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# How Society Handles Self-Imposed Death

## A Perspective

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*Declaration of bias from the author: I believe that those considering/recovering from a suicide attempt should always be met with love and acceptance, as suicide is a faulty solution to a problem that requires phenomenal patience to address.*

Ifeanyi Ugokwe, a twenty-five-year old Nigerian man living in Lagos, Nigeria, attempted to take his own life. Hungry and unable to find a job for weeks, a rough dispatch from a failed worksite sent Ugokwe into a spiral of desperation, resulting in an altercation with a security guard prior to leaving the jobsite. Humiliated, hungry, and tired, Ugokwe deemed he could no longer persist in this way and attempted to drown himself in the nearby Lagos Lagoon. Pulled from the water by a group of fishermen, Ugokwe was transferred to police officers, who, in line with Nigerian penal code, placed him in a prison cell for weeks, subject to abysmal conditions typified by overcrowding, sedation, and abject maltreatment. Only through a number of fortuitous encounters with beneficent legal help and charities was Ugokwe able to evade the standard fate of similar “criminals” who are imprisoned for a maximum of one year for having failed a suicide attempt (Busari 2018).

This sort of system, in which individuals who fail in their attempts at suicide face criminal consequences, is not the norm, per se, but assuredly not in the vast minority. Ten countries, comprising approximately thirty-five percent of the population of the continent of Africa, maintain some form of this law in their penal code with different degrees of enforcement. On the whole, forty-five nations of varying economic conditions and geographic locales maintain these sorts of rules on the books (Mishara and Weisstub 2016). In this—a most intimate and often self-initiated action—a single question inevitably rises: Who holds power or control in this situation? In other words, who, or what, leads in the address of self-initiated death?

Within the realm of ethics, one considers the ramifications of an action. This perception, which is well equipped for interacting with many of the largest questions that our society faces, tends to fall short with regard to death,

insofar as ethics considers a set of circumstances that predicate a finite direction or action (Steffen and Cooley 2014, 1–6). Yet, it is certainly within the Western view of death (partly influenced by cultural and religious bearing) that such an event is quite the opposite of an action, in that it is the silent conclusion of the prolonged action of life. This tends to serve us well on the whole. However, it can act as a hindrance to a discourse about death as an impacted and influenced entity (Steffen and Cooley 2014). Thus, I implore you to view death as the final decisive action of life, in that death may adopt the philosophical space and weight to be analyzed and acted upon through ethical decision making.

With that in mind, it is important, as in psychology and other sciences, to operationally define a term that will become critical to this portrayal. The term “self-imposed death” allows for the dialogue about death to be endowed with a degree of action and license that might not otherwise be considered. In this way, we can understand the power dynamics, or leadership, that dictates the conduct involved in the action of self-imposed death. In this discussion, self-imposed death as a descriptive umbrella term will include suicide as well as medical aid in dying.

Such an action as self-imposed death naturally lends itself to a counterpart, one which will be called “externally imposed death.” Although externally imposed death is not the subject of this article, to strike a comparison with self-imposed death is necessary, especially when considering the power dynamics involved in both. Homicide, infanticide, genocide, xenocide, etc. are all regarded as forms of externally imposed death. Common among them is that death is composed primarily as an action by one or some onto other/s. Additionally, all of these different forms of externally imposed death maintain that they are condemned in a turn of moral universalism, regardless of societal background or national governing body (Jankowiak). With regard to ethics, to broadly accept externally imposed death would, among a battery of justifications, elicit a catastrophic violation of Immanuel Kant’s moral view of the world, in which an action is justified as morally good if it can be applied beneficially through the whole of society. It doesn’t take much of a mental leap to note that everyone killing each other would be grossly detrimental to society, given there would unlikely be any society remaining to speak of (Jankowiak).

What sort of position do governmental bodies—the bastions of society within their own borders—have on the issue of externally imposed death? Although this topic in itself may merit a longer ethical discourse, to our ends

we adopt the perspective that nations, for any number of reasons, have varying positions on the matter. On one end of the spectrum, governments, like in most first world nations, do not award themselves the ability to exercise externally imposed death on their citizenry. Yet, the opposite is the case in other nations, such as the United States, China, Russia, and a majority of African and Asian nations (BBC News 2018). Another question with comes in response: What justification do nations provide to inflict legal death on their citizens, given such a unanimous condemnation? In short, governments widely reserve such a decisive punishment exclusively for the most severe of crimes, and justify the punishment in itself as having spread the responsibility of such an externally imposed death into infinitesimally small allotments among the whole of a tacitly complicit citizenry. In short, governments have differing ideas on how violable the notion of externally imposed death is, yielding complex ramifications for ethical leadership in self-imposed death (Van den Haag 1986).

Suicide, when considering the layers of self-imposed death, seems to be what many would consider to be its very poster child and is generally discouraged. However, most governments worldwide recognize the ability of their citizenry to act in accordance with their wants. In the United States Declaration of Independence, all citizens reserve the right to “life, liberty, and the pursuit of happiness.” Given such a seemingly broad and low bar for fulfillment, the individual follows these guidelines in daily life as dictated by their free will. This autonomy of action and thought is widely enjoyed by individuals, utilizing the catalog of their personal experiences and the dictates of their culture to proceed in their own best interest.

In a society that strictly governs according to this notion, what barrier would stand in the way of a person committing suicide while acting in adherence to their own free will? In this, leadership—or the true legislative power of the execution of self-imposed death—lies wholly within the individual. This circumstance lies in a hypothetical and impossible vacuum in which an individual acts solely within one’s physical and mental parameters. Yet, the impossibility of this situation, or at least, the attempt to achieve this state of being, is not lost with regard to established governmental bodies. Considering that, in the most immediate sense, self-imposed death implicates only one individual (or citizen) in the act of instigator and recipient, we see that many governments do not enact legislation on suicide, even after failed attempts, given that its realm of disruption remains contained and would not promote a public upheaval. A large portion of this stance

can be generalized to the secularization of governments removing themselves from socially dictated societal constructs (Behere, Sathyanarayana Rao, and Mulmule 2015). The closest approach of a broad governmental leadership to the item of self-imposed death within these structures is the abetting of the act, which is illegal and felonious in a majority of nations (Mishara and Weisstub 2015). This comes as no surprise, as this would tend to fall within the parameters of externally imposed death, given one acts in causality with the death of another.

Yet, in this situation, we find another form of governance acting on the incidence of self-imposed death. Morals, and the morality of self-imposed death, guides much of a person's choices in life, and discussions of self-imposed death should be addressed no differently. When external collaborative governmental bodies abstain from legislation against suicide, only moral parameters act to mediate an individual inclination or declination to suicide. Since the moral parameters of suicide as a form of self-imposed death manifest in the acting individual, it is important to ask where these moral values were established.

The easiest and simplest answer to this question lies within the environment in which we live. Again a topic of enormous psychological weight that merits its own volumes, I would like to introduce the notion that the environment in which we are raised acts as a form of incubation toward a certain line of thought, translated into action. Our morals, or, our general sense of right and wrong, are not something that is fully intact as we come out of the womb. Instead, morals are in significant part cultivated and grown with the guidance of others. Who acts as the farmer who nurtures the formation of morals and possesses partial ownership over the product? There is no simple answer to this question, nor does the same party maintain the same degree of sway over a long period of time. For juveniles, in which autonomy of the individual is at least partially vested in the youth's guardian, morality is in accordance with the parental body. What that dictates is beyond summary in its breadth, but we often look to religion, socioeconomic status, and the parent's personal history as common actors in the cultivation of morality (Lyons 1983).

To recap, we have introduced three primary actors in the imposition of suicide: an unencumbered deference to free will, parameters placed by societal morality, and governmental dissuasion (or lack thereof). These three primary actors are inseparable from each other with regard to the citizenry, although the exact details and priorities of each vary from person to person.

Given the vastly individual nature of suicide as a form of self-imposed death, the intervention of government may seem a secondary or unusual contributor to the issue's composite ethical leadership. Governmental intervention provides the means through which unassociated individuals, through a generally beneficent, communal infrastructure, maintain an implicit right to make a decision—a form of leadership—with regard to the possible suicide of another of their own.

With that in mind, how can a governmental body lead ethically with regard to self-imposed death? Should a failed suicide attempt be punishable by law? What moral justification would reinforce that choice? Considered in a different and hypothetical way, would it be morally justifiable for a government, barring logistical restrictions, to posthumously punish an individual who had committed suicide? These questions, I believe, are critical to understanding our own values about ethical leadership with regard to suicide.

To many, myself included, suicide seems abrupt and internally disruptive, even if not seen that way by large institutional influences such as governmental bodies or societal constructs. Generally speaking, it may seem as though suicide is a loss of potential, a future unknown and lost, an unrealized ability for general good. But how do we address self-imposed death when the actor is presented with the unavoidable reality of impending death? In other words, what is the proper and ethical address of medical aid in dying, in which a terminally ill patient chooses to autonomously end their life?

Before leading into the dialogue of ethical ramifications on this topic, it is important to first address what medical aid in dying is. According to the Canadian Public Health Association, “medical aid in dying” is defined as “care consisting in the provision, by a medical professional, of ‘medications or substances to an end of life patient, at the patient’s request, in order to relieve their suffering by hastening death’” (Canadian Public Health Association 2016). This also goes by terms such as “medical assistance in dying,” “death with dignity,” “physician-assisted dying,” and “physician aid in dying,” among others. The typical process—at least within the eight US states and the District of Columbia (plus New Jersey, pending governor’s approval as of March 2019) that have made this practice legal—tends to be fairly consistent between states as well as among the eight nations worldwide that in some capacity permit medical aid in dying (Dignitas 2018). Oregon state law, the basis for similar American legislation, dictates, in summary, that a patient must a) have a terminal diagnosis of less than six months, b)

be of clear medical decision making capability, c) have expressed in writing their intent with a witness, and d) administer the lethal dose with no assistance (Oregon State Legislature 1994).

What is particularly fascinating about medical aid in dying is that conversation in support of the topic elevates the process of death to a conscientious action that derives its justification from one's ethical standing. Where this was an abstraction for ease of discussion, particularly with the use of the term "self-imposed death" earlier, it is actually a situational reality with regard to medical aid in dying. Ethical decision making concerning this process assuredly occurs in two primary locations on the microscale: the diagnosing/prescribing physician (as a proxy for the greater healthcare infrastructure) and the patient. Although vitally important and hotly contested within the healthcare profession, the choice to either prescribe or administer lethal dosage is left to decision making on an individual basis. In a baseline research survey among medical students in Canada—a nation in which medical aid in dying is legalized—eighty-eight percent supported a Supreme Court decision to strike down a ban on medical assistance in dying, sixty-one percent would personally provide the means for a patient to end their life by legal means, and thirty-eight percent would administer a lethal injection to candidates for medical aid in dying (Bator, Philpott, and Costa 2017).

This cues into the crux of the issue of medical aid in dying with regard to ethical leadership. At face value, this seems to violate the seemingly universal wrong of externally imposed death, in that the medical provider abets the accelerated self-imposed death of a patient. Yet, governmental bodies, in their ability to impose legal punishment, provide an initial judgment on the matter, be it deterrence or tacit advocacy through legal moderation of the process. Within governments that punish suicide, through legal mandate or through Sharia law, this debate is easily concluded. There is no precedent or space within the governmental atmosphere for self-imposed death and so medical aid in dying is quickly dismissed and deemed felonious through existing channels of externally imposed death punishments. However, the waters of ethical leadership are murkier in countries that do not punish suicide.

In order to understand the moral parameters of suicide, governments must weigh whether they should focus on the sanctity of autonomous action by the individual or on the possible condemnation by morally contrarian societal structures in their choice of legislative action. Both maintain immense sway within the individual choice to conduct medical aid in dying, yet, it is through external leadership provided by a government's

ethical stance that provides a dictum for action. The system implemented in most nations that allow medical aid in dying (with a notable exception in the Netherlands, which allows for euthanasia unencumbered) is designed to maintain clearly defined boundaries that maintain autonomy of the execution of death with dignity. These proceedings provide an interesting dichotomy, in which willing physicians partake in the proceedings of medical aid in dying, yet the governmental apparatus inhibits them from active participation, despite a patient who actively supports the concept. Medical aid in dying, on the whole, maintains a similar balance of ethical leadership regarding individual and societal influence, despite a much more nuanced and fluctuating governmental opinion.

In conclusion, a few general questions arise: What reliably leads ethical decision making in self-imposed death? Can any corollary of ethical leadership be reliably applied to self-imposed death on a universal level? The short answer is that the complexity of the human spirit seems to limit the individual's action of self-imposed death, reliant on each individual's unique collection of events and their context to provide a seemingly correct moral action. This is not to say that trends never arise, in reference to the moral universalism in opposition of externally imposed death or an abstract deference to personal fulfillment through independent action. Yet, no one form of ethical leadership, through free will, moral guidance by societal cues, or external governmental mandate, is fully free from the other. If anything, these three act analogously to the primary colors, which mix and intermingle to create a vastly colorful backdrop to the occurrences that make up the concept of identity. It is this collection of experience within a combination of contexts that dictates every living action as a human, and so guides the ethical decision making of self-imposed death.

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