me. I seem to be riding a long, fine-quality remission, even improving. This is not the sort of thing I could or would have predicted six months ago, or that anybody, medical or not, could have.

Am I now weakening the argument of this chapter, perhaps fatally? After all, if I had killed myself at any of the times when I desperately wanted to, I would not have had the delightful experience of this remission, of a magically enhanced quality of life, increased productiveness, a strength in the face of adversity I had never suspected I could have. This suggests the obverse of my charge that doctors infantilise patients by enforcing precautions against suicide. Perhaps the depressed infantilise themselves by trying to commit suicide, even at the darkest times, given the opacity of the future, and the possibility that it might bring good things not imagined? After all, it is supposedly a classic mark of immaturity not to be able to tolerate adversity, even more not to be able to postpone immediate gratification. If I had killed myself years ago, this book would not have been written, I would not be enjoying my remission, I would not even know of the possibility that this late on in a nearly lifelong depression remissions of new and precious kinds could happen.

I have to answer yes, no, undecided. This is a desperate problem, and I have no solution. The easy answer might be simply that such speculation is an irrelevancy. Since at this imagined and possible (or impossible) future time I would be dead, there would be no 'I' to know anything about it, no grounds for regret; my absence makes the possibility of remission a dead issue. Corpses do not get better (or worse). What might have been (as opposed to what is pretty well expected to have been) is simply not up for consideration. So I, and those who love me, have been exceedingly and unexpectedly lucky that I did not kill myself, and lived to see better and better days. On the other hand I might just as well not have killed myself and got more and more

miserable over the years. Or killed myself and left the question suspended. I suppose the only final response in the face of this prophetic indeterminacy is a pretty crude and simple one, for me or anybody else in the same boat. If every hand is both a winner and loser, there is no way we can ever tell. In the face of our invincible ignorance there is unfortunately only one response to the possibility of lost golden futures: tough shit baby—that's the way the world is.