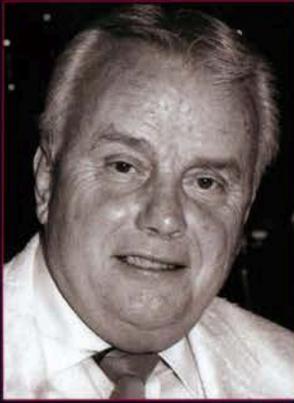


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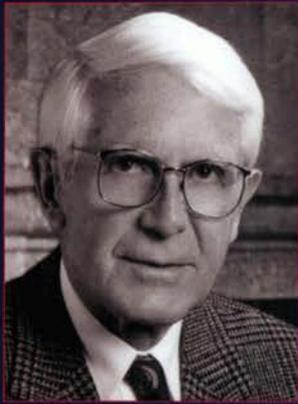
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How to Reconcile Advance Care Directives With Attempted Suicide

by Casey Frank

Advance care directives allow persons to request or refuse medical treatment when they become incapacitated. If incapacity arises from a suicide attempt, a countervailing value to protect the vulnerable may challenge implementation of the directives. Using facts from an actual case, this article suggests a way to reconcile these imperatives.

“It is not a thing to do while one is not in one’s best mind.
Never kill yourself while you are suicidal.”
—Edwin Shneidman¹

“There is only one prospect worse than
being chained to an intolerable existence:
The nightmare of a botched attempt to end it.”
—Arthur Koestler²

Ken was a physically healthy 35-year-old man who for a long time suffered from depression and drug abuse. His life was tormented in part because at age 7 he witnessed the death of his father. Ken blamed himself for not saving him.

In the autumn of 2011, Ken was at home with his family. He told them that he was going to his second-floor bedroom to change his clothes. What his family did not know was that he had received a call from the police telling him that his arrest was imminent. Ken had been in jail before and had vowed never to return. A few minutes later, the family discovered that he had jumped from a second-floor window with a chain around his neck. They cut him down and called an ambulance.

EMTs found Ken without a heartbeat. He was diagnosed at the hospital as suffering from an anoxic brain injury (from lack of oxygen); he was in a coma and unresponsive, but was not brain dead. He was being kept alive on a ventilator.

This presented the hospital an ethical and legal dilemma, because Ken directed in advance that he did not want to be kept alive on a ventilator. The reason he was on one is that he attempted to commit suicide. Respecting Ken’s directive would allow the

attempt to succeed, but ignoring the directive would repudiate the patient’s wishes.

An ethical or legal dilemma occurs when there are competing values or laws—both of which are ordinarily respected—that become irreconcilable. Every choice is not an ethical or legal dilemma. For example, it is not an ethical dilemma when someone finds a wallet with money and contact information and wonders whether to return it. Returning it is commanded by ethics and law; keeping it is both unethical and illegal.³

In medical treatment decision making, the preference of the patient is accorded great deference, for both ethical and legal reasons.⁴ The decision to decline medical treatment is as respected as the choice to accept one. However, another ethical and legal principle applies—that of *parens patriae*, the responsibility of the state to protect people from harming themselves (or others).⁵ This is the basis for mental health certification, which allows a person believed to be mentally ill and “in danger of serious physical harm” to be confined. This includes someone who has attempted suicide, which is why the attempt is not respected as just another patient preference.⁶ The fact that people can be deprived of their liberty without due process even though they are not accused of personal wrongdoing is extraordinary: it shows how strongly society believes an intervention is warranted to prevent self-harm.⁷

The Principles That Apply

The ascendant ethic in modern patient–physician relationships is patient autonomy, the opportunity for a patient to give informed consent for medical treatment or to refuse it, in contrast with deci-

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sions made directly by a physician. This is so even though the physician is acting in the patient's best interests, called beneficence.⁸ Beneficence posits an affirmative duty to benefit the patient, above and beyond the famous dictum "first do no harm."⁹ This is the heart of medicine.

With continued advances in medicine over time, as U.S. Supreme Court Justice William J. Brennan once noted: "The timing of death—once a matter of fate—is now a matter of human choice."¹⁰ Many of the choices are problematic, with no obvious answers. This has strengthened the need for patient autonomy, which has become a kind of universal salve for resolving intractable medical dilemmas.

Autonomy is inextricably intertwined with issues of decisional capacity, the ability to give informed consent. One must have capacity to exercise autonomy. Many commentators try to make distinctions between "competence" and "capacity."¹¹ This is a futile exercise, at least in Colorado, because different Colorado statutes use the terms interchangeably, and also intermix the term "disability."¹²

Incapacity is the status of a patient who "lacks the ability to satisfy essential requirements for physical health."¹³ Advances in medical treatment have allowed patients to remain alive longer, in sicker and possibly incapacitated states. The need to protect autonomy has been addressed by the implementation of advance care directives, which in ordinary circumstances must be respected as the voice of the patient.

When legitimate instructions in a medical directive call for the withdrawal of curative treatment, they normally are followed, even if

the foreseeable consequence is the patient's death. In 1990, the U.S. Supreme Court held in *Cruzan* that persons with capacity have a "constitutionally protected liberty interest in refusing unwanted medical treatment."¹⁴ In other words, patients are entitled to say no. Every state and the District of Columbia has codified this right through some form of these directives, enabling patient choices to be heard and wishes to be followed.¹⁵ The Federal Patient Self-Determination Act of 1990 mandated that hospitals receiving Medicaid or Medicare funds provide information on directives.¹⁶

Honoring Advance Care Directives

There are many forms of advance care directives, which allow patients to project their preferences for a time when they are unable to make or communicate treatment decisions.¹⁷ The law demands compliance with such choices. Treating a patient against the wishes expressed in an advance directive would be unprofessional conduct "contrary to recognized standards." Those standards prohibit the "refusal of an attending physician to comply with the terms of a declaration [an advance medical directive] or to refer and transfer care to another physician."¹⁸

The possible consequences to a physician for treating contrary to a directive include a letter of admonition, suspension or revocation of a license to practice, and a fine of up to \$10,000. Other consequences that may be imposed include therapy or courses, and review or supervision of the medical practice.¹⁹ Treating contrary to a directive also could be considered patient battery. This is a civil claim for money damages, and is not a crime.²⁰

There are similar sanctions for other medical professionals. Physician assistants are subject to the same rules as physicians.²¹ Nurses are regulated under the Nurse Practice Act.²²

However, questions arise when a patient attempts suicide: What happens if a patient relies on advance directives to finish a suicide attempt? What if the patient is being kept alive on a ventilator, though there had been unambiguous prior discussions refusing such treatment? Physicians are inclined to treat, but an attempted suicide can complicate the situation.

Suicide

It is not a crime to attempt to commit suicide in any state.²³ This tolerant view stands in contrast to past condemnation. William Blackstone, the eminent legal authority, asserted that suicide was a crime against both God and King.²⁴ There was one case in Russia where a man was hanged for unsuccessfully attempting to commit suicide and depriving the Tsar of his property, namely the man's own life.²⁵

Lest one think this is ancient history, the principle survives that control of one's body belongs to a higher, governmental authority. In May 2013, it was reported that most of the prisoners at the U.S. Guantánamo Bay prison were on a hunger strike, and that twenty-one of them were being force fed. President Barack Obama defended this intervention, saying: "I don't want these individuals to die."²⁶ The president of the American Medical Association, Dr. Jeremy A. Lazarus, wrote to Secretary of Defense Chuck Hagel and reminded him that any physician who participated in forcing prisoners to eat against their will was violating "core ethical values of the medical profession."²⁷

Government control over one's body is still found in Colorado, as well, at least indirectly. It is manslaughter under state law to

assist someone to try to end his or her life.²⁸ However, compliance with an advance directive is explicitly excluded from the statute criminalizing intentional assistance in ending a life. The law reads:

This section shall not apply to a person, including a proxy decision-maker as such person is described in section 15-18.5-103, C.R.S., who complies with any advance medical directive in accordance with the provisions of title 15, C.R.S., including a medical durable power of attorney, a living will, or a cardiopulmonary resuscitation (CPR) directive.²⁹

A plain reading of this statute seems to eliminate any legal concern about compliance with an advance directive in the context of suicide. It appears that physicians may feel free to use their best clinical judgment without worrying about prosecution. However, the law does not supply the ultimate guide to behavior; it supplies only a minimum standard.³⁰

This is closely related to the legal concept of proximate cause: “[a] cause that is legally sufficient to result in liability.”³¹ Society assigns legal liability to some acts but not others. In the case of the manslaughter statute, society has determined that the act of the physician who respects a validly made patient choice to forgo life-saving treatment is not the proximate cause of the patient’s death. The patient’s choice and the disease are the intervening proximate cause. The values that are expressed as proximate cause change as society does. As Warren and Brandeis put it, “the common law, in its eternal youth, grows to meet the new demands of society.”³²

Another question is: What is it that makes a suicide attempt different from other patient choices? An important feature is that it is often impulsive and transient. Consider, for example, the Golden Gate Bridge. This iconic “suicide magnet” is the most popular place in America to commit suicide,³³ despite a 24/7 suicide watch at the Bridge that regularly stops fifty to eighty people a year from jumping. Dr. Richard Seiden, a suicide expert at the University of California, Berkeley, published a study in 1978, called “Where are they Now?” It followed the lives of 515 people prevented from jumping between 1937 and 1971. After an average of twenty-six years, 94% were alive or had died of natural causes.³⁴

A smaller but longer study followed those who had attempted suicide by poisoning. Subsequent to their initial attempt, after thirty-seven years, 87% were alive or had died of natural causes.³⁵ A 2002 meta review of ninety studies of suicide attempts serious enough to require medical care found that, on average, 93% did not ultimately die by suicide.³⁶

The lethality of the 220-foot drop from Golden Gate Bridge approaches 99%.³⁷ However, at least twenty-eight jumpers have survived. One reported later:

The last thing I saw leave the bridge was my hands. It was at that time that I realized what a stupid thing I was doing. . . . It was incredible how quickly I had decided that I wanted to live.

That person was in his thirteenth year of marriage and working as a high school teacher as of 2009.³⁸ The compelling notion that people will change their minds contradicts the primacy of patient autonomy in the consideration of suicide. This is what distinguishes an impulsive suicide attempt from other informed choices to obtain or refuse medical treatment by patients.

To a degree, suicide as detrimental is socially constructed, which means that the detriment is not inherent in the act, but in the values chosen by society to apply.³⁹ An analogous principle is found in the law. An act may be considered inherently wrong, *malum per se*,⁴⁰ or an act may be prohibited by consensus, *malum prohibitum*.⁴¹

The former is prohibited because it is wrong, and the latter is wrong because it is prohibited.

Notably, the voluntary and intentional deaths of three of the most famous men in history are not considered suicides. Briefly, their three lives looked at in chronological order:

- Buddha Shakyamuni (b. 563 BCE) knowingly ate a poisoned mushroom, stating: “It is a gain to you, friend Cunda, a blessing that the Tathagata [Buddha] took his last alms meal from you, and then came to his end.”⁴²
- Socrates of Athens (b. 469 BCE) was offered exile instead of his sentenced execution. He refused, saying: “I should only make myself ridiculous in my own eyes if I clung to life and hugged it when it has no more to offer.”⁴³
- Jesus of Nazareth (b. 7 BCE) chose to give his life voluntarily for the sake of others. Speaking of his own life, he stated: “No man takes it from me, but I lay it down of myself. I have power to lay it down, and I have power to take it again.”⁴⁴

All suicides are not created equal; in fact some are not even considered suicide. Altruistically giving one’s life, such as the soldier who sacrifices himself or herself to save comrades, is not considered suicide; if anything, it is considered heroism. Another form of intentional self-killing is sometimes called “rational suicide,” but it is not considered suicide either. A terminally ill patient who has decided he or she has had enough suffering is respected, and not treated like a Golden Gate Bridge jumper.

Oregon⁴⁵ and Washington state⁴⁶ make well-known efforts to distinguish an impulsive suicide and a considered, rational wish to die. In Oregon, a request for a lethal prescription by a terminally ill patient must be made twice, approved by two physicians, and witnessed by two independent persons. There also is a seventeen-day waiting period between the patient’s first requests and the providing of a prescription. (Washington has similar provisions.) Between 1994, when the law was passed, and 2011, 935 persons obtained prescriptions in Oregon, and 596 of them died from ingesting them.⁴⁷

The likelihood of hospitals confronting patients who have attempted suicide and have advance care directives is great. According to the Substance Abuse and Mental Health Services

Administration survey, 1.1 million Americans attempted suicide in 2008. Of those, 46% stayed overnight or longer in a hospital.⁴⁸ Some of those patients will have directives that inevitably will contradict the clinical best efforts to prevent the suicide from succeeding. Analogous cases provide guidance on how physicians should act in those situations.

Other Precedential Cases

There have been few published cases where a suicide attempt led to a hospitalization. In 2012, Dr. Sean Marks⁴⁹ discussed a 69-year-old patient who overdosed on hydrocodone. The patient had advanced brain cancer, had suffered a stroke, and was depressed over the death of his partner. On admission to the hospital, he was treated for his overdose and was in a coma. A ventilator was recommended, but the patient's family objected. The family supported the patient's previous refusal of treatment, and asked for do-not-resuscitate and do-not-intubate orders. The physicians and family deliberated over a period of seven days and concluded that it was appropriate to forego treatment, even though it would allow the suicide to succeed. The following reasons informed their decision: treatment would not restore the patient to what for him was an acceptable quality of life; the patient's prognosis was short, measured in weeks; and the patient's wishes would be respected. The patient was discharged and died ten days later.

In 2003, Dr. Theodore Bania⁵⁰ discussed an 80-year-old patient who poisoned herself with diltiazem. On admission to the hospital she was put on a ventilator and treated for her poisoning. She had suffered an anoxic brain injury and was in a coma. Her surrogate decision maker, a nephew, reported that she lived with chronic pain, "wanted to die peacefully," and that she "did not want to be on a respirator." The physicians referred to the "early decision" stage used to evaluate prognosis, patient preferences, and quality of life. Clinical and family consensus developed at the "later decisions" stage—because of the poor prognosis, the patient's advance directive to die was honored. The patient was taken off the ventilator and died twelve hours after admission.

In 2008, Dr. D. Sontheimer⁵¹ treated a 52-year-old nurse who was admitted because of a massive insulin overdose. She had been treated and hospitalized in the past for depression and suicidal ideation. She had consistently told her family that she wanted to live only until her children were grown. Her children were adults and her family described her life as "one of torment." She was initially treated and stabilized, put on a ventilator, and was in a coma. When she was found, she had an advance directive by her side that she had completed with an attorney two years earlier. The directive unambiguously called for treatment to be withdrawn. The family and the physicians respected her directive as the valid choice of the patient and withdrew the ventilator and fluids; she died six

days later. Again, the prognosis of the patient's quality of life, even if successfully treated, would have been unacceptable to her.

In 2004 in Illinois, Dr. Rinata Wagle⁵² discussed a 59-year-old man who shot himself in the face after suffering from chronic pain and bipolar depression. When the patient was admitted to the hospital, he was in a coma. He had not produced any written advance care directive. The family wanted treatment to be withdrawn, reasoning that the suicide attempt was the expression of the patient's desire to not be treated, made more emphatic by the severe disabilities he would suffer if he lived. There is a legal distinction that drove the Wagle case. In Illinois—unlike Colorado—a surrogate cannot forgo life-sustaining treatment on behalf of an incapacitated patient who has not made a written advance directive to that effect, unless the patient is permanently unconscious or has a terminal disease. Neither of those circumstances applied in this case, so the team was required to treat the patient.⁵³ He was treated back to capacity and asked what he wanted. The patient wanted to live. After six months of intensive treatment, he went home.

Waiting Periods

The reconciliation of autonomy and protective beneficence is achieved starting with a crucial initial treatment: a liberal dose of the tincture of time. For example, the reason for the initial seventy-two-hour mental health certification is for evaluation. That period can be renewed by the physician evaluating the patient and, if extended, the patient has the right to a hearing in front of a judge after ten days of the initial hold to challenge it.⁵⁴ Another example is the seventeen-day waiting period used by Oregon and Washington.

Another example of a waiting period related to end-of-life decisions comes from Texas. A physician there can refuse to honor a request for life-sustaining treatment if he or she concludes it will not prevent imminent death and is supported by the hospital ethics committee. Treatment nevertheless must continue for ten days, to give the patient time to agree or to find alternate treatment.⁵⁵

The Colorado living will statute previously had a seven-day suggested waiting period before withdrawing treatment.⁵⁶ However, in 2010, the legislature amended the statute and substituted a two-day waiting period before treatment could be withdrawn.⁵⁷ Both versions also have a five-day waiting period to convene a hearing if a challenge is filed.⁵⁸

These intervals also suggest a range of time needed to investigate and understand the true nature of a patient's position and best interests. This is further discussed below and summarized in the accompanying sidebar.

Ken's Case

Ken's suicide attempt left him with an anoxic brain injury, in a coma, and unresponsive, but not brain dead. (If a person is brain

Suggestive Legal Waiting Periods to Implement End-of-Life Choices

Colorado Mental Health Certification	Colorado Living Will	Oregon Death with Dignity	Washington State Death with Dignity	Texas Refusal to Treat
3 to 10 days	2 days (7 days pre-2010)	17 days	17 days	10 days
CRS § 27-65-105	RS § 15-18-107	ORS 127.850 § 3.08	RCW 70.245	Code § 166.052

dead, he or she is dead, clinically and legally.⁵⁹) After a few days, a consensus emerged that Ken was not going to recover a functional life, though he could live on a ventilator in a bed. His biological life would continue, but his biographical life was essentially over. This is the physician's case note:

Expected Course of Illness: The patient may only make minimal neurological recovery, and per neurology, "His prolonged coma with no improvement is not a good prognostic sign" and [he] is unlikely to regain consciousness, although he does have signs of cortical function. [He is not brain dead.] He will likely continue to require complete care and medical support.⁶⁰

As in the earlier published cases, poor prognosis is a crucial factor. However, this may be accepted by the medical staff sooner than by the loved ones of the patient. The social and familial evaluation is vitally important. Ken was attended in the hospital by his mother, a sister, a brother, and two mothers of his children. When Ken was admitted to the hospital, there was a great deal of anguish and intra-family conflict.

Ken had unambiguously communicated to his family that he would not want to be kept alive on a ventilator. Thus, he did not want the treatment he was receiving. In ordinary circumstances, that would control the outcome. However, the countervailing ethical principles and legal sanctions cannot be ignored. Protection of the helpless from harm is the fundamental mission of medicine in particular, and of the state in general.

Ken had never named a medical decision maker. No one had preeminent authority to make decisions. Colorado has a proxy statute to deal with such situations, which allows for interested persons to elect a decision maker among themselves. Only Colorado and Hawaii have no priority of appointment in the law—not even a spouse has a categorical priority.⁶¹ The law calls for appointment of the person "most likely to be currently informed of the patient's wishes regarding medical treatment decisions."⁶² If appointment of the proxy had been rushed, it could have led to increased tensions within this family, who were in disagreement as to what should be done about Ken.

The treating team did not force the appointment of a proxy at the beginning, even though that would have been the most conservative and literal interpretation of the proxy law. Instead, they worked with the family for several days until a consensus emerged as to what needed to be done, and who would be the proxy. Tensions dissipated and the family came together. A forced proxy might have produced perceived winners and losers. The proxy law was not strictly followed, which is why this case highlights the principles of equity as adjustments to literal legality. As Aristotle put it: "This is the nature of the equitable, a correction of law where it is defective owing to its universality."⁶³

On day thirteen, Ken's sister had become the consensus proxy decision maker, and the family had reached a consensus to allow Ken to die. The sister gave informed consent to remove Ken from the ventilator and he died in hospice care soon after. Clinical skill, compassion toward the family, respect for the ethical imperatives, and guidance from the law brought this travail to its ultimate conclusion.

Conclusion

Hospital counsel and risk managers should hesitate before reflexively promoting a strict and speedy compliance with statutory imperatives by physicians. Bioethicists and patient advocates

should balance autonomy with beneficence in protecting the patient. Physicians should allow clinical and social consensus to naturally emerge in the confidence that the purpose of ethical and legal directives is always to benefit the patient, so that best clinical practices can be followed.

Notes

1. Stone, *Suicide and Assisted Suicide* 69 (Carroll and Graf, 1999).
2. Colt, *The Enigma of Suicide* 392 (Summit Books, 1991).
3. CRS § 18-4-401(1)(a) ("theft" is defined as exercising "control over anything of value of another without authorization").
4. Law and ethics converge, because laws embody related ethics. For example, a living will embodies and extends one's autonomy. The author calls this "*Lawthics*: Law is congealed ethics."
5. See, e.g., *Perreira v. State*, 768 P.2d 1198, 1215-16 (Colo. 1989) (recognizing this principle as the basis for involuntary commitment of a mentally ill person).
6. CRS § 27-65-102(9)(a)(I) (Care and Treatment of Persons with Mental Illness).
7. CRS § 27-65-105 (Emergency Procedure).
8. "Physician" in this article stands for all healthcare professionals. In ideal medical treatment, autonomy and beneficence are not in conflict. A patient needs a physician's expert guidance, and a physician needs a patient's input. In this shared decision-making process, respectful physician beneficence helps ensure the successful exercise of a patient's autonomy.
9. Gifford, "Primum Non Nocere," *JAMA* 589-90 (Aug. 1977).
10. *Cruzan v. Director, MDH*, 497 U.S. 261, 302 (1990).
11. See, e.g., Resnick and Sorrentino, "Competence vs. capacity: an analysis for medical professionals," *XXIII Psychiatric Times* (Dec. 2005) ("This article addresses the difference between competence (as a legal concept) and capacity (as in capacity to give informed consent for medical treatment).").
12. The statute for proxy decision makers uses "decisional capacity," CRS § 15-18.5-103(3) and (5). "Incapacity" is used in the guardianship statute, CRS § 15-14-304. "Decisional capacity" is used for CPR directives, CRS § 15-18-102. "Disability" and "competency" are used in the medical durable power of attorney statute, CRS § 15-14-501(1).
13. CRS § 15-14-102(5) (Persons Under Disability—Protection).
14. *Cruzan*, *supra* note 10 at 278.

15. Public Agenda Research Organization, “State laws on advance directives,” available at www.publicagenda.org/charts/state-laws-advance-directives.

16. 42 USC §§ 1395cc(a)(1), 1396a(a), and 1395mm(c).

17. The oldest directive, a Living Will, expresses specific preferences only if one is terminally ill or in a persistent vegetative state. CRS § 15-18-104. A Health Care Agent is a substitute decision maker explicitly appointed by a Medical Durable Power of Attorney. CRS § 15-14-506. A Proxy who best knows the patient’s wishes is elected after incapacity. CRS § 15-18.5-103 (because the Proxy is not chosen directly by a patient, strictly speaking it is not an advance directive). A Designated Beneficiary has priority to be a proxy decision maker. CRS § 15-22-105(3)(f). A CPR Directive instructs pre-hospital and emergency personnel to withhold CPR. CRS § 15-18.6-104. The newest directive, M.O.S.T. (Medical Orders for Scope of Treatment), aspires to consolidate patient preferences. CRS § 15-18.7-103. Guardianship is the longest established method providing surrogate medical care decisions for another, but it is not the expressed wishes of a patient and thus is not relevant to this article. A guardian may “consent to medical or other care.” CRS § 15-14-315(d).

18. CRS § 12-36-117(1)(s) (Unprofessional Conduct).

19. CRS § 12-36-118(5)(g)(III).

20. C.J.I. 15:7-9 (2011), Operation or Treatment Without Consent of Patient. See also *Eslander v. Cramer*, 903 P.2d 1171, 1173 (Colo.App. 1995) (“A physician who operates on a patient without the patient’s consent, or who performs an operation different from that to which the patient consented, commits a battery and is liable for [money] damages resulting therefrom. . .”).

21. CRS § 12-36-102.5(7).

22. CRS §§ 12-38-101 *et seq.*

23. Beauchamp and Childress, *Principles of Biomedical Ethics* 228 (4th ed., Oxford University Press, 1994).

24. Stone, *supra* note 1, citing Wallace and Eser, eds., *Suicide and Euthanasia* 74-76 (University of Tennessee Press, 1981).

25. *Id.* at 16-17.

26. Savage, “Amid Hunger Strike, Obama Renews Push to Close Cuba Prison,” *The New York Times* 1 (May 1, 2013).

27. *Id.* at 3. This also is reflected in international norms that state:

Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially.

This is the declaration of the World Medical Association (WMA), of which the American Medical Association is a member. “WMA Declaration of Tokyo—Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment” (rev. May 2005), available at www.wma.net/en/30publications/10policies/c18.

28. CRS § 18-3-104(1)(b). Manslaughter is a class 4 felony, punishable by a fine of \$2,000 to \$500,000, two to six years in prison, and three years of mandatory parole. CRS § 18-1.3-401(1)(a)(III)(A) and (V)(A).

29. CRS § 18-3-104(3). This is congruent with the living will statute, CRS § 15-18-111: “The withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to this article shall not, for any purpose, constitute a suicide or a homicide.”

30. Thus, it is said that the law is merely a floor, not a ceiling. See, e.g., *Caperton v. A.T. Massey Coal Co., Inc.*, 556 U.S. 868, 889 (2009). The U.S. Supreme Court ruled that although due process mandated a certain irreducible level of protection against legal conflicts of interest (the floor), states were free to enact greater protections (raising the ceiling).

31. *Black’s Law Dictionary* 213 (7th ed., West, 1999).

32. Warren and Brandeis, “The Right to Privacy,” 4 *Harvard L.Rev.* 1 (Dec. 15, 1890).

33. Friend, “Jumpers,” *The New Yorker Magazine* 55 (Oct. 13, 2003).

34. *Id.* at 51.

35. Suominen *et al.*, “Completed Suicide After a Suicide Attempt: A 37-Year Follow-Up Study,” *American J. Psychiatry* 562-63 (2004).

36. Owens *et al.*, “Fatal and non-fatal repetition of self-harm: systematic review,” *British J. of Psychiatry* 193-99 (2002).

37. Golden Gate Bridge Highway and Transportation District, available at goldengatebridge.org/research/factsGGBDesign.php.

38. Blaustein and Fleming, “Suicide From the Golden Gate Bridge,” *Am. J. Psychiatry* 1116 (2009).

39. Audi, ed., *The Cambridge Dictionary of Philosophy* 855 (2d ed., Cambridge University Press, 1999).

40. *Bailey v. Lincoln General Ins. Co.*, 255 P.3d 1039, 1056 (Colo. 2011) (homicide, kidnapping, and so forth are *malum per se*).

41. *Kelley v. Sonny Boy*, 491 P.2d 67, 69 (Colo.App. 1971) (a contract prohibited by statute but not immoral is merely *malum prohibitum*).

42. “Maha-parinibbana Sutta” (DN 16), verse 56, available at www.accesstoinsight.org/tipitaka/dn/dn.16.1-6.vaji.html.

43. Plato, “Crito,” *The Collected Dialogues of Plato* 31; “Phaedo,” *The Collected Dialogues* 96-97 (Princeton University Press, 1973).

44. John 10:18, *New International Version* (Biblica, 2011).

45. ORS 127.850. Montana also has established a right to die by court decision, *Baxter v. State*, 224 P.3d 1211 (Mont. 2009), but it has not been formally codified into statute.

46. RCW 70.245.

47. See “Oregon Ballot Measure 16 (1994), available at [en.wikipedia.org/wiki/Oregon_Ballot_Measure_16_\(1994\)](http://en.wikipedia.org/wiki/Oregon_Ballot_Measure_16_(1994)). The law was upheld by the U.S. Supreme Court in *Gonzales v. Oregon*, 546 U.S. 243 (2006).

48. “Results from the 2008 National Survey on Drug Use and Health: National Findings” (DHHS Publication No. SMA 09-4434, NSDUH Series H-36) (Substance Abuse and Mental Health Services Administration). The rate of suicide has increased to such an extent that as of 2009, more Americans died from suicide than from motor vehicle crashes. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 62 *Morbidity and Mortality Weekly Report* 1 (May 3, 2013).

49. Marks *et al.*, “Case Report: Are Clinicians Obligated To Medically Treat a Suicide Attempt in a Patient with a Prognosis of Weeks?” 15 *J. of Palliative Medicine* 134 (2012).

50. Bania *et al.*, “Ethics Seminars: Health Care Proxies and Suicidal Patients,” 10 *Academic Emergency Medicine* 65-66 (Jan. 2003).

51. Sontheimer, “Suicide by advance directive?” *J. Medical Ethics* (2008).

52. Wagle *et al.*, “An Ethical Dilemma: When the Family Wants the Withdrawal of Care,” 10 *J. of Psychiatric Practice* (Sept. 2004).

53. 755 ILCS 40/10; 755 ILCS 40/20(B)(1); 755 ILCS 40/25.

54. CRS §§ 27-65-105(1)(a)(I) (Care and Treatment of Persons with Mental Illness—Emergency Procedure), and -107(6) (Care and Treatment of Persons with Mental Illness—Certification for Short Term Treatment).

55. Tex. Health & Safety Code Ann. § 166.052, Advance Directives.

56. CRS § 15-18-104(3).

57. CRS § 15-18-107.

58. CRS § 15-18-108(2)(b)(I).

59. CRS § 12-36-136, Determination of Death; Torpy *et al.*, “Brain Death,” *JAMA* (2009).

60. Provided by the treating physicians.

61. CRS § 15-18.5-103(3).

62. CRS § 15-18.5-103(4)(a).

63. Aristotle, “Moral Virtue,” in *Nicomachean Ethics*, Book V, William David Ross, trans. (Clarendon Press, 1908). ■

