



Review Article

Religious, Ethical, and Spiritual Considerations in Individuals Who Attempt Suicide by Intentional Poisoning: A Narrative Review

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ABSTRACT

Background: Intentional self-poisoning is a clinical toxicology emergency that may also raise questions about 16 suicide risk, capacity, ethics, law, spirituality, family context, and prevention after survival. The primary objective of this research is to integrate perspectives from clinical toxicology, medical ethics, law, philosophy, religion, spirituality, psychology, public health, and social-familial domains regarding individuals who attempt suicide through intentional poisoning (an interdisciplinary study).

Methods: A narrative review was conducted using the article's original literature base (1999–2025). The search strategy covered PubMed/MEDLINE, Google Scholar, ScienceDirect, SpringerLink, SID, Magiran, and NoorMags, supplemented by official primary-authority sources from Shi'a maraji', Sunni fatwa institutions, the Vatican/USCCB, the World Medical Association, WHO, and NICE. Search concepts combined suicide/self-harm, intentional self-poisoning/poisoning, medical ethics, treatment refusal, decision-making capacity, confidentiality, spiritual care, Islamic ethics, Shi'a jurisprudence, Sunni jurisprudence, euthanasia, and physician-assisted suicide. Sources were screened for relevance, traceability, authority, and direct applicability to the review question.

Results: The evidence supports a consistent clinical principle across contemporary guidance: patients who self-poison should receive appropriate medical treatment, privacy, non-punitive care, and timely psychosocial assessment. Religious sources examined here generally prohibit intentional self-killing, but they differ in terminology, jurisprudential reasoning, and treatment of responsibility, especially where severe psychological disturbance may affect responsibility. Contemporary bioethics distinguishes suicide attempts from capacitated treatment refusal and from euthanasia or physician-assisted suicide. These distinctions are essential in poisoning emergencies.

Conclusion: Religious and ethical perspectives should inform, but not replace, evidence-based toxicological and psychosocial care. An interdisciplinary, patient-centered continuum from acute poisoning treatment through structured follow-up may support the prevention of recurrent intentional self-poisoning.

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Introduction

Intentional self-poisoning is simultaneously a medical emergency and a multidimensional clinical, ethical, psychological, social, legal, and spiritual problem. Clinical toxicology therefore provides the immediate treatment framework. At the same time, safe and respectful care may require collaboration across medical ethics, psychology/psychiatry, philosophy, religious and spiritual studies, public health, and family/social care.

This review's clinical anchor is intentional self-poisoning as a presentation in clinical toxicology and emergency medicine. The religious, philosophical, ethical, legal, psychological, and social perspectives reviewed here are examined insofar as they inform decisions arising in the care of a patient who has intentionally ingested a potentially harmful substance, including acute stabilization, risk and capacity assessment, confidentiality, treatment refusal, family involvement, spiritual support, discharge planning, and prevention of recurrent self-poisoning.

These distinctions are clinically important. A patient who survives an overdose and subsequently refuses a particular intervention is not automatically refusing all care, nor is treatment refusal automatically evidence of continuing suicidal intent. Conversely, a patient who lacks decision-making capacity because of intoxication, delirium, severe physiological compromise, or another condition may require temporary protective intervention under the applicable legal and ethical framework. Capacity is decision-specific and time-specific, not a global label (Table 1).

Methods

This study is a narrative review with a structured, reproducible search and source-verification component. It covered publications from 1378 to 1404 SH (1999–2025). The review was not presented as a formal systematic review or meta-analysis. The study complied with ethical principles and national norms and standards for conducting Medical Research in Iran: IR.ARI.MUI.REC.1405.170.

The search was conducted across PubMed/MEDLINE, Google Scholar, ScienceDirect, SpringerLink, SID, Magiran, and NoorMags. In addition, primary or institutional sources were searched directly when a normative claim concerned religious jurisprudence, professional ethics, or clinical guidance. These included the official office of Ayatollah Ali al-

Table 1. Conceptual definitions.

Term	Operational distinction
Suicidal ideation	Thoughts, wishes, or preoccupation concerning suicide; ideation does not by itself establish that an attempt has occurred.
Self-harm	For the NICE guideline, intentional self-poisoning or injury irrespective of apparent purpose. Thus, self-harm is broader than a suicide attempt.
Suicide attempt	A self-injurious act with at least some intent to die; intent may be difficult to establish retrospectively and should be assessed rather than assumed.
Intentional self-poisoning	Deliberate ingestion or exposure to a substance with self-harm or suicidal intent, although the apparent purpose may be ambiguous.
Treatment refusal	A patient's decision not to accept a proposed medical intervention. Ethical validity depends on decision-making capacity, voluntariness, adequate information, and applicable law; it is not synonymous with suicide.
Euthanasia	Deliberate administration of a lethal intervention by another person, usually a physician, with the intention of causing death at the patient's voluntary request.
Physician-assisted suicide	A physician intentionally provides the means for a patient with decision-making capacity to end their own life; the patient performs the final act.

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Sistani; official Sunni fatwa institutions such as Egypt's Dar al-Ifta and Jordan's General Iftaa Department; The Vatican/The United States Conference of Catholic Bishops (USCCB); the World Medical Association (WMA); the World Health Organization (WHO); and the National Institute for Health and Care Excellence (NICE).

English and Persian/Arabic equivalents of the following concepts were combined with AND/OR: suicide, suicidal ideation, suicide attempt, self-harm, intentional self-poisoning, poisoning, overdose, toxicology, treatment refusal, informed refusal, decision-making capacity, confidentiality, involuntary treatment, spiritual care, religious ethics, Islamic bioethics, Shi'a jurisprudence, Sunni jurisprudence, euthanasia, physician-assisted suicide, and end-of-life care. Because database syntax varies, the exact string was adapted to each platform; the core PubMed structure was: (suicide OR suicidal ideation OR suicide attempt OR self-harm) AND (poisoning OR self-poisoning OR overdose OR toxicology) AND (ethics

OR religion OR spirituality OR capacity OR consent OR confidentiality OR treatment refusal OR euthanasia OR physician-assisted suicide).

Included sources addressed at least one of the following: (a) intentional poisoning or self-harm; (b) ethical decision-making in suicide attempts; (c) religious or jurisprudential views relevant to suicide, treatment, or preservation of life; (d) capacity, consent, confidentiality, involuntary treatment, or end-of-life ethics; or (e) spiritual care and clinical implications for patients after self-harm. Primary legal, religious, and institutional documents were eligible if issued by an identifiable authoritative body. We excluded sources that could not be traced to a reliable bibliographic or institutional record.

We screened titles and abstracts for relevance, then verified potentially eligible sources in full text. For each retained source, we recorded the year, author/institution, source type, population or doctrinal scope, principal finding/position, and relevance to intentional poisoning or clinical ethics (Table 2, Figure 1).

Because this is a narrative review, a single quantitative risk-of-bias score was not assigned across heterogeneous source types. Instead, sources were classified by authority and traceability: (1) primary religious/legal/professional authority; (2) peer-reviewed systematic review/meta-analysis; (3) peer-

reviewed empirical or clinical study; (4) peer-reviewed conceptual/ethical review; and (5) secondary or non-peer-reviewed material. High-impact normative statements were retained only when supported by category 1 sources or by identifiable peer-reviewed scholarship.

Results

Contemporary Medical Ethics and Clinical Toxicology

WHO guidance states that people who attempt suicide should receive necessary medical care, monitoring, and psychosocial support, and be treated with the same care, respect, and privacy as other patients rather than punished. NICE NG225 similarly recommends concurrent physical healthcare and psychosocial assessment after self-harm, including intentional self-poisoning [1, 2].

Capacity should be assessed for the specific decision at the specific time. The presence of suicidal ideation, mental illness, substance use, or disagreement with the clinician does not, by itself, establish incapacity. When capacity is impaired, and an immediate life-threatening emergency exists, clinicians should follow applicable emergency and mental-capacity law and adopt the least restrictive, clinically appropriate approach. When capacity is intact, a patient may have a legally and ethically relevant right to refuse

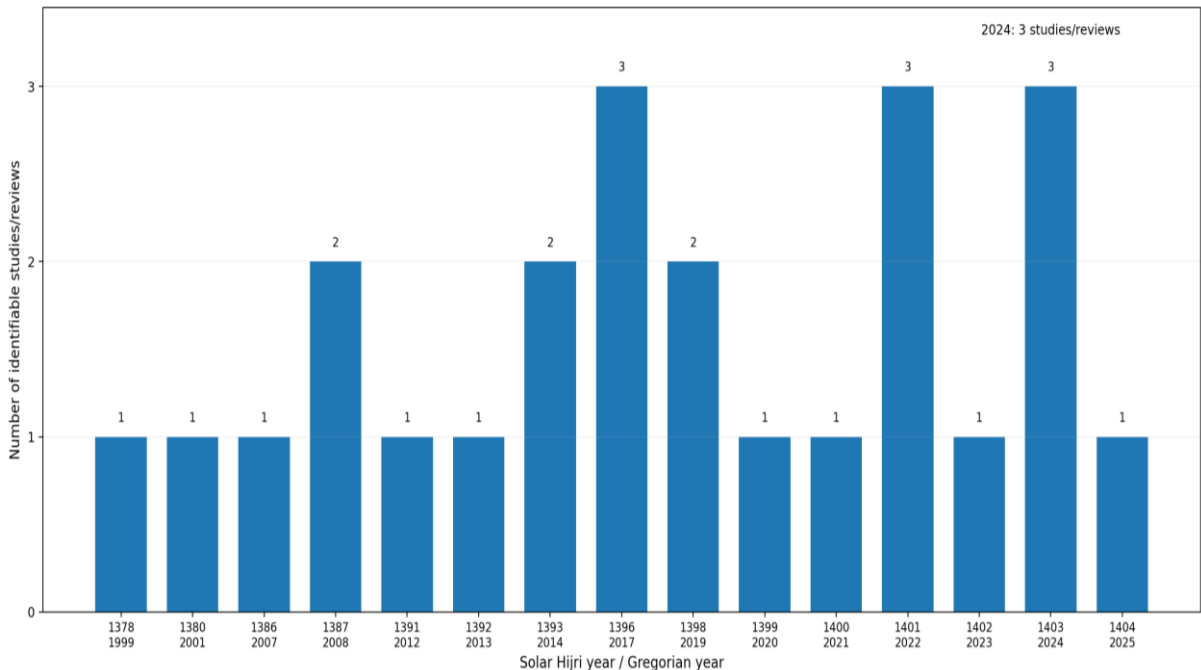


Figure 1. Chronological distribution of identifiable studies, 1378–1404 SH (1999–2025). The figure is descriptive and does not measure evidence quality.

a particular intervention; this is conceptually distinct from a request for euthanasia or physician-assisted suicide. Clinicians should clarify what is being refused, why, whether the patient understands the expected benefits and burdens, whether the decision is stable and voluntary, and whether intoxication, delirium, hypoxia, severe pain, or acute psychiatric symptoms are impairing capacity. The therapeutic relationship should be preserved even when a particular intervention is declined. However, confidentiality is not absolute when disclosure is legally required or necessary to address a serious and imminent safety threat. NICE recommends private psychosocial assessment and consideration of consent and safeguarding. Limit disclosure to information relevant to safety or care needs, and follow applicable laws and institutional policies. Involuntary intervention should depend on the patient's decision-making capacity, the immediacy and severity of risk, the nature of the proposed intervention, and applicable law. In jurisdictions where mental-health or capacity legislation authorizes protective treatment, the intervention should be legally grounded, proportionate, documented, time-limited where possible, and subject to reassessment. These concepts should not be used interchangeably with emergency treatment of poisoning. Refusal of treatment is not equivalent to suicide, and respecting a capacitated refusal is not equivalent to physician-assisted suicide. The World Medical Association (WMA) recognizes that a patient with decision-making capacity may refuse medical treatment. The clinician must determine what is being refused and whether the decision is informed and voluntary. This distinction is directly relevant to patients who survive intentional poisoning. The WMA and contemporary clinical ethics sources explicitly distinguish these concepts. Similarly, a clinician's duty to treat an overdose does not require continuing every intervention indefinitely against the valid wishes of a patient with decision-making capacity [3, 4].

The primary religious and earlier bioethics literature in the evidence base provides the conceptual foundation for this clinical approach. It situates privacy, confidentiality, autonomy, beneficence, non-maleficence, and respect for persons within clinical decision-making. Applied to intentional self-poisoning, the sources support balancing immediate life-preserving treatment with respect for the patient's rights and circumstances rather than treating the suicidal act as grounds for punitive care; however, a bridge between professional ethics and the religious context is considered [5-20].

In addition to medical ethics, the management of self-poisoning must consider socioeconomic factors (such as staff well-being), cultural context, and

behavioral problems [21-30].

Religious Perspectives

It is important to note that a religious prohibition should not be converted into an absolute claim that every individual who attempts suicide bears identical moral or legal responsibility. The Catholic Catechism, for example, explicitly states that grave psychological disturbance, anguish, or grave fear can diminish responsibility and rejects despair about the eternal salvation of a person who dies by suicide. In the Islamic sources reviewed for this revision, the primary authorities establish the prohibition of suicide; clinical determination of mental capacity and the legal consequences of incapacity remain distinct questions that the applicable clinical and legal framework must govern [5, 6].

[L026] Shi'a jurisprudence. The official website of Ayatollah Ali al-Sistani states that suicide is prohibited and considered a major sin. His published legal rulings also address the legal consequences of acts undertaken with suicidal intent, including a specific ruling concerning a person who injures himself with intent to commit suicide or ingests deadly poison and then makes a will. These primary-source rulings are preferable to broad statements about 'Islam' because they identify the jurist and the legal context [7, 8].

Sunni jurisprudence. Egypt's Dar al-Ifta states that suicide is prohibited in Islamic law and is a major sin, while also stating that a person who dies by suicide remains Muslim and is subject to the general rules governing Muslim burial. The same source explicitly includes poisoning among active means of suicide. Jordan's General Iftaa Department, a state religious authority operating within a Hanafi-influenced institutional tradition, likewise describes suicide as a major sin [9, 10].

For Muslim patients, clinicians may ask about religious preferences relevant to care without assuming a specific level of religiosity or a single interpretation of Islam. When a patient requests a religious ruling, refer to an appropriate, identifiable religious authority rather than making an unsupported jurisprudential statement.

The Catholic Catechism prohibits suicide while explicitly acknowledging diminished responsibility in severe psychological disturbance and emphasizing prayer rather than despair concerning salvation. The Church of England's contemporary institutional materials emphasize pastoral support for people at risk of self-harm and suicide. These examples are presented

Table 2. Selected Chronological Evidence-Based Studies, 1378–1404 SH. It distinguishes empirical studies, systematic reviews, ethics/jurisprudence reviews, and clinical references. Do not interpret the table as a bibliometric ranking; it is a transparent map of the key sources used in the revised synthesis.

Year (SH) / Gregorian / Ref. No	Author(s)	Title	Source	Type
1378/1999 / 11	Iserson	Principles of biomedical ethics	Emerg Med Clin North Am	Conceptual/ethics review
1380/2001 / 12	Kuhse & Singer	A Companion to Bioethics	Blackwell	Bioethics reference
1386/2007 / 13	Shirzad & Gharedaghi	Study of methods and causes of suicides resulting in death referred to the Legal Medicine Organization of Iran	Iranian Journal of Forensic Medicine	Iranian observational study
1387/2008 / 14	Ghoreishi & Mousavinasab	Systematic Review of Research on Suicide and Suicide Attempt in Iran	Iranian Journal of Psychiatry and Clinical Psychology	Systematic review
1387/2008 / 15	Hosseini et al.	The Principles and Standards of Medical Ethics and Their Compatibility with the Fundamentals of Islamic Ethics	Studies in Medical Sciences	Ethics study
1392/2013 / 16	Bidel et al.	Prevalence of important poisoning methods used in Iranian suicides: a systematic review and meta-analysis	Koomesh	Systematic review/meta-analysis
1393/2014 / 17	Madani & Madani	Ethical and practical considerations on refusal of medical treatment	Journal of Medical Ethics & History of Medicine	Ethics review
1396/2017 / 18	Mohammadi et al.	Patients' attitudes about privacy and confidentiality in selected hospitals in Tehran	Iranian Journal of Medical Ethics and History of Medicine	Cross-sectional study
1396/2017 / 19	Yavari & Parsapoor	The domain of autonomy, limitations, and solutions	Iranian Journal of Medical Ethics and History of Medicine	Ethics review
1396/2017 / 20	Rahaie & Heidari	Right to Choose between Life-Sustaining Treatments and Palliative Care in the Shiite Jurisprudential Perspective	Iranian Journal of Medical Ethics and History of Medicine	Jurisprudential review
1398/2019 / 21	Delirrad et al.	Status of clinical toxicology education and ethics in medical care of poisoned patients in Iran and comparison with other countries	Basic & Clinical Pharmacology & Toxicology	Clinical toxicology review
1398/2019 / 22	Moukarzel et al.	Burnout syndrome among emergency department staff: prevalence and associated factors	BioMed Research International	Observational study
1399/2020 / 23	Zhang et al.	Burnout in emergency medicine physicians: a meta-analysis and systematic review	Medicine	Systematic review/meta-analysis
1400/2021 / 24	Zarani & Ahmadi	Suicide in Iranian culture: A systematic review study	Rooyesh-e-Ravanshenasi Journal	Systematic review

Year (SH) / Gregorian / Ref. No	Author(s)	Title	Source	Type
1401/2022 / 25	Phillips et al.	Emergency Department Nursing Burnout and Resilience	Advanced Emergency Nursing Journal	Literature review
1401/2022 / 26	Monsef Kasmaei et al.	Comparative Study of Occupational Burnout between Professors and Residents of Emergency Medicine	Research in Medical Education	Comparative study
1403/2024 / 27	Baker et al.	Telehealth Brief Cognitive Behavioral Therapy for Suicide Prevention: A Randomized Clinical Trial	JAMA Network Open	Randomized clinical trial; indirect post-self-harm prevention relevance
1403/2024 / 28	Sharma et al.	Prevention of self-harm and suicide in young people up to the age of 25 in education settings	Cochrane Database of Systematic Reviews	Systematic review; indirect prevention relevance
1403/2024 / 29	Ahmadi et al.	Burnout in emergency nurses: A systematic review	Iranian Journal of Systematic Review in Medical Sciences	Systematic review
1404/2025 / 30	Royal College of Emergency Medicine & National Poisons Information Service	Management of patients with suspected but unidentified poisoning in the emergency department: joint best practice guideline	Emergency Medicine Journal	Clinical toxicology guideline

as named institutional perspectives, not as a claim that all Western Christians or all Western legal systems share one position [5].

Jewish ethical and legal traditions generally regard suicide as prohibited and place the preservation of human life among their highest duties. The principle of *pikuach nefesh* (preservation or saving of life) provides a central framework in Jewish law, under which protecting human life and health can take precedence over many other religious obligations when life is endangered. Contemporary Jewish discussions also recognize the importance of mental disturbance in assessing responsibility, as severe mental illness can affect the legal and moral classification of an individual act. In intentional self-poisoning, these principles are relevant to the immediate priority of preserving life, compassionate care, and avoiding punitive responses to the surviving patient [31, 32].

These Items are presented comparatively and descriptively, not as interchangeable or universally binding moral systems. At the same time, the immediate and ongoing management of poisoning remains grounded in clinical toxicology, emergency medicine, psychosocial assessment, patient rights, and

evidence-based prevention.

Islamic moral and mystical traditions: Nahj al-Balagha, Miskawayh, al-Ghazali, Rumi, and Saadi

Nahj al-Balagha offers a classical Islamic account of inward moral and spiritual self-care. In Sermon 198, Imam Ali describes *taqwa* as a remedy for the heart's illnesses and a means of purifying the inner self, linking spiritual vigilance to the heart's condition and to practical conduct. This passage can serve as a culturally grounded model of spiritual care. Still, it should not be treated as a clinical intervention or a substitute for toxicological, psychiatric, or psychosocial treatment [33]. Sermon 176 likewise emphasizes reflective self-control: the believer is described as considering speech before expressing it, while the broader counsel stresses restraint and ethical self-monitoring [34].

Ibn Miskawayh's ethical tradition emphasizes cultivating and preserving virtue and refining character; his *Tahdhīb al-akhlāq* addresses the preservation or recovery of the soul's virtues. Al-Ghazali develops the related concept of disciplining the soul (*riyādat al-nafs*), emphasizing habituation and the rational regulation of potentially harmful dispositions. Rumi's

mystical writings emphasize guidance, transformation, love, and overcoming self-centered preoccupations, while Saadi's moral literature emphasizes virtues such as generosity, truthfulness, forgiveness, humility, and ethically ordered social conduct. Regarding intentional self-poisoning, these traditions can serve as sources of moral and spiritual reflection on self-regulation, meaning, hope, interpersonal responsibility, and the preservation of health; they should not replace toxicological, psychiatric, or psychosocial treatment [37-42].

Comparison with Kantian ethics and the Hippocratic medical tradition

Kantian ethics places human dignity and humanity as an end in themselves at the center of moral reasoning, and Kant argues that no one can rationally will suicide to become a law. The Hippocratic tradition, within a different historical framework, emphasizes entering into patient care to help the sick, abstaining from intentional harm, and maintaining professional confidentiality. In intentional self-poisoning, these perspectives highlight the importance of preserving life, respecting dignity, avoiding additional harm, providing compassionate treatment, and protecting confidential information, while differing in their philosophical foundations [43-45].

Iranian Legal and Patient-Rights Context

In Iran, the legal analysis should not be reduced to the religious prohibition of suicide. Articles 958–960 of the Iranian Civil Code (Articles 958 to 960) recognize civil rights, link their exercise to legal capacity, and limit blanket renunciation of civil rights and liberty. These provisions do not, by themselves, provide a simple rule for every emergency treatment-refusal scenario; decisions about capacity, consent, emergency treatment, confidentiality, and protective intervention must therefore be interpreted in light of applicable medical regulations, the patient-rights framework, and other governing law [35].

The Iranian Patient Rights Charter also provides a relevant ethical context by emphasizing access to appropriate, safe care; adequate information; free decision-making within the legal framework; privacy and confidentiality; and respect for the patient's cultural and religious values. Accordingly, an Iranian clinical approach to intentional self-poisoning should combine urgent medical care with individualized assessment of capacity and risk, rather than treating the religious prohibition as automatic evidence of incapacity or as automatic authorization for coercion [36].

Spiritual Care and Cultural Competence

Spiritual care should be offered as supportive care rather than as religious coercion. This revised approach aligns with the principle that clinicians should ask whether the patient wants spiritual or religious support and, if so, whether they prefer a trained chaplain, clergy member, or another trusted person. Religious language may be meaningful to some patients but harmful or alienating to others. Therefore, spiritual care should be patient-led, nonjudgmental, and integrated with medical and psychosocial treatment rather than substituted for it [4].

In a clinical setting, the key implication is not to impose a religious interpretation on the patient but to recognize that some Muslim patients may understand recovery through concepts such as *taqwa*, remembrance, hope, repentance, and responsible self-care. When the patient seeks this framework, clinicians may connect them with an appropriate religious adviser while maintaining nonjudgmental medical care.

Discussion

The World Health Organization (WHO) explicitly recommends care, respect, and privacy rather than punishment, while the National Institute for Health and Care Excellence (NICE) emphasizes nonjudgmental, culturally competent, and collaborative care. In a poisoning unit, this means the ethical response to the act and the compassionate response to the person must be held together [1, 2].

The central finding of this review is not simply that suicide is prohibited in many religious traditions. Rather, the clinically important issue is how normative, cultural, and ethical considerations interact with emergency care obligations. The biomedical ethics literature provides the conceptual basis for balancing the preservation of life, respect for persons, non-maleficence, beneficence, and autonomy in this setting. Iranian evidence on suicide and poisoning further shows why these principles must be interpreted within the local epidemiological, cultural, and clinical context [11-16].

The evidence and primary authorities reviewed here support four analytically distinct propositions. First, major Islamic jurisprudential authorities and the Catholic tradition examined in this review prohibit intentional self-killing, although they do not necessarily treat responsibility as identical in every case. Second, clinical ethics requires that patients who self-poison receive appropriate medical treatment and respectful care. Third, capacity, refusal, confidentiality, and protective intervention require case-specific clinical and legal analysis. Fourth, spiritual care can be clinically relevant when it is requested and delivered

without coercion [1-10, 31, 32].

The primary religious sources reviewed in this study also establish the normative context for clinical care. The Catholic Catechism and USCCB materials address suicide and diminished responsibility in severe psychological disturbance; Shi'a rulings from Ayatollah Ali al-Sistani prohibit suicide and address intentional self-poisoning; and Sunni authorities, including Dar al-Ifta and Jordan's General Iftaa Department, likewise prohibit suicide. These sources articulate religious positions, not clinical capacity or authorization for treatment coercion [5-10].

The earlier bioethics literature in the evidence base provides the conceptual foundation for this clinical approach. Iserson's discussion of biomedical ethics emphasizes the ethical dimensions of emergency care. Kuhse and Singer's bioethics framework likewise situates autonomy, beneficence, non-maleficence, and respect for persons within clinical decision-making. Applied to intentional self-poisoning, these sources support balancing immediate life-preserving treatment with respect for the patient's rights and circumstances, rather than treating the suicidal act as grounds for punitive care [11, 12].

Shirzad and Gharedaghi documented methods and causes of fatal suicides referred to the Iranian Legal Medicine Organization, while Ghoreishi and Mousavinasab synthesized Iranian research on suicide and suicide attempts. Together, these studies demonstrate the importance of examining intentional self-poisoning within the Iranian epidemiological and social context rather than relying solely on evidence from other countries [13, 14]. Hosseini et al. examined the compatibility of medical-ethical principles with Islamic ethics, providing a relevant bridge between professional ethics and the religious context considered in this review. Bidel et al.'s systematic review and meta-analysis of poisoning methods used in Iranian suicides provide direct evidence linking poisoning to suicide-related behavior in Iran, thereby strengthening the clinical-toxicology relevance of the present review [15, 16].

Zarani and Ahmadi's systematic review adds an important cultural dimension by showing that suicide in Iran should be understood within its social and cultural context. This supports the present review's emphasis on culturally responsive assessment rather than assuming that a single explanatory model applies to every patient. Ahmadi et al.'s review of emergency-nursing burnout similarly strengthens the implementation perspective by highlighting staff well-being as a contextual issue [24, 29].

Delirrad et al. directly link clinical toxicology in Iran to the ethical care of poisoned patients, reinforcing the central role of toxicological competence within the proposed interdisciplinary framework. The burnout literature by Moukarzel et al., Zhang et al., Phillips et al., and Monsef Kasmaei et al. does not show that clinician burnout leads to poorer care in intentional poisoning. However, it identifies an implementation context that may affect emergency teams' capacity to sustain demanding, compassionate, and ethically sensitive care [21-23, 25, 26].

The findings on treatment refusal, privacy, autonomy, and Shi'ite jurisprudence are directly relevant to the post-stabilization phase. Madani and Madani distinguish between refusing a particular treatment and refusing care as a whole; Mohammadi et al. highlight the importance of privacy and confidentiality from patients' perspectives; Yavari and Parsapoor describe the limits of autonomy; and Rahaie and Heidari offer a Shi'ite jurisprudential perspective on choices involving life-sustaining treatment. In the present study, these sources support a case-specific approach in which capacity, voluntariness, privacy, patient preferences, and applicable law are assessed together rather than inferred from the fact of a suicide attempt [17-20].

Baker et al. evaluated brief telehealth cognitive behavioral therapy for suicide prevention and therefore informs the post-self-harm prevention and follow-up dimension of this review, but it was not a clinical toxicology trial and should not be interpreted as direct evidence for the treatment of poisoning. Sharma et al. reviewed the prevention of self-harm and suicide in educational settings; its relevance is similarly indirect, supporting broader early-prevention principles rather than acute management of intentional poisoning. These distinctions prevent extrapolation beyond the populations and interventions actually studied [27, 28].

The findings of this review have implications for prevention beyond acute toxicological management of intentional self-poisoning. Prevention should include patient and family education on the correct use, safe storage, and safe disposal of medicines; reduction of medication misuse and hazardous alcohol or substance use; early identification of psychological distress and emerging mental-health problems; and appropriate prescribing, dispensing, and access practices. At the population and health-system levels, unnecessary or unsupervised access to potentially dangerous medicines and other highly lethal means should be reduced while preserving reasonable access to essential treatment. Evidence-based restriction of access to highly lethal means (for example, pesticides) is an



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Figure 2. Interdisciplinary clinical-toxicology framework for intentional self-poisoning: acute stabilization, risk/capacity assessment, ethical-legal and religious/spiritual perspectives, prevention after survival, structured follow-up, and prevention of recurrent intentional self-poisoning.

established component of suicide prevention (Table 3) [1, 2, 30, 46].

Prevention should also address potentially modifiable family, social, interpersonal, and individual circumstances, including family conflict, social isolation, domestic or interpersonal difficulties, bereavement, persistent psychosocial stress, and other sources of distress. Care may incorporate support for hope, meaning, dignity, health preservation, and personally meaningful reasons for continuing life, without imposing a particular religious or moral belief. Ethical, religious, or spiritual values should be supported only in accordance with the patient's preferences and consent. Family members and other supportive persons may be involved when clinically appropriate and consistent with confidentiality and the patient's wishes [1, 2, 43-46].

Survival from intentional poisoning should not be regarded as the endpoint of care. After toxicological stabilization and medical recovery, patients should receive appropriate psychosocial and, when indicated, psychiatric assessment; an individualized safety plan; education on safe access to medicines and other potentially harmful substances; and structured follow-up. Follow-up should repeatedly assess suicidal ideation, self-harm thoughts or behavior, medication use and adherence, alcohol and substance use, psychological and social stressors, family and social support, and other factors associated with recurrent

Table 3. Practical clinical framework.

Step	Clinical implication
1- Stabilize	Provide appropriate toxicological assessment and treatment; do not delay life-saving care because the exposure was intentional.
2- Protect dignity	Use non-punitive, respectful, and private communication.
3- Clarify intent	Differentiate between suicidal ideation, self-harm, suicide attempt, and accidental poisoning.
4- Assess capacity	Evaluate the patient's capacity for the specific decision at that time.
5- Manage refusal	If the patient refuses, determine whether the refusal is informed, voluntary, and capacity-based, and document the reasoning.
6- Assess psychosocial needs	Arrange timely psychosocial/psychiatric assessment and a collaborative safety plan. Maintain confidentiality while adhering to applicable exceptions for serious safety risks or legal requirements.
7- Apply confidentiality carefully	
8- Address spirituality if wanted	Ask about religious or spiritual preferences and facilitate requested support. Do not discharge based solely on a risk score; complete a psychosocial assessment, safety planning, and appropriate follow-up.
9- Plan discharge	

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risk. WHO guidance recommends regular contact following self-harm, with frequency and intensity adjusted to the patient's condition and continuing risk [1, 2, 30, 46].

A specific plan to prevent recurrent intentional self-poisoning should be documented before or shortly after discharge and reviewed during subsequent contacts. Depending on individual circumstances, this plan may include safe medication storage or dispensing arrangements, reducing unnecessary access to potentially dangerous medicines, identifying warning signs and triggers, coping and support strategies, crisis and professional contacts, involving trusted family or other supportive persons when appropriate, and clear arrangements for continued medical, psychological, psychiatric, toxicological, or social care. The plan should be revised when the patient's risk, treatment, circumstances, or support network changes.

Accordingly, preventing both initial and recurrent intentional self-poisoning should be viewed as a continuum extending from safe medication practices and appropriate means restriction to early recognition of distress, reduction of medication and substance misuse, strengthening psychosocial and family support, promoting hope, meaning, and health-preserving values, respecting patient-selected ethical and religious resources, and sustained follow-up after discharge. The 2026 emergency department guideline addresses suspected poisoning in unidentified patients and reinforces structured emergency assessment and management. It complements the poisoning-specific evidence reviewed above and supports maintaining a strong toxicological foundation within the interdisciplinary model. The Iranian Civil Code and Patient Rights Charter also provide the legal and patient-rights context for applying these principles in Iran [30, 35, 36].

This integrated approach is particularly relevant to clinical toxicology because successful treatment of acute poisoning does not necessarily resolve the psychological, social, family, ethical, or environmental circumstances associated with the episode. The interdisciplinary framework therefore integrates clinical toxicology and emergency medicine with medical ethics, law, psychology/psychiatry, philosophy, religious and spiritual studies, mysticism and moral thought, public health, and family/social perspectives (Figure 2, Table 3).

This review remains a narrative review and therefore does not provide the quantitative certainty of a formal systematic review with protocol registration and a dual independent risk-of-bias assessment. Legal standards vary substantially by jurisdiction; therefore, interpret the clinical recommendations in this review alongside the law applicable to the treating institution.

Conclusion

Patients who attempt suicide by intentional poisoning should receive prompt, evidence-based toxicological treatment alongside respectful, non-punitive care. Religious traditions may shape a patient's understanding of life, death, responsibility, and suffering, but religious prohibitions should not be conflated with clinical or legal incapacity, nor should they automatically authorize involuntary treatment. A sound approach requires an explicit distinction among suicide attempt, self-harm, suicidal ideation, treatment refusal, euthanasia, and physician-assisted suicide; careful assessment of decision-making capacity; protection of confidentiality within its lawful limits; timely psychosocial care; and culturally responsive spiritual support when requested. An interdisciplinary,

patient-centered continuum from acute poisoning treatment through structured follow-up may help prevent recurrent intentional self-poisoning.

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Conflicts of Interest

The authors declare no known competing financial interests or personal relationships that could have appeared to influence the work reported in this manuscript. All authors contributed to the manuscript and approved the final version.

Ethical Considerations

Not applicable.

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