Suicide, Assisted Suicide, and Medical Illness

Herbert Hendin, M.D.

Medical illness is an important part of the motivation for suicide—a significant factor in about 50% of suicides in patients over the age of 50 years and 70% of suicides in patients over the age of 70 years. Depression, anxiety, and ambivalence about dying characterize both medical patients who attempt suicide and those who request assisted suicide. When the physical and psychological sources of the desperation that underlies requests for assisted suicide are addressed, the desire for death diminishes and patients are usually grateful for the time remaining to them. Improved psychiatric and medical care for those who are terminally ill offer significant possibilities for suicide prevention.

(J Clin Psychiatry 1999;60[suppl 2]:46–50)

Physical illness is a motivation for suicide; this was known long before recent proposals to legalize assisted suicides of patients who are seriously or terminally ill. Medical illness plays an important role in 25% of suicides, and this percentage rises with age: from about 50% in persons over 50 years old who commit suicide to over 70% in persons older than 60 years of age who commit suicide.[1] Medical conditions shown to be associated with high suicide rates include cancer, acquired immunodeficiency syndrome (AIDS), peptic ulcer (although here alcoholism is a confounding variable), Huntington's chorea, head injury, renal disease, and spinal cord injury.

Most suicide attempts reflect a person's ambivalence about dying, and patients requesting assisted suicide show an equal ambivalence. When interviewed 2 weeks after a request for assisted suicide, two thirds of these patients show a significant decrease in the strength of the desire to die.[2]

Patients may voice suicidal thoughts in response to transient depression or severe pain, but these patients usually find relief with treatment of their depression, or with pain medication, and are grateful to be alive. Strikingly, the overwhelming majority of people who are terminally ill fight for life to the end: only 2% to 4% of suicides occur in the context of terminal illness.

From the Department of Psychiatry, New York Medical College and the American Foundation for Suicide Prevention, New York, N.Y.

Presented at the symposium "Effects of Medical Interventions on Suicidal Behavior," which was held February 26–28, 1998, Miami, Fla., cosponsored by the American Foundation for Suicide Prevention, the Johns Hopkins University School of Medicine, and the Long Island Jewish Medical Center, with the cooperation of the Suicide Prevention Advocacy Network, and supported by an educational grant from Solvay Pharmaceuticals, Inc.

Reprint requests to: Herbert Hendin, M.D., American Foundation for Suicide Prevention, 120 Wall St., New York, NY 10005.

DEPRESSION

Mental illness raises the suicide risk even more than physical illness. We know that nearly 95% of all people who kill themselves have a psychiatric illness diagnosable in the months before suicide.[3–5] The majority suffer from depression that can be treated. This is particularly true of those over 50 years of age who are more prone than younger victims to take their lives during an acute depressive episode.

Like other suicidal individuals, patients who desire an early death during a serious or terminal illness are usually suffering from a treatable depressive condition. Although pain and other factors, such as a lack of family support, contribute to their wish for death, depression is the most important factor, and researchers have found it to be the only factor that significantly predicts the wish for death.[2]

Depression, often precipitated by discovering one has a serious illness, exaggerates the suicidal patient's tendency to see problems in black and white terms, overlooking solutions and alternative possibilities. Suicidal patients are especially prone to setting absolute conditions on life: "I won't live ...without my husband," "...if I lose my looks, power, prestige, or health," or "...if I am going to die soon." These patients are afflicted by the need to make demands on life that cannot be fulfilled. Determining the time, place, and circumstances of their death is the most dramatic expression of their need for control.[6]

Both patients who attempt suicide and those who request assisted suicide often test the affection and care of others, confiding feelings like "I don't want to be a burden to my family" or "My family would be better off without me." Such expressions usually reflect depressed feelings of worthlessness or guilt and/or may be a plea for reassurance. Not surprisingly, they are also classic indicators of suicidal depression in people who are in good

Table 1. Physician-Assisted Suicide and Euthanasia

Reasons given for requesting
Pain and suffering
Loss of dignity
Dependency on others
Losing control of one's life
Side effects of treatment
Impoverishing treatment costs
Burden to family
Psychological factors
Presence of depression
Fear of death
Testing the affection of others
Fear of abandonment
Seizing control by determining how and when one dies
Purification by destroying a bad part of the self
Receiving a deserved punishment
Uniting with others who died
Uniting with the physician
Social factors
Presence or absence of family support
Availability of a competent doctor
Ability to afford treatment
Earlier experiences with relatives and friends who died

physical health. Whether physically healthy or terminally ill, these individuals need assurance that they are still wanted; they also need treatment for their depression. Unfortunately, although most people who kill themselves are under medical care at the time of death, their physicians often fail to recognize the symptoms of their depressive illness, or fail to provide adequate treatment.[7]

FEAR OF DEATH

The uncertainties surrounding death also play a role in patient requests for assisted suicide. "Tim," for example, was a professional in his early 30s when he developed acute myelocytic leukemia. He was told that medical treatment would give him a 25% chance of survival, and that without it he would die in a few months.

His immediate reaction was a desperate, angry preoccupation with suicide and a request for support in carrying it out. He was worried about becoming dependent and feared both the symptoms of his disease and the side effects of treatment. Tim's anxieties about the painful circumstances that would surround his death were not irrational, but all his fears about dying amplified them.

Once Tim could talk about the possibility or likelihood of his dying—what separation from his family and the destruction of his body meant to him—his desperation subsided. He accepted medical treatment and used the remaining months of his life to become closer to his wife and parents.

At first he would not talk to his wife about his illness because of his resentment that she was going on with her life while he would likely not be going on with his. A session with the 2 of them cleared the air and made it possible for them to talk openly with each other. Two days before he died, Tim talked about what he would have missed without the opportunity for a loving parting.[8]

Like Tim, the vast majority of those who request assisted suicide or euthanasia are motivated primarily by dread of what will happen to them rather than by current pain or suffering—they fear pain, dependency on others, loss of dignity, the side effects of medical treatment, and, of course, death itself (Table 1).

Patients do not know what to expect and cannot foresee how their conditions will unfold as they decline toward death. Facing this uncertainty, they fill the vacuum with their fantasies and fears. When these fears are dealt with by a caring and knowledgeable physician, the request for an expedited death usually disappears.

It is not possible to understand the relation of suicide to assisted suicide and medical illness or to understand what assisted suicide and euthanasia mean in actuality without studying the Netherlands, where both have been practiced with legal sanction for 2 decades.

THE DUTCH CURE

What happens in the Netherlands to patients, like Tim, who become suicidal when confronted with serious or terminal illness? Early in my work in the Netherlands, I was shown "Appointment with Death," a film by the Dutch Voluntary Euthanasia Society that was intended to promote euthanasia. In the film, a 41-year-old artist was diagnosed as positive for human immunodeficiency virus (HIV). He had no physical symptoms, but had seen others suffer with them and wanted his physician's assistance in dying.

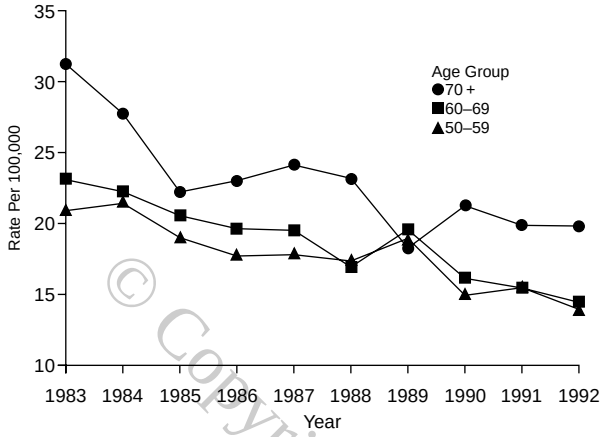
The doctor compassionately explained to him that he might live for some years symptom-free. Despite this explanation, over time the patient repeated his request for assisted suicide. Although the doctor thought his patient was acting unwisely and prematurely, he did not know how to deal with his patient's terror. He rationalized that respect for the patient's autonomy required that he grant the patient's request.

Consultation in the case was pro forma; a colleague of the doctor saw the patient briefly to confirm his wishes. Although the primary doctor continued to establish that the patient was persistent in his request and competent to make the decision, thus formally meeting criteria required for assisted suicide in the Netherlands, he did not address the terror that underlay the patient's request.

This patient had clearly been depressed and overwhelmed by the news of his situation. Had his physician been able to deal with more than formal criteria regarding a request to die—more likely in a culture not so accepting of assisted suicide and euthanasia—this man would probably not have been assisted in suicide.[9]

In the decade between 1983 and 1992, by making assisted suicide and euthanasia easily available, the Dutch

Figure 1. Suicide Rates in the Netherlands, 1983–1992*



*From reference 8, with permission.

have significantly reduced—by a third—the suicide rate of those over 50 years of age in the population (Figure 1), the age group containing the highest numbers of euthanasia cases (86% of the men and 78% of the women receiving euthanasia) and the greatest number of suicides.[8]

This was the period of growing Dutch acceptance of euthanasia. The remarkable drop in the older age group appears to be due to the fact that older suicidal patients are now asking to receive euthanasia. The likelihood that patients would end their own lives if euthanasia was not available to them was one of the justifications given by Dutch doctors for providing such help.[8,9]

Of course, one can maintain that making suicide "unnecessary" for those over 50 who are physically ill is a benefit of legalization rather than a sign of abuse. Such an attitude depends, of course, on whether one believes that there are alternatives to assisted suicide or euthanasia for dealing with the problems of older people who become ill.

Among an older population, physical illness of all types is common, and many who have trouble coping with physical illness become suicidal. In a culture accepting of euthanasia, their distress is accepted as a legitimate reason for dying. It may be more than ironic to see euthanasia as the Dutch cure for suicide.

GUIDELINES AND AUTONOMY

Ignorance of how to relieve psychological and physical suffering is probably the most frequent reason that doctors comply with or encourage patients' assisted suicide and euthanasia requests, although they rationalize what they do as respecting patient autonomy. At a small, international workshop that addressed problems in the care of the terminally ill, 2 American cases were presented in which terminally ill patients requested assisted suicide.

In one case, a man was confined to a wheelchair because of advanced symptoms of AIDS that included cystic lung infection, severe pain due to inflammation of the nerves in his limbs, and marked weight loss. By the appropriate use of steroids, antidepressants, and psychological sensitivity in dealing with his fears of abandonment, he was able to gain weight, be free of his pain and his wheel chair, and live an additional 10 months, for which he was grateful.[8]

In another case, a woman with great pain due to lung cancer that invaded her chest wall wished for assisted suicide. A nerve block relieved her pain, and she was happy to be able to leave the hospital and live her remaining months at home.[10]

I presented these cases to physicians who were euthanasia advocates in the Netherlands and in this country. They at first agreed that the patient with AIDS had a right to have euthanasia performed, but were not so sure after they heard the actual outcome. In the second case, aware that a nerve block could provide relief, most would not have performed euthanasia.

In other words, doctors felt free to ignore patient autonomy when they knew how to help the patient. "Patient autonomy" was in essence a rationale for assisted suicide when doctors felt helpless and did not know what else to do. It is not surprising that research has shown that the more physicians know about palliative care, the less they favor legalization of assisted suicide; the less they know, the more they favor it.[11]

Caring for people at the end of life takes considerable skill and requires a great deal emotionally of a physician; the Dutch experience suggests that legal sanction for the easier option of assisted suicide and euthanasia makes it harder to engage physicians in the process.[12]

THE ROLE OF THE PSYCHIATRIST

The request for death ordinarily comes from patients who are desperate whether they are medically ill or not. Supporting or denying such a request is not an adequate response. A comprehensive psychiatric evaluation—which should be made in all such patients—must include inquiring into the source of such desperation and undertaking to relieve it. Such inquiry must include a history of the patient's experiences with the death of those close to him or her, a history of past crises in the patient's life and how they were dealt with and, of course, a past history of depression as well as any suicide attempts.

COMPETENCE

In considerations of legalizing assisted suicide, psychiatrists are generally assigned the role of assessing whether patients are competent to make the request. Such an assessment is supposed to include an evaluation to determine the presence of depression and to distinguish it from the sadness that may accompany illness.

Even patients with severe depression may pass tests of legal competency to make medical decisions. In the Netherlands, in statutes proposed in several of our states, and in the law permitting assisted suicide adopted in Oregon, depression per se is not accepted as indicating incompetence.

If assisted suicide were legal, Tim probably would have visited a doctor whom he knew was likely to support his request. Because he was mentally competent, he would have qualified for assisted suicide and would surely have found a doctor who would have agreed to his request. He could have been put to death in an unrecognized state of terror, unable to give himself the chance of getting well or of dying in the dignified way he did. It was the fact that I was not the arbiter of his fate, but rather in the more traditional role of sympathetic but engaged listener, that permitted Tim to talk freely with me and to change his mind about wanting to die.

CONCLUSION

Although inadequate psychiatric and medical training of physicians is a major obstacle to providing adequate palliative care to patients who are seriously or terminally ill, there are problems in our health care delivery system that compound the problem. State laws written before the advent of modern palliative care and designed to curb drug abuse will have to be revised because currently they often make it impossible for hospitals to stock adequate amounts of analgesic medication. Health maintenance organizations and insurance companies will need to be obliged to make palliative care an integral part of their policies. In particular, we will need to insist that treatment of depression in terminally ill patients be included in their policies.

Legalization of assisted suicide would compound the problem. Although palliative care is cheaper than unwise medical care that only painfully prolongs the dying process and characterized our medical system in the past, assisted suicide is the cheapest solution of all.

No group of suicidal patients has been more ignored than those who become suicidal in response to serious or terminal illness. This is true despite the fact that the highest suicide rates are found in those over 50 years of age—white men over 50 years of age, comprising 10% of the population, are responsible for 33% of all U.S. suicides—and this is the age group in which medical illness plays such a significant role in suicide. In addition, the aging of the population makes it likely that within a few decades the majority of all suicides will occur in this age group.

The need for research is great. Of the over 170 grant applications the American Foundation for Suicide Prevention (AFSP) has funded over the past 10 years, only a handful have dealt with suicide or requests for assisted suicide in medical patients. All of them, however, made important contributions.

A project evaluating requests for assisted suicide demonstrated that depression was the only predictor of such requests. Another project was the first to demonstrate that the incidence of suicide in men aged 20 to 59 years found to be HIV-positive or diagnosed with AIDS was 36 times higher than for a matched group of men without the disorder. This study indicated that suicide occurs within 9 months of the onset of the disease and is not related to the severity of symptoms; other AFSP-funded research was able to show that suicide in AIDS patients is related to psychiatric status and to the level of social support available to the patient. Now that treatment has improved the prognosis for those who are HIV-positive or who have AIDS and the death rate for AIDS has declined, it will be worthwhile to replicate this study to determine if the death rate for suicide has also declined in this population.

Social support has a demonstrable therapeutic role to play. A Swedish study found that when patients with chronic medical illnesses made suicide attempts, their overburdened families often did not want medical intervention to help these patients recover. When social workers were able to obtain help in caring for the patients, the patients wanted to live and their families wanted them to.[13]

There has been no formal study, however, of cases in which assisted suicide was requested to confirm the experience of palliative care experts and psychiatrists—that treatment of depression and anxiety combined with proper palliative care is successful in restoring these patients' desire to live and enabling them to find meaning and satisfaction in the end of their lives. The interface between the biological and the psychological is particularly challenging. For example, we do not understand why tricyclic antidepressants can relieve intractable pain in patients whether or not they are depressed.

No suicide prevention measure holds more immediate promise of success than providing the psychological and medical care that makes suicide not seem to be the only option for patients with serious or terminal medical conditions.

Knowledge of how to minister to the physical and psychological needs of terminally ill people is, I believe, one of the most promising developments in medicine in the past 2 decades, but dissemination of that knowledge has only begun.

Our challenge is to bring that knowledge and that care to all patients who are terminally ill. If we succeed, there is reason to believe that their need for suicide will disappear and the issue of assisted suicide and euthanasia will become irrelevant.

REFERENCES

1. MacKenzie TB, Popkin MK. Medical illness and suicide. In: Blumenthal SG, Kupfer DJ, eds. Suicide Over the Life Cycle. Washington, DC: American Psychiatric Press; 1990:205–232
2. Emanuel EJ, Fairclough DL, Daniels ER, et al. Euthanasia and physician-

assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public. Lancet 1996;347:1805–1810
3. Robins E, Murphy G, Wilkenson RH Jr, et al. Some clinical considerations in the prevention of suicide based on a study of 134 successful suicides. Am J Public Health 1959;49:888–889
4. Dorpat TL, Ripley HS. A study of suicide in the Seattle area. Compr Psychiatry 1960;1:349–359
5. Barraclough B, Bunch J, Nelson B, et al. A hundred cases of suicide: clinical aspects. Br J Psychiatry 1974;125:355–373
6. Hendin H. Suicide in America. New York, NY: WW Norton; 1995
7. Murphy GE. The physician's responsibility for suicide: (1) an error of commission and (2) errors of omission. Ann Intern Med 1975;82:301–309
8. Hendin H. Seduced by Death: Doctors, Patients, and Assisted Suicide. New York, NY: WW Norton; 1998
9. Hendin H. Assisted suicide, euthanasia, and suicide prevention: the implications of the Dutch experience. Suicide Life Threat Behav 1995;25:193–204
10. Hendin H. Suicide and the request for assisted suicide: meaning and motivation. Duquesne Law Rev 1996;35:285-310
11. Portenoy RK, Coyle N, Kash KM, et al. Determinants of the willingness to endorse assisted suicide: a survey of physicians, nurses, and social workers. Psychosomatics 1997;38:277–287
12. Hendin H, Rutenfrans C, Zylicz Z. Physician-assisted suicide and euthanasia in the Netherlands: lessons from the Dutch. JAMA 1997;277: 1720–1722
13. Wasserman D. Passive euthanasia in response to attempted suicide: one form of aggression by relatives. Acta Psychiatr Scand 1989;79:460–467