

What's Wrong with Making Assisted Suicide Legal?

Many argue that a decision to kill oneself is a private choice about which society has no right to be concerned. This position assumes that suicide results from competent people making autonomous, rational decisions to die, and then claims that society has no business "interfering" with a freely chosen life or death decision that harms no one other than the suicidal individual. But according to experts who have studied suicide, the basic assumption is wrong.

suicide.² There is a great body of psychological evidence that those who attempt suicide are normally ambivalent,³ that they usually attempt suicide for reasons other than a settled desire to die,⁴ and that they are predominantly the victims of mental disorder.

A careful 1974 British study, which involved extensive interviews and examination of medical records, found that 93% of those studied who committed suicide were mentally ill at the time.¹ A similar St. Louis study, published in 1984, found a mental disorder in 94% of those who committed

Still, shouldn't it be the person's own choice?

Almost all of those who attempt suicide do so as a subconscious cry for help,⁵ not after a carefully calculated judgment that death would be better than life.

A suicide attempt powerfully calls attention to one's plight. The humane response is to mobilize psychiatric and social service resources to address the problems that led the would-be suicide to such an extremity. Typically, this counseling and assistance is successful. One study of 886 people who were rescued from attempted suicides found that five years later only 3.84% had gone on to kill themselves.⁶ A study with a 35-year follow-up found only

10.9% later killed themselves.⁷ The prospects for a happy life are often greater for those who attempt suicide, but are stopped and helped, than for those with similar problems who never attempt suicide. In the words of academic psychiatrist Dr. Erwin Stengel, "The suicidal attempt is a highly effective though hazardous way of influencing others and its effects are as a rule...lasting."⁸

In short, suicidal people should be helped with their problems, not helped to die.

But shouldn't we distinguish between those who are emotionally unbalanced and those who are making a rational, competent decision?

Psychologist Joseph Richman, writing in the Journal of Suicide and Life-Threatening Behavior, notes,

[A]s a clinical suicidologist, and therapist who has interviewed or treated over 800 suicidal persons and their families... I have been impressed [that those] who are suicidal are more like each other than different, including ... those who choose "rational suicide".... [A]ll suicides, including the "rational," can be an avoidance of or substitute for dealing with basic life-and-death issues. ... The suicidal person and significant others usually do not know the reasons for the decision to commit suicide, but they give themselves reasons. That is why rational suicide is more often rationalized, based upon reasons that are unknown, unconscious, and a part of social and family system dynamics.... The proponents of rational suicide are often guilty of tunnel vision, defined as the absence of perceived alternatives to suicide.⁹

What about those who are terminally ill?

Contrary to the assumptions of many in the public, a scientific study of people with terminal illness published in the American Journal of Psychiatry found that fewer than one in four expressed a wish to die, and all of those who did had clinically diagnosable depression.¹⁰ As Richman points out, "[E]ffective psychotherapeutic treatment is possible with the terminally ill, and only irrational prejudices prevent the greater resort to such measures."¹¹ And suicidologist Dr. David C. Clark observes that depressive episodes in the seriously ill "are not less responsive to medication" than depression in others.¹² Indeed, the

suicide rate in persons with terminal illness is only between 2% and 4%.¹³ Compassionate counseling and assistance, such as that provided in many hospices, together with medical and psychological care, provide a positive alternative to euthanasia among those who have terminal illness. They are not getting adequate medical care and should be provided up-to-date means of pain control, not killed. Even Dr. Pieter Admiraal, a leader of the successful movement to legalize direct killing in the Netherlands, has publicly observed that pain is never an adequate justification for euthanasia in light of current medical techniques that can manage pain in virtually all circumstances.¹⁴

Why, then, are there so many personal stories of people in hospitals and nursing homes having to cope with unbearable pain? Tragically, pain control techniques that have been perfected at the frontiers of medicine have not become universally known at the clinical level. What we need is better training in those techniques for health care personnel -- not the legalization of physician-aided death.

What about those with severe disabilities?

What would it say about our attitude as a society were we to tell those who have neither terminal illness nor a disability, "You say you want to be killed, but what you really need is counseling and assistance," but, at the same time, we were to tell those with disabilities, "We understand why you want to be killed, and we'll let a doctor kill you"? It would certainly not mean that we were respecting the "choice" of the person with the disability. Instead, we would be discriminatorily denying suicide counseling on the basis of disability. We'd be saying to the nondisabled person, "We care too much about you to let you throw your life away," but to the person with the disability, "We agree that life with a disability is not worth living."

Most people with disabilities will tell you that it is not so much their physical or mental impairment itself that makes their lives difficult as it is the conduct of the nondisabled majority toward them. Denial of access, discrimination in employment, and an attitude of aversion or pity instead of respect are what make life intolerable. True respect for the rights of people with disabilities would dictate action to remove those obstacles -- not "help" in committing suicide.

Opponents of legalizing assisting suicide say it will lead to non-voluntary euthanasia. Aren't these overblown scare tactics?

Absolutely not. As attorney Walter Weber has written in the Journal of Suicide and Life-Threatening Behavior,

Under the equal-protection clause of the Fourteenth Amendment to the U.S. Constitution, legislative classifications that restrict constitutional rights are subject to strict scrutiny and will be struck down unless narrowly tailored to further a compelling governmental interest. ... A right to choose death for oneself would also probably extend to incompetent individuals. ... [A] number of lower courts have held that an incompetent patient does not lose his or her right to consent to termination of life-supporting care by virtue of his or her incompetency.... [T]he ["substituted judgment"] doctrine authorizes-- indeed, requires -- a substitute decision maker, whether the court or a designated third party, to decide what the incompetent person would choose, if that person were competent. ... Therefore infants, those with mental illness, retarded people, confused or senile elderly individuals, and other incompetent people would be entitled to have someone else enforce their right to die.¹⁵

Thus, if direct killing is legalized on request of a competent person, under court precedents that have already been set, someone who is not competent could be killed at the direction of that person's guardian even though the incompetent patient had never expressed a desire to be killed.

1. Barraclough, Bunch, Nelson, & Salisbury, *A Hundred Cases of Suicide: Clinical Aspects*, 125 BRIT. J. PSYCHIATRY 355, 356 (1976).
2. E. Robins, THE FINAL MONTHS 12 (1981).
3. See, e.g., Dorpat & Boswell, *An Evaluation of Suicidal Intent in Suicide Attempts*, 4 COMPREHENSIVE PSYCHIATRY 117 (1964).
4. See H. Hendin, SUICIDE IN AMERICA 223 (1982); Jensen & Petty, *The Fantasy of Being Rescued*, 27 PSYCHOANALYTIC Q. 327, 336 (1958); K. Menninger, MAN AGAINST HIMSELF 50 (1938); Rubinstein, Meses & Lidz, *On Attempted Suicide*, 79 A.M.A. ARCHIVES NEUROLOGY AND PSYCHIATRY 103, 111 (1958); & Stengel, SUICIDE AND ATTEMPTED SUICIDE 113 (1964).
5. Jensen & Petty, *supra* note 4; Rubinstein, *supra* note 4, at 109; & Stengel, *supra* note 4, at 73.
6. Rosen, *The Serious Suicide Attempt: Five Year Follow Up Study of 886 Patients*, 235 J.A.M.A. 2105, 2105 (1976).
7. Dahlgren, *Attempted Suicides 35 Years Afterward*, 7 SUICIDE AND LIFE-THREATENING BEHAVIOR 75, 76, 78 (1977).

8. Stengel, *supra* note 4, at 113-14.
9. Joseph Richman, "The Case Against Rational Suicide," *Suicide and Life-Threatening Behavior*, Vol. 18, No. 3 (Fall 1988): p. 285, 285-86.
10. James H. Brown, Paul Henteleff, Samia Barakat, and Cheryl J. Rowe, "Is It Normal for Terminally Ill Patients to Desire Death?" *American Journal of Psychiatry*, Vol. 143, No. 2 (February 1986): p. 210.
11. Joseph Richman, Letter to the Editor, "The Case against Rational Suicide," *Suicide and Life-Threatening Behavior*, Vol. 18, No. 3 (Fall 1988): p. 288.
12. Flora Johnson Skelly, "Don't dismiss depression, physicians say," *American Medical News*, September 7, 1992, p. 28.
13. *Id.*
14. Pieter Admiraal, "Euthanasia in the Netherlands - A Dutch Doctor's Perspective," (speech presented at the national convention of the Hemlock Society, Arlington, VA, 1986).
15. Walter Weber, "What Right to Die?" *Suicide and Life-Threatening Behavior*, Vol. 18, No. 2 (Summer 1988): p. 181-96.

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15. Walter Weber, "What Right to Die?" *Suicide and Life-Threatening Behavior*, Vol. 18, No. 2 (Summer 1988): p. 181, 183-84.