The Request to Die
Role for a Psychodynamic Perspective on Physician-Assisted Suicide

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Published reports indicate that 2.5% of deaths in the Netherlands are the result of euthanasia or physician-assisted suicide. It is not known how many patients make these requests in the United States, but the issue has gained considerable attention, including that of the Supreme Court. The focus of the writing and discussion regarding the request to die has been on a patient's capacity. There has not been an adequate focus on the possible meanings contained within the request to die. A patient's request to die is a situation that requires the physician to engage in a dialogue to understand what the request means, including whether the request arises from a clinically significant depression or inadequately treated pain. This article outlines some of the thoughts and emotions that could underlie the patient's request to die. Recommendations are made regarding the role of the primary care physician and the role of the psychiatric consultant in the exploration of the meaning of the request.

THE ISSUE to be addressed in this article is not one of ethics or law. The focus is on the variety of potential psychodynamic meanings contained within a patient's request for assistance in bringing about his or her death, and the important role a psychodynamic understanding can play in the physician's response to the patient. Some treatment refusals will result in the death of the patient and, thus, should also be carefully assessed. The principle that every request to die should be subjected to careful scrutiny of its multiple potential meanings has not been part of the standard response to such requests.

Data from a 1995 survey of death certificates in the Netherlands reveals that 2.5% of all deaths result from euthanasia. This is an increase from the 1.7% rate found in the 1990 survey. Whether this increase indicates a "slippery slope" is a matter of controversy. It is not known how many patients in the United States request help in dying. As noted by Hendin, "Strikingly, the overwhelming majority of those who are terminally ill fight for life to the end." Choehinov et al reported that 44% (89 of 200) of terminally ill patients report occasional wishes that death would come soon. Only 9% report a "serious and pervasive wish to die." As in other studies, the desire for death correlates with both physical pain and with poor social support. The most significant correlation is with depression, as 59% of patients who wish to die have a depressive syndrome. Breitbart et al found that 63% of patients infected with the human immunodeficiency virus (HIV) supported policies favoring physician-assisted suicide, and 55% considered physician-assisted suicide as a personal option. This study demonstrated a strong correlation with depression and low social support (patients' rating of fewer visits by family and friends, patients' experiencing less support from family and friends), but not with patients' rating of physical pain. It is possible that the stigma, prejudice, and discrimination that patients with HIV infection experience increases their risk for depression and the wish to die. Some studies demonstrate that uncontrolled pain correlates strongly with suicide in cancer patients; others show a negative correlation between patients with pain and a positive attitude toward euthanasia and physician-assisted suicide. The survey of oncology patients by Emanuel et al found that 25% thought about asking their physician for euthanasia or physician-assisted suicide. This study confirmed the association between depression and patients' consideration of death. The patients who were "depressed and psychologically distressed were significantly more likely to seriously discuss euthanasia, hoard drugs, or bought or read Final Exit." Surveys report a wide range in physicians' reports of requests from patients for assisted death and in physicians' willingness to give a lethal dose of a drug or perform assisted death. Seventeen percent of critical care nurses reported receiving requests for death from patients or from the patient's family; 16% reported they aided in a patient's death, and 4% reported that they hastened a patient's death by pretending to provide life-sustaining treatment ordered by the physician. Fifteen percent of nurses who work with patients with the acquired immunodeficiency syndrome in San Francisco, Calif, have assisted in a patient's suicide. Physicians...
and other clinicians thus find themselves continuing to struggle with patients’ requests to die.

A psychodynamic approach to a patient’s communication attempts to understand both the manifest content and also to explore unconscious meanings. Critics of this approach label the search for meaning reductionist, indicating that it entails seeking a different origin or a “true” meaning hidden from that apparent on the surface, without acknowledging the importance of the manifest content. A modern view of psychodynamics is expansionist, i.e., seeking to find other important hidden meanings within emotion, thought, and behavior rather than searching for a singularity, a core unity, or a “truth.” The premise that follows from this conceptual framework is that every case of a patient requesting to die should be explored in depth by the physician primarily responsible for the care of the patient, mindful of the complex psychodynamics that might be involved. No action should be taken prior to such close scrutiny. Discussions of the psychiatric evaluation of a patient’s request to die often focus on whether the patient is “competent,” which is too simplistic an approach for so complex a matter. This article is designed to explore some of that complexity using general categories of thoughts and emotion present in patients who express suicidal ideation. This may shed light on the significance to the patient and to the physician of conscious and unconscious meanings in a medically ill patient’s request to die.

THE REQUEST TO DIE AS A COMMUNICATION

When a person commits suicide, the note left behind communicates (overtly and symbolically) the reasons for the choice of death. Of greatest importance is the fact that this communication follows the death. There must be a difference between patients who commit suicide, with no communication save the note left behind, and patients who say to their physicians “Would you assist me in my death?” or “Would you kill me?” The very fact that there is a communication while the person is alive suggests the expectation of an interaction with the physician. What could such a communication mean to the patient and what does the request signify as a communication to the physician? There are many possibilities, but one that should be considered is that the request to die is an attempt to be given a reason to live⁵; i.e., the patient is asking, “Does anyone care enough to talk me out of this request, to want me to be alive, to be willing to share my suffering?” Acting on a patient’s wish because he or she is judged to be rational and competent ignores the unspoken or unconscious meaning(s) of the request. Acknowledging this dynamic without stating it overtly, a physician might respond to the patient, “I want to try to do everything I can to work with you and provide you with the best care I can offer. If you die, you will be greatly missed; how can we understand together why you want to die right now?”

CONTROL

“It is always consoling to think of suicide: in that way one gets through many a bad night.”²² Nietzsche’s comment suggests that one possibility contained within a patient’s request to die may be an effort to take control over life, even if this control is illusory and paradoxical. When a patient has lost control over every aspect of life, the only place control may be established is by asking for death. Many patients find great solace in knowing they can kill themselves at any time by hoarding a lethal dose of medication, even though the medication is never used. Is the person actually seeking death or a magical protection in the form of the pills, a talisman against the agonizing helplessness of having no control? A discussion with the physician could provide the patient with the reassurance that the ability to control his or her destiny is maintained without requesting to die.

A patient awaiting a heart for transplant informed the physician that patients had the “right” to request physician-assisted suicide. A psychiatric consultation was requested to evaluate the patient’s “suicidality,” and there was great concern on the ward that the patient might remove the battery from the left ventricular assist device (LVAD). When interviewed, the patient was lively and engaging, clearly enjoying the back-and-forth discussion of a patient’s right to end his or her life. There were no symptoms of depression, and the patient was hopeful about obtaining a new heart. The patient came from a tradition of argument as a way of interaction with others, and physician-assisted suicide was a topic of personal importance. The discussion made clear the patient’s need to feel in control of every aspect of life, control that the idiopathic cardiomyopathy had taken away. In talking about the “right to die,” the question of the LVAD arose, especially the fact that this individual could end life at any moment by removing the batteries. The patient responded instantly and passionately that a major concern was that there would not be an adequate supply of batteries to guarantee a charged battery be available every moment of the day, at work, at home, or while traveling. The patient looked directly at the interviewer and said, “Do you think I am crazy, if I did that I would die! We’re not talking about death here, we’re talking about my rights.”

SPLIT IN THE EXPERIENCE OF THE SELF

A cognition found in suicide and in some medically ill patients’ request to die is the wish that the bad, i.e., medically sick, part of the self be killed, leaving the healthy self to survive. This fantasized split may be unconscious; however, some patients may have a conscious experience of another, “sick self,” who feels like an alien within the patient. Such patients make comments such as “I don’t know the person I’ve become” or “This isn’t how I usually act.” Patients may complain that they feel “taken over” by their physical, medical, or emotional needs to the exclusion of their “normal” personality. Conscious or not, the wish to kill off a part of the self in order to survive or to be willing to die along with the sick self with the fantasy that the healthy self will be reborn may be a motivation contained within the request to die. In such a situation a psychological intervention could enable the individual to resolve this split so that there is no longer a healthy and sick self but one self who is suffering and ill. The physician might make a comment such as “It may feel at times as if you don’t recognize yourself, particularly when you have many complaints or when you have a great deal of physical discomfort. But the ‘real’ you still comes through. It’s okay to complain and okay to have needs.” Such patients, after an initial discussion with their physician, should be referred for psychological treatment if the split in self-experience persists.

RAGE AND REVENGE

Patients who are desperately ill may feel some degree of rage: rage at themselves, rage at their doctors, rage at the world, rage at God for their illness and for their suffering. Rage, caused by physical suffering, psychological suffering, or
both, may induce wishes to kill. The impact of hopelessness, the experience of being helpless, the agony of experiencing oneself as out of control, the terror of the unknown, and the physical suffering from inadequately treated pain may cause the patient to seek revenge by demanding death. To kill whom? Along with the emotion of rage comes the wish for revenge. A psychodynamic understanding of some suicidal patients indicates they are seeking revenge by murdering what is an unconscious image of an important person who is simultaneously loved and hated. Atonement for the murder is achieved by the person’s death via suicide. This mental mechanism is presumed to be unconscious, though patients with severe character disorder are often aware of the wish to seek revenge on others via their own death. These are patients for whom a psychiatric consultation is necessary. Patients can have fantasies of harming the doctor or of harming significant others by dying. A successful psychotherapeutic intervention could lead to the realization on the part of the patient that there is no actual revenge that will accrue from his or her death. The patient arrives at an understanding that the focus of this love and hatred is a psychological creation. Suicide will end his or her life and potentially have an emotional impact on people who care about the person, but not the impact the patient desires.

HOPELESSNESS AND SUFFERING

Beck et al\(^23\) note that the seriousness of suicidal intent correlates better with the degree of hopelessness about the future than with any other indicator of depressive severity. When a patient is hopeless, the physician should investigate whether the patient is depressed. Hopelessness, desperation, and despair are also emotions that accompany suffering. Suffering poses a great challenge to patient and physician. Is it the prospect of death some days, weeks, months, or years in the future that causes the patient to feel despair, hopelessness, and desperation and request death now? Or is it the patient’s prospect of suffering unremitting physical pain that prompts the request for death (see below)? Patients’ experience of hopelessness or hopefulness is associated with what they have been told by their physician. Informing patients about their illness and treatment necessitates that the physician strike a balance between giving too little or too much information. Inadequate information fosters a situation of hopelessness because patients have no facts with which they can make decisions. Patients can usually sense when information is withheld or is slanted. This creates distrust of the physician and seriously damages the potential effectiveness of the patient-physician relationship. At the other end of the communication spectrum is “truth dumping,” which takes away all hope by telling patients morbid statistical “facts” without balancing the seriousness of the illness with a basis for hope. The physician’s evaluation of the patient’s hopelessness relies on his or her understanding of what information has been provided to the patient, and how that information has been communicated. The physician of a patient with diabetes, hypertension, and renal disease received a call when the patient regained consciousness after an unsuccessful suicide attempt. The patient requested that the physician assist in suicide because the diabetes and renal dysfunction were experienced as intolerable. The physician arranged for the patient to be taken to an emergency room of another hospital, where the patient was admitted in mild diabetic ketoacidosis and uncontrolled hypertension. The patient described a state of despair and felt physician-assisted suicide was a reasonable plan given the hopelessness of the renal disease. The ketoacidosis and hypertension were quickly stabilized. The family was contacted, and the patient’s mother flew from out of state to bring her adult child home. History from a friend and the mother and some from the patient revealed the onset of juvenile onset diabetes 20 years previously. The patient had recently sent all personal effects to the parents’ home, simultaneously refusing to talk with them or with friends. This occurred after the physician had informed the patient of the need for dialysis (and likelihood of a kidney transplant) within the next year at the rate the renal function was declining. It was also revealed that the physician had presented the “facts” that there was little long-term hope for a successful transplant 2 days before the suicide attempt and the request for physician-assisted suicide. The patient’s mother, having contacted a group investigating renal and pancreatic transplants, came ready to take the patient home for such an evaluation. The despair disappeared when this news was received. The patient spoke about the “important things left to do with life” and was “glad” that the suicide attempt had been unsuccessful.

PAIN

Pain is a physical experience that also creates emotional suffering. Inadequate pain control may cause rage, sadness, and hopelessness or contribute to the development of an affective illness. Some patients suffer from ineffective treatment of physical pain as a result of insufficient analgesia, the product of inadequate physician education and moralistic views regarding narcotics.\(^24\)\(^25\) The situation has not been remedied by journal articles, textbooks, newspaper articles, or guidelines.\(^26\)\(^29\) In the Netherlands the request for “hastened death” is withdrawn in 85% of patients when their symptoms are better controlled.\(^30\) The availability of reliable and effective palliative care may reduce dramatically the requests for physician-assisted suicide.\(^31\) Without optimal treatment, we cannot be sure that the request for death does not derive from an attempt to escape from physical pain. No more powerful statement can be made to a patient who is in pain than that of the physician who says, “I will do everything that can be done to alleviate your pain, and I guarantee that nothing will be withheld from you unless you tell me to do otherwise.”

SADNESS AND DEPRESSION

Distinction must be made between depression, a treatable medical illness, and the experience of sadness. “Periods of sadness are inherent aspects of the human experience. These periods should not be diagnosed as a Major Depressive Disorder.”\(^32\) Arriving at a diagnosis of depression in physically ill patients may be complicated by the somatic symptoms that accompany illness and medical or surgical therapies.\(^33\)\(^35\) Nonpsychiatric physicians frequently miss the diagnosis of depression,\(^36\)\(^38\) particularly where “depression” is presumed to be a normal response to the situation. This “pseudoempathy” prevents physicians from distinguishing sadness from depression.\(^1\) Physicians are not convinced that they could recognize depression in terminally ill patients.\(^10\) As the patient’s request for death may arise from a depression, the evaluation should be performed by physicians skilled in making the diagnosis. The judge who ruled that the Oregon physician-assisted suicide law was unconstitutional commented, “The very lives of
terminally ill persons depend on their own rational assessment of the value of their existence, and yet there is no requirement that they be evaluated by a mental health specialist.°°°° The physician should ask for a psychiatric consultation in every case where he or she is unsure whether the patient's request for death arises from a depression.

That does not mean that every patient who is depressed is suicidal or that the depression is the source of every patient's request to die. Ganzini et al notes, “When depression influences decision making, this influence is evident to a trained observer on clinical interview.” While it may be difficult for physicians always to be sure of the diagnosis of depression, Chochinov et al recently demonstrated that the easiest and best method for quickly assessing depression in terminally ill patients is to ask the question, “Are you depressed?” A 90-year-old woman was admitted to the hospital after a fall. Though she did not sustain a fracture, she was found to be in congestive heart failure, with pitting edema of her legs. She was anemic and had heme-positive stools. She had been widowed several years and complained that all of her friends had passed away. All of her family lived out of state except for a grandchild attending a local college. It was expected that she would fully recover with medical treatment. From the beginning of her admission she asked if she could die, and she was uncooperative with the medical evaluation. Ambulation had become increasingly difficult for her, and she stated strongly that she was “old and had lived long enough.” A piece of history casually revealed during the psychiatric consultation was that she was once a professional dancer with a famous dance troupe. The many losses in her life, including the recent loss of the use of her legs, suggested a clinically significant depression, and a psychostimulant was prescribed. She was disappointed in the doctor’s decision not to end her life but reluctantly complied with the continuation of the medical evaluation and with taking medication. After a week of treatment, realizing that she would regain the ability to walk, she began to press for more aggressive physical therapy. When a nursing home placement was obtained, she refused the transfer because she believed the physical therapy offered in the hospital was superior to the nursing home, and she was anxious to regain full use of her legs and return home.

GUILT, SELF-PUNISHMENT, AND ATONEMENT

Guilt is a potentially destructive emotion that may occur in both patient and physician. Patients may attribute their cancer to unacceptable emotions and bad deeds. Some patients may conclude, “If I was not bad, I would not have gotten this terrible illness. I don’t love people who are bad; thus, nobody could love me. Now I have been a bad patient because I have not recovered from my illness. My failure has made my doctor fall and my doctor must hate me. If I die, it will make amends for being a bad person.” Self-punishment and the desire to atone thus become a motivation for the request to die. In patients for whom illness is equated with a personal failure, death is equated with deserved punishment. Such thoughts may seem logical to patients influenced by the regressive pull of physical illness, by pain, by the threat of loss of body parts or functions, by the chaos of the hospital, and by the intrusive nature of being a patient. Patients’ feelings of guilt may be stimulated or exacerbated by interactions within the patient-physician relationship. Physicians are imbued with omnipotent powers by patients, derived from the child’s experience of the parent as omnipotent.°°°° One has only to witness or participate in the “kissing of a boo-boo” to perceive the power of the child’s belief in the parent’s omnipotence to heal. Powerful fantasies about the physician, deriving from the patient’s childhood experiences, often remain unknown. The patient may perceive that his or her physical and emotional suffering causes the physician to suffer, accompanied by the patient’s perception of the physician’s wish to end his or her own emotional suffering. This wish may be interpreted by the patient as the physician’s wish that the patient be dead. The patient’s request to die can therefore be an attempt to accede to what the patient believes is the “doctor’s wish.”

When the physician cannot accept that some patients do not respond to treatment, he or she may experience guilt for having failed. Some physicians blame the patient for having the illness or for the poor treatment response. The patient’s guilt influences the physician’s response to the patient’s request to die.°°°°°° The patient’s experience of the physician’s guilt and the physician’s unchallenged acquiescence to the patient’s request to die confirm the patient’s guilty experience of being bad and unworthy of the physician’s healing power. Where there is no avenue for a discussion that will uncover these complex dynamics, action may replace affects and words. The patient’s death thus replaces the opportunity for understanding and life. Miles has stated, “Openness to my distress at a patient’s suffering improves therapeutic insight into a patient’s pain, demoralization, and depression.” There are times that the physician might benefit from a discussion with a psychiatric colleague about thoughts and feelings encountered in the relationship with a particular patient.

THE LIVING DEAD

Some patients who request to die seem to experience themselves as already dead. This may occur more readily in individuals rendered vulnerable by a childhood devoid of a warm, nurturing parent. This self-experience may also occur as the result of physical suffering, emotional suffering, or both, the fear of unrelenting agony, the loss of social support that accompanies catastrophic illness for some patients, and the impact of significant depressive and/or anxiety disorders. While not a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, this self-experience takes the form of a condition that might be called “the living dead,” and it robs the person of all hope for recovery or for a more comfortable existence. The person “knows” that he or she is going to die, which leads to the decision to attempt to get it over with quickly. It is extremely challenging for the physician to work with such a patient, as the physician too may have the experience that the person, though alive, feels already deceased. The physician’s confrontation of the patient’s self-experience requires skill, tact, and the belief that there remains life worth living for this patient. Therapeutics for pain, insomnia, anxiety, and depression, as well as recommending and instituting psychological treatments, can effectively treat this condition. The patient is restored to the living, able to acknowledge the seriousness of the illness, without feeling overwhelmed. An emergency consultation was requested for a woman in her mid-40s who decided she was unable to continue with chemotherapy. She complained of severe pain, nausea, and fear of the pain associated with each treatment. Aware that she had a rare cancer that carried a poor prognosis, she
questioned continuation of the treatment that had just begun. During the consultation, which lasted 3 hours, she cried continuously, referring frequently to the fact she would never see her garden bloom again, though spring was only a few months away. “I have no reason to go on with this,” she stated, simultaneously listing all of the things and people that were important to her, especially her impending graduation from professional school, while repeatedly emphasizing the pain of not seeing her garden again. The comment was made to her that she acted as if she were already dead, in spite of the fact that the indications were that she had many months to live, and live comfortably, even if the therapy was ultimately unsuccessful. Her response was dramatic and instantaneous, her tears dried up, she looked at the consultant and took his hand, “You mean I have something to live for?” she asked; “I will see my garden bloom again, won’t I.” This was not asked as a question. She never again, through her difficult course and her death a year later, stopped being alive, often reminding the consultant and herself of the importance of “not being dead until your time comes.”

THE ROLE OF THE PSYCHIATRIST

Psychiatrists bring the potential for expert exploration and understanding of the issues involved in a patient’s request to die. In the evaluation of the patient’s request, psychiatrists help identify both the psychodynamic issues and psychiatric disorders, particularly depression, that would benefit from treatment. These evaluations should not be limited to the determination of a patient’s capacity to make decisions. Nor should the evaluation be a single diagnostic visit. Only a small number of psychiatrists surveyed in the Oregon study felt confident that they could determine whether a psychiatric disorder impairs a patient’s judgment in a single visit. There is an additional significant role for the psychiatrist, who, through the psychotherapeutic process, can offer relief from psychological suffering in a terminally ill patient. This is not the tendering of foolish optimism or naive hope, but offers an expectation of self-understanding that can lead to a reduction of the individual’s suffering. It is a coming to terms with oneself and with the significant people in one’s life, both those who are living and those who are dead but with whom the patient continues an active relationship. In concert with the physician responsible for the person’s medical care, psychiatrists can assist in assuring the patient that his or her suffering will be reduced to a minimum with appropriate treatment. This includes a frank discussion of the possibility that the person’s consciousness might be compromised by maximal analgesic treatment.

There may be times that the psychiatrist’s role in the process requires that he or she tell a colleague “You are overinvolved, it is time to let this patient die” or “You are not adequately treating this patient’s pain” or “You have given the patient information in such a way as to rob him or her of hope.” In each of these and other communications, the psychiatrist must make it clear that these observations do not reflect on the colleague’s competence or ideals, but rather that the psychiatrist’s focus is on different needs of the patient that may have gone unrecognized.

In speaking with patients, I (and psychiatrists who have described their experiences to me) have encountered the criticism from patients and families that, under the guise of investigating the meaning of a patient’s communication, we are violating the patient’s basic human rights, ie, “the right to die.” I contend that not discussing a patient’s motivation is the real violation of his or her rights, as there exists the possibility that the role of psychological factors has been underestimated. Some of the skills in communication required for this exploration are those that every physician should possess; however, some of the skills required for the in-depth exploration are not those of the primary care physician, the oncologist, or the surgeon. These are the skills of the psychiatrist who has the training and skills in both psychodynamic exploration and interaction with medically ill patients. Not all psychiatrists are comfortable in this arena, nor do all psychiatrists have clinical experience with medically ill and dying patients. The psychiatrist in these cases should have the training and experience to provide patient and physician with a meaningful consultation. There are some psychologists and social workers who have clinical expertise from their work with patients who have medical illness. Such consultants would also be appropriate to conduct this type of psychological exploration.

POLICY, PHYSICIAN-ASSISTED SUICIDE, AND THE ROLE OF THE PHYSICIAN

In every situation where a patient makes the request for his or her physician to end the person’s life, the physician’s answer should not be a simple yes or no. Answering yes without exploring the meaning of the request, while seemingly giving the patient what he or she asks for, in actuality may abolish the opportunity for patient and physician to more fully understand and know one another. Answering no leaves the patient in a situation of helpless control his or her destiny and closes off further communication. Inquiring about the patient’s emotional state, validating the patient’s experience, and helping the patient identify the motivations for the request to die allow the physician to engage in a truly meaningful communication at a crucial time in the patient’s life. An initial response might be, “That is a serious request. Before we can know what would be the best way to proceed, let’s talk about why you are asking me to help you die now.” Not every request for physician-assisted suicide indicates complex unspoken psychodynamics, but that cannot be known until the physician and the patient talk. A psychiatric consultation is necessary in cases where there is complexity regarding the psychological motivations, cases where the physician feels there is a psychiatric disorder, cases where there is a suggestion that the patient is clinically depressed, and cases where the physician has intense emotions regarding the patient (particularly feelings of guilt, anger, or inadequacy). The request for suicide may be found to be “rational” but not until there has been an adequate exploration of its meaning. The willingness of a physician to enter into such a dialogue with patients is not without an emotional impact on the physician, but it is what is required if physicians are to appropriately respond to such requests.

The US Supreme Court decision on physician-assisted suicide has not ended the debate. Decriminalizing physician-assisted suicide is insufficient as there is no requirement to explore the patient’s request. It is our professional responsibility to make provision for an exploration of the motivation in patients who make such a request. Regardless of the outcome of the societal and legal debate regarding physician-assisted suicide, physicians should recognize that patients who make a request to die deserve a compassionate and comprehensive evaluation.
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References