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Suicide

THE SHAME OF MEDICINE

Prohibition

Thomas Szasz

SYRACUSE UNIVERSITY PRESS

emphasis and approach to the care of the mentally ill. . . . We need . . . to return mental health care to the mainstream of American medicine." Kennedy proposed the establishment of community mental health centers and promised to cure the majority of "schizophrenics."[9]

Subsequent presidents escalated the rhetoric about the magnitude of the problem of mental illness and the successes of its medical solution. In 1999, at a White House conference, President William Clinton declared: "Mental illness can be accurately diagnosed, successfully treated, just as physical illness." Tipper Gore, the president's mental health adviser, emphasized, "One of the most widely believed and most damaging myths is that mental illness is not a physical disease. Nothing could be further from the truth." First Lady Hillary Clinton added, "The amygdala acts as a storehouse of emotional memories. And the memories it stores are especially vivid because they arrive in the amygdala with the neurochemical and hormonal imprint that accompanies stress, anxiety, and other intense excitement. . . . We must . . . begin treating mental illness as the illness it is on a parity with other illnesses."[10]

We have come a long way since Pierce. He saw that if the federal government assumed responsibility for relieving the people of the demands of life, the result would be the destruction of the limited government that was the original raison d'être of the United States of America and the individual liberty it guaranteed. Pierce did not foresee how soon the American people would reject their commitment to local versus central government, how quickly the very term *states' rights* would become a term of disdain and disapprobation.

4

Separation

Emigration, Secession, Suicide

1

Why do people kill themselves? Because they are mentally ill. Death from suicide, experts on mental health insist and the press repeats, is the result of mental illness, just as death from cancer is the result of bodily illness.[1] This is nonsense—mindless belief in a literalized metaphor endowed with the power of agency: "Suicide kills."

According to prevailing psychiatric dogma, answering the question, "Why did X kill himself?" with "Because he wanted to die" is *empirically and statistically* wrong. I believe it is a priori right. Declared famous Roman poet Ovid (Publius Ovidius Naso, 43 BCE–AD 18): *"Spectemur agendo"* (Let us be judged by our acts). Although most people today might say and believe that they agree with that principle, in fact they do not: they do not judge people by their acts; they judge them by the politically correct *interpretation of the meaning* of their acts. Thus, killing oneself does not signify wanting to die. It signifies mental illness, religious fanaticism, sometimes even heroism in an admirable cause. Never a decision to leave life. Thus, when a "researcher" of Islamic suicide bombers "discovers" that his subjects want to kill themselves, his contrarian "findings" are "news." From a 2010 report in the *Boston Globe*, titled "The Truth About Suicide Bombers," we learn:

> Qari Sami [a suicide bomber] was a young man who kept to himself, a brooder. He was upset by the US forces' ouster of the Taliban in the months following 9/11—but mostly Sami was just upset. He took antidepressants daily. One of Sami's few friends told the media he was "depressed." . . . Brian Williams, associate professor of Islamic studies at the University of Massachusetts Dartmouth, was in Afghanistan at the time. Williams thinks that "Sami never really cared for martyrdom; more likely, he was suicidal." The traditional view of suicide bombers is well established, and backed by the scholars who study them. . . . But Williams is among a small cadre of scholars from across the world pushing the rather contentious idea that some suicide bombers may in fact be suicidal.[2]

In the United States, 10.9 out of 100,000 persons die by suicide. For persons between twenty and twenty-four, the figure is 12.5, and for those persons above sixty-five, it is 14.2. In short, the persons most likely to kill themselves are the young and the old. After listing these prevalence rates, the Web site of the National Institute of Mental Health adds, "A person who appears suicidal should not be left alone and needs immediate mental-health treatment. . . . [B]ecause research has shown that mental and substance-abuse disorders are major risk factors for suicide, many programs also focus on treating these disorders as well as addressing suicide risk directly."[3]

Like virtually all so-called mental health information, this statement is false, intended to distract attention from the reasons people choose death over life. What are the reasons? Simply put, escaping a life they view as worse than death. Although each person's reason for killing himself is uniquely personal, we might say that the young choose voluntary death to escape the pain and responsibility of having to make a life for themselves, the old to escape the loss of autonomy owing to age, disease, and disability.

In short, the simplest and most plausible explanation-motive for suicide at any age is the desire to separate oneself from "it," the nature of "it" differing among age groups, socioeconomic classes, cultures, and nations. As always, the actions of the suicide speak louder than the words of the persons who presume to speak for them, while seeking to deprive them of liberty. The suicidal person wants to get away from his life, his social environment. *His action is best viewed as a form of emigration or secession.* As Jean Améry, the Austrian "Jewish" Holocaust survivor and bitter opponent of suicide prevention, put it, "I don't like the word *Selbstmord* (self-murder). . . . I prefer to speak of *Freitod* (voluntary death). . . . [T]here is no carcinoma that devours me, no infarction that fells me, no uremic crisis that takes away my breath. *I* am that which lays hands upon me, who dies after taking barbiturates, 'from hand to mouth.'"[4]

Webster's defines *emigration* as "leav[ing] one's place of residence or country to live elsewhere" and *secession* as "withdrawal into privacy or solitude, retirement; formal withdrawal from an organization." Both terms refer to and are in part synonymous with *separation*, defined as "the act or process of separating: the state of being separated . . . cessation of cohabitation between a married couple by mutual agreement or judicial decree; termination of a contractual relationship (as employment or military service)."

Interpreted as a kind of emigration, the suicide decides to move from the land of the living to the land of the dead. Viewed as a kind of secession, the suicide chooses to firmly separate himself from his family and society.

Every emigrant knows from personal experience that it is painful to leave one's home and exchange one's mother tongue for a "foreign" language. Many people are deeply unhappy with their circumstances in their homeland, but few emigrate even if

they have the opportunity to do so.[5] The situation with respect to suicide is similar: many people are deeply dissatisfied with their life, but few choose to leave it. Why? Because of feelings of responsibility for dependents left behind, fear of the unknown, the dread of nonexistence, and many other reasons.

Our sense of existence is intrinsically dialogic. We are social creatures through and through. Strictly speaking, there is no such thing as an independent, self-sufficient, autonomous individual. That fact does not render the term *autonomous* less useful. It requires only that we keep in mind that our need for autonomy is permanently at odds with our need for relationships with other human beings (or imaginary or nonhuman beings endowed with human attributes, such as gods and pets).

This understanding of autonomy requires that we attribute it only to *persons as individuals*, never to persons-in-relation—for example, patients. It is as foolish to talk about "patient autonomy" as it is to talk about "spouse autonomy" or "orchestra player autonomy" or "soccer player autonomy." Each member of such a pair or team willingly enters into a human bond, the very point of which is to relinquish some portion of his autonomy (independence) in exchange for some other goods (such as security or service or team effort). Why else would man create God, if not to love him and be loved by him in return? I suspect that this point is why the gods of the monotheistic religions condemn suicide.

2

The conventional explanation that, in the monotheistic religions, suicide is forbidden by the commandment "Thou shalt not kill"—a mistranslation of "Thou shalt not murder"—is unpersuasive. Other types of killings-murders are permissible, some even praiseworthy. It seems more plausible to interpret the prohibition against suicide as God's commanding man never to abandon him,

a directive explicitly stated in the Old Testament: "Thou shalt have no other gods before me" (Exod. 20:3).

Why this demand for exclusivity? The Greeks and Romans had numerous gods who kept each other company. The Jewish God is alone in the world, married to man. His greatest fear is divorce; hence, he prohibits it.

Formerly, we protected ourselves from our fatal freedom by clinging to monotheism, monarchy, and monogamy.[6] Today, we protect ourselves by placing our faith in monomedicine, monoscience, and monogovernment (the total state, the therapeutic state). Each of these arrangements promises to satisfy our craving for security and certainty, conditions absent in real life. Hence the ever-recurring lament of the pious abandoned, "My God, my God, why hast thou forsaken me?" (King David, Psalm 22).

It seems likely that the invention of a god whom we must never abandon and who promises never to abandon us originates from the infant's need never to be separated from his mother. Human life is inherently precarious, and humans *know* it is. The prohibition "You must never leave (me)!" and the promise "I will never leave (you)!"—communications lovers sometimes exchange in precisely those terms—are effective, albeit illusory, protections against this basic anxiety. This point is why autohomicide qua selfish suicide and autohomicide qua selfless self-sacrifice are two sides of the same coin.

If we perceive suicide as a selfish act—the egoistic *detachment* of the self from the Other in the here and now—we interpret it as sinful or sick. On the other hand, if we perceive suicide as the timeless *attachment* of the self to the Other—in the hereafter as in *Romeo and Juliet*, or to God as in martyrdom—we interpret autohomicide as reasonable and admirable.

In the traditional religious worldview, the sole agent with legitimate power to decide who should live and who should die is God, the Creator. In the modern medical view, the sole such agent

is the therapeutic state. Secession—defiance of control by church, state, medicine—is the ultimate escape from oppression, the ultimate declaration of freedom.

3

"Secession" is the peaceful (nonviolent), voluntary separation of political entities. Analogically, we may view divorce as marital secession and suicide as personal secession. (The fact that not all those individuals personally affected may find the separation voluntary or peaceful—for example, children in a divorce—is important but does not affect the argument I am advancing.)

As Americans, we tend to associate the term *secession* with the Civil War, slavery, and states' rights. This view is shortsighted. The sole aim of the Revolutionary War (War of Independence) was *secession* from the government of King George III. "Most Americans seem to be unaware that 'Independence Day' was originally intended to be a celebration of the colonists' *secession* from the British empire," writes historian Thomas J. DiLorenzo. "The Revolutionary War was America's first war of secession. . . . The word 'secession' was not a part of the American language at that time, so Jefferson used the word 'separation' instead to describe the intentions of the American colonial secessionists."[7]

From the beginning, there were disagreements among the founders: some wanted to form a powerful centralized state, while others wished to maintain the independence of their respective regions by creating a loose confederation of states. "If any state in the Union will declare that it prefers separation . . . to a continuance in union . . . I have no hesitation in saying, 'let us separate,'" wrote Thomas Jefferson to William H. Crawford, Monroe's secretary of the Treasury, in 1816.[8] In 1862, Abraham Lincoln defended his war on the South with the opposite rationale:

> My paramount object in this struggle is to save the Union, and is not either to save or to destroy slavery. If I could save the Union without freeing any slave I would do it, and if I could save it by freeing all the slaves I would do it; and if I could save it by freeing some and leaving others alone I would also do that. What I do about slavery, and the colored race, I do because I believe it helps to save the Union; and what I forbear, I forbear because I do not believe it would help to save the Union.[9]

Consistent with his view on political secession, Jefferson regarded suicide as a rational remedy for personal disaster. In 1779, the Virginia legislature was considering a bill for the repeal of the punishment for suicide. Jefferson supported repeal and offered the following statement on its behalf:

> Suicide is by law punishable by forfeiture of chattels. This bill exempts it from forfeiture. The suicide injures the State less than he who leaves it with his effects. If the latter then not be punished, the former should not. As to the example, we need not fear its influence. Men are too much attached to life, to exhibit frequent instances of depriving themselves of it. At any rate, the quasi-punishment of confiscation will not prevent it. For if one can be found who can calmly determine to renounce life, who is so weary of his existence here, as rather to make experiment of what is beyond the grave, can we suppose him, in such a state of mind, susceptible of influence from the losses to his family by confiscation? That men in general, too, disapprove of this severity, is apparent from the constant practice of juries finding the suicide in a state of insanity; because they have no other way of saving the forfeiture. Let it then be done away.[10]

Jefferson's reasoning here echoes David Hume's reasoning in his essay "On Suicide," published two years earlier. Also

pertinent to Jefferson's views on suicide is his correspondence with Dr. Samuel Brown, a professor of medicine at the university in Lexington, Virginia, concerning the use of toxic plants for killing oneself. On July 14, 1813, Jefferson wrote to Brown, "The most elegant thing of that kind known is a preparation of the Jamestown weed, *Datura-Stramonium,* invented by the French in the time of Robespierre. Every man of firmness carried it constantly in his pocket to anticipate the guillotine. It brings on the deep sleep as quietly as fatigue does the ordinary sleep, without the least struggle. . . . It seems far preferable to the Venesection of the Romans, the Hemlock of the Greeks, and the Opium of the Turks. . . . There are ills in life as desperate and intolerable, to which it would be the rational relief."[11]

Jefferson is describing, perhaps even recommending, the use of *Datura stramonium* as an herbal medicine useful for suicide. The source of this toxic chemical is the common plant known by many names, among them angel's trumpet, devil's weed, jimsonweed, and Jamestown weed. The term *stramonium* is originally from the Greek *strychnos* (nightshade) and *manikos* (mad). All parts of *Datura* plants contain significant quantities of the alkaloids atropine, hyoscyamine, and scopolamine, chemicals that may be fatal if ingested by humans or animals. In the United States the plant is called "Jamestown weed" after the city in Virginia, where British soldiers were drugged with it while attempting to suppress Bacon's Rebellion in 1676. Today, a person who so casually informs another of the suicidal potential of a readily available substance, as Jefferson did, runs the risk of being charged with the crime of "assisting suicide."

The result of this cultural-legal atmosphere is the destruction of privacy and trust in the helping professions. Suicide prohibitions have not succeeded in preventing suicides but have succeeded in preventing people from having an honest, private

conversation about life and death. Those persons who trust mental health professionals with their innermost thoughts may quickly find themselves punished with a "seventy-two-hour hold" or worse. Suicidal persons and their would-be helpers alike are paralyzed by prohibitionist censorship, deception, and legislation requiring the betrayal of trust. The first and major victim of the war on suicide, as in all wars, is loss of liberty.

4

Psychiatrists are expected—legally, medically, socially—to prevent individuals from killing themselves. As professionals, they are also expected to lie and withhold information about the subject and instruct journalists to do the same, all in the name of public health.

In 2009, *Psychiatric News* ran an article titled "Psychiatrists Urged to Work with Journalists on Reporting of Suicides."[12] Medical writer Mark Moran reports that the Canadian Psychiatric Association instructed its members to "educate" journalists about ways of reporting that do not encourage copycat suicides: this was one of the recommendations in a policy paper titled "Media Guidelines for Reporting Suicide," in which the CPA summarized recommendations formulated by the US Centers for Disease Control and Prevention and the Canadian Association for Suicide Prevention for journalists. "Since media often call psychiatrists to comment on suicide," states the paper, "it is crucial for psychiatrists to have this knowledge readily available. These requests can be an opportunity for educating the media and ultimately saving lives." The recommendations include avoiding reporting the following: details of the suicide method, the word *suicide* in the headline, and approval of the suicide. In contrast, the recommendations encourage journalists to convey the following when

reporting a suicide: alternatives to suicide (that is, treatment); community resource information for those with suicidal ideation; examples of a positive outcome of a suicidal crisis, such as calling a suicide hotline; warning signs of suicidal behavior; and ways to approach a suicidal person. Similar recommendations have been published by the American Foundation for Suicide Prevention, in collaboration with the American Association of Suicidology, the Centers for Disease Control and Prevention, the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, the Office of the Surgeon General, and the Annenberg Public Policy Center. These efforts to transform the media into loyal soldiers in the war on suicide are similar to the efforts that medical politicians used to mobilize the country—indeed the Western world—to fight the war on drugs.

Accordingly, people can no longer trust physicians, teachers, science writers, or journalists, most of whom have been co-opted, suborned, or simply seduced by the antisuicide apparatus of the Mental Health System. If they have lived well or are just lucky, people may be able to trust parents, siblings, adult children, or friends. In their anonymous identity in the protected sphere of the Internet, they can also trust one another to engage in honest dialogue, safe from Big Brother as Grand Therapeutic Inquisitor.

Physicians, especially psychiatrists, have abandoned their traditional roles as trustworthy confidants and counselors of troubled persons, forfeiting their ministerial functions. People seeking to engage in a meaningful conversation about suicide must bypass newspapers, radio, television, and even monitored Web sites and create their own protected sphere. The Usenet newsgroup ASH (ash or a.s.h., alt.suicide.holiday) has provided such a service.[13]

The term *Usenet* refers to an *unmoderated Internet discussion system*. Some newsgroups are moderated, that is, messages submitted by readers are e-mailed to the moderators of the newsgroup,

for approval. The job of moderators is to ensure that "messages that the readers see in newsgroups conform to the charter of the newsgroup. Such articles bear the Approved: header line." Messages submitted by readers for unmoderated newsgroups are published for everyone to see.[14]

While ASH's original purpose was to discuss the relationship between suicide rates and holiday seasons, hence its name, it has "evolved into a broad discussion forum where suicidal and depressed people can openly share their thoughts. Some participants are not suicidal, but post to provide psychological support and other input to suicidal or depressed posters. According to its FAQ [frequently asked questions], its purpose is neither to encourage nor discourage suicide."

The community has developed its own unique terminology, revealingly based on the metaphors of travel. Thus, "'Catch the bus' refers to the act of suicide, and the group is described as: 'A bus stop where several people have decided to stop and chat before deciding on whether or not to get on the bus.'" According to the ASH site,

> Because ASH is a non-moderated Usenet newsgroup, it is technically impossible to ban any person from posting to ASH. Because of this, ASH cannot be classified as being pro-choice or pro-life: posters in the newsgroup represent wide range of positions from strict anti-suicide to right-to-die.
>
> ASH is often mistakenly called a website; in fact it is a Usenet newsgroup from the alt.* hierarchy and not a website. This makes a significant legal difference, and allows ASH to exist despite attempts to close suicide websites. Unlike websites, Usenet newsgroups are not regulated by any central authority, and there is no organization or individual responsible for a particular newsgroup. . . . Recent research shows that suicide websites indeed could be more efficient in providing emotional help for people contemplating suicide than suicide hotlines. . . .

> High degree of anonymity is another advantage of newsgroups like ASH, allowing people to openly talk about their feelings without fear of consequences. . . . ASH does not censor information on suicide methods and does not prohibit such discussion. Opponents see discussion of suicide methods as potentially endangering vulnerable people—people who would otherwise live through crisis, might commit suicide given information on lethal methods. Supporters of open discussion state that methods information is widely and legally available; . . . there is no indication that making such information available changed suicide rates.

The passion to control others—manifested, for example, by censoring what people can hear or read or what drugs they may ingest—can be restrained only by self-control. Citing empirical evidence demonstrating the ineffectiveness—or, indeed, the counterproductivity—of certain social practices generated by the passion to control is a notoriously feeble counterpoise against it. The futility of appeals to evidence is illustrated by the fact that even such ostensible opponents of suicide prohibition as Final Exit use medicalized premises, absurdly promoting a "right to suicide" contingent on medical criteria and medical judgment. Under the heading "Our Guiding Principles," the Web site of the organization states: "Mentally competent adults have a basic human right to end their lives when they suffer from a fatal or irreversible illness or intractable pain, when their quality of life is personally unacceptable, and the future holds only hopelessness and misery. . . . We do not encourage anyone to end their life, do not provide the means to do so, and do not actively assist in a person's death. We do, however, support them when medical circumstances warrant their decision."[15] The Bill of Rights presumes that the people to whom it is addressed are mentally competent. There is no mention in that document of "mental competence,"

a term that implies a "medical" judgment, granted or withheld by psychiatric authority. The fact that today even individuals and organizations that ostensibly condone suicide treat voluntary exit from life as a psychiatrically permitted option, yet call it a "basic human right," illustrates how medically contaminated and morally degraded our concept of human rights has become.

There is only one US Constitution and Bill of Rights. Supporters of the therapeutic state deprive individuals they deem mentally ill of the protections of the Bill of Rights, posit that the protections apply only to the mentally healthy, and occupy themselves with drafting new "Mental Patients' Bills of Rights."

5

Everyone wants to die a "good death." Where people differ is in their understanding of the term. The ancient Greeks viewed a "good death" as the culmination of an "objectively desirable 'good' life," creating eudaimonia, usually translated as "happiness." Such a death was considered a rare and admirable achievement.[16] Today, most people believe that how they die has nothing to do with how they live, that they have a "right" to a good death, defined as a death free of pain and suffering. *Imperfect Endings*, a recent book by Zoe FitzGerald Carter, is an example of the death of such a person.[17]

Ostensibly a tribute to her mother, Mary Curtis Ratcliff (Margaret in the book), *Imperfect Endings* is an overlong lament about her egotism, vanity, and determination to control her children's lives, capped by her plans for killing herself in their presence, her idea of a "perfect death."[18] This was the last thing the daughters—Katherine, Zoe, and Hannah—wanted.

Why does Margaret—seventy-five and generally healthy—want to end her life? Because, she says, she suffers from

Parkinson's disease and does not want to wait until the disease kills her. In fact, she is nowhere near death from Parkinsonism or any other illness. Ostensibly, the three daughters support their mother's decision:[19]

"'You know, Zoe [says Katherine], I do think Momma has the right to die if she wants to.' 'I do too,' I say, wondering if this is true. 'But it's not just a question of rights. It's about whether or not it makes sense.' . . . It made perfect sense to my mother, so who am I talking about? Myself, obviously. And the reason it doesn't make sense to me is that I don't want her to die. Her willingness to consider it makes me feel inconsequential, like I'm not worth sticking around for.'"[20] Margaret—a moneyed member of Washington high society, the widow of an alcoholic, womanizing lawyer—regards herself entitled to a comfortable death. Together with Zoe, they set off on a round of visits to physicians whom they expect to assist them.

"My mother and I went to see Dr. Harmon, a local psychiatrist and prominent member of the Hemlock Society . . . and request a prescription for Seconal." Harmon goes through the ritual mental-status examination required before providing such a medical service. Reassured by both women that the "patient" is not depressed, he says, "You have come to get a prescription for Seconal. Am I right? . . . Good. I'll write it for you and you can get it filled today if you wish. Wait a couple of months and then get it refilled. Your third refill should be two months after that. We don't want to alarm the pharmacist."[21]

Scoring Seconal so easily leaves Margaret and Zoe unsatisfied. After egging on one another with fears that ingesting the drug might fail to be fatal, they contact the local branch of the Hemlock Society and make arrangements to be visited by a suicide counselor. The counselor—whom Margaret and Zoe promptly belittle, dubbing him "Mr. Death"—is a poor naif "from Tulsa, Oklahoma," who asks to be called "Bud": "My mother is a solid Washington

Democrat, a liberal even, but she is also a cultural and intellectual snob, and this man is definitely not a member of the tribe."[22]

Bud ignores the disrespect of his clients and explains that the Hemlock Society offers to supplement Seconal, if necessary, with helium, to asphyxiate the patient: "We stay with her until we're sure she is dead, take the tank and everythin' and leave. Y'all call the coroner's office to let 'em know there's been a death. They show up." Worried about detection and blame, Zoe pesters Bud: "So what if they notice she's has just been suffocated? Or has helium in her system?" "Well, I can tell you, in my experience, that's never happened. . . . I jus' want you folks to know I don't get paid to do this job. I do it 'cause I believe in it."[23]

Worried that Rosa—Margaret's loyal, longtime Chilean Catholic housekeeper—might denounce the daughters for facilitating their mother's suicide, Katherine admonishes Zoe: "You may be willing to play along with her games, but I'm not."[24] Margaret—who has a master's degree in clinical psychology from Columbia University—pleads: "'I was hoping all three of you could be here.' 'Okay, so all three of us will be facing murder charges,' Katherine bellows."[25]

Meanwhile, in San Francisco, Zoe's devoted husband, Jack—in-house counsel for a Silicon Valley high-tech company—grows tired of his wife's limitless willingness to subordinate his needs and the needs of their family to Margaret's vagaries:

> "She's toying with you, honey," Jack says in a terse, aggrieved voice the morning after my return. "I doubt she has any intention of killing herself at all. It's just a weird bid for attention. And the worst part is, you keep falling for it. . . . Your mother isn't dying, she's talking about dying, or killing herself, or getting someone else to kill her, or whatever it is this week. And she's got you in a state over it. . . . How long is she going to keep this up? Calling everyone to announce some new plan

> every five minutes. . . . How long are you going to run to her every time she calls? . . . This has been going on for close to a year. How much longer are you going to put up with it?" I can't answer that question. No, I can answer that question. . . . I will always run to her when she calls.[26]

Jack understands what's going on but is too decent to make Zoe's life even more difficult. Margaret is a spoiled, rich woman, commanding a stable of doctors who cater to her wish to rotate her suicide plan. Rejecting both Seconal and suffocation, she reports to Zoe: "Dr. Fielding had prescribed me morphine. . . . Apparently it's quite easy to do. And it's unlikely anyone would notice since I'd be taking it for pain anyway. So I was thinking perhaps morphine is the way to go." Zoe erupts: "I'm sick of talking about this all the time. It's all we ever talk about. . . . Do you ever think for one second that I might be doing something? Like playing with my children?"[27]

Unrepentant, Margaret retaliates: "'Well, it won't be for very much longer,' my mother says coldly. . . . Doesn't she have some responsibility to help me process this? Isn't that part of the message in all those books she reads, the Good Death creed she so ardently subscribes to? . . . 'Don't try to make me feel sorry for you [Zoe soliloquizes]. Remember, you are not dying—you are choosing to die.'"[28]

Margaret continues to set new suicide dates and justifies the extensions by attributing them to her love for her children and grandchildren: "Don't worry. . . . I am waiting to get copies of my novel made for the three of you. And then there's that children's story I told you about. Something I want to finish for all the grandchildren."[29]

And so mother and daughters stumble from one deception and self-deception to another. Margaret obtains a bottle of liquid morphine. Zoe's phobic, war-on-drugs mind-set now takes over: "To me the bottle looks radioactive, evil. . . . Morphine is a drug

I associate with madness and stupor and tragedy, not with my well-controlled and controlling mother."[30]

The mention of morphine reminds Zoe of hearing the story of twenty-year-old Margaret's visiting her father in a New York hotel room and watching him inject himself with it and her own use of illegal drugs at seventeen. Sent to an "ecology camp" in Nevada, supervised by a counselor nicknamed "Weed," Zoe learns to be a "junkie." Her usage discovered after her return home, she assures her mother, "'It's not that big a deal, Momma. It really didn't affect me that much.' But it wasn't true. I'd loved the dizzy, disconnected feeling it gave me. . . . I knew it was a promise I'd never keep. Taking drugs had inducted me into a secret society, an alternate universe of empty attics and deserted parks, roach clips and wrinkled Baggies."[31]

Margaret's and Zoe's dishonest and distorted thinking about "drugs" becomes a source of their own misery. They reject suicide by Seconal and other drugs and choose death by starvation, which turns out to be protracted, painful, and undignified—a model "imperfect ending":

> An overdose is an overdose, and this is exactly the scenario that Hannah, Katherine, and I wanted to avoid. Not only did the idea of watching my mother take pills or morphine repulse me, my sisters and I stood to gain financially [evidently substantial bequests] from her death. What was to stop some overzealous prosecutor from deciding that we had grown tired of waiting for our inheritance? . . . Stopping eating and drinking will allow us to be with her at the end, I say, without legal risk. It's that simple. . . . It suddenly seems imperative to me that she choose that method of death.[32]

Predictably, mother and daughters' mindless efforts fail. Margaret starves and suffers but fails to die. She asks her daughters'

permission to take morphine. The day for the final act of the drama finally arrives. Jack joins the sisters. Zoe's fear of being formally blamed for her mother's assisted suicide escalates. Margaret asks how much morphine to take:

> Hannah, who's sitting next to my mother's bed, reaches over and takes the bottle, looks at the label for a moment, and hands it to Jack. Mesmerized, I watch from the couch. . . . I start to shiver. . . . They are talking about milliliters and ounces and droppers. It's a conversation I can't follow. . . . I can see their mouths moving but can barely hear them over the roaring voice inside my head: DON'T TOUCH THAT BOTTLE. Except it's too late, they've touched it. Both of them. And all I can think about is that their fingerprints are on it and that, we're arrested for murder, I'll be the only one able to say I had nothing to do with it, the bottle was never in my hands.[33]

On cue, Margaret reasserts herself: she drops the bottle of morphine, spilling some of its contents. Hannah picks it up, hands it back to her, and waits until she drinks its content: "'I just didn't like handing it to her,' she says angrily. . . . I can tell she is still upset about the dropped bottle. I want to tell her it's okay. That she did what she had to do. And I want to tell her how much I owe her for stepping into the breach tonight, taking on the heaviest burden while I cowered fearfully in the corner."[34]

One finishes reading *Imperfect Endings* wondering what made Carter write and publish this pathetic confessional, incriminating both her mother and herself as morally deficient individuals. That she has produced a worthwhile contribution to the literature on assisted suicide? The editors of the *Washington Post* evidently thought so. On March 17, 2010, the paper published a long review-essay, quoting Zoe Carter concluding, "In the end, I thought she [Margaret] had a beautiful and dignified death."[35] Nowhere in her book does Carter assert this patent untruth, inconsistent with its

very title. In fact, Carter paints her mother's death, and life, as ugly and undignified, recalling, for example, her wailing, "'I need a parent.' Is that what she wants me to be—her parent? . . . Of course she's afraid. But I am also afraid and I also need a parent."[36] It is no excuse that mother and daughter alike are the products of long-term psychotherapy aimed at validating moral weakness as faultless medical illness.

Although Carter says little directly about suicide prohibition, what she does say is inaccurate and self-serving: "If assisted suicide was legal, and we hadn't been forced to spend so much time worrying about getting caught, we might have been able to better prepare ourselves."[37] Carter and company were not "forced to spend time worrying about getting caught." Gutless, ill-informed, confused, they chose to do so. In fact, Zoe Carter was not really interested in suicide—that is, autohomicide—which she viewed as a job to be delegated to hired help.

Let us here recall Steven Schnipper's suicide, mentioned in chapter 1. What made Schnipper's unassisted suicide so bad that its very nature had to be buried with him? What made Ratcliff's assisted suicide so good that its story is deemed important and uplifting enough to be published by a leading publisher and praised by respectable reviewers? Is it that Schnipper acted alone, exiting life by himself, and Ratcliff did not? Schnipper killed himself, in private, without burdening others with his voluntary exit from life. Ratcliff turned her exit into a family Grand Guignol.

Is this where our "medical ethics"—with its pretended devotion to "benevolence, beneficence, and patient autonomy"—has brought us? To where a daughter is afraid to be present when her mother dies, lest she, the daughter, be charged with murder? Advocates of our suicide prohibition policies might call this an unintended consequence of our meritorious efforts to prevent "drug abuse" and suicide. I contend that it is not, that anyone with a modicum of skepticism about medical ethics and the

therapeutic state could have anticipated and predicted precisely such an outcome.

A comparison of these two accounts of voluntary death highlights a disturbing aspect of our contemporary culture, namely, our fear and hatred of autonomy, of self-reliance, of taking care of our business without unnecessarily burdening others with it. We have transformed our old ethic of self-reliance from virtue into vice. We must not be responsible—for our children's education, our medical care, our economic support in old age. As soon as we acquire a measure of self-control, we must begin to relinquish it and acquiesce in being "taken care of" by benevolent agents of the therapeutic state.

5

The Shame of Medicine

1

Throughout most of history, medical care was a personal service provided by physicians to individuals who sought their help. The recipient-patient selected the individual whose assistance he desired and paid for the service he received. By paying for the help, he implicitly consented to the intervention. That relationship is what we mean by a private, personal medical service.

Since ancient times, there has existed another kind of medical service as well, exemplified by Greek slave owners procuring medical assistance for their slaves. In the *Laws*, Plato (428–348 BCE) contrasts the two arrangements as follows:

> Now have you further observed that, as there are slaves as well as free men among the patients of our communities, the slaves, to speak generally, are treated by slaves, who pay them a hurried visit, or receive them in dispensaries? A physician of this kind never gives the servant any account of his complaint, nor asks him for any; he gives him some empirical injunction with an air of finished knowledge, in the brusque fashion of a dictator, and then is off in hot haste to the next ailing servant—that is how he lightens his master's medical labors for him. The free practitioner, who, for the most part, attends free men, treats their diseases by going into things thoroughly from the beginning in a scientific way, and takes the patient and his