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Suicide and Communal Values: Ethical Implications for Psychiatrists

Ronald W. Pies, MD | January 27, 2014

Our Collective Grief

No man is an island,

Entire of itself,

Every man is a piece of the continent,

A part of the main...

Any man's death diminishes me,

Because I am involved in mankind,

And therefore never send to know for whom the bell tolls;

It tolls for thee.

-- John Donne

I remember my uncle's final phone call with unusual clarity, because it came the same week in 1992 that Johnny Carson went off the air. In our yard, the late-May lilacs were starting to fade, and the warm weather was already easing us toward summer.

I had been out when my uncle phoned, but our answering machine picked up the message: He was calling because my mother had been "noodging" him -- not because he really wanted to speak with me. Having recently lost his job, my uncle sounded angry and enervated, as if he had marshaled his last bit of energy to fulfill this final duty. I tried calling him back, but there was no answer and no means of leaving a message.

A few days later, my uncle was dead of a self-inflicted gunshot wound, leaving a wife and 2 young children behind. More than 20 years later, the anguish of his suicide still tears at our family, and the questions we ask ourselves have never gone away: Could we have prevented this tragedy? Did we fail our loved one? Did we not see the clues? How could we have been so blind? What had we done to deserve such pain?

Psychiatrists are not moral philosophers by training, and the question of whether suicide is "immoral" is arguably the wrong one for psychiatrists to ask. As mental health professionals, we are, understandably, more concerned with the day-to-day challenges of detecting suicidal ideation; determining who is at high risk for suicide; and treating the psychiatric conditions most commonly associated with suicide, such as major depressive disorder.

Yet, as Dr. Cynthia M.A. Geppert points out, "the work of healing and caring is intrinsically about values and virtues." (Personal communication. December 1, 2013.) Thus, the ethical status of suicide is not a question that psychiatrists can ignore, any more than we can ignore human values in general. After all, our duty to preserve and protect life is founded on moral values, even if they are so deeply embedded in our medical ethos that we no longer sense their

moral underpinnings.

Recently, the moral status of suicide has been scrutinized by the poet and philosopher Jennifer Michael Hecht in her book *Stay: A History of Suicide and the Philosophies Against It*.[1] Hecht wrote the book in the aftermath of 2 suicides -- both victims were close friends and fellow poets. In essence, Hecht argues that suicide cannot be evaluated solely in terms of "personal autonomy," as some modern ethicists might claim; rather, we must hold suicide up to the clarifying light of communal values.

In an audiotape accompanying her book, Hecht argues that "when a person kills himself, he does wrenching damage to the community." In general, I agree -- and this damage, arguably, may be counted among the "moral harms" of deliberate self-destruction.

Self-chosen Dying

Yet, I do not want to convey the view that "all suicides are created equal" insofar as their ethical or moral status is concerned. In my view as a psychiatrist and bioethicist, the momentous issue of self-chosen dying must be carefully examined in the context of the patient's circumstances, motivations, clinical status, and "provisions" for friends and loved ones. I will give just 2 very condensed examples.

Mr. Jones. Mr. Jones, aged 75 years, is in the final stages of pancreatic cancer and has made a decision to end his own life. He is in moderate pain, despite optimal medical management and substantial pain medication.

Mr. Jones has explained his decision to his family and closest friends. According to both his internist and a consultant psychiatrist, Mr. Jones has no psychiatric history of significant mood disorder, is not clinically depressed, remains mentally alert and lucid, and has no psychotic ideation or major cognitive distortions. He has made adequate and thorough provisions for the care of his family, including taking care of the necessary financial and legal issues. Mr. Jones's family, while understandably heartbroken, are supportive of his decision and plan for his final days at home, with experienced hospice nurses available for palliative care and treatment of his pain.

Mr. Jones, in a lucid state of mind, voluntarily elects to decline further food and drink. The hospice nurses provide support and education to his family about this method of ending one's life, known as "voluntarily stopping eating and drinking" (VSED).[2] After drifting into unconsciousness, Mr. Jones dies without evident distress, surrounded by family, within 8 days.

Mr. Smith. Mr. Smith, aged 23 years, has a history of recurrent major depressive episodes and impulsive suicide attempts. Three weeks ago, he experienced a painful break-up of his long-standing romantic relationship of 3 years, after his girlfriend left him for another man. Mr. Smith is angry, embittered, and outraged that this has happened.

For the past 2 weeks, he has slept poorly, lost interest in nearly all of his usual activities, lost 8 pounds, and feels that "there is just no point" in life anymore. He sees no reason to talk to his friends or family about the situation. Instead, he impulsively buys a handgun, checks into a motel, and fatally shoots himself. He made no provisions for any of his legal or financial affairs, left no will, and died with a credit card debt of more than $15,000. His mother, the joint account holder, was saddled with the debt.

Mr. Smith leaves behind grieving and perplexed parents, 2 siblings, and many friends who say, "We didn't see this coming -- he never talked to us about how the break-up affected him. Did we miss something we should have seen? What did we do to deserve this?"

Clearly, there are important clinical and psychiatric differences between these patients. Moreover, from the standpoint of communal values -- that is, one's ethical obligations to friends, family, and community -- I believe that

we can view the cases of Mr. Jones and Mr. Smith quite differently. Indeed, I believe that most psychiatrists would have approached each case with different clinical and ethical goals in mind, had they been asked to intervene early in the course of events.

The "Reality Test"

As physicians, we have ethical and legal responsibilities to protect our suicidal patients from self-harm. Furthermore, it is our charge, as psychiatrists, to understand the genesis of suicide and to treat its underlying psychiatric precipitants -- most commonly, severe major depressive episodes. This is not to say that *all* suicides are a consequence of psychopathology. But even if we accept the notion of a perfectly "rational" suicide -- a dubious and rarely applicable concept, in my view -- the communitarian argument made by Hecht is compelling.

Most suicides leave a deep and painful wound in the emotional life of families and communities. It may take years for such a wound to heal, if it heals at all. I can attest to suicide's emotional damage in the microcommunity of my own family, following my uncle's death. To this day, my uncle's widow and her daughters bear the deep emotional scars of his action. And I, too, still second-guess my own involvement, often wondering if more persistence on my part might have prevented my uncle's death.

To be clear: Nothing I have said means that we, as physicians, should affix a scarlet letter to those who contemplate or attempt suicide. Nor do suicidal patients need high-minded lectures on "communal responsibility." Neither should we endorse the benighted view that suicidal people are "selfish" or indifferent to the feelings of others. On the contrary, the suicidal person is already burdened by the darkest of thoughts, and often by corrosive self-loathing. The last thing we should do is add our censure to the person's suffering. Rather, it is our task to comfort, care for, and heal those so afflicted.

Nevertheless, as psychiatrists, we may have good reason to discuss the issue of family and communal values with suicidal patients, without condemning their feelings or impulses. Many suicidal patients expound, at great length, on how important their friends and families are to them -- yet many are irrationally and tragically convinced that their loved ones would be better off without them. In my experience, this view is virtually never shared by the patient's friends and family, who believe that their lives would be immeasurably diminished by the patient's death. Psychiatrists can and, in my view, should "reality test" such distorted perceptions -- not as a way of guilt-tripping the suicidal patient, but as a means of exploring the patient's own values.

In principle, there may be rare circumstances in which ending one's life is both understandable, and by some lights even justifiable. Perhaps many readers would reach this conclusion in the case of Mr. Jones. Indeed, Dr. Judith Schwartz[2] questions whether VSED should even be considered in the same moral sphere as suicide:

> It is generally thought that those who commit suicide inflict shock and tragedy on their surviving loved ones, and that "typical" suicidal acts are expressions of despair and futility -- acts that are secretive, impulsive, and often violent in nature. Such a description seems at odds with a thoughtful and considered decision to stop further intake of food and fluids as a means to slowly but surely hasten an inevitable death as a means to escape further intolerable suffering.

Perhaps Schwartz is right in suggesting that VSED in the context of painful, terminal illness represents a special case of self-chosen dying, clinically and ethically distinct from suicide. But such "thoughtful and considered" actions before inevitable death are rarely the case in most instances of suicide. As an ethicist, I largely agree with Jennifer Hecht, that suicide's communal damage is a compelling reason to urge our suicidal loved ones to stay, and respectfully to suggest that life isn't too hard to bear -- only, as Hecht poignantly puts it, "almost too hard to bear."[1]

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Geppert, MD, PhD; Steven Moffic, MD; Boris Vatel, MD; and James L. Knoll IV, MD, on earlier versions of this essay. The views stated here, however, are my own. This piece is expanded and considerably revised from my blog on the *Psychiatric Times* Website.

Suggested Reading

Gebbia R. Understanding suicide: mental illness, not irony. *New York Times*. December 10, 2013.

Moffic HS. Suicide among the elderly. Over 65 Blog. November 11, 2013.

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Web Resource

American Foundation for Suicide Prevention

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1. Hecht JM. Stay: A History of Suicide and the Philosophies Against It. New Haven: Yale University Press; 2013.

2. Schwartz J. Exploring the option of voluntarily stopping eating and drinking within the context of a suffering patient's request for a hastened death. J Palliat Med. 2007;10:1288-1297. Abstract

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