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Mental Illness, Physical Illness, and the Legalization of Physician-Assisted Suicide

Ellen H. Moskowitz
Associate, Proskauer Rose LLP.

MENTAL ILLNESS, PHYSICAL ILLNESS, AND THE LEGALIZATION OF PHYSICIAN-ASSISTED SUICIDE

*Ellen H. Moskowitz**

A basic difficulty with legalizing physician-assisted suicide has thus far received inadequate attention. It is a mistake to presume we can realistically identify severely ill individuals seeking lethal drugs from their physicians in order to die, do so willingly, knowingly, and voluntarily. Two main reasons support this conclusion, and this article explores them. The first reason concerns medical science. The second rests on medical practice.[1]

Under Western medicine, the identification and treatment of mental illness is a function of science. Clinical models, developed through empirical research, are used by physicians and other mental health professionals to identify the mental and behavioral characteristics of an individual indicating the presence of mental illness or dysfunction, and to craft therapeutic responses. Knowledge of these models, including an understanding of how to relate their generalities to each case, is what gives mental health professionals their medical authority in our society, and, most believe, their ability or power to heal mental illness. It is what makes them different from even the most empathetic and sensitive lay person.

If science and its clinical models matter a great deal to psychiatric medicine in general, they also matter importantly to the problem of suicide, including the special case of suicidal wishes and acts among the critically ill. As this Article shows, a substantial body of research has already been conducted on suicide among persons with physical illness. This research shows that these persons are medically indistinguishable from suicidal persons without physical illness. The two patient populations share the same cluster of mental and behavioral characteristics. Both are virtually certain to

* Associate at Proskauer Rose LLP. Formerly Associate for Law at the Hastings Center. The views expressed in this article are solely the author's.

1. This article is based on the Brief of the American Suicide Foundation (now called the American Foundation for Suicide Prevention), *Amicus Curiae*, to the United States Supreme Court, Supporting Reversal of *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (No. 96-110) [hereinafter American Suicide Foundation *Amicus Curiae* Brief], which was largely the product of the scholarship, good sense, and tireless efforts of Herbert Hendin, M.D., the then Executive Director of the Foundation, and who is now its Medical Director.

suffer from temporary and reversible mental disorders, including impaired cognitive function, that lead them, in often unrecognized ambivalence, to take their own lives.

Of course, even if medical science indicates the virtual certainty that these suicidal individuals suffer from a clinical disorder, a subset reasonably may not. (It is equally reasonable to believe that a subset of the physically healthy who are suicidal will show no presence of a mental disorder.) Medical science is based on probabilities, not certainties. Exceptions, not absolutes, are the rule.

However, this Article also considers why this necessary element of probabilism does not alter the judgment that our healthcare system cannot, within tolerable levels of error, identify severely ill, suicidal individuals free of incapacitating mental illness. It discusses the failings of medical practice to the suicidal: how healthcare professionals have a demonstrated inability to identify and provide standard treatments to average depressed, suicidal patients, particularly when such patients are elderly. Accordingly, one may not reasonably assume that healthcare professionals will prove able to identify the relatively rare suicidal person who is free of mental disability. Thus, even if one may easily suppose that at least some suicidal individuals exist, both physically healthy and physically ill, who lack mental disorders, this supposition is irrelevant to the case in favor of legalizing physician-assisted suicide among the critically ill. It is unreasonable to assume that now, or in the foreseeable future, any significant numbers of such individuals could be identified.

This Article concludes that suicide, including suicide by the physically ill, presents an urgent, unmet public health need in the United States. Meeting this need depends, in part, on lawmakers and the public taking full measure of what is already known about mental illness, physical illness and suicide, both in terms of medical science and medical practice. As a society, we cannot afford legal responses similar to those of the Ninth Circuit and Second Circuit Federal Courts of Appeals in *Compassion in Dying v. Washington*[2] and *Quill v. Vacco*.[3] These decisions presume the existence of a reasonably identifiable competent suicidal patient who is terminally ill, without engaging, let alone mentioning, the sizable empiri-

2. 79 F.3d 790 (9th Cir. 1996), *rev'd sub. nom.* Washington v. Glucksberg, 117 S. Ct. 2258 (1997).

3. 80 F.3d 716 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).

cal literature to the contrary.[4] They also identify a constitutional right for this speculative patient to have medical assistance in committing suicide.[5] Together, they strike down as unconstitutional about a quarter of this nation's laws against assisted-suicide under these circumstances.[6] At the very least, laws and policies on physician-assisted suicide should not ignore what is now known about the medical science and medical practice regarding suicide by the physically ill. This Article goes further than this recommendation, however, and argues that serious consideration of this science and practice makes plain that legalization is ill-advised.

I. Medical Science and the Elusive Competent Suicidal Patient With Severe Physical Illness[7]

Based upon what medical science has discovered about mental illness, physical illness, and suicide, it is a mistake to posit a reasonably identifiable patient population of adults with terminal diagnoses who can provide informed, voluntary consent to prescription lethal drugs. To date, there exists no sound clinical basis for distinguishing suicidal patients with terminal conditions from suicidal patients without terminal conditions. Rather, treatable, reversible mental disorders characterize both groups of patients.

In twenty-five percent of all suicides, problems from a physical illness play an important role in suicidal ideation.[8] Among older

4. In *Quill*, the Second Circuit wastes few words on the matter. Aside from noting that the three physician plaintiffs agree they have treated competent patients who seek lethal drugs, the court neither cites psychiatric literature in support of this assumption, nor addresses the significant literature that suggests the opposite. In *Compassion in Dying*, the Ninth Circuit's lengthy opinion also fails to engage the substantial contemporary scientific literature on physical illness, mental illness, and suicide, and instead falls into a scientifically unsupported and unfortunate societal bias about the "naturalness" of suicidal urges among the severely ill. 79 F.3d at 821. The court found, "While some people who contemplate suicide can be restored to a state of physical and mental well-being, terminally ill adults who wish to die can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends." *Id.*

5. *Compassion in Dying*, 79 F.3d at 816; *Quill*, 80 F.3d at 727 (stating that New York State's prohibition of physician-assisted suicide violated the Equal Protection Clause because the distinctions made by New York law did not further a legitimate state purpose).

6. The Ninth Circuit decision affects the laws of California, Alaska, Arizona, Hawaii, Idaho, Montana, Nevada, Oregon, and Washington. The Second Circuit decision affects the laws of New York, Connecticut, and Vermont.

7. With some alteration and augmentation, this section is taken largely from Part I of the American Suicide Foundation *Amicus Curiae* Brief, *supra* note 1, at 5.

8. Thomas Mackenzie & Michael Popkin, *Medical Illness and Suicide*, *in* Suicide Over the Life Cycle 205, 206 (Susan J. Blumenthal & David J. Kupfer eds., 1990).

suicidal patients, physical illness is more apt to figure in suicidal ideation: rising from thirteen percent in those under thirty-nine when they kill themselves to seventy percent in those over the age of sixty.[9]

However, like other suicidal individuals, patients who desire an early death during a serious or terminal illness characteristically suffer from a treatable mental illness, most commonly a depressive condition or alcoholism.[10] Numerous studies have confirmed that at least ninety-five percent of those who kill themselves (regardless of their physical condition) can be shown to have a treatable, diagnosable psychiatric illness, usually depression, in the months preceding suicide.[11] A comprehensive 1996 review on decades of studies on suicide and physical illness there is an assertion that, "[t]here is little evidence, however, 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]

Moreover, while many assume it is normal for persons with severe or terminal illness to respond to their situation with suicide, this is not, in fact, the case. Studies show such behavior to be substantially outside the norm. The overwhelming majority of terminally ill patients do not attempt or commit suicide.[13]

The physical pain that can accompany severe or terminal disease can be a factor contributing to suicidal urges. Pain has been shown to be an issue in thirty percent of euthanasia requests, and a major factor in about six percent of cases.[14] Nonetheless, current medical research clearly shows that pain is insignificant, compared to the

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9. *Id.* at 208.

10. *Cf.* James Henderson Brown et al., *Is it Normal for Terminally Ill Patients to Desire Death?*, 143 AM. J. PSYCHIATRY 208, 208 (1986) (discussing that thoughts of suicide is one of the criteria used to determine depression in a patient); Harvey Max Chochinov et al., *Desire for Death in the Terminally Ill*, 152 AM. J. PSYCHIATRY 1185, 1185, 1188 (1995); *see also* David C. Clark, *'Rational' Suicide and People with Terminal Conditions or Disabilities*, 8 ISSUES IN LAW & MED. 160, 160-61 (1992).

11. *See* Eli 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 (1959); *see also* Theodore L. Dorpat & Herbert S. Ripley, *A Study of Suicide in the Seattle Area*, 1 COMP. PSYCHIATRY 349 (1960); B.M. Barraclough et al., *A Hundred Cases of Suicide: Clinical Aspects*, 125 BRIT. J. PSYCHIATRY 355 (1974); Charles L. Rich et al., *San Diego Study, I: Young vs. Old Subjects*, 43 ARCHIVES GEN. PSYCHIATRY 577 (1986).

12. Eve K. Moscicki, *Epidemiology of Suicide*, *in* SUICIDE AND AGING: INTERNATIONAL PERSPECTIVES 3, 10 (J.L. Pearson & Y. Conwell eds., 1996).

13. *See* Robins et al., *supra* note 11, at 890 (finding that fewer than five percent of all suicides occur in the context of terminal illness); *see also* C.P. Seager & Anthony Flood, *Suicide in Bristol*, 11 BRIT. J. PSYCHIATRY 919 (1965).

14. *See* P.J. VAN DER MAAS ET AL., *Euthanasia and Other Medical Decisions Concerning the End of Life* 2 (1992).

presence of depression or other mental disorders, as a predictor of the desire to commit suicide.[15]

Like pain, social circumstances also have been found to exacerbate the suicidal urges of those suffering from depression or other mental disorders, including persons with severe illness. At the turn of the century, the French sociologist Emile Durkheim recognized that vulnerability to suicide was affected by the extent to which people were integrated and accepted into community and family life.[16] Then, as now, the single, widowed, and divorced, were observed to have higher suicide rates than married people. The presence of children also tends to lessen the likelihood of suicidal behavior, as does having a job. In addition, "[c]ontemporary observations on the high suicide rates of socially isolated older men are consistent with Durkheim's hypothesis."[17] These exacerbating social circumstances suggest that perhaps it should not be clinically surprising that patients with AIDS have become a significant group in attempting and committing suicide and requesting assisted suicide and euthanasia.[18] Research suggests that the absence of social support is as significant as actual symptoms, or even the stage of the disease, in determining the desire of patients with AIDS to end their lives or to request help in doing so.[19]

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15. *See* Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 THE LANCET 1805 (1996); Herbert Hendin & Gerald L. Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143 (1993). Fortunately, palliative care specialists have developed a wide range of techniques for pain management. Pain can invariably be relieved if the physician is knowledgeable about how to do so, although this at times involves degrees of sedation. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 37-40 (1994); *see also* Clark, *supra* note 10, at 161. However, advances in our knowledge of how to treat pain have not been accompanied by adequate dissemination of that knowledge, and too often pain is under treated. Kathleen Foley, *Pain and America's Culture of Death*, WILSON QUARTERLY 19, 20-21 (Autumn 1994).

16. *See* EMILE DURKHEIM, SUICIDE: A STUDY IN SOCIOLOGY 152-240 (John A. Spaulding et al. trans., 1951).

17. Herbert Hendin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation*, 35 DUQ. L. REV. 285, 301 (1996).

18. *See* William Breitbart et al., *Interest in Physician-Assisted Suicide Among Ambulatory HIV Infected Patients*, 153 AM. J. PSYCHIATRY 238, 241 (1996); *see also* Peter Marzuk et al., *The Increased Risk of Suicide in Persons with AIDS*, 259 JAMA 1333 (1988).

19. *See* Alexandra Beckett & Douglas Shenson, *Suicide Risk in Patients with Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome*, 1 HARV. REV. OF PSYCHIATRY 27 (1993); *see also* Breitbart et al., *supra* note 18, at 239.

For the physically and mentally ill, social isolation can also occur from a lack of support and acceptance by family and physicians for the patient's continued living. A study focusing on the role of family in suicide among the chronically ill in Sweden showed that when chronically ill patients attempted suicide, their overburdened families often did not want them resuscitated.[20] However, when government social services provided home care helpers, most families became supportive of the patient's continued living, and most patients were no longer suicidal.[21]

While depression is the key clinical characteristic that suicidal patients with terminal conditions share with suicidal patients without terminal conditions, other distinctive mental and emotional disorders are also typical to both classes of patients. For example, researchers have observed suicidal patients, both with and without terminal illness, who have possessed a compelling urge end an emotional torment linked to a life crisis, by ending their lives.[22] For the physically ill, this affective crisis typically centers on the fear of death more than the fear of disease. Patients do not consciously confront anxieties about death. Instead, they are distracted from this central fear by strong, exaggerated concerns, even rage, about what they will experience physically and emotionally prior to death.[23] Moreover, for the physically ill suicidal person, these fears will focus more on what they imagine will happen in the future, and not on current physical pain or disability.[24]

Research on the cognitive functioning of the suicidal also demonstrates that impaired thought processes and irrationality characterize the mental state of these individuals, regardless of their physical condition.[25] The mental disorders that are present sub-

20. *See* Danuta Wasserman, *Passive Euthanasia in Response to Attempted Suicide: One Form of Aggression by Relatives*, 79 ACTA PSYCHIATRICA SCANDINAVICA 460, 463-64 (1989).

21. *Id.*

22. *See* Hendin & Klerman, *supra* note 15, at 143-45.

23. *See* Herbert Hendin, *Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience* 25 SUICIDE AND LIFE-THREATENING BEHAV. 193, 195-96 (1995).

24. Pieter V. Admiraal, *A Physician's Responsibility to Help a Patient Die*, *in* EUTHANASIA: THE GOOD OF THE PATIENT THE GOOD OF SOCIETY 77, 80 (Robert I. Misbin ed., 1992).

25. *See, e.g.*, Aaron T. Beck, *Thinking and Depression*, 9 ARCHIVES GEN. PSYCHIATRY 324 (1963); *see also* David C. Clark et al., *Intellectual Functioning and Abstraction Ability in Major Affective Disorders*, 26 COMPREHENSIVE PSYCHIATRY 313 (1985); Harold Bursztajn et al., *Depression, Self-Love, Time, and the "Right" to Suicide*, 8 GEN. HOSP. PSYCHIATRY 91 (1986); Linda Ganzini et al., *Depression, Suicide,*

stantially impair cognitive functioning.[26] Patients' awareness and reasoning are colored by unrealistically low self-regard, ideas of deprivation and rejection, often in the face of overt demonstrations of affection, and a tendency toward self blame with no logical basis.[27] A magnification of problems, impossible self-demands, exaggerated desires for control, and a rigid tendency to see suicide as the only possible solution to their problems is characteristic.[28]

One particular cognitive impairment typically found in depressed suicidal patients is the tendency to develop a distorted and overly negative perception of their physical condition, while remaining unaware of their depression. This lost understanding can sometimes become so intense as to lead to an erroneous belief that they are ill and dying, when in fact they are healthy. For example, according to two separate community-based studies of elderly persons who died by suicide, more persons killed themselves because they mistakenly believed they had cancer than died with cancer or any other terminal illness.[29] In the same vein, preoccupation with suicide is greater in those awaiting the results of tests for HIV antibodies than in those who know they are HIV positive.[30]

The ambivalent and variable nature of the wish to die also characterizes both terminally and non-terminally suicidal patients.[31] For example, in one study of patients with terminal illness, only two weeks after they had expressed the wish to commit suicide, two-thirds showed less of a desire to die.[32] This characteristic ambivalence has been studied in the rare cases of survival following suicidal jumps from high bridges. Of four people who survived six story jumps, two wished to survive as soon as they jumped, two did

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and the Right to Refuse Life-Sustaining Treatment, 4 J. OF CLINICAL ETHICS 337 (1993).

26. *See* Ganzini et al., *supra* note 25, at 337

27. *Id.*

28. *Id.*

29. *See* Yeates Conwell et al., *Suicide and Cancer in Late Life*, 41 HOSP. & COMMUNITY PSYCHIATRY 1334 (1990); G.K. Murphy, *Cancer and the Coroner*, 237 JAMA 786, 788 (1977).

30. *See* Samuel Perry, *Suicidal Ideation and HIV Testing*, 263 JAMA 679 (1990).

31. *See* Chochinov et al., *supra* note 10 at 1185-90; *see also* Clark, *supra* note 10, at 161; Viggo Jensen & Thomas Petty, *The Fantasy Of Being Rescued In Suicide*, 27 PSYCHOANALYTIC Q. 327 (1958).

32. *See* Chochinov et al., *supra* note 10, at 1185-90. In this study, the authors note that although persistence of request is a requirement for euthanasia in the Netherlands, sixty-five percent of euthanasia cases occur within two weeks of the initial request.

not, but one of the latter, who professed to be furious at being saved made no subsequent suicide attempt.[33]

An assisted-suicide case which *The New York Times Magazine* featured as its cover story illustrates this characteristic suicidal ambivalence in a woman with severe illness.[34] The story describes the suicide of Louise, a Seattle woman whose death was arranged by her doctor and the Reverend Ralph Mero, head of Compassion in Dying.[35] Louise is shown to express both the wish to live and to die, but only for death does she find support—her family, her physician, and Reverend Mero become part of a network pressuring her to commit suicide.[36] For example, at one point Louise, described as looking terrified, tells her mother "I just feel as if everyone is ganging up on me, pressuring me. I just want some time."[37] Shortly thereafter, she commits suicide.[38]

Another characteristic of suicidal patients, regardless of their state of physical health, is a sometimes calm demeanor that masks a fearful, ambivalent mental state. For example, David C. Clark notes:

> People do not always show their depression on their faces, in their voices, in their gait, or in their demeanor. Many individuals, university professors, physicians, lawyers, real estate brokers, telephone operators, bricklayers—who smile politely, have a kind word for their spouses and co-workers every morning, accomplish their work with great dispatch, and appear "normal" live in anguish and despair, struggling each day with a decision about whether to kill themselves or not. Some seek treatment, and become known to us in our treatment centers—but most do not."[39]

In particular, some patients who are depressed and suicidal appear calm and less depressed after deciding to end their lives, although the fact that these patients currently find relief in the prospect of suicide is not necessarily a sign that the decision is appropriate.[40]

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33. *See* HERBERT HENDIN, SUICIDE IN AMERICA 237 (2d ed. 1995).

34. *See* Lisa Belkin, *There's No Simple Suicide*, N.Y. TIMES MAG. Nov. 14, 1993, at 48.

35. *Id.* at 50.

36. *Id.* at 52.

37. *Id.* at 53.

38. *Id.*

39. Clark, *supra* note 10, at 155-56.

40. Hendin & Klerman, *supra* note 15, at 144.

Finally, it must be underscored that the specific desire to be put to death by one's doctor is not unique to suicidal patients with terminal illness, nor is it uncommon for suicidal patients in general to have this wish.[41] Physicians unaware of this may assume that physically ill patients who seek physician-assistance in committing suicide see their physicians as saviors. That these patients see their physicians as executioners is actually more likely, with the patient typically fantasizing about a closeness or union with the doctor through death.[42]

The prominent suicide case involving the internist, Timothy Quill, and his patient, Diane, illustrates the hazards of physicians offering lethal drugs to suicidal patients with serious physical illness, rather than the treatments and interventions ordinarily prescribed for suicidal patients.[43] The case, published in the *New England Journal of Medicine* years before Quill's involvement as a plaintiff in *Quill v. Vacco*[44], involved oversights regarding the indicators of Diane's depression, shared reunion fantasies, and the physician's apparently one-sided encouragement of the patient's suicidal urges.[45]

Diane, who suffered from depression and alcoholism through much of her adult life, was diagnosed with acute leukemia. She reacted with rage and despair, which shortly turned to suicidal ideation. Moreover, soon after her diagnosis, she decided to refuse chemotherapy, a treatment described to her as having a twenty-five percent chance of success. Quill responded to her emotional turmoil, as well as to her decision to refuse treatment, by joining together with her to lament "her tragedy and the unfairness of life."[46] When Diane asked for his help in committing suicide, after justifying it by her need to be in control and her conviction that she would die during treatment for leukemia, Quill never questioned her insistence on total control, an impossible demand in the face of

41. Stuart Asch, *Suicide and the Hidden Executioner*, 7 INT'L REV. PSYCHOANALYSIS 51 (1980).

42. The contemplated deaths of suicidal patients are very often understood to them as a means of addressing separation or abandonment, and as a way to strive towards closeness. Herbert Hendin, *Psychodynamics of Suicide With Particular Reference to the Young*, 148 AM. J. PSYCHIATRY 1150, 1155 (1991).

43. Timothy E. Quill, *Death and Dignity - A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991).

44. 79 F.3d 790 (9th Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).

45. The following analysis of this case is taken from Herbert Hendin, *Seduced by Death: Doctors, Patient, and the Dutch Cure* 10 (1996). *See also* P. Wesley, *Dying Safely*, 8 ISSUES IN LAW & MED. 467 (1993).

46. Quill, *supra* note 43, at 692.

serious illness. Nor did he see this as a potential an aspect of depression, instead of simply a reasonable response. Moreover, he did not challenge her firm insistence that treatment would fail, which she had no way of knowing.

Although, initially, Quill told Diane he could not take part in her suicide, he appears to have conveyed to her just what he later communicated to the general public: that her "request made perfect sense" to him.[47] Quill ultimately responded to Diane's suicidal wishes by referring her to the Hemlock Society, which he described to her as "helpful," and by eventually prescribing for her the barbiturates the Society recommended she use. When Diane said goodbye to Quill, shortly before her death, she promised "a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons shining in the sunset."[48] Quill concluded his account of the case in the *New England Journal of Medicine* by wondering whether he "will see Diane again, on the shore of Lake Geneva at sunset, with dragons swimming on the horizon."[49]

II. The Failure of Medical Practice to Identify and Treat Suicidal Disorders, Including Among the Physically Ill

Suicide presents a public health crisis in the United States. This is particularly true among the elderly—a population with a high level of ill health relative to the rest of the population, and thus a large proportion of persons qualified for physician-assisted suicide under legalization schemes.

Suicide was the ninth leading cause of death in 1992, and has exceeded the number of homicides every year since 1981.[50] Among the elderly, suicide is the third leading cause of death from injury, following deaths from falls and motor vehicle crashes, and although the suicide rates for older Americans decreased between 1950 and 1980, since then they have increased dramatically.[51] Between 1980 and 1992 the suicide rate of Americans sixty-five and older increased nine percent.[52] Given that older persons constitute

47. *Id.* at 693.

48. *Id.*

49. *Id.* at 694.

50. CENTERS FOR DISEASE CONTROL AND PREVENTION, SUICIDE IN THE UNITED STATES: 1980-1992 at 1, 5 (1995).

51. P.J. Meehan et al., *Suicides Among Older United States Residents: Epidemiologic Characteristics and Trends*, 81 AM. J. OF PUB. HEALTH 1198, 1198-99 (1991).

52. U.S. DEP'T OF HEALTH & HUMAN SERV., *Suicide Among Older Persons – United States, 1980-1992*, 45 MORBIDITY & MORTALITY WKLY. REP. 3 (1996).

the fastest growing age group in the United States, the number of suicides in this age group likely will rise.[53]

While elderly Americans make up about 13% of the country's population, they already account for about 20% of all suicides.[54] Compared to other age groups, those sixty-five and older have the highest suicide rate in the United States; their rate is more than 50% higher than the rate of the general population.[55]

However, recent studies also indicate that suicide rates have, in general, been greater among younger adults than among their grandparents at a similar age.[56] It is predicted that as these younger Americans age, their suicide rates may actually increase above those of currently older United States residents.[57]

Depression and the other mental and physical disorders motivating suicidal acts and urges are treatable and reversible, and when these mental illnesses are addressed with sensitivity and clinical expertise, the suicidal ideation ordinarily subsides.[58] In fact, when depressive illness is untreated, and the patient has not, in the interim, taken his or her own life, the disorder typically lasts six to eight months before spontaneously remitting.[59]

Depression is also under diagnosed and often inadequately treated. 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, even if they do, give inadequate treatment.[60]

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53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.*

58. *See* NIH CONSENSUS DEVELOPMENT PANEL ON DEPRESSION IN LATE LIFE, *Diagnosis and Treatment of Depression in Late Life*, 268 JAMA 1018 (1992)(discussing treatment of depression in the elderly); NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *supra* note 15, at 175-77; A.J. Roth & J.C. Holland, *Treatment of Depression in Cancer Patients*, 14 PRIMARY CARE IN CANCER 23 (1994); Irene Elkin et al., *National Institute of Mental Health Treatment of Depression Collaborative Research Program: General Effectiveness of Treatments,* 46 ARCHIVES OF GEN. PSYCHIATRY 971 (1989).

59. Clark, *supra* note 10, at 155.

60. *See, e.g.*, Martin Keller et al., *Treatment Received by Depressed Patients*, 248 JAMA 1848, 1853 (1982); George Murphy, *The Physician's Responsibility for Suicide: (1) An Error of Commission and (2) Errors of Omission*, 82 ANNALS INTERN. MED. 301, 306-07 (1975); Barraclough et al., *supra* note 11, at 368-69; NIH CONSENSUS DEVELOPMENT PANEL ON DEPRESSION IN LATE LIFE, *supra* note 58, at 1021-22; Clark, *supra* note 10, at 155-58; NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *supra* note 15, at 175-77.

A number of reasons for medicine's failure to responsibly identify and treat suicidal disorders have been proposed. One main concern is the difficulty of diagnosing the mental disorders underlying suicidal wishes and acts. There exist no specific, simple or efficient diagnostic tests, instruments, or screens to identify patients with suicidal disorders. Only focused, attentive clinical assessment is effective.[61] Whether for lack of skill, lack of time, or lack of interest, primary care physicians are not engaging in such assessments.

For example, interesting research has begun on the biologic basis for suicide, but it is in its infancy. This research suggests that abnormalities regarding the brain's neurotransmitter serotonin distinguish suicide attempters from nonattemptors, with diagnoses not only of depression, but of schizophrenia, personality disorders, addictive disorders, and other forms of psychiatric illness.[62] However, this research has yet to offer any biochemical diagnostic tools.

Another diagnostic difficulty is the extent to which patients' preoccupation with physical symptoms, noted above, can deflect or distract physicians from observing these patients' mental disorders. Among the elderly, the hallmark of suicidal depression is its comorbidity with physical illness. Physicians are currently focusing on the physical illness, instead of the geriatric patients' state of mind.[63] Moreover, physicians, like the lay public, have a tendency to overlook the presence of treatable and reversible clinical depression when "reasons" such as advanced age or physical illness exist for a severely depressed or fearful mood.[64]

Certain psychological factors which may adversely affect the therapeutic relationship between physicians and suicidal patients may compound the difficulties experienced by healthcare professionals in identifying and treating suicidal patients. Studies suggest that psychological transference and countertransference dynamics

61. NIH CONSENSUS DEVELOPMENT PANEL ON DEPRESSION IN LATE LIFE, *supra* note 58, at 1023.

62. *See* S.P. Kachur et al., *Suicide: Epidemiology, Prevention, Treatment*, 6 ADOLESCENT MED.: ST. OF THE ART REV. 171, 175-76 (1995); Yeates Conwell, *Physician-Assisted Suicide: A Mental Health Perspective*, 24 SUICIDE & LIFE-THREATENING BEHAV. 326, 329 (1994).

63. *See* NIH CONSENSUS DEVELOPMENT PANEL ON DEPRESSION IN LATE LIFE, *supra* note 58, at 5.

64. *Id.*; *see also* Clark, *supra* note 10, at 161; Yeates Conwell et al., *Suicide and Cancer in Late Life*, 41 HOSP. & COMMUNITY PSYCHIATRY 1334 (1990) (describing the complex relationship between suicidal thoughts and a person's physical state).

can become particularly complex and unmanageable when involving a suicidal, terminally ill patient.[65]

Transference typically refers to the transfer by a patient to the therapist or doctor, of patterns of feelings and behaviors that were experienced with important figures in earlier life. Countertransference is the analogous process in which feelings are evoked in the healthcare provider by the patient. To act professionally and effectively, providers must be intimately familiar with their own attitudes and the nature of their expression in a wide variety of circumstances. If that familiarity is lacking, providers' responses risk addressing their own needs and discomforts, not the patient's.[66]

The transference and countertransference dynamics between critically ill, suicidal patients and physicians are particularly complex and difficult for physicians to professionally navigate. Research has shown that healthcare providers often feel aversion and an urge to abandon suicidal patients.[67] The threat of suicide can arouse both a sense of personal injury and an angry vulnerability in physicians that impair his or her ability to respond professionally.[68] Some have suggested that this countertransference response is particularly potent among healthcare providers, whose primary goal and self-image is as a healer, which, as a result of their psychological predispositions, is perhaps linked to a greater than average fear of death.[69]

Furthermore, typically the physician treating a severely ill and suicidal patient will evoke and be the target of strongly negative and positive transference feelings that make it difficult and clinically challenging to maintain professionalism. The negative emotions may include envy, betrayal, and rage. The positive feelings are equally hazardous, and can include the idealization of the physician and his or her abilities, and a tendency to espouse the physician's values as a means of maintaining closeness.[70]

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65. *See* Conwell, *supra* note 62, at 330-31; *see also* John T. Malsberger & Daniel H. Buie, *Countertransference Hate in the Treatment of Suicidal Patients*, 30 ARCHIVES OF GEN. PSYCHIATRY 625 (1974); Ganzini et al., *supra* note 25, at 339; Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure* 10 ISSUES IN LAW & MED. 123 (1994).

66. Conwell, *supra* note 62, at 330-31.

67. Ganzini et al., *supra* note 25, at 339; *see also* Malsberger & Buie, *supra* note 65, at 625.

68. *See* HENDIN, *supra* note 45, at 10.

69. *See* Conwell, *supra* note 62, at 332.

70. *Id.* at 330-31.

Finally, one may reasonably assume that the inadequate identification and treatment of suicidal individuals will be exacerbated if current societal prohibitions on suicide are loosened by legalizing physician-assisted suicide. From a public health perspective, restricting access to lethal means to commit suicide is an important preventive tool.[71] A society with legalized physician-assisted suicide is one where drugs intended to facilitate suicide will enter the community in a relatively uncontrolled and unprecedented fashion, with predictable and unwanted ripple effects. Recent research on suicide clusters or suicide contagion suggests that exposure to suicide or suicidal behavior heightens the suicide risk of those exposed. It has been suggested that this risk may not be limited to geographically localized clusters of suicides, and research has been focusing on whether the incidence of suicide in the general population is increased by exposure through, for example, television news stories.[72] Socially accepting and facilitating suicide among the physically ill will predictably increase suicide rates among those with and without physical illness.

Conclusion

In crafting public policies on physician-assisted suicide it is essential to take account both of what medical science knows about suicide among the physically ill, and of what medical practice now fails to deliver to suicidal individuals. A substantial body of research makes it unrealistic to posit the existence of anything but a *de minimis* class of terminally ill patients with the decisional competence to commit voluntary suicide. Studies demonstrating healthcare professionals' current failure to diagnose and treat the suicidal make it unreasonable to imagine that the healthcare system competently will identify persons with physical illness who are in the throes of treatable and reversible mental disorders, and who seek lethal drugs from physicians. If physician-assisted suicide is legalized, intolerable numbers of physically ill persons who should be supported to live, will instead be helped to die.

71. *See* Lloyd B. Potter et al., *Suicide Prevention from a Public Health Perspective*, 25 SUICIDE & LIFE-THREATENING BEHAVIOR 82, 89 (1995).

72. Patrick W. O'Carroll, *Suicide*, *in* PUBLIC HEALTH & PREVENTIVE MEDICINE 1054 (1992).