Suicide in the Medically and Terminally Ill: Psychological and Ethical Considerations

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For the clinician who works in a behavioral-medicine or primary-care setting, this article presents the association between medical illness and suicide. Specific illnesses such as HIV/AIDS, cancers of the brain and nervous system, and multiple sclerosis all are associated with an increased risk of suicide. Rates of major depression rise with increasing rates of serious medical illness; however, depression and associated suicidal ideation tend to be undertreated in the medically ill. When medical illness becomes terminal, the clinician's patient may be confronted with difficult end-of-life decisions. Great concern exists in the United States about the ethics of end-of-life decision making and the issue of physician-assisted suicide. The latter part of this article examines the terminally ill patient's right to refuse life-sustaining treatments or to have death hastened according to the principle of the "double effect." It also reviews psychologists' apparent acceptance of the concept of rational suicide, as well as assisted suicide under certain conditions, and offers several caveats. A reexamination of psychology's role, standards, and principles with respect to rational suicide is recommended. © 2000 John Wiley & Sons, Inc. J Clin Psychol 56: 1153–1171, 2000.

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A 45-year-old man is referred to you by his primary-care physician for evaluation of depression. The patient seems to have constricted affect. In a matter-of-fact manner, he reports that he took two extra antidepressant tablets the previous night in the hopes that it would give him the courage to kill himself. On further questioning, he admits that he attempted to hang himself, but the coat hook to which he had tied the rope gave way. You inquire about what led up to his attempt at suicide. The patient explains that several

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months ago, he had seen his neurologist, who had informed him that he had multiple sclerosis. The neurologist had explained that MS is a disease that progresses slowly and that he could have many years of productive life ahead. The patient, however, increasingly fears that he soon will lose control of his body and become wheelchair dependent. He does not wish to live under such conditions.

Patients such as this one remind the clinician who works in a behavioral-medicine or consultation–liaison service that it is important to know what relationship there may be between medical illness and suicide. Since suicide is conceived of as a multidetermined event (Maris, Berman, Maltsberger, & Yufit, 1992), it seems unlikely that there is a simple, one-to-one relationship. In fact, there is little in the research literature to implicate medical illness as a sole determinant of suicide (Hughes & Kleespies, 1998). There are, however, certain medical illnesses with suicide rates that exceed the general population rate (Harris & Barraclough, 1994), and these medical illnesses can be prominent factors in suicide (Stenager & Stenager, 1992). Moreover, when a medical illness becomes terminal, the behavioral-medicine clinician may find his or her patient thrust into difficult end-of-life considerations that may include suicide.

The article that follows is divided into two sections. In the first half, we examine which medical illnesses may have an increased risk of suicide, how the combination of medical illness and clinical depression heightens suicide risk, and what suicide-prevention efforts hold promise for the medically ill who are at risk. Since terminal illness sometimes has been viewed as a particular risk factor for suicide, in the second half we also review the data that exists on the prevalence of suicide among the terminally ill. Moreover, we discuss the difficult ethical issues raised by the "right-to-die" movement in regard to suicide among the terminally ill.

Suicide and Suicide Prevention in the Medically Ill

The Prevalence of Medical Illness among Suicides

The data on the prevalence of suicides among the medically ill are limited (Hughes & Kleespies, 1998). There is information, however, that the prevalence of medical illness among suicides is in the range of 30 to 40% (Mackenzie & Popkin, 1990; Whitlock, 1986).

Across 15 studies, Whitlock (1986) reported that an average of 34% of the suicides had a medical illness at the time of self-inflicted death, while Mackenzie and Popkin (1990) reported a mean of 43% across 11 studies. The studies reviewed used the psychological-autopsy method, and the number of suicides in the majority of them was greater than 100 (e.g., 170 completed suicides in the study by Jacobsen & Jacobsen, 1972). Estimates of the prevalence of medical illness in these samples varied greatly from 18% (Edwards & Whitlock, 1968a; 1968b) to 70% (Dorpat & Ripley, 1960; Stewart, 1960). The majority of these investigations lacked a matched-comparison group; however, studies with comparison groups found similar results. Thus, Chynoweth, Tonge, and Armstrong (1980), in Australia, and Whitlock (1986), in England and Wales, compared the observed rates of specific physical disorders among suicides with the rates of these disorders in the general population as recorded in the *Morbidity Statistics from General Practice* (1979).

Chynoweth et al. (1980) reported a heightened rate of diseases of the nervous system and disorders of the gastrointestinal tract among suicides, while Whitlock (1986) found a significantly higher rate of epilepsy, dementia, multiple sclerosis, head injury, cerebral tumor, cerebrovascular disease, peptic-ulcer disease, cancer, and cirrhosis. Thus, certain medical illnesses, such as neurologic disorders and cancers, appear to be over represented among those who complete suicide.

Suicide and Specific Diseases/Injuries

There are many medical illnesses and conditions and most of them appear to have no associated increased risk of suicide (Harris & Barraclough, 1994). Examples of such illnesses and conditions include amyotrophic lateral sclerosis, diabetes (both juvenile and late-onset types), heart transplants, hypertension, certain neoplasms like cervix or prostate, and rheumatoid arthritis:

Some medical illnesses have significant rates of suicide associated with them, but they also are associated highly with mental illness, substance abuse, or adverse psychological effects of prescribed medication, factors that confound our understanding of the link between the specific medical illness and suicide. These illnesses and conditions include amputation, Parkinson's disease, renal disease, peptic-ulcer disease, and spinal cord injuries (Mishara, 1999). With Parkinson's disease, for example, Harris and Barraclough (1994) reviewed seven studies and found a statistically significant increase in suicide. However, they also found wide variation among the seven studies and noted numerous methodological concerns. Some of these concerns involved adverse psychologic effects of some antiparkinsonian medications and the presence of mental illness. In addition, Stenager and Stenager (1992) reviewed three investigations and found no demonstrable relationship between Parkinson's disease and suicide. Thus, the available data does not appear to allow a definite conclusion of an increased risk of suicide that is related directly to Parkinson's disease.

Likewise with spinal-cord injuries, Harris and Barraclough (1994) examined 17 studies that collectively reported on a population of over 22,00 people with such injuries, and Stenager and Stenager (1992) reviewed five investigations that looked at a collective population of 12,000. The best studies in these reviews indicated a 4-to-5-fold increase in suicide risk, but again the rate varied greatly between studies. Mood disorders, alcohol/drug abuse, and number of prior suicide attempts were considered factors in explaining the increase in observed suicide rates. The authors pointed out that the accidents resulting in the spinal-cord injuries often were related to alcohol or drug abuse and/or to an unsuccessful suicide attempt.

Medical Illnesses with a Clearly Elevated Risk of Suicide

Large studies consistently found increased suicide risk for patients suffering from HIV/AIDS, certain cancers, and certain neurological conditions (Harris & Barraclough, 1994; Rihmer, Rutz, & Pihlgren, 1995; Stenager & Stenager, 1992). Evidence that a single disease is associated with increased suicide risk is clearest for HIV/AIDS because it usually affects younger people who, as opposed to the elderly, are not as likely to have multiple chronic medical illnesses that may confound the findings.

HIV/AIDS. Mishara (1999) has reviewed a number of studies with small samples that have suggested that the fear of having contracted AIDS could be a risk factor for suicidal ideation/behavior. This hypothesis needs testing on a larger scale. On the other hand, there is evidence, as noted above, of an increased rate of suicide for patients who actually have HIV/AIDS. These findings, however, have not been without controversy. Dannenberg, McNeil, Brundage, and Brookmeyer (1996) reported only a minimal increased risk of suicide in a study of 4147 HIV-seropositive military-service applicants who prospectively were followed along with a matched cohort of 12,437 HIV-negative applicants for a median time of over five years. This study was flawed, however, since the comparison population consisted of applicants who were rejected from the service and who had a

higher risk of suicide. In fact, the comparison group had a suicide rate of 36/100,000, while the suicide rate for active-duty military personnel was 12/100,000. The suicide rate for the HIV-seropositive group was 49/100,000.

Other studies of suicide risk among those who have HIV/AIDS have reported a range of rates from two times the general population rate (Marzuk, Tardiff, Leon, & Hirsch 1997) to the extremely high rate of 66 times the general population rate (Starace, 1995). Conwell (1994) compared an HIV cohort to a group of men with similar demographics and found the risk of suicide to be 7 times greater for the HIV cohort.

The suicide rate in persons infected with HIV/AIDS may have been substantially higher in the earlier years of the epidemic. The rate began to fall between 1987and 1989. This decline may have been due to the promise of improved treatments and emerging therapies (Cote, Biggar, & Dannenberg, 1992). Nonetheless, recent studies still find a significantly heightened rate of suicide in HIV/AIDS patients (Cote et al., 1992; Harris & Barraclough, 1994). It is not clear what factors (e.g., hopelessness, depression, neurologic changes secondary to the disease) contribute to the pathways to suicide among HIV/AIDS patients.

Cancers of the Brain and Nervous System. A large Danish study of 296,331 patients with cancer (Storm, Christensen, & Jensen, 1992) linked the National Cancer Registry and mortality files from 1971 to 1986. The investigators found significantly higher rates of suicide in persons with cancers of the brain and nervous system. Harris and Barraclough (1994) conducted a meta analysis of 235 studies of medical disorders that had a mean follow up of two years or more and that had lost fewer than 10% of cases at follow up. They found that the rates of death by suicide were 9 times higher in persons with malignant neoplasms of the head and neck than in the general population, and about 4 times higher than in persons with other cancers. Other studies have found persons with cranial tumors at increased risk of suicide relative to the general population (Stenager & Stenager, 1992).

Multiple Sclerosis. According to the meta-analytic studies (Harris & Barraclough, 1994; Stenager & Stenager, 1992), patients with multiple sclerosis appear to be at increased risk of suicide. The increase in risk is up to twice that of the general population rate. The risk has been found greater in males and, in these studies, relatively early in the disease (within the first five years after diagnosis).

In a retrospective study (Berman & Samuel, 1993), MS patients who completed suicide were compared with MS patients who had made suicide attempts and nonsuicidal MS patients. The patients who committed suicide were more likely to be in a "chronic-progressive" as opposed to an "exacerbating-remitting" pattern of symptoms at the time of death. They also had more-impaired mobility, more problems with vision, more problems with bladder and bowel control, and more-severe depression. The suicides in this study occurred, on average, 7.1 years after diagnosis, and, in contrast to the meta-analytic studies noted above, the authors stated that the suicide completers were in the late stages of the disease at the time of death.

Depression as a Risk Factor for Suicide in the Medically Ill

As Cassem (1995) has noted, the rates of major depression rise when serious medical illness is present. Elderly patients in outpatient-primary-care settings have rates of depression ranging from 2.7 to 8.6% while community-dwelling elders have rates of only 1%

(Coyne, Fechner-Bates, & Schwenk, 1994; Koenig & Blazer, 1992; Schade, Jones, & Wittlin, 1998). Rates of major depression in elders hospitalized with medical illness have been found to be over 10 times that reported in the community (Koenig & Blazer, 1992). Males over 70 and under 40 years of age who require medical hospitalization have particularly high rates of depression. In hospitalized men over 70, the rate for major depression increases to 13.5%, and in hospitalized men under 40, rates of major depression were noted to be 22.4% (Schade et al., 1998). In a study of three U.S. sites involving 11,242 outpatients, Wells, Golding, and Burnam (1989) noted that depression and chronic medical conditions had unique and additive adverse effects on patient functioning. The combination of depression and current advanced-coronary-artery disease was associated with roughly twice the reduction in social functioning as that which occurs in either condition alone. Cole and Bellevance (1997), in a meta analysis of eight studies, found that elderly medical inpatients who were depressed had significantly higher mortality rates than elderly patients in hospital-based psychiatric services.

It is now accepted generally that the great majority of completed suicides (an estimated 93% of adult cases) suffer from a major psychiatric disorder (Clark & Fawcett, 1992). Depression is the disorder most frequently associated with suicide. An estimated 50% of suicides suffer from depression at the time of death (Pokorny, 1983; Rich, Young, & Fowler, 1986). It would stand to reason that if serious medical illness leads to an increased rate of depression, then it also would lead to an increased risk of suicide. It is known, however, that physicians often fail to detect depression in the medically ill, or they view it as "appropriate" to the patient's condition (Cassem, 1995; Rihmer et al., 1995). Therefore, depression, an important risk factor for suicide, is missed frequently and/or goes untreated.

A Suicide-Prevention Strategy: The Education of Primary Providers

Murphy (1986) has pointed out that health-care practitioners (e.g., primary-care physicians, nurse practitioners, family-practice physicians, etc.) may have a unique role to play in suicide prevention. In their large, retrospective study of 134 consecutive suicides, Robins, Murphy, Wilkinson, Gassner, and Kayes (1959) found that half or more of the suicides had consulted a physician within a month or less of their death with complaints associated with a psychiatric disorder. In a related study of 50 alcoholic suicides, Murphy, Armstrong, Hermele, Fischer, and Clendenin (1979) reported that 50% of the suicides had sought medical care within the month and 84% within the year preceding death. Only 37% of this sample had sought psychiatric care within the year. Surveying seven studies of elderly suicides, Conwell (1997) found that an average of 62% of the older people who committed suicide saw a primary-care provider within 30 days of death and an average of 35.5% within a week of death. Data such as these led Murphy (1986, p. 171) to refer to the physician's office as "the primary suicide prevention center."

As noted above, the majority of completed suicides are individuals who have a major psychiatric disorder (Clark & Fawcett, 1992). Cassem (1990) reported a 41% higher adjusted-prevalence rate of recent psychiatric disorders and a 28% higher prevalence rate of lifetime psychiatric disorders in persons with one or more chronic medical illnesses compared with no chronic medical illnesses. Recent epidemiologic studies have found that the majority of patients with depression are seen in primary-care medicine. These patients often present with medically unexplained somatic symptoms and may be diagnosed incorrectly as being hypochondriacal (Escobar et al., 1998). The National Depressive and Manic-Depressive Association has presented compelling evidence indicating

that individuals with depression are being seriously undertreated (Hirschfeld et al., 1997). It seems likely that other psychiatric disorders associated with high suicide risk, such as substance abuse, also go undetected or, in a medical setting, are not perceived as high risk.

The fact that physicians generally undertreat mental disorders in the medically ill led the Swedish Committee for Prevention and Treatment of Depression to introduce a trial educational program for all general practitioners on the island of Gotland (pop. 56,000). As Rutz, von Knorring, and Walinder (1989) have stated, the primary goal of this program was to increase knowledge about diagnosis and treatment of patients with affective disorders.

The study found that, during the year after the educational program, significantly more patients with depressive disorder were identified and treated adequately than during the prior year. The suicide rate on Gotland also dropped significantly, both relative to the rate for Gotland and to the rate for Sweden as a whole. In fact, the year following the educational program was the only year in a 17-year period in which there was a significant difference in the suicide rate between Gotland and Sweden as a whole.

The educational effort consisted of two 2-day programs to which all general practitioners were invited. About 90% attended. The first program included lectures on classification, etiology, and pathogenesis of depressive disorders, treating depressed patients, depressive disorders in old age, and treatment practice for depressive illness in Gotland. The second program included lectures on depressive disorders in childhood and adolescence, suicidology, psychosocial background factors, psychotherapy, and depressed patients and their families.

A follow-up study three years after the project ended (Rutz et al., 1992) found that the positive effects of the program had not lasted. In particular, the suicide rate had returned to near baseline levels. The authors concluded that the program had a pronounced effect, but it was related strictly in time to the educational effort. They suggested that if a long-term effect is to be achieved, the educational program needs to be provided about every two years. They calculated that the cost of providing the educational program was only an estimated 0.5% of the annual benefit in economic terms, and, thus, the effects must be regarded as extremely beneficial, both economically and in terms of years of life saved.

Criticisms of the Gotland study are that the approach has been tested on a relatively small population that lives in a very delimited geographic and cultural area, and that the effect was found to be limited to one or two years after the presentation of the program (Hughes & Kleespies, 1998). Nonetheless, the findings of the study seem worthy of an effort at a multisite replication and further investigation of how they might best be applied in the clinical setting.

The Terminally Ill, End-of-Life Decisions, and Suicide

In terms of medical illnesses, one might think that those illnesses that are in a terminal phase most likely would engender despair, and, thus, would be found frequently among completed suicides. To the contrary, the major psychological-autopsy studies conducted over the past 40 years seem to indicate that a rather small percentage of suicide victims (in the range of 2–3%) suffered from terminal illness at the time of death (Clark & Horton-Deutsch, 1992). Some would argue that this estimate is low given that some suicides of the terminally ill may be reported to the coroner as due to their physical illness (Quill, 1991), but, nonetheless, there does not seem to be a large percentage of suicides who have a terminal illness. Some possible explanations for this might include:

1. the condition of those who are seriously ill may limit their access to the means for ending life;
2. an increase in medical intervention and psychosocial support may help to resolve the causes of the suicidal state;
3. terminal illness may eliminate the need for suicide in foreshortening life; and
4. some may feel that when the decision to live or die is removed from them by an illness, they prefer to attempt to regain personal control by resisting death.

There is, in fact, a great deal of concern in the US about loss of control of the final stages of life that has resulted in concerted efforts to increase the individual's autonomy in making decisions about the dying process. Thus, we have seen the emergence of the hospice movement, the formation of organizations such as Compassion in Dying and the Hemlock Society, the enactment of the Patient Self-Determination Act (PSDA) by Congress in 1991, a national debate on physician-assisted suicide, and the passage of the Oregon Death with Dignity Act (ODDA), which permits physicians to prescribe lethal doses of medication to hasten the death of competent, terminally ill persons who voluntarily request it (Fenn & Ganzini, 1999).

As Kleespies and Mori (1998) have noted, concern over control of the dying process seems to have been sparked in recent times by several factors. First, technological advances in medicine have made it possible to sustain life beyond the point where it is meaningful. The case of Karen Ann Quinlan, who, at the age of 20, sustained irreversible brain damage and was kept alive in a comatose state on a respirator, brought this state of affairs to national attention in 1976. Second, improvements in the treatment of diseases have extended life expectancy to the point where 70 to 80% of people now die later in life; however, death occurs more slowly and essentially of degenerative disease rather than of acute disease (Battin, 1994). Many of these deaths are prolonged and agonizing, and the prospect of dying in this way has raised alarm. Third, such prolonged deaths often become "medicalized" in that they occur in hospitals and nursing homes with attendant medical procedures that can deprive the individual of dignity and privacy.

The Refusal of Life-Sustaining Treatment: An Option with Unresolved Issues

Whereas, prior to the Quinlan case, health professionals were reluctant to discontinue life-sustaining treatments for the terminally ill, it now is not uncommon to have Do Not Resuscitate (DNR) or Do Not Intubate (DNI) orders in hospitals, or to manage a terminal patient with comfort measures only. These changes have occurred in a relatively short space of time, and many unresolved issues remain. Thus, for example, although the refusal of life-sustaining treatment now is regarded generally as a right of the competent terminally ill patient, there is no real consensus as yet on such critical issues as a medical definition of "terminal" (Powell & Cohen, 1994), the criteria for mental competence (Grisso & Appelbaum, 1995), or how to have an unbiased representative to make decisions for those most-vulnerable patients, the incompetent terminally ill who have no family or friends to act as surrogates.

One definition of terminal illness found with some frequency is that an illness is taken to be terminal when it has a predictably fatal outcome and there is no known cure. Often this definition is set within a time frame and limited to cases in which death is expected within six months. Yet, Maddi (1990) has pointed out that medicine is not an exact science and it often is difficult to predict with accuracy when a patient will die. Mishara (1999) has reported that, among patients with congestive heart failure, the actual

survival rate at the end of six months was ten times the rate expected by physicians. Complicating matters still more, there are those rare instances when illnesses remit for no known reason.

Concerning the issue of competence, there have been numerous attempts to define criteria for competency to consent to or refuse treatment over the past 20 to 25 years (Kleespies & Mori, 1998). Despite these efforts, Grisso and Appelbaum (1995, 1998) have pointed out that considerable confusion remains about what criteria or standards to apply and how to assess a patient's functioning on any given standard. They indicate that there are currently four standards found in case law:

1. the ability to express a choice;
2. the ability to understand information relevant to the decision about treatment;
3. the ability to appreciate the significance of the information disclosed for one's own illness and possible treatment; and
4. the ability to manipulate the information in a rational way or in a manner that permits one to make comparisons and consider options.

To date, however, it has not been clarified, either clinically or legally, whether one is to apply one standard, all four standards, or some combination of two or three. Of course, it can have serious implications for patients if one standard or one set of standards is applied and is either more or less demanding than other standards. Overly demanding criteria might have the effect of ruling out some people who should be allowed to make decisions about refusing treatment, while criteria that demand too little might fail to protect people who are incapacitated and make poor judgments (Grisso & Appelbaum, 1995; 1998).

The U.S. Supreme Court now has established that individuals who are no longer competent due to the progression of their illness still may forego life-sustaining treatment if there is clear and convincing evidence that this would have been what the individual wanted were he or she still able to make such decisions (Wachter & Lo, 1993). The Court strongly advocated the use of advance directives, i.e., a legal document that allows an individual to state his/her treatment preferences and/or to designate a health-care proxy to make his/her decisions in the event that he/she no longer is able to do so. Despite the enactment of the Patient Self-Determination Act, which promoted the use of advance directives, and despite widespread support for this legislation, it is estimated that only one in five people have completed an advance directive or named a health-care proxy (Gallup & Newport, 1991). Thus, in many cases, hospitals and nursing homes are faced with the dilemma of how to decide whether to discontinue treatment without any advance guidance from the patient. When there are family members, they typically are enlisted as surrogate decision makers, but the greater problem arises with those patients who are terminally ill, incompetent, and have no available family or friends. Since, in many states, the courts lack an adequate pool of individuals who are willing to act as guardians, the possibility of obtaining a court-appointed surrogate often is not a real option. In such instances, the Hospital Ethics Advisory Committee (EAC) sometimes is asked to serve as representative for the patient. Yet, the EAC typically consists of hospital staff who, although not part of the patient's treatment team, may identify more with the team than with the patient, and who, in any case, may find it hard to be unbiased by the needs, mores, and values of the institution for which they work. In an era when healthcare has been dominated by managed care and issues of cost containment, this is no small concern. A few jurisdictions have managed this problem by assigning a judge to be available to hear cases of terminally ill patients for whom there is no available surrogate.

Does the Refusal of Life-Sustaining Treatment Constitute Suicide?

Given issues such as those mentioned above, some have had reservations about how the right to refuse life-sustaining treatment is implemented at times. Still others, because of their mores or values, have opposed it as "suicide" on the part of the patient. Mayo (1992), for one, would not disagree with considering it as such, but he also would not assume that all suicides are immoral or blameworthy or in need of intervention, particularly not those of the terminally ill who are suffering without relief, who have very poor quality of life, and who wish to die. His position is that "much of the controversy in the literature about euthanasia and suicide (and about the definitions thereof) is obfuscated by the suspicious premise that anything that can be labeled 'suicide' is to be condemned, discouraged, pitied, or treated" (Mayo, 1992, p.91).

Mayo (1992) has defined suicide as ending one's life intentionally. Since to refuse life-sustaining treatment is to bring about intentionally one's end, it could be considered consistent with his definition. The issue, however, of whether the refusal of life-sustaining treatment constitutes suicide becomes complicated when one takes into account situational variables. For example, life-sustaining treatments include patients who are having multi-system failures and are kept alive on a ventilator with very poor quality of life, as well as patients with end-stage renal disease who are maintained with dialysis treatments and may have very good quality of life. In general, life-sustaining treatment can be taken to mean any medical intervention that would have little or no effect on the underlying disease, injury, or condition, but is administered to forestall the time of death (Hafemeister, Keilitz, & Banks, 1991; Maddi, 1990; McKnight & Bellis, 1992). In the case of the patient on the ventilator noted above, it would seem that meaningful life is essentially at an end and the refusal of further treatment is closer to what Parry (1990) and McCamish and Crocker (1993) have referred to as allowing the underlying disease or condition to take over, or what Farrenkopf and Bryan (1999) have characterized as an attempt to exercise some control of the dying process. Allowing oneself to die when life is basically over would hardly seem to have the same connotation as is ascribed typically to the term *suicide*. On the other hand, if the dialysis patient above, who seemed to have the opportunity for meaningful life, were to find the need for such intrusive and restricting interventions unacceptable and choose to forego them, it would seem more likely to be within the parameters of what is meant by suicide.

These are complicated issues, and there are situations that seem to defy easy definition. The same may be said, however, regarding the issue of hastening death according to the so-called principle of the *double effect*.

The Principle of the "Double Effect" and the Question of Intentionality

The principle of the "double effect" often is raised in bioethical discussions of hastening death, euthanasia, and assisted suicide (Battin, 1994; Kleespies & Mori, 1998; Mayo, 1992). According to this principle, one can perform an act that has a foreseen bad effect (e.g., death) and still be judged in a morally favorable light, if one intends only a good effect (such as relief of intractable pain) and does not intend the bad effect (death). As cited in Battin (1994, p. 17), the following four conditions are necessary to qualify for the *double effect*:

> (1) the action must not be intrinsically wrong; (2) the agent must intend only the good effect, not the bad one; (3) the bad effect must not be the means of achieving the good effect; and (4) the good effect must be "proportional" to the bad one, that is, outweigh it.

When applied to decisions in assisting a terminally ill patient with end-of-life care, it could be argued, for example, that a physician who prescribed increasing doses of morphine was acting out of an intention to ease pain and suffering, with the secondary effect of slowing respirations and ending life more quickly. In such a case, the intent was to relieve suffering, not to kill or assist the patient in committing suicide.

Critics of this argument (Battin, 1994), however, have claimed that it is implausible to imagine that intelligent individuals are not conscious of both the primary and secondary effects of their decisions, especially if one of those effects is so significant as death, and therefore could hardly be said not to intend it. Thus, in the case of the physician who prescribed increasing doses of morphine, he/she is likely to have intended both pain management and a hastening of death. Those who hold this position do not see such killing or assisted death as immoral or unethical, since there can be instances of both that promote human dignity rather that destroy it. In this regard, they often cite the coup de grace granted a mortally wounded soldier who cannot be saved on the battlefield, or an abortion to save the life of the mother (Battin, 1994).

Proponents of the double-effect argument have countered by maintaining that it is possible to distinguish between "intended results and unintended but accepted consequences" (Annas, 1996, p. 685). Whether a physician can or does maintain such a distinction in end-of-life care would seem to be a question that is open for empirical investigation.

The Question of Rational Suicide and the Terminally Ill

For some, it may seem to be a contradiction in terms to speak of "rational" suicide. This was, in fact, the perspective of a small percentage of psychologists in a survey of members of Division 29 (Psychotherapy) of the American Psychological Association (APA) (Werth & Cobia, 1995). These respondents expressed the views that suicide is always an emotionally based decision and that the suicidal person feels hopeless and therefore unable to consider the full range of options open to him or her. They also expressed concern about the impact of suicide on the surviving family and friends.

Eighty-one percent of the psychologists who participated in this same survey (which had a 50% response rate), however, stated that they believed in the concept of rational suicide. The rationale most frequently given for their point of view was the existence of a hopeless condition such as terminal illness for which there was no foreseeable improvement or relief. In a previous publication on this same topic, Werth and Liddle (1994) reported that psychotherapists viewed suicide that stemmed from a painful terminal illness as significantly more acceptable than suicide in response to such difficulties as chronic physical pain, chronic depression, or catastrophic events such as bankruptcy, etc.

As suggested by the results of the survey above, perhaps the most compelling argument for the notion of rational suicide comes with the patient who is terminally ill, has the capacity to make health-care decisions, is suffering physically and emotionally and/or is in severe pain, and may live for 5 to 6 months or longer, but wishes to die. Such a patient, when he/she is receiving life-sustaining treatment, has the legally protected right to refuse treatment and allow death to occur. For a patient who is terminally ill and suffering, but not in need of life-support systems, however, it is a different matter. If the patient is on pain medication and the pain is poorly controlled, he/she might request or agree to an increase in medication to relieve pain. To provide relief, the medication might need to be adjusted to the point where the patient is sedated heavily much of the time (i.e., existing more than living), or to the point of hastening death (i.e., making the "double-effect"

decision). On the other hand, if the patient is not in such physical pain as to require heavy doses of pain medication, invoking the double-effect argument obviously is not an option. Under such circumstances, it seems conceivable that a patient might decide to end his/her life intentionally and not be considered as having impaired judgment. In fact, it also seems conceivable that such a decision might allow the individual to retain some ability to preserve dignity and autonomy rather than dying in an even more debilitated state.

There are a number of reasons, however, to be very cautious about accepting that suicide may be a rational decision among the terminally ill. (It should be noted that these reasons are not unique to the rational-suicide debate, but also may apply to decisions about withholding or withdrawing life-sustaining treatment.) First, as noted earlier in this article, there is an elevated rate of clinical depression among those with serious medical illness (Cassem, 1995). Depression can influence the patient's perception to the point that a difficult situation may seem hopeless prematurely. Depression, even in the terminally ill, sometimes can be treated and the patient's outlook may improve. As Battin (1994) and Sullivan and Youngner (1994) have argued, however, any evidence of depression should not necessarily be taken as indicating that the patient's decision-making capacity is impaired. Clearly, the research by Grisso and Appelbaum (1995, 1998) has shown that a large percentage of depressed patients are capable of meeting even the most rigorous existing standards for decision-making capability.

Second, for clinicians who work with the terminally ill and for the patients themselves, it would seem that the effort should always be to make the necessity of decisions about ending life as infrequent as possible. As Kleespies and Mori (1998) have noted, such an effort requires that great attention be given to pain management and palliative care; to the recognition of treatable anxiety and depression; to assisting the patient in bringing closure to previously unresolved issues with family and friends; to supporting the patient in grieving and saying farewell; to bringing about the good death or, in Battin's terms, "the least worst death" (Battin, 1994, p. 36). Thus, the patient may miss many important end-of-life interchanges if he or she takes a fear-driven or despair-driven early exit.

Third, there exists a significant concern that our society could become suicide permissive; that is, if suicide is presented as a rational option in some cases, an ideological change might occur in which suicide is seen as more socially acceptable. In fact, as discussed by Battin (1994, p. 198), there has been a "profusion of recent literary accounts favorable to suicide and assisted suicide in terminal illness cases," and these accounts, as well as increased concerns about autonomy around end-of-life decisions, already have led to changing societal views regarding suicide.

Concern rises when one considers the possibility that societal acceptance of suicide could influence individuals to choose suicide as an option when they otherwise would not do so. As pointed out by Hendin (1995), social acceptance alone could lead to a form of subtle coercion in that terminally ill individuals might feel pressure to choose suicide because it is the expected or honorable thing to do.

Lastly, coupled with the fear of a suicide-permissive society is the fear that elderly and terminally ill patients will be coerced into choosing suicide either by caregivers or family members. Battin (1994) has provided numerous examples of situations in which an individual may feel pressured by others to end his or her life prematurely. These situations include becoming a financial burden to the family and sparing one's family members of the need to take on the caretaker role or watch the dying process. She has pointed out that families may express in subtle, or not-so-subtle ways, their desire to free themselves from the burden of elderly or terminally ill family members. If faced with such a scenario, would a vulnerable terminally ill person be able to resist the pressure? In

addition to possible family pressures, there is a risk of institutional pressures. Thus, if there is a need to cut or contain costs, will caregivers manipulate the institutionalized elderly or terminally ill to choose suicide?

The Question of Assisted Suicide and the Terminally Ill

Whether the suicide of a terminally ill person might be a rational decision that potentially could preserve human dignity is one question. Whether such a death should be assisted by a second party is another. Clearly, there are some terminally ill patients who are capable of ending their own lives should they wish to do so, but there are others who may be too physically debilitated or restricted by their situation to have that option. The question then becomes whether the moral principle of mercy justifies a second party in assisting in the patient's suicide.

Battin (1994) has articulated the principle of mercy as follows:

> The principle of mercy asserts that where possible, one ought to relieve the pain or suffering of another person, when it does not contravene that person's wishes, where one can do so without undue costs to oneself, where one will not violate other moral obligations, where the pain or suffering itself is not necessary for the sufferer's attainment of some overriding good, and where the pain and suffering can be relieved without precluding the sufferer's attainment of some overriding good. (p. 101)

This principle and the principle of autonomy are basic to the 1994 voter-approved Oregon Death with Dignity Act (ODDA), which permits physicians to prescribe lethal medication that can be used to hasten death for competent terminally ill persons who voluntarily request it. In a survey of the attitudes of Oregon psychologists toward physician-assisted suicide and the ODDA, Fenn and Ganzini (1999) found that 91% of the respondents felt that, for a competent terminally ill person, both suicide and assisted suicide morally were acceptable as either a matter of individual choice or at least under certain conditions. When those surveyed were asked if a physician should be allowed to write a prescription whose sole purpose would be to allow such a patient to end his/her life, 85% responded either *always* (29%) or *under some circumstances* (56%). Eighty-two percent of the psychologists indicated that they would consider obtaining a physician's assistance to end their own lives *under some circumstances*, and the most commonly given circumstance had to do with alleviating pain and suffering (74%). Thus, the results of this survey indicated that the majority of psychologists in Oregon appear to believe in the application of the principle of mercy and the relief of suffering for the terminally ill under certain conditions, even when that relief entails assistance in suicide by a second party (i.e., a physician). The extent to which these results can be generalized to psychologists in other regions of the United States has not been tested empirically.

As Fenn and Ganzini (1999) have pointed out, those who oppose having physicians assist in suicide usually argue that physicians have a time-honored and fundamental ethic to do no harm. If they assist in suicide, the concern is that they no longer will be seen purely as healers, but also as potential agents of death. Such a perceived shift in role might erode trust in the doctor–patient relationship. Voluntary euthanasia and physician-assisted suicide are both practiced in The Netherlands, and the Dutch seem to see their practice in this regard as bringing into the open and gaining control of events that have gone on in the shadows of medical practice, in all countries, for a very long time (Battin, 1994). There are widely varying accounts of whether they indeed have gained control over end-of-life events, however. Hendin (1999), for example, has argued that the Dutch in fact have lost adherence to medical standards, and palliative care for the terminally ill

has become a casualty of acceptance of euthanasia or assisted suicide as the solution for those who are terminal. Opponents of assisted suicide also have pointed out that what might work in a country like The Netherlands, where there is universal health coverage, may not work so well if legalized in a country like the United States, where the health-care system currently is chaotic and concern with medical-cost containment could lead to callous and coercive practices, as noted earlier. Yet, still other commentators on the Dutch experience (e.g., Angell, 1996) have pointed out that the Dutch government commissioned two carefully conducted nationwide studies of euthanasia and assisted suicide (see van der Maas et al, 1996) and the results hardly could be construed as indicating a "descent into depravity" (Angell, 1996, p. 1677) or a slide down the slippery slope. Rather, the studies found that only a small percentage of deaths in the Netherlands (at 2–3 %) were due to euthanasia or assisted suicide. Moreover, the relatively few, disturbing instances in which a patient's life was ended without an explicit request from the person, if anything, had decreased over time. Angell (1996) further pointed out that, in the United States, the debate is over assisted suicide, which, since it requires patient consent, seems somewhat less likely than euthanasia to be subject to abuse.

The Role of Psychologists in End-of-Life Decision Making

As Kleespies and Mori (1998) have indicated, psychologists have a great deal of expertise to bring to bear on the end-of-life decision-making process. In the section that follows, we present a summary of some of the roles that they may have with the dying patient. For a more complete discussion of this topic, see, for example, Goldblum and Martin (1999) and Werth (1999).

First, psychologists can use their therapeutic skills to bring about more-effective communication at a time when communication can be difficult. Some patients are reluctant to burden family or staff with the weighty issues they are considering. Psychologists can help patients, families, and staff to examine and talk about the emotional, legal, and ethical problems that can complicate end-of-life decisions. As those who work with dying patients can attest, this is a challenging task and clinicians must prepare themselves through appropriate education and training (Werth, 1999), and by becoming informed about all the dimensions involved in such cases.

Psychologists also can work with the terminally ill to enhance the quality of their remaining life. Those who work in behavioral medicine have developed strategies to aid in pain management and to deal with difficult and invasive treatments. With such assistance, continued medical treatment may become tolerable. Likewise, the application of stress-management skills can promote a positive attitude about one's ability to function effectively. In addition, providing compassion and support can help to sustain patients who wish to continue living, or alternatively others in their conviction to stop treatment.

Helping patients and families come to grips with dying and the associated grief is emotionally demanding work. There can be great rewards as well, however. Thus, Maddi (1990) has pointed out that psychologists should be aware that "the patient may actually improve his or her psychosocial quality of life through the confrontation of death" (p. 175). At times, patients and families work through or resolve conflicts that have existed for a lifetime, or they reach a level of expression and communication not previously thought possible. Such experiences can bring peace to the dying patient and to their family members.

When end-of-life decisions need to be made, it is not uncommon for questions to arise about the patient's mental capacity or competence to participate. Psychologists clearly can become qualified by education and experience to evaluate a patient's emotional and

mental state and his/her functional capacity to make treatment decisions. As noted earlier in this article, there are currently four standards utilized in case law for determining the capacity for making health-care decisions. These standards, the complex issues associated with them, and the existing methods for assessing them have been discussed elsewhere, and that discussion will not be repeated here. The interested reader is referred to Grisso and Appelbaum (1998) and Kleespies and Mori (1998).

As mentioned, psychologists who are qualified by appropriate training can evaluate the decision-making capacity of patients who wish to refuse life-sustaining treatment or who wish to have their pain alleviated with an increase in medication even though it will hasten death. Regarding the terminal patient who is requesting assistance with suicide, however, some psychologists have expressed reservations. Thus, Abeles and Barlev (1999) have suggested that state-mental-health laws may expect mental-health professionals to prevent patients from committing suicide. If this is true, the psychologist who finds a patient capable of deciding to commit suicide and does not intervene potentially could be in conflict with his or her state laws. In addition, Peruzzi, Canapary, and Bongar (1996) have been of the opinion that the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (1992) are too inflexible to allow for participation in assisted suicide.

It would seem that the legal questions raised by the authors noted above only can be resolved by an actual investigation of the mental-health laws in each state, and the ethical questions might be informed better by an APA-authorized interpretation of the ethical code on this issue. With regard to the latter question, the American Psychological Association, in fact, has established a working group on assisted suicide and end-of-life decisions that is to make recommendations to the APA about whether it should take a position on these matters. In this regard, Werth and Cobia (1995) have suggested that since a large percentage of psychologists believe in the possibility of rational suicide for the terminally ill, perhaps it is time to revise the standards and principles so that practitioners have other options.

Summary and Conclusions

There appears to be a 30 to 40% rate of medical illness among completed suicides. Although most specific medical illnesses do not have an elevated risk of suicide, a few clearly do. Large studies and meta-analytic reviews consistently have found that HIV/AIDS, cancers of the brain and nervous system, and multiple sclerosis are associated with an increased risk of suicide. Other medical illnesses have significant rates of suicide associated with them, but other factors (e.g., the adverse psychological effects of medications used in treatment) confound our understanding of the link between the illness and suicide.

Rates of major depression rise with increasing rates of serious medical illness. Depression is the mental disorder most frequently associated with suicide. If serious medical illness leads to an increased rate of depression, then it is likely to lead to an increased risk of suicide. Yet, it is known that physicians often fail to detect depression in the medically ill, or they view it as an appropriate response to the patient's condition. Therefore, an important risk factor is missed frequently or undertreated.

Epidemiologic studies have suggested that the majority of patients with depression are seen in primary-care medicine. It also has been found that up to 60% of the elderly who committed suicide saw a primary-care provider within 30 days of death, and approximately 35% saw a primary-care provider within a week of death. As a result of these

findings, the physician's office has been referred to as the primary suicide-prevention center (Murphy, 1986).

Given that depression tends to be undertreated in the medically ill, a study in Sweden provided an educational program for general practitioners about the diagnosis and treatment of depression. The effect of this educational program was that significantly more patients with depression were identified and treated adequately, and the suicide rate for the region dropped significantly. Since the effect did not last beyond two years, it has been suggested that repeated educational programs might provide a longer-term benefit. An effort to replicate the findings of this study needs to be undertaken.

In terms of medical illnesses, it might be thought that those illnesses that are considered terminal would be found frequently among completed suicides. The major psychological autopsy studies, however, have indicated that a rather small percentage (2–3%) of suicide victims suffered from terminal illness at the time of death. This fact suggests that most people with terminal illness do not foreshorten their lives by suicide. Yet, there is great concern in the United States about how we die and the issue of physician-assisted suicide. This concern seems to have been fueled by such factors as the medical profession's ability to sustain life beyond the point where it is meaningful, and its ability to extend life expectancy to the point where a majority of people die slowly of degenerative disease.

In response to the possibility of a prolonged but meaningless life that might entail considerable suffering and loss of dignity, there seems to be a consensus that competent terminally ill patients or their surrogates may refuse life-sustaining treatments or may invoke the "double-effect" principle and have morphine increased to relieve pain and suffering even though it also may hasten death. Generally, these deaths are not regarded as suicides, but are seen as attempts to exercise some control of the dying process. If, however, the terminally ill patient is suffering greatly but not in need of life-support systems and not on pain medication, it seems conceivable that he or she might decide to end his/her life intentionally and necessarily not be considered as having impaired judgment. Such a decision might preserve dignity and autonomy rather than destroy it. Cases of this sort have been referred to as rational suicides, and a majority of psychologists in a recent survey (Fenn & Ganzini, 1999; Werth & Cobia, 1995) stated that they believed in this concept.

While apparently accepting the concept of rational suicide, psychologists need to observe several caveats. First, there is an elevated rate of depression among those with medical and terminal illness, which, if untreated, could lead a patient to contemplate suicide. Second, psychologists always should be working to improve the patient's quality of life and to make the necessity of decisions about ending life as infrequent as possible. Third, if suicide is presented too readily as a rational option, our society may become more generally suicide permissive. Finally, societal acceptance of suicide could open elderly and terminally ill patients to family and institutional pressures to end their lives prematurely.

Acceptance of the concept of rational suicide necessarily does not imply that the legalization of assisted suicide is seen as a wise decision in the current health-care climate. Thus, while a majority of psychologists in a recent survey (Fenn & Ganzini, 1999) believed that assisted suicide was morally acceptable under certain conditions, there may be good reason to be cautious about legalization. For one, there are widely varying interpretations of the practice of voluntary euthanasia and assisted suicide in The Netherlands, with some arguing that the Dutch have lost adherence to medical standards and have abandoned efforts at palliative care to the convenience of euthanasia or assisted suicide, and others arguing that the evidence does not support the notion that the Dutch have gone into a moral decline on this issue. Second, the health-care system in the United States

currently is preoccupied with medical-cost containment, a situation that easily could lead to coercive practices concerning suicide and the terminally ill. The society might be served better if it focused on attaining a more-stable health-care environment before attempting the legalization of assisted suicide.

Psychologists have a great deal of expertise that can be utilized for the benefit of patients who are faced with end-of-life decisions. They have therapeutic skills in facilitating communication at these difficult times. Those in behavioral medicine have developed strategies to aid in pain management and stress management. Many have expertise in assisting patients and their families with the grieving process. They can be qualified by education and experience to evaluate the terminal patient's capacity to make end-of-life decisions, such as refusing life-sustaining treatment or agreeing to increased pain relief that also may hasten death. Regarding the evaluation of the terminally ill patient who requests assistance in suicide, psychologists need to investigate if their state-mental-health laws allow them to conduct such evaluations and refrain from preventing the suicide. In addition, the current APA code of ethics needs to be examined to see if it will allow for participation in assisted suicide. Since a large percentage of psychologists seem to believe in the possibility of rational suicide for the terminally ill, some have called for a reexamination of psychology's standards and principles in this regard.

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