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Suicide and the Request for Assisted Suicide: Meaning and Motivation

*Herbert Hendin**

What motivates some seriously or terminally ill individuals to request euthanasia when the overwhelming majority of such individuals do not? What are the medical, psychological and social factors that contribute to this request? Why are more individuals making the request? What do patients requesting euthanasia have in common with patients who kill themselves without asking for a physician's assistance?

Long before the current consideration of the legalization of assisted suicide for seriously or terminally ill patients, mental and physical illness were known to contribute to an individual's motivation for suicide. Close to 95% of individuals who kill themselves have a diagnosable psychiatric illness in the months preceding suicide.¹ The majority of these individuals suffer from a form of depression which can be treated. This is particularly true of the elderly, who are more likely than younger victims to take their lives during the type of acute depressive episode that responds most effectively to modern available treatments.² Other diagnoses among the suicide victims include alcoholism, substance abuse, schizophrenia, and panic disorder.

Over 40% of suicide victims have suffered from some medical illness at the time of their death.³ For 25% of the victims, problems derived from a medical illness were an important factor in their suicide.⁴ The percentage for whom illness was an impor-

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1. E. Robins et al., *Some Clinical Considerations in the Prevention of Suicide Based on a Study of 134 Successful Suicides*, 49 AM. J. PUB HEALTH 888-89 (1959); T.L. Dorpat & H.S. Ripley, *A Study of Suicide in the Seattle Area*, 1 COMPR. PSYCHIATRY 349-59 (1960); B. Barracough et al., *A Hundred Cases of Suicide: Clinical Aspects*, 125 BRIT. J. PSYCHIATRY 355-73 (1974); D.C. Rich et. al, *San Diego Study, I: young vs. old subjects*, 43 ARCH GEN PSYCHIATRY 577-82 (1986).

2. Barraclough et al., *supra* note 1.

3. T.B. MACKENZIE AND M.K. POPKIN, *MEDICAL ILLNESS AND SUICIDE, SUICIDE OVER THE LIFE CYCLE* (S.J. Blumenthal and D.J. Kupfer eds., 1990).

4. *Id.*

tant factor rises to 70% when dealing with individuals who were over sixty years old when they killed themselves.⁵

Fewer than 5% of suicides, however, have occurred in the context of terminal illness.⁶ The percentage of suicide victims with terminal illness has been found to be no greater than that of a controlled sample of non-suicide victims in similar age groups.⁷ Cancer, AIDS, peptic ulcer⁸, spinal cord injury, Huntington's chorea⁹, head injury, and renal (kidney) dialysis are conditions associated with increased rates of death by suicide.¹⁰

Like other suicidal individuals, patients who desire an early death during a serious or terminal illness are usually suffering from a treatable mental illness; most commonly a depressive condition or alcoholism.¹¹ A review of studies relating suicide and physical illness concluded that "there is little evidence to support the notion that chronic or terminal illness is an independent risk factor for suicide, outside the context of depression or other mental disorder."¹² Although pain and other factors such as lack of family support contribute to the patient's wish for death, no factor is as significant as the presence of depression, which researchers have found to be the only predictor of the desire for death.¹³

Strikingly, the overwhelming majority of the patients who are terminally ill fight for life to the end. While some of these patients may voice suicidal thoughts in response to transient depression or severe pain, they usually respond well to treatment for depressive illness and pain medication and are grateful to be alive.¹⁴

5. *Id.*

6. E. Robins et al., *supra* note 1; SUICIDE IN LONDON (P. Sainsbury ed., 1995); C.P. Seager and R.S. Flood, *Suicide in Bristol*, BRIT. J. PSYCHIATRY 919-32 (1965).

7. Barraclough et al., *supra* note 1.

8. A peptic ulcer is a developmental defect of the mucous membrane of the esophagus, stomach or duodenum caused by the action of acid gastric juice. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1783 (27th ed. 1988).

9. Huntington's chorea is a relatively common chromosomal dominant disease characterized by chronic progressive rapid, highly complex and involuntary jerky movements and mental deterioration terminating in dementia. *Id.* at 327.

10. MacKenzie & Popkin, *supra* note 3.

11. J.H. Brown et al., *Is it normal for terminally ill patients to desire death?*, 143 AM. J. PSYCHIATRY 208-111 (1986); H.M. Chochinov et al., *Desire for Death in the Terminally Ill*, 152:8 AM. J. PSYCHIATRY 1185-91 (1995).

12. E.R. Mościcki, *North American Perspectives: Epidemiology of Suicide*, 7 INTERNATIONAL PSYCHOGERIATRICS 137-48 (1995).

13. E.J. Emanuel et al., *Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public*, THE LANCET, June 1996 at 1805-10.

14. H. Hendin & G.L. Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143-45 (1993).

I. DEPRESSION

Depression is a mood disorder that may exist by itself ("unipolar depression") or alternate with manic¹⁵ or hypomanic¹⁶ episodes ("bipolar disorder").¹⁷ Depression must be carefully distinguished from the ordinary sadness that may accompany illness or the grief that accompanies loss.¹⁸

Depressive disorders, which include a chronic, less intense form of depression known as dysthymia, are associated with change in appetite, weight, sleep disturbances and usual daily activities. Fatigue, irritability, inertia¹⁹, depersonalization, change in motor activity, difficulty concentrating, indecisiveness, feelings of inadequacy and self-reproach, or guilty, pessimistic attitudes toward the future are also common symptoms of depressive disorders. Additionally, suicidal thoughts, suicidal threats and suicidal attempts are symptoms of these disorders, but by themselves these symptoms cannot be used to make the depressive disorder diagnosis.²⁰

A depressive disorder is distressing not only due to the unpleasant (dysphoric²¹) mood that characterizes it, but also because it may significantly impair the cognitive functioning of the affected individual.²² Depressed subjects' awareness and reasoning have been found to be colored by unrealistically low self-regard, ideas of deprivation and rejection often in the face of overt demonstrations of affection,²³ and a tendency toward self-blame with no logical basis.²⁴ A magnification of problems, impossible self-demands and a rigid tendency to see only one possible solution (such as suicide) to their problems are also charac-

15. A manic episode is an episode pertaining to mania, which is a mood disorder characterized by expansiveness, elation, agitation, hyperexcitability, hyperactivity and increased speed of thought and speech. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 978 (27th ed. 1988).

16. A hypomanic episode is an episode pertaining to hypomania, which is an abnormality of mood resembling mania but of lesser intensity. *Id.* at 805.

17. AMERICAN PSYCHIATRIC ASSOCIATION, 1994 DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed.). A mood disturbance involves a prolonged emotion that colors the whole psychic life. AMERICAN PSYCHIATRIC ASSOCIATION, 1980 DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 205 (3rd. ed.).

18. AMERICAN PSYCHIATRIC ASSOCIATION, 1994 DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 326 (14th ed.).

19. Inertia is the inability to move spontaneously. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 833 (27th ed. 1988).

20. AMERICAN PSYCHIATRIC ASSOCIATION, 1994 DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 320-23 (4th ed.).

21. Dysphoria is characterized by excessive pain, anguish or agitation. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 519 (27th ed. 1988).

22. A. Beck, *Thinking and Depression*, ARCH. GEN. PSYCHIATRY 324 (1963).

23. *Id.* at 321.

24. *Id.*

teristic of individuals with depressive disorders.²⁵ Moreover, such persons suffer from systematic bias against themselves, which distorts the facts in their lives and leads to errors in judgment. These distortions are not preventable while the disorder persists, even when the affected individuals are aware of their susceptibility to the distortions.²⁶

When seriously or terminally ill and depressed, a patient's reasoning process is impaired due to a negative mental attitude that usually affects the patient's capacity to make well-considered life-and-death decisions. Furthermore, demoralization and lack of assertiveness are likely to make the terminally ill patient more vulnerable to the suggestions of others, thereby increasing the potential for abuse.²⁷

Fifteen percent of persons with mood (affective) disorders, including depression, will ultimately commit suicide.²⁸ The annual rate of suicide in depressed patients ranges from 3.5 to 4.5 times higher than in other diagnostic groups, and 22 to 36 times higher than the general population.²⁹

Unfortunately, depression is underdiagnosed and often inadequately treated.³⁰ Although most people who kill themselves are under medical care at the time of death, their physicians often fail to recognize the symptoms of depressive illness or to provide adequate treatment for the illness.³¹

Some patients who are depressed and suicidal appear less depressed and more calm after deciding to end their lives. The fact that patients may find relief in the prospect of death, however, is not necessarily a sign that the decision is appropriate. Coping with the uncertainties of life and death is what agitates and depresses these patients.³²

II. THE REQUEST FOR ASSISTED SUICIDE

Inexperienced individuals are apt to assume that seriously or terminally ill people who wish to end their lives are different from individuals who are otherwise suicidal. Yet, the first reac-

25. *Id.* at 328.

26. *Id.* at 327.

27. P.A. Singer & M. Siegler, *Euthanasia: A Critique*, NEW ENG. J. MED. 1881-83 (1990).

28. MacKenzie & Popkin, *supra* note 3.

29. *Id.*

30. M.B. Keller et al., *Treatment received by depressed patients*, JAMA 1848-55 (1982).

31. G.E. Murphy, *The Physician's Responsibility for Suicide: (1) an error of commission and (2) errors of omission*, 82 ANN INTERN. MED. 301-09 (1975); Barraclough et al., *supra* note 1.

32. Hendin & Klerman, *supra* note 13.

tion of many patients learning that they have a serious illness and will possibly die is anxiety, depression and a wish to die. Such patients are not significantly different from patients who react to other crises with the desire to end the crisis by ending their lives.³³

Although the fear of death itself is not usually expressed by patients as a reason for requesting euthanasia, clinicians treating such patients recognize that many displace anxieties about death onto the circumstances of dying, such as loss of dignity, pain, being dependent on others and the unpleasant side effects resulting from medical treatments. Focusing on or becoming enraged at the dying process distracts the patients from the fear of death itself.³⁴

For example, a young professional ("Tim") in his early thirties who had acute myelocytic leukemia³⁵ was referred for consultation. With medical treatment, Tim had a 25% chance of survival; without the treatment, Tim would die in a few months.

Tim, an ambitious executive whose focus on career success had led him to neglect his wife and family, was stunned by the news. Tim's immediate reaction to the news was a desperate, angry preoccupation with suicide and a request for support in carrying out the suicide. Tim was worried about becoming dependent on others, and feared both the symptoms of his disease and the side effects of treatment.³⁶

Although Tim's anxieties about the painful circumstances that would surround his death were not irrational, all of his fears about the dying process amplified these anxieties. Once Tim could talk about the possibility or likelihood of his dying, and about what the separation from his family and destruction of his body meant to him, his desperation subsided. Tim accepted medical treatment and used the remaining months of his life to become closer to his wife and parents. Two days before Tim died, he talked about what he would have missed without the opportunity for a loving parting from his family.

Pieter Admiraal, one of the most experienced Dutch authorities on euthanasia, indicates that anxiety over "spiritual and

33. *Id.*

34. H. Hendin, *Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience*, 25(1) SUICIDE AND LIFE-THREATENING BEHAVIOR; Spring 1995 at 193-204.

35. Leukemia is a progressive, malignant disease of the blood-forming organs, characterized by distorted proliferation and development of the white blood cells and their precursors in the blood and bone marrow. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 914 (27th ed. 1988).

36. Hendin, *supra* note 34.

physical decay" is far more important than pain to a patient as a reason for euthanasia.³⁷ Admiraal graphically describes the anxiety over dying that triggers a patient's request for euthanasia as follows:

Dying is the loss of the world in which one has lived, worked and loved. There is also anxiety about the moment of dying. Patients fear what comes after death. This can vary from a vague fear of the unknown to a literal deathly fear of punishment which may be eternal.³⁸

The vast majority³⁹ of patients who request assisted suicide or euthanasia are motivated primarily by the dread of what will happen to them in the dying process rather than by their current pain or suffering. Patients do not know what to expect and cannot foresee how their conditions will unfold as they decline into death. In facing this ignorance, patients fill the vacuum with their fantasies and fears. When these fears are dealt with by a caring, sensitive physician, the patient's requests for death usually disappear.

Studies of individuals who have committed suicide have also pointed out the irrational elements of the wish to die in reaction to serious illness. More individuals, and particularly elderly individuals, killed themselves because they feared or *mistakenly* believed they had cancer than killed themselves, and actually had cancer.⁴⁰ In the same vein, preoccupation with suicide is greater in individuals awaiting the results of tests for HIV antibodies than in individuals who know they are HIV positive.⁴¹

Suicidal patients are also prone to make conditions on life, such as, "I won't live without my husband, . . . or if I lose my looks, power, prestige or health, . . . or if I am going to die soon."

Suicidal persons are afflicted by the need to make demands on life that cannot be fulfilled. Determining the time, place, and cir-

37. See P. ADMIRAL, *A PHYSICIAN'S RESPONSIBILITY TO HELP A PATIENT DIE, THE GOOD OF THE PATIENT: THE GOOD OF SOCIETY* (R.I. Misbin ed., University Publishing Group 1992).

38. *Id.*

39. Interview with B. Zyliz, a Dutch palliative care specialist (July 1996). Zyliz puts the figure at 85%. *Id.* Kathleen Foley, an American palliative care specialist, indicates that the Zyliz figure is approximately what is seen in the United States. Conversation with K. Foley (Sept. 1996).

40. Y. Conwell et al., *Suicide and Cancer in Later Life*, 41 *HOSP. COMMUNITY PSYCHIATRY* 1334-39 (1990); T.L. DORPAT ET AL., *THE RELATIONSHIP OF PHYSICAL ILLNESS TO SUICIDE*, IN *SUICIDAL BEHAVIORS: DIAGNOSIS AND MANAGEMENT*, (H.L.P. Resnick ed., 1968).

41. S. Perry, *Suicidal Ideation and HIV Testing*, — *JAMA* 679-82 (1990).

cumstances of their death is the most dramatic expression of their need for control.⁴²

A patient whose fearful response to the crisis of a serious or terminal illness is to seek death may be quite different from a patient who seeks relief from undue suffering in the last days of life. Whenever there is legal sanction for assisted suicide for patients who are not imminently dying (such as in the Netherlands or in the recent Oregon law currently under challenge in court), the two groups of patients become hopelessly confused, and our current knowledge does not permit us to separate them.⁴³

III. AMBIVALENCE

Studies and descriptions of individuals who have attempted suicide yet survived the attempt by accident or outside intervention demonstrate that most suicidal individuals have neither an unequivocal nor irreversible determination to die. As British psychiatrist Erwin Stengel, conductor of extensive studies of attempted suicide, has commented:

Many suicidal attempts and quite a few suicides are carried out in the mood "I don't care whether I live or die," rather than with a clear and unambiguous determination to end life. A person who denies, after what seems an obvious suicide attempt, that he really wanted to kill himself, may be telling the truth. Most people, in committing a suicidal act, are just as muddled as they are whenever they do anything of importance under emotional stress.⁴⁴

Stengel emphasizes in his studies of suicide and attempted suicide that completed suicide is merely the end point on a continuum of suicidal behavior. It is worth noting in support of Stengel's thesis that about one third of actual suicide victims

42. Hendin & Klerman, *supra* note 13. Patients are not alone in their inability to tolerate situations that they cannot control. From a physician's viewpoint, Lewis Thomas has written insightfully about the sense of failure and helplessness that doctors may experience in the face of death. See L. Thomas, *Dying as Failure*, 444 AMERICAN POLITICAL SCIENCE REVIEW 1-4 (1984). Indeed, such feelings might explain why doctors have such difficulty discussing terminal illnesses with patients. A majority of doctors avoid such discussions, while most patients would prefer candid talk. These feelings might also explain both a doctor's tendency to use excessive measures to maintain a patient's life and a doctor's need to make death a physician's decision. By deciding when patients die and making death a medical decision, the physician preserves the illusion of mastery over the disease and the accompanying feelings of helplessness. The physician, not the illness, is responsible for the death. Assisting suicide and providing euthanasia become ways for the doctor to deal with the frustration of being unable to cure the disease.

43. H. HENDIN, *SEDUCED BY DEATH: DOCTORS, PATIENTS, AND THE DUTCH CURE*, (1996).

44. E. STENDEL, *SUICIDE AND ATTEMPTED SUICIDE* 71 (1964).

have previously attempted suicide.⁴⁵ Moreover, in the United States, it is estimated that about one in eight suicide attempts results in death.⁴⁶

A study of the mortality rates of suicide survivors has shown that 1% of the survivors kill themselves within one year of their last suicide attempt.⁴⁷ A Swedish study conducted over a longer period of time indicated that 10.9% of the individuals (14% of the men and 8.8% of the women) killed themselves within thirty-five years after the initial suicide attempt.⁴⁸

Three-fourths of all suicide victims indicate their ambivalence about committing suicide by communicating their suicide intention to others, often with the hope of provoking intervention.⁴⁹ In numerous cases, the pleas for help are varied, repeated, and expressed to more than one person. Studies of individuals who have survived serious suicide attempts have revealed that the suicidal individual often fantasizes about being rescued.⁵⁰

What has misled persons who make a rigid separation between individuals who survive suicide attempts and individuals who do not is the evidence that many so-called "attempted suicides" clearly want to live. This in no way contradicts the clinical evidence that a large number of the individuals who kill themselves or make serious suicide attempts are ambivalent in the sense that they do something irrevocable in a state of uncertainty.⁵¹

For years, many people have speculated that if they could talk to an individual who was in midair after jumping from a tall tower, they might find out that the individual was no longer so sure that he or she wanted to die. Observation of people who have survived such jumps seems to confirm this hypothesis. Specifically, of four people who survived six story jumps, two people wished to survive as soon as they had jumped.⁵² The other two people stated that they did not want to survive, but one of these people, who professed to be furious at being saved, made no sub-

45. Barraclough et al., *supra* note 1; Robins et al., *supra* note 1.

46. Stengel, *supra* note 44, at 73; E.S. SHNEIDMAN AND N. FARBEROW, *STATISTICAL COMPARISON BETWEEN ATTEMPTED AND COMMITTED SUICIDES, THE CRY FOR HELP* (1961).

47. R.E. Hinger, *Evaluation of Suicide Prevention After Attempted Suicide*, 260 *ACTA PSYCHOTRICA SCANDINAVICA* 1-135 (1975).

48. DAHLGREN, *ATTEMPTED SUICIDE 35 YEARS AFTERWARDS, SUICIDE AND LIFE-THREATENING BEHAVIOR*, 7:75-78 (1977).

49. H. HENDIN, *SUICIDE IN AMERICA* (1995).

50. Jensen & Petty, *The Fantasy of Being Rescued*, 27 *PSYCHOANALYTIC QUAR.* 327 (1958).

51. HENDIN, *supra* note 49.

52. *Id.*

sequent suicide attempt.⁵³ One individual out of a handful of survivors who leapt off of the one hundred and seventy-four foot high Aurora Bridge in Seattle in an attempt to commit suicide also revealed that he changed his mind before hitting the water. Some of the other individuals who jumped had little memory of what transpired, but were glad to be alive.⁵⁴

A study of individuals who survived suicide attempts revealed that the individuals' main wish was not to die, but rather to communicate with an important person in their lives.⁵⁵ A separate, large Seattle study revealed that attempted suicide survivors took a "risk of death" to "test the affection and care of others."⁵⁶ An analysis of the suicide notes left by actual suicide victims indicates that the victims' desire to get a message across to someone else was a major aspect of the suicide.⁵⁷ The need to use one's death to express desperation, rage or guilt reflects, among other things, the difficulty individuals have in expressing these feelings in less extreme ways.⁵⁸

The request for assisted suicide is usually also made with as much ambivalence on the part of the patient as are most suicide attempts. In making the request, these patients, like other suicidal individuals, are often testing the affection and care of others. The overwhelming number of patients drop the request to die, however, if their anxieties are dealt with sensitively and effectively.⁵⁹ If the doctor does not recognize this ambivalence as well as the anxiety and depression that underlie the patient's request for death, the patient may become trapped by the request and die in a state of unrecognized terror.⁶⁰

The desire for death is variable over time even for patients who are terminally ill. This is true even among the small number of terminally ill patients expressing a persistent wish to die. When interviewed two weeks later, two-thirds of these patients show a significant decrease in the extent of the desire to die.⁶¹

53. *Id.*

54. D. Raley, *Suicide survivors carry scars, zeal for life*, SEATTLE STAR TRIBUNE, May 7, 1996.

55. Rubenstein et al., *On Attempted Suicide*, 103 ARCH. NEUROLOGY PSYCHIATRY 111.

56. T. Dorpat & Boswell, *An Evaluation of Suicidal Intent in Suicide Attempts*, 4 COMPR. PSYCHIATRY 117 (1963).

57. HENDIN, *supra* note 49.

58. *Id.*

59. *Id.*

60. H. Hendin, *Selling Death and Dignity*, HASTINGS CENTER REPORT 25, 3:19-23.

61. Chochinov et al., *supra* note 11. The authors of this study note that although persistence of request is a requirement for euthanasia in the Netherlands, 65% of euthanasia cases occur within two weeks after the initial request.

IV. PSYCHODYNAMICS

Since the vast majority of patients with depression, manic depression, alcoholism, schizophrenia⁶² or organic psychosis⁶³ (conditions most frequently associated with suicide) are not suicidal, physicians in recent years have begun to separate the factors within any diagnosis that distinguish suicidal patients from nonsuicidal patients, and to identify the lethal factors that cross traditional diagnostic boundaries. Psychodynamic,⁶⁴ biological, and genetic studies have all moved forward from this starting point.⁶⁵

As used in contemporary psychiatry, psychodynamics deals with the quality of interpersonal relations, recurrent conflict patterns, and ultimately the meaning of actions and experiences. Such meaning is refined by the psychosocial context in which suicide occurs, but it is also understood through its affective and cognitive (perceptual) components, both of which have been more clearly defined in the last decade.

Although suicide is often described imprecisely as an escape, patients usually commit or contemplate suicide to escape from an intolerable affective state. Hopelessness has been defined by Aaron Beck and his colleagues at the University of Pennsylvania as one affective state that helps physicians to distinguish depressed patients who are suicidal from those who are not.⁶⁶ Beck and his colleagues found that the seriousness of an individual's suicidal intent is related less to the degree of depression than it is to one particular aspect of depression; hopelessness about the future. Beck and his colleagues observed a high suicidal intent in patients who showed minimal depression but had slight expectations for the future.

62. Schizophrenia is a mental disorder comprising most major psychotic disorders and characterized by disturbances in form and content of thought, mood, sense of self and relationship to the external world, and bizarre behavior. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1492 (27th ed. 1988).

63. A psychosis is a mental disorder characterized by gross impairment in reality testing as evidenced by delusions, hallucinations, markedly incoherent speech, or disorganized and agitated behavior without apparent awareness on the part of the patient of the incomprehensibility of his [or her] behavior. *Id.* at 1385.

64. Psychodynamics is the interplay of forces, such as anxiety, conflict, and mechanisms, that give rise to the expression of mental processes. *Id.* at 1384.

65. The finding of low levels of serotonin (a substance involved in the transmission of nerve impulses) in the spinal fluid of suicidal patients cuts across diagnostic categories.

Although there has long been evidence that manic-depressive illness is inherited, genetic studies are now focusing on identifying which families with the illness are vulnerable to suicide.

66. K. Minkoff et al., *Hopeless Depression and Attempted Suicide*, 130 AM. J. PSYCHIATRY 455-59 (1973).

The Beck group reported that of two hundred and seven patients who were followed after being hospitalized while contemplating suicide, eighty-nine ranked high on a measure of hopelessness utilized by the group. In the five years after the patients' hospitalization, fourteen of the two hundred and seven patients committed suicide, and thirteen of these patients were from the group of the eighty-nine patients who ranked high on the measure of hopelessness.⁶⁷

The diagnosis given to patients who ranked high on hopelessness cut across the spectrum. Half of the patients were diagnosed as having some form of depression, about a quarter of the patients were diagnosed as schizophrenics, and the rest were diagnosed as patients with personality disorders, neuroses,⁶⁸ or other syndromes.⁶⁹

In addition to hopelessness, some of the predominant emotions in suicidal patients are desperation, rage and guilt. The nature and intensity of these emotions also helps physicians distinguish patients who are suicidal from those who are not.⁷⁰

Experience with patients seen a few days prior to their suicide suggests an affective state closer to desperation than to hopelessness. Some patients who feel hopeless about the future are resigned to their situation. Desperation implies not only hopelessness about change, but also a feeling that life is impossible without such change. Anxiety and urgency are an integral part of desperation.⁷¹ The importance of these affective elements as they relate to suicidal patients was confirmed by Jan Fawcett and his co-workers in Chicago. These researchers demonstrated that, among patients with major affective disorders, anxiety rather than hopelessness is the stronger predictor of short-term risk for suicide.⁷²

In the past two decades, the interrelation of anger, rage, violence, and suicide has become clearer. Although earlier observations of depressed but not necessarily suicidal patients assumed

67. A. Beck et al., *Hopelessness and Eventual Suicide: A Ten Year Prospective Study of Patients Hospitalized With Suicidal Ideation*, 142 AM. J. PSYCHIATRY 559-63 (1985).

68. A neurosis is a functional mental disorder in which reality testing is intact (as opposed to psychosis, in which reality testing is impaired) and ego-dystonic symptoms, such as obsessions, anxiety attacks, and phobias are present. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1132 (27th ed. 1988).

69. Beck, *supra* note 67.

70. H. Hendin, *Psychodynamics of Suicide With Particular Reference to the Young*, 148 AM. J. PSYCHIATRY 559-63(1985).

71. *Id.*

72. J. Fawcett et al., *Time Reflected Predictors of Suicide in Major Affective Disorder*, 147 AM. J. PSYCHIATRY 1189-94 (1990).

an inverse relation between suicide and open anger or rage, this has not proven to be true. About 30% of violent individuals of all ages have histories of self-destructive behavior, while about 10% to 20% of suicidal persons have histories of violent behavior.⁷³ Angry, depressed patients are more at risk for suicide than patients who are not.⁷⁴

The subjective, often irrational, role that guilt plays in depression has been observed for centuries. Studies undertaken in this century of concentration camp survivors and Vietnam veterans have shown that feelings of guilt which lead to suicide can be related to specific experiences in adult life.⁷⁵ Guilt over actions which individuals have taken in order to survive was the variable best able to explain the suicidal behavior of both groups.⁷⁶ An individual's guilt over surviving a loved one was also a contributing factor. William Styron captures both of these dimensions of guilt in his fictional narrative "Sophie's Choice."⁷⁷ Within the narrative, Sophie is tormented both by her action of sacrificing her daughter in order to save her son, and by her own survival of loved ones who had died during the war.⁷⁸

Clinicians and researchers working with patients who request assisted suicide during an illness have described the patients as having the same intense emotions, such as hopelessness, despair, anxiety, rage and guilt, seen in suicidal patients without physical illness.⁷⁹ As of yet, however, physicians do not have the controlled studies necessary to validate the significance of these observations.

The cognitive component of the meaning of suicide helps clarify the affective aspects of the suicidal act. For example, the guilt of veterans over their combat actions complements their view of suicide as a deserved punishment. As Otto Kernberg aptly points out, "[i]n clinical practice the question is not the patient's

73. R. PLUTCHIK & H.M. VAN PRAAG, *PSYCHOSOCIAL CORRELATES OF SUICIDE AND VIOLENCE RISK, VIOLENCE AND SUICIDALITY: PERSPECTIVES IN CLINICAL AND PSYCHOLOGICAL RESEARCH* (1990).

74. M. Weissman et al., *Hostility and depression associated with suicide attempts*, 130 AM. J. PSYCHIATRY 450-55 (1973).

75. See, e.g., H. Hendin & A.P. Haas, *Suicide and Guilt as Manifestations of PTSD in Combat Veterans*, 148 AM. J. PSYCHIATRY 586-91 (1991).

76. *Id.*

77. W. STYRON, *SOPHIE'S CHOICE* (Random House 1990).

78. *Id.*

79. W. BREITBART & S.D. POSIK, *PSYCHIATRIC ASPECTS OF PALLIATIVE CARE*, OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 609-26 (D. Doyle et al., eds., 1993); N. Farberow, *Suicide Among General Medical and Surgical Hospital Patients with Malignant Neoplasms*, 9 MED. BULLETIN U.S. VETERANS ADMIN. (1963).

general feeling of 'hopelessness,' but what, concretely, the patient is hopeless about."⁸⁰

Cognition generally refers to conscious ideation, whereas *meaning* includes both conscious and unconscious affects and perceptions. The meanings of suicide can be usefully organized around the conscious and unconscious meanings given to death by the suicidal patient.⁸¹

Physicians have learned that suicidal patients give a special meaning to death, using death in their adaptation to life. The suicidal patients' actual or fantasized use of their own death is critical in their effort to control others or to maintain illusory control over their own lives. Some of the common meanings given to death by suicidal patients are: death as reunion; death as rebirth; death as retaliatory abandonment; death as revenge; and death as self-punishment or atonement.

Sigmund Freud's original formulation of suicide suggested that the suicidal act originates in anger toward a lost love object that turns back on the individual.⁸² In destroying himself or herself *and* the object, the suicidal individual accomplishes atonement as well as revenge.⁸³

A later understanding of narcissistic pathology has modified Freud's view of suicide. In a classic paper on suicide, Elizabeth Kilpatrick wrote, "[w]hen we understand narcissism not as love of the self, but as love of the idealized image of self, we become aware of the gravity of self-hate and alienation which needs to be present."⁸⁴ Kilpatrick pointed out that the unconscious idealized self-image is often accompanied by its counterpart, a despised self-image. Contemporary psychodynamic theory, with its emphasis on the importance of "splitting" as a mechanism of defense, has increasingly seen suicide as an attempt by the good self to eliminate the bad self.⁸⁵ Loss, self-hatred and failure are directly and inextricably intertwined for suicidal individuals.

All of the psychodynamic meanings ascribed to death by suicidal patients can be conceptualized as responses to loss, separation or abandonment.⁸⁶

80. O. KERNBERG, DIAGNOSIS AND CLINICAL MANAGEMENT OF SUICIDAL POTENTIAL IN BORDERLINE PATIENTS, *THE BORDERLINE PATIENT*, VOL 2 (Analytic Press 1987).

81. HENDIN, *supra* note 49.

82. S. FREUD, MOURNING AND MELANCHOLIA (1917 [1915]), *THE STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS*, VOL. 14 (J. Strachery trans. and ed., 1976).

83. *Id.* at 243-58.

84. E. Kilpatrick, *A Psychoanalytic Understanding of Suicide*, 8 *AM. J. PSYCHOANALYSIS* 13-23 (1948).

85. O. Kernberg, *A Psychoanalytic Classification of Character Pathology*, 18 *J. AM. PSYCHOANALYTIC ASSOC.* 800-22 (1970).

86. HENDIN, *supra* note 49.

- * Rebirth and reunion fantasies may be attempts to undo or deny such a loss.
- * Becoming the one who leaves is one way to avoid the feeling of having been left.
- * Feelings of rage that are repressed, suppressed, or expressed may derive from the experience of loss.
- * Self-punishment may express guilt at having been responsible for a loss and the fantasy of rapprochement through atonement.
- * Numbness or deadness and the insistence that one is already psychologically dead may reflect determination not to live without the lost object.

For most suicidal patients, a rejection of life usually includes a rejection of the patients' parents (whether or not they are alive) from whom life originated. A patient rejecting his or her parents is likely to feel in a deep way that he or she was abandoned first. In that sense, although physicians now see a wider range of psychodynamics involving suicide than did Freud, Freud's insight into the relationship of abandonment, loss and suicide has perhaps the most meaning and has stood the test of time.

Although physicians are only beginning to study patients who request assisted suicide, fantasies of reunion with a lost love object appear common among them. For example, a fifty-year-old Dutch woman whose two sons had died requested assisted suicide. The woman fantasized about reuniting with her dead sons and arranged to be buried on a plot between them. Although the woman's second son had died only two months earlier, rather than deal with the woman's understandable depression, the doctor who assisted in her suicide supported and encouraged her fantasies.⁸⁷

Suicidal patients sometimes have the unconscious wish to be put to death by their doctor. Psychiatrists who are unaware of this incorrectly assume that patients who have sought their help see them as saviors when actually they have been cast in the role of executioners. In such a situation, the patient often fantasizes closeness or union with the doctor through death.⁸⁸ Suicidal patients may see ridding their body of a perceived bad part of themselves as a necessary precondition for such a union. Patients may also see death as a deserved punishment in such a process. Similar dynamics can be seen with patients requesting assisted suicide and euthanasia,⁸⁹ as often the patients' illness is

87. H. Hendin, *Seduced by Death: Doctors, Patients and the Dutch Care*, 10 ISSUES IN THE LAW AND MEDICINE 123-68 (1994).

88. S. Asch, *Suicide and the Hidden Executioner*, 7 INT. REV. PSYCHOANALYSIS 51-60 (1980).

89. HENDIN, *supra* note 49.

seen by the patients as part of the bad self that must be eliminated by death before the desired union can take place.

The patient who Timothy Quill assisted in suicide ("Diane"), and whose case Quill later published in the *New England Journal of Medicine*, had fantasies of a reunion with Quill on the shores of Lake Geneva, a fantasy that Quill reveals he also had.⁹⁰ With patients contemplating suicide or requesting assisted suicide, if the dynamics are not understood and explored, the patient's death will be the result.

Statements such as, "I don't want to be a burden to my family," or "[m]y family would be better off without me," are often made by patients requesting assisted suicide or euthanasia.⁹¹ Such expressions reflect the patient's depressed feelings of worthlessness and guilt, and/or may be a plea for reassurance. These statements are also classic indicators of suicidal depression in patients who are in good physical health. Whether healthy or terminally ill, however, such patients need assurance that they are still wanted and also need treatment for their depression.

V. PAIN AND SUFFERING

Some of the other reasons that patients give for requesting euthanasia, such as pain, loss of dignity and the desire not to be dependent on others,⁹² can all contribute to the suffering⁹³ that makes patients want to die.

Pain is more apt to cause a patient to suffer if it is out of control, overwhelming, if its source is unknown or if its meaning is frightening to the patient. A classic example which reveals the nature of pain and suffering is that of a woman who could control the pain in her leg with small amounts of codeine when she believed the pain was sciatica,⁹⁴ but who could not control the pain without much more medication when she learned that the pain was caused by a malignant disease. Another example is that of terminally ill cancer patients whose suffering can be relieved by demonstrating that their pain could be controlled;

90. T. Quill, *Death and Dignity: A case of individualized decision making*, 32 *NEW ENG. J. MED.* 691-94 (1991).

91. BRIETBART & POSIK, *supra* note 79.

92. P.J. VAN DER MASS ET AL., *EUTHANASIA AND OTHER MEDICAL DECISIONS CONCERNING THE END OF LIFE* (1992).

93. See E.J. Cassell, *The Nature of Suffering and the Goals of Medicine*, 306 *NEW ENG. J. MED.* 639-45 (1982).

94. Sciatica is a syndrome characterized by pain radiating from the back into the buttock and into the lower extremity along its posterior or lateral aspect, and most commonly caused by prolapse of the intervertebral disk. *DORLAND'S ILLUSTRATED MEDICAL DICTIONARY* 1494 (27th ed. 1988).

they then tolerate the pain without medication, preferring to avoid the side effects of the analgesics.⁹⁵

Pain is a factor in 30% of euthanasia requests but it is the major reason for the request in only 5% of cases.⁹⁶ A patient's pain can invariably be relieved if the physician is knowledgeable about how to do so. Unfortunately, however, advances in knowledge of how to treat pain have not been accompanied by adequate dissemination of the knowledge. Physicians undertreat patients even in the most severe states of pain due to inappropriate fears of heavily sedating the patients.⁹⁷ Or they resist giving analgesic medicine to patients at regular intervals even though administering the medicine in this manner, rather than waiting for a patient's pain to intensify, provides better relief for the patient's chronic pain.

Patients justifiably complain most of the indignity in dying associated with futile medical treatments. Although doctors are learning to forgo such treatments,⁹⁸ patients are only beginning to learn that they can refuse the treatments.⁹⁹ Patients are also afraid, however, of being abandoned by their doctors during the dying process. Unfortunately, there is a basis for these fears, since only in the past two decades have physicians been educated that caring for patients who cannot be cured is an integral part of medicine.

There are patients who find it hard to be dependent on other individuals. Yet serious illness usually requires such dependency. The dependency is hardest for patients when their families do not want the responsibility of caring for them. A change in family attitudes, however, can modify the outcome in cases where patients wish to die. A 1989 Swedish study revealed that when chronically ill patients attempted suicide, their overburdened families often did not want them resuscitated.¹⁰⁰ When social services stepped in and relieved the family's burden

95. Cassell, *supra* note 93.

96. P.J. VAN DER MAAS ET AL., *supra* note 92.

97. K. Foley, *Pain and America's Culture of Death*, WILSON Q. AUTUMN 1994, at 20-21.

98. N.K. Brown & D.J. Thompson, *Nontreatment of Fever in Extended-Care Facilities*, 300 NEW ENG. J. MED. 1246-50 (1979); R. Noyles Jr. et al., *The Changing Attitudes of Physicians Toward Prolonging Life*, J. AMER. GERIATR. SOC. 470-74 (1977); S. Neu & C.M. Kjellstrand, *Shopping Long-Term Dialysis — an empirical study of withdrawal of life-supporting treatment*, 314 NEW ENG. J. MED. 14-20 (1986).

99. The Tarrance Group, *A Survey of Voter Attitudes in the United States*, July 18-20, 1995.

100. D. Wasserman, *Passive Euthanasia in Response to Attempted Suicide: One Form of Aggression by Relatives*, 79 ACTA PSYCHIATRICA SCANDINAVICA 460-67 (1989).

by sending in home care helpers, most patients wanted to live and their families wanted them to live as well.¹⁰¹

VI. SOCIAL FACTORS

In 1897, the French sociologist, Emile Durkheim, published a book entitled *Suicide* in which he suggested that rising suicide rates in the western world were the result of the failure of the state, church and family to remain, as they had been prior to the industrial revolution, forces for social integration.¹⁰² Durkheim wrote that vulnerability to suicide existed in people who were not integrated into any religious, communal or familial group (egoistic suicide).¹⁰³ Durkheim noted that even more vulnerable to suicide were those individuals who suffered a disruption in their previous pattern of social integration (anomic suicide).¹⁰⁴

Single, widowed and divorced individuals were observed then, as now, to have higher suicide rates than married people. Marriage was believed to protect against suicide, more so for men than women. Children were an additional protective factor. So was a job. Contemporary observations on the high suicide rates of socially isolated older men are consistent with Durkheim's hypothesis.

Many observers believe that there is a greater contemporary anxiety about death resulting from the weakening social integration that Durkheim described.¹⁰⁵ This greater anxiety may explain, in part, the appeal of legalizing euthanasia.¹⁰⁶ How to manage the anxiety associated with death, however, has been a problem for all cultures throughout history. In a culture in which life is perceived as lacking continuity or significance beyond itself, death becomes more threatening and intolerable.

Connectedness somewhat relieves the anxiety about death, as it helps fulfill an individual's need for immortality, or, at least, for what Robert Lifton has called symbolic immortality.¹⁰⁷ Religion comes first to mind, albeit not necessarily in the sense of an afterlife. Although some religious believers may not accept a literal afterlife, they may achieve a sense of symbolic immortality by sharing the enduring values and purpose of life prescribed in church teachings. Symbolic immortality is obviously achieved

101. *Id.*

102. E. DURKHEIM, *SUICIDE: A STUDY IN SOCIOLOGY* (J. Spaulding and G. Simpson trans., 1951).

103. *Id.*

104. *Id.*

105. See R. LIFTON & E. OLSON, *LIVING AND DYING* (1974).

106. HENDIN, *supra* note 49.

107. LIFTON & OLSEN, *supra* note 105.

biologically, by living on through one's sons and daughters and, in an extended way, through the continuity of the family with larger social units such as the culture and the nation. Creative immortality is achieved through work; not simply from doing something that achieves recognition, but from the feeling of influencing the lives of others and in that sense of connecting in a human experience that transcends oneself, whether through teaching, writing, preaching, building or business. The Protestant concept of "works" as opposed to "work" reflects a recognition of the importance of such experience. Indeed, in a period when family integration is threatened, government is not trusted, religion is less influential and when few individuals find significant meaning in their work, greater anxiety about death does not seem surprising.¹⁰⁸

Social historians have described our society as a culture of narcissism.¹⁰⁹ Psychiatrists increasingly see what they describe as narcissistic pathology. Regardless of whatever else these terms imply, the terms refer to an egocentric quality that is derived from a lack of connectedness. Heinz Kohut sees narcissistic pathology as the product of families in which children are more isolated and less involved with parents, which is in contrast to the less severe pathology associated with the over-involvement between parents and children more common forty years ago.¹¹⁰ The diminished connectedness that develops in such an environment of isolation leaves the individual vulnerable to the anxieties of disintegration. While age and approaching death threaten everyone's sense of self, they are particularly intolerable for narcissistic individuals. In a culture that fosters narcissism, aging and death are harder to bear. Assisted suicide and euthanasia appear aimed at providing individuals with an illusory control over their fear of death.

A consequence of the fragmentation evident in the current culture is the increasing absence of a shared set of values, which leads many individuals to believe that anything goes if it is chosen freely, regardless of social consequences. Understood in this context, the concern for autonomy used to justify euthanasia is a euphemism for "narcissism" and less a new value than a reflection of the loss of social cohesion.¹¹¹

American attitudes toward older people may intensify the problems. Arnold Toynbee, the English historian, once stated

108. HENDIN, *supra* note 49.

109. C.L. ASCH, *THE CULTURE OF NARCISSISM* (1979).

110. H. KOHUT, *THE RESTORATION OF SELF* 262-312 (1977).

111. HENDIN, *supra* note 49.

that death is un-American.¹¹² Toynbee explained that death has no place in a culture that emphasizes progress, strength, and the vitality and beauty of youth and that devalues the wisdom and dignity of age. In such a society, dying can be a terribly lonely and desperate experience.

A hundred years ago, there were no old age homes; people died at home surrounded by their loved ones. The dying person and the person's family were conscious of both the connection and continuity of their lives and had a sense of death as a part of life.¹¹³ Pain, suffering and death itself were easier to bear in such a context.

Not surprisingly, given their social isolation, patients with AIDS have also become a significant group attempting and committing suicide and requesting assisted suicide and euthanasia.¹¹⁴ Research has shown that the absence of social support for patients with AIDS, including good medical care, is as significant as the actual symptoms or stage of the disease in determining the desire of these patients to end their lives or request help in doing so.¹¹⁵ The alienation from family, frequent in AIDS patients, the absence of children and the isolation from the larger community all contribute to the patients' increased anxiety about death.

VII. WHO IS MOST VULNERABLE?

The United States is the only industrialized democracy that does not guarantee medical care to a large number of its population. Without such care, euthanasia becomes a forced choice for large numbers of poor people, minority groups and older people because many such individuals would be vulnerable to pressure for assisted suicide and euthanasia by family, physicians, hospitals and nursing homes. In the words of the 1994 report on physician-assisted suicide and euthanasia issued by the New York State Task Force on Life and the Law:

The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group. The risks of legalizing assisted suicide

112. LIFTON & OLSEN, *supra* note 105.

113. P. ARIES, *THE HOUR OF OUR DEATH*, (Helen Weaver trans., 1981).

114. P. Marzuk, *The Increased Risk of Suicide in Persons with Aids*, 259 *JAMA* 1333-37 (1988).

115. A. Beckett & D. Shenson, *Suicide Risk in Patients with Human Immunodeficiency Syndrome and Acquired Immunodeficiency Syndrome*, 1 *HARV. REV. PSYCHIATRY* 27-35 (1993); W. Breithard, *Interest in Physician-Assisted Suicide Among Ambulatory HIV Infected Patients*, 153 *AM. J. PSYCHIATRY* 238-42.

and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantages, would be extraordinary.¹¹⁶

Some awareness of these possibilities may be responsible for the fact that in contrast to younger groups that support euthanasia, 56% of individuals between the ages of fifteen and thirty-four favor it, while 55% of individuals over the age of sixty-five, the presumed beneficiaries of the practice, oppose euthanasia. While a slight majority of caucasian individuals favor euthanasia, African-Americans oppose it by more than two to one.¹¹⁷

A more equitable medical system, however, has not protected the Dutch.¹¹⁸ Depressed patients, regardless of economic status, are vulnerable in the Netherlands and would be endangered here, as well. Individuals who are terrified of serious illness are particularly vulnerable to suicide, assisted suicide or euthanasia. Ultimately, all seriously or terminally ill people are vulnerable. As D. J. Bakker points out, "[a] very ill or terminally ill patient is completely dependent on others who through their attitude, gesture, tone of voice, and so on and so on, can suggest that the patient, even unconsciously, should ask for euthanasia."¹¹⁹ Edmund Pellegrino recognizes much of the suffering of dying patients as deriving from "being subtly treated as nonpersons. The decision to seek euthanasia is often an indictment against those who treat or care for the patient."¹²⁰

VIII. RATIONAL SUICIDE

Psychiatrists treating patients who are seriously or terminally ill are often asked whether a patient's request for assisted suicide or euthanasia is not in some cases rational. Irrational decisions are perceived as decisions made by an individual when the individual's strong emotions or mental condition interferes with the reasoning process. The desperation that invariably underlies a patient's request for assisted suicide ordinarily makes it impossible for a patient to make an informed decision, whether or not

116. THE NEW YORK TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 120 (1994).

117. The Terrance Group, *A Survey of Voter Attitudes in the United States* (Sept. 25-28, 1995).

118. See H. Hendin, *The Slippery Slope: The Dutch Experience*, 35 DUQ. L. REV. 429 (1996).

119. D.J. BAKKER, ACTIVE EUTHANASIA: IS MERCY KILLING THE KILLING OF MERCY?, EUTHANASIA: THE GOOD OF THE PATIENT, THE GOOD OF SOCIETY (R.L. Misbin ed., 1992).

120. E. PELLIGRINO, DOCTORS MUST NOT KILL, EUTHANASIA: THE GOOD OF THE PATIENT, THE GOOD OF SOCIETY (R.L. Misbin ed., 1992).

he or she meets the formal criteria for a psychiatric diagnosis of depression or other disorder.

When assisted suicide is legally sanctioned, as in the Netherlands or in laws currently being considered in various states, the psychiatrist's role is seen as determining whether a patient is competent (rational) to make the decision to die. The evaluation of patients by psychiatrists who are knowledgeable about suicide, depression and terminal illness, however, does not provide a simple solution to a complex social problem. A patient requesting assisted suicide is expressing a desperation that needs to be explored. When assisted suicide is given legal sanction and the psychiatrist is the gatekeeper, that exploration is compromised. It is the psychiatrist's broader traditional role that permits patients to air their fears, often permitting the psychiatrist to relieve them.

Philosopher and ethicist Daniel Callahan is right to point out that rationality refers to the logic of our thinking processes, not to whether a decision is right or even reasonable.¹²¹ Rationality is a necessary but not a sufficient condition for truth or reasonableness. Rational people often disagree because they embrace different premises and values, not because their thinking is faulty.

Long before Durkheim, most societies recognized that suicide, like crime and substance abuse, has destructive consequences to society as well as to the suicidal individual. Callahan has tried to explain the social values involved with respect to suicide.¹²² Callahan asks: "Should individuals build into their conception of a good life that suicide is a rational and reasonable solution to a miserable outcome to that life? Should society legitimate suicide to the point that it is a socially acceptable way for people to deal with the most grave misfortunes of life?"¹²³ Callahan sees most societies as having a repugnance to suicide because suicide represents the failure to cope with life, which breaks the solidarity that people should have in the face of the evils and tragedies of life.¹²⁴

Individuals have been socially tutored that despite pain, tragedy and misfortune, people owe it to one another to go on with life. Callahan writes:

121. D. Callahan, *Reasons, Rationality and Ways of Life* (unpublished manuscript) (on file with author).

122. *Id.*

123. *Id.*

124. *Id.*

We need the help of other people in coping with what life throws our way, and one of the most fundamental goods that people can give us is the example of their lives. . . . If others can do it so can I. And if I cannot do it I will be failing in my duty to others, failing to give them the kind of help that they by simply enduring have given me. One reason, however, why we typically feel a sense of loss and pity when someone commits suicide is because we guess that the person has not only chosen to leave life, but also to leave the human community in some way that does harm to those of us who remain; the harm of someone who could not find a way to maintain solidarity with the rest of us in the presence of pain and suffering.¹²⁵

Callahan sees an attempt to counter this traditional social value system with an ethos which holds that competent individuals may make whatever choices they want, including killing themselves, if there is no demonstrable harm to others resulting from a choice. In this view, a reasonable choice is one that is compatible with an individual's values and perceived self-interests. Callahan denotes such a choice as perhaps rational in the narrow sense of consistency and coherence, but as a choice which does not answer the issues of whether it is reasonable for an individual to end life and for society to legitimate the choice as a reasonable option.¹²⁶ He recognizes that a person who is unwilling to tolerate any suffering which might be avoidable, determined to control life as far as possible, or who sees suicide as a purely private act might mistakenly wish to reject the older tradition of solidarity in favor of a tradition of self-determination and the right to suicide.¹²⁷ While Callahan would like people to understand and empathize with individuals who commit suicide in the face of severe travail, he equally wants people to understand why society should not legitimate such acts as a standard part of a way of life.¹²⁸

IX. WITHDRAWING TREATMENT VERSUS ASSISTED SUICIDE

Individuals who see no difference between doctors who withdraw a patient's treatment and those who actively participate in assisted suicide or euthanasia point out that in either case, death is the usual outcome.

There is no evidence, however, that terminally ill patients who refuse or wish to discontinue treatment suffer from depression or any mental disorder that would affect their competence any more than comparable terminally ill patients who desire more active

125. *Id.*

126. Callahan, *supra* note 121.

127. *Id.*

128. *Id.*

treatment. This is in striking contrast to terminally ill patients who request assisted suicide or euthanasia, who are characterized by a degree of depression and anxiety that compromises their ability to make decisions, and who are basically similar to the general population of suicidal patients. It must be acknowledged, however, that observations contrasting individuals who wish to forgo treatment with individuals who request assisted suicide or euthanasia are relying on clinical observation and experience rather than systematic comparison of the two groups, which has yet to be done.

Since physician-assisted suicide and euthanasia are social acts affecting at least one doctor in addition to a patient, doctors' reactions to their experiences in treating these patients are helpful in shedding some psychological light on the differences between assisted suicide, euthanasia and withdrawing treatment. Although the law and medical ethics equate withholding treatment with withdrawing treatment as both are rooted in the right of a competent patient to protect against invasions of bodily privacy, in practice doctors find it harder to withdraw treatment than to withhold it. Doctors are accustomed to patients exercising their right to refuse even what doctors may see as life-saving treatment. Not beginning treatment that is likely to be futile presents relatively few difficulties.

While withdrawing a life-preserving respirator at the request of a patient or patient surrogate when such treatment is simply prolonging the dying process may be medically warranted, it puts doctors in uncomfortable and unfamiliar territory. Physicians may even be in situations where they are asked to act against their better judgment, particularly in cases where patients are not imminently dying.

Nevertheless, doctors who withdraw treatments upon patient request have not been found to be ordinarily troubled afterward. Doctors see the patient as having died from his or her disease; they do not see themselves as having killed the patient and accept that the patient can set limits on the continuation of treatment.

Euthanasia, however, is another matter. Performing euthanasia appears to have a troubling influence on many physicians who practice it as they do perceive themselves as having killed the patient. The Dutch experience indicates that this feeling is not relieved by legally sanctioning euthanasia. In fact, recently the Royal Dutch Medical Association has suggested that wherever possible, assisted suicide rather than euthanasia should be performed because doctors who have performed euthanasia

found it disturbing.¹²⁹ This was particularly true for many Dutch doctors who seldom performed euthanasia and when they did, performed it reluctantly.

The average doctor's discomfort with ending a patient's life is not so surprising. Even when justified by the exigencies of war, most soldiers pay a price for participating in killing.¹³⁰

Just as a minority of soldiers deal with the horror of war by embracing the power of being able to end someone's life,¹³¹ so too a minority of doctors embrace assisted suicide and euthanasia with fervor.¹³² Dutch doctors who perform euthanasia regularly prefer it to assisted suicide and state that they will continue to use euthanasia because it is more reliable and less subject to complications.¹³³ Several doctors described the bonding experience that they had with patients they put to death as one of the closest and most meaningful experiences of their lives.¹³⁴ At the same time, these physicians describe a need for absolution, which implies some feelings of guilt.¹³⁵ Assisted suicide provides a fig leaf that the Dutch medical association hopes will enable physicians to rationalize their participation in a patient's death.

For some doctors, continued participation in and advocacy of euthanasia appear to be a way of denying the guilt that they feel over their initial involvement. The fact that a small number of doctors do a great number of the total number of euthanasia cases is one of the unexamined aspects of the Dutch euthanasia story.¹³⁶ A similar situation would develop in the United States if assisted suicide and euthanasia were legalized. Legal sanctioning of these practices is likely to lead to a few hundred "Kevorkians," even if none of them is likely to be as eccentric as Jack Kevorkian.

X. THE EXCEPTIONAL PATIENT

What about a terminally ill patient, not in the last days of life, who requests euthanasia stating that he or she does not want to live with the physical and psychological distress of illness? Palliative care specialists see such patients frequently, as do psychi-

129. KNMG GUIDELINES ON ASSISTED SUICIDE AND EUTHANASIA (August 1995).

130. H. HENDIN & A. HAAS, *THE WOUNDS OF WAR* (1984).

131. *Id.*

132. HENDIN, *supra* note 49.

133. M. Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, *NY TIMES*, September 11, 1995 at A3.

134. HENDIN, *supra* note 49.

135. *Id.*

136. Herbert Hendin, *The Slippery Slope: The Dutch Example*, 35 *DUQ. L. REV.* 429 (1996).

atrists handling consultation-liaison work in general hospitals. If physicians respond to these patients empathetically and make it possible for them to discuss their fears of death while addressing their physical suffering, most of these patients regain the desire to live.¹³⁷

What about patients who say, "I don't want treatment even if it will make me feel better; I just want to die?" When so many patients will accept relief and want to live if responded to sensitively by a caring and capable physician, and when those who cannot be helped can be sedated and allowed to die, our society should not change social policy to accommodate the patients who say "I want to die even if treatment will make me feel better."¹³⁸ What if a patient is one of the small group whose suffering cannot be relieved by any palliative care measure now available? It is currently accepted practice, supported by the American Medical Association, courts, and most churches, that when patients cannot be helped in any other way, they can refuse food and fluids and request sedation.¹³⁹

Euthanasia advocates maintain that there is no difference between a doctor's intention in sedating dying patients and in deliberately ending patients' lives. Clearly, there are doctors who use sedation as a covert form of euthanasia. There is no evidence, however, for the euthanasia advocates' assumption that what is true for these doctors is also true for most doctors who see sedation as a way of relieving pain while allowing patients to die.

XI. THE LIMITATIONS OF OUR KNOWLEDGE

Physicians cannot make a determination, on the basis of criteria like rationality, whether a patient's decision to die is reasonable. Physicians also cannot reliably determine who has six months or less to live and define a group of terminally ill patients on that basis, especially when the patients' survival may be a function of their willingness to accept treatment. Physicians cannot qualify or quantify suffering among seriously or terminally ill people, or even say whether their suffering is greater than that of other patients who are not terminally ill.

There is much that medicine needs to know. Clinical experience suggests that patients who want relief from suffering in the last days of their lives (relief that can be provided under current

137. *Id.*

138. AMERICAN SUICIDE FOUNDATION, OCTOBER 1996 POLICY STATEMENT: PHYSICIAN ASSISTED SUICIDE 3 (1996).

139. A. DeTOCQUEVILLE, DEMOCRACY IN AMERICA (F. Bowen trans., 1994).

law by sedation) are different than patients loosely designated as terminally ill, who want to die but are not imminently dying. This observation clearly needs to be verified.

Comparative studies are needed to confirm the clinical impression that, unlike terminally ill patients who request assisted suicide or euthanasia, individuals who forgo treatment do not suffer from the anxiety or depression that would impair their ability to make decisions, at least not any more than comparable terminally ill patients who want more active treatment.

The handful of studies conducted on patients who request assisted suicide have understandably concentrated on the current emotional state of the patients making the request. Knowledge is needed of these patients' past histories, however, including their past suicide attempts, which are a strong predictor of future suicidal behavior. With both cancer and AIDS patients who commit suicide, there is strong evidence of premorbid psychopathology.¹⁴⁰ As these are the two groups of patients from whom most requests for assisted suicide derive, information about these patients' lives as they were prior to the patients' illness would be particularly valuable.

XII. CONCLUSION

Alexis De Tocqueville observed that Americans rush to the law to solve all problems.¹⁴¹ In America's eagerness to legalize assisted suicide and euthanasia, De Tocqueville surely would recognize a wish to legislate a quick fix for the larger problem of caring for individuals who are terminally ill. It is the country's failure to address this problem that has created a vacuum which doctors like Jack Kevorkian are willing to fill. In the light of how recently medicine has begun to address the problems involved in such care, society should heed the admonition implicit in De Tocqueville's remark and not rush to legitimate death as the answer. Knowledge of the harmful consequences of the Dutch embrace of assisted suicide and euthanasia on the care of terminally ill patients would seem persuasive that legalization of these practices will prove more destructive than disease.

140. Premorbid psychopathology is the pathology of [a patient's] mental disorders which occurred before the development of the patient's illness. See DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1351, 1385 (27th ed. 1988).

141. A. DETOCQUEVILLE, DEMOCRACY IN AMERICA (F. Bowen, trans., 1994).