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Physician-Assisted Suicide: The Ultimate Freudian Legacy

by

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Rational Suicide?

I am a physician; a board certified psychiatrist. I have a sensational terminal disease, AIDS. My view is simple. Active, voluntary euthanasia should be a legal option for all terminally ill patients. At the patient's request, it should be provided by the patient's physician or a consultant on the hospital staff. A rational model for this relationship between physician and patient is the reported professional relationship between Dr. Sigmund Freud and his doctor, Max Schur. Dr. Freud, on retaining Dr. Schur, asked him for assurance that he would always tell him the whole truth, charge him a reasonable fee, and, lastly, not let him suffer needlessly at the end. After a long and painful fight with cancer, Dr. Freud asked for relief and was given large doses of morphine by Dr. Schur that led to his death within hours.

So spoke Dr. Stephen Yarnell at a clinical conference for mental health professionals entitled "Suicide, AIDS, and Dignified Death" in San Francisco, February 26, 1988, sponsored by the University of California San Francisco Medical Center and the Suicide Education Center of Boston. The title of his talk "AIDS and the California Humane and Dignified Death Act" indicated the personal interest San Francisco

homosexuals had in promoting the first of a series of initiatives to legalize Physician-Assisted Suicide (PAS) in California. Yarnell's doctor had already agreed to PAS for him if the initiative passed. He had already assisted a woman whose husband had AIDS and who died in a few days after another physician ordered a morphine drip for him which not only stopped his screaming but also his life in a few days.¹

Dr. Yarnell knew that a Christian believes his suffering can bring salvation, but he did not share that belief, gained no spiritual benefit from his pain, and did not want such belief forced on him. He cited a poll indicating 59% of practicing Catholics support the PAS initiative.² He professed at the conference: In the privacy of my death bed, I would like to be able to call the shots. The legal prohibition against assisting patients to die is based on religious belief... I am a Universalist with a humanist view... Within this belief is the idea that humane and kind treatment of the dying could and should include the option of active, voluntary euthanasia... my belief is that I should be helped to die, and that option should be open to me in our pluralistic society, since it is shared by many of us who are called humanist... My minister is a woman who has hundreds of power of attorney to end life."

Although Dr. Yarnell's views and practices differ from mine, we share several other characteristics. One of the organizers of the conference who spoke on "Rational Suicide" had been his professor at the University of California San Francisco Medical Center and my final psychiatric residency supervisor at the San Francisco General Hospital Psychiatric Consultation Service. Dr. Jerome Motto seemed equivocal, disagreeing with Yarnell's advocacy while claiming Yarnell wanted a choice, not an act. He claimed a sense of control and autonomy is most important and cited a case of Dr. Laurens White who responded to his 38-year-old woman cancer patient's request for PAS by leaving her a lethal dose of pills. She did not use the pills, but having them gave her a sense of control. Accordingly, Dr. Motto asserted that giving people the option to suicide would help them persist to natural death, a familiar rationalization used by PAS supporters. He recalled a debate at a 1984 American Psychiatric Association meeting when two participants considered suicide pathological and did not accept the concept of "rational suicide."

I reminded my former mentor of a patient I had seen in consultation at SFGH in 1972 who had received a massive dose of morphine and who had died before I could see him the next day on a follow-up visit. He seemed concerned. I had documented that case in a paper warning about the impending Natural Death Act in 1976. A young woman I was treating who regretted her abortion identified herself with her baby and Karen Ann Quinlan and was disturbed about the New Jersey Supreme Court's

decision to accede to Karen's parents' wishes to let her die by stopping her respirator.³ The Quinlan case invoked the right to privacy which had been initially conjured up to interfere with the generative act in 1965 and later in the infamous *Roe v. Wade* decision eliminating the consequences of the generative act in 1973. Quinlan and its progeny would interrupt the life of those who escaped the effects of *Roe*.

Another attendee at the 1988 conference was Derek Humphrey, who traces the beginning of the right-to-die movement's success to *Roe v. Wade*. "The doors began to open for me and my ideas once a wonderful thing happened — *Roe v. Wade*", Humphrey related in 1996.⁴ Humphrey had a table outside the conference room signing up people for the PAS initiative and selling books, including one entitled *Euthanasia and Religion*. He claimed to be an atheist and did not consider humanism to be a religion, since it was not theistic. I mentioned the 1920 book by German psychiatrist Hoche and jurist Binding which he had heard of and wanted a reference. He complained about the lack of finances as he later would in 1992 when another PAS initiative in California failed. However, he remains undaunted after success in Oregon. "To see the protests here about abortion, you would think it is against the law in this country when it's been legal since 1973. We're going to face 20 or more years of opposition of doctor-assisted suicide, because it is a religious belief."⁵

On August 26, 1992 Humphrey was interviewed by Lee Rogers on KGO radio after the second edition of his best seller *Final Exit* had been published. The suicide instructional manual has been used by many to kill themselves, including the Heaven's Gate cult in 1997, following their castrated leader Marshall Applewhite. Humphrey claimed 55% of U.S. physicians favor PAS and many have done it surreptitiously and none have been prosecuted. He noted that suicide is most popular among homosexual AIDS patients and over half of them suicide. Questioned about the suicides of his two wives, he absolved himself of responsibility by helping the first at her request and divorcing the second when she developed cancer. Rita Marker befriended the second, Ann, and related that Humphrey suffocated Jean and was unfaithful and cruelly abandoned Ann.⁶

A watershed occurred for PAS at the election of President Clinton in 1992, which coincided with the defeat of California Proposition 161. Humphrey was at a meeting of the American Academy of Psychosomatic Medicine to announce that the groundswell for PAS would mount whether psychiatrists were ready or not. The California Psychiatric Association had gone on record against the measure. Humphrey said psychiatrists could not assume they would be able to help every terminally ill patient change his mind about suicide and did not agree that everyone requesting

PAS undergo a psychiatric evaluation. "That interferes with personal liberty," he declared. Nevertheless, "We want a dialogue with the health professions. Public opinion on this issue is demonstrably strong, and we must continue an intelligent dialogue."⁷

Death at the APA 1993

At the American Psychiatric Association meeting in San Francisco in 1993, the focus was on sprucing up the image of psychiatry to insure psychiatrists would get their fair share of the proposed Clinton Health Plan. Although the strategy involved a papal audience, the use of religion then and now in psychiatry is "transpersonal", prescinding from a personal God, especially the Christian God as proposed by the Catholic Church. In that respect psychiatry today perpetuates Freud's animus.^{8, 9} As usual, suicide was a major topic. Dr. Motto presented a study of 843 patients hospitalized for depression or suicide who declined follow-up care. Suicide rates were lower in the group contacted on a preset schedule for five years, and continued lower than the non-contacted group for a 14-year period. There were about as many presentations on care of the dying as well, more often ignoring the role of religion.

"How Can a Psychiatrist Help a Dying Patient?" by Armand M. Nicoli, M.D., noted "the prospect of death creates anxiety, not only in the patient, but also in the clinician. The common mechanism of denial breaks down as disease progresses. Drawing on writings of Freud and interviews with Anna Freud", this paper could reflect Freud's long-standing anxiety about his own death which he tried to predict and later explain by the "death instinct" in *Beyond the Pleasure Principle*, where he claimed "the aim of all life is death".¹⁰ When he executed his PAS, he instructed Dr. Schur to tell only his daughter Anna whom he had twice psychoanalyzed and sabotaged the prospect of marriage with his official biographer, Dr. Ernest Jones. It took a posthumous letter from Oskar Pfister to Martha Freud to inform her that Freud had planned his death many years before he even met Dr. Schur, as revealed in *Psychoanalysis and Religion*, the correspondence between Freud and the liberal Protestant minister who remained a friend and analytic propagandist while divorcing his wife early in his relationship with Freud.¹¹ The American Psychiatric Association memorializes Pfister each year at its meeting with an award given in his name to someone who advances the cause of psychiatry in religion.

Nicoli's was not the only paper focusing on terminally ill AIDS patients. A workshop comprised of clinicians who treat AIDS patients noted "patients may struggle with their 'right to die' whether by natural cause, suicide, or assisted suicide".¹² Edwin Cassem, M.D., a priest and

Chief of Psychiatry at the Massachusetts General Hospital reported on over 250 cases about which the Optimum Care Committee had been consulted regarding limiting or terminating treatment in a terminal patient. His eighteen-year study focused more on family disputes rather than the occasional request for PAS.¹³ In another presentation on "The Role of Psychiatry in Palliative Medicine", he proposed that psychiatrists on a palliative care team could help resolve the problems which most commonly lead patients to request euthanasia in Holland.¹⁴

A Dutch psychiatrist attended a small workshop conducted by the incoming president of the APA, Dr. John McIntyre, on the proposed new guidelines for treating depression. Palliative care is virtually non-existent in Holland since PAS and euthanasia have become the standard of care. Dr. McIntyre requested consultation from the Dutch psychiatrist, who deferred to the APA to lead the way. Perhaps he was concerned about his Dutch colleague, Dr. Boudewijn Chabot, who was later found "guilty of giving a fatal dose of sleeping pills to a severely depressed woman who was otherwise healthy." For over twenty years Dutch courts have been using cases to expand the use of PAS and euthanasia rather than punish doctors and, accordingly, the court stated Chabot should not face a criminal penalty. His attorney claimed that this ruling established the principle that someone who is suffering mentally should be able to receive mercy killing.¹⁵

A final note on the 1993 San Francisco APA meeting both highlights its economic theme and brings closer to home the ominous threat of PAS. Issue Workshop 28 entitled "What's Happening in Oregon: Prioritization and Its Discontents" announced: "Since 1989 the Oregon Health Plan process has been developing a novel and controversial model for the delivery of health care. The cornerstone of this plan is an explicit rationing effort that prioritizes all health services by diagnosis and associated treatment. Parity for mental health services appears to have been achieved. Implications on prospects for parity for mental health and the development of a workable national health care system (were discussed)." Although the national Clinton Health Plan apparently fizzled after the meeting, a reasonable facsimile proceeds apace. Kenneth J. Simac, M.D., warns, "We should remember that Holland's slide into involuntary euthanasia and into euthanasia for the non-terminal and the very young occurred in a country that has universal health care."¹⁶

Anticipating the Supreme Court at the 1996 APA

By 1996, Oregon had passed a PAS initiative which was working its way through the courts and New York resident George Delury was a

featured speaker at the APA on his way to jail for assisting his wife's suicide. An Orthodox rabbi on the same panel protested Delury's presence. "Euthanasia and PAS were the topics of about 20 symposia, paper and multimedia presentations at the 149th APA meeting in New York City." *The Psychiatric Times* focused on one symposium including psychiatrists such as Dr. Herbert Hendin whose study of the Dutch experience has prompted him to favor palliative care as a substitute for PAS, Dr. Jan A. Fawcett who prefers large doses of addicting tranquilizers to avert anxiety leading to suicide, rationalizing "dependence is better than death", bioethicist Daniel Callahan, president of the Hastings Center in New York who predicted "A move to euthanasia and/or PAS seems to be a logical step in giving people ultimate control over their lives", and law professor Yale Kamisar, a long-time critic of PAS.¹⁷

Shortly before the meeting Dr. Hendin, the executive director of the American Suicide Foundation, had testified at a congressional hearing on PAS, taking issue with another psychiatrist, Samuel Klagsbrun, M.D., who presented four criteria for PAS. Klagsbrun reiterated an argument used by most PAS promoters that giving a person the option of PAS not only relieves anxiety but can forestall a person's suicide, and used his 84-year-old aunt as an example. Since his aunt was now an "incompetent person" with Alzheimer's Disease, she would not meet one of his conditions for PAS. He contrasted himself with Dr. Kevorkian, saying he supported PAS done "carefully and thoughtfully". Klagsbrun has worked with hospice patients and is a consultant for the premier St. Christopher's Hospice in London. Yet, even Hendin admitted there are probably circumstances in which he could sanction PAS, but "That doesn't mean we should make it legal."¹⁸

The congressional hearings had been prompted by two favorable federal court decisions in 1996 favoring PAS. Klagsbrun had been a plaintiff in the New York case which carried the name of another doctor plaintiff, Timothy Quill, who also testified in the congressional hearing. Quill was a palliative care doctor who wrote in the *New England Journal of Medicine* in March, 1991, how he prescribed a lethal dose of barbiturates to his 45-year-old patient with leukemia he had treated for eight years. The patient wanted to die when she was no longer able to maintain control over herself. Hendin faults Quill for not exploring Diane's feeling after lamenting with her "the unfairness of life" and claiming her request for PAS "made perfect sense". He had referred her to the Hemlock Society. She returned to him with a fantasy promising a reunion on Lake Geneva with dragons shining in the sunset. Quill wondered if he would see her there "with dragons swimming on the horizon."¹⁹

While one might surmise that Quill and Diane share a deadly delusional disorder, this doctor commands respect in both legal and medical circles. After attending the First National Training Conference for Physicians on Doctor-Patient Relationships in Terminal Illness at the University of California School of Medicine in San Francisco, in 1976, I was concerned about the conference advocating passage of the Natural Death Act and called Dr. William Lamers, a psychiatrist and medical director of Hospice of Marin, one of the first hospices in the U.S. I told him that a counselor for the dying had spoken at the conference about hearing medical staff planning to terminate his life support, and how a living will as outlined in the Natural Death Act would have been his death warrant. I was disappointed that Dr. Lamers supported the Act and was unconcerned that some people like this counselor would lose their lives prematurely.²⁰

One might also wonder how Quill's PAS gets such a respectable coverage in the *New England Journal of Medicine*. An editorial in the 1980s in that journal had recounted a gynecology resident administering a fatal dose to a young woman with metastatic ovarian cancer who had become weary of medical procedures and had asked him to get it over. "It's Over Debbie" and many subsequent articles in *NEJM* reflect the PAS advocacy of Dr. Marcia Angell, a Boston pathologist and editor of *NEJM*. Her father had been undergoing treatment for prostate cancer when he committed suicide in the late 1980s. She claims that she has no doubt her father would have opted for PAS if the option had been open to him.²¹ While she denies the Dutch are on a slippery slope, she also fails to acknowledge that the most active promoters of euthanasia in Nazi Germany were distinguished physicians like herself.²²

A prominent psychiatrist, William Pollin, M.D., former director of the National Institute on Drug Abuse was pleased with the Washington and New York rulings favoring PAS. Before the 1996 APA meeting he had testified in favor of a Maryland PAS bill which did not pass. He cited a study reportedly showing that nursing home patients given maximum control as opposed to hospice care did better. Dr. Kevorkian had prompted him and a pioneer abortion-promoting psychiatrist and George Washington School of Medicine professor, E. James Lieberman, M.D., to form a study group on end-of-life issues.²³ Although the APA joined the American Medical Association in filing a brief against PAS with the U.S. Supreme Court, Lieberman marshaled six former APA presidents in support of PAS, saying the APA brief "was made in relative haste without debate among the membership or even the assembly."²⁴

Australia Leads the Way at the 1997 APA

By the time of the 1997 APA meeting in San Diego, the U.S. Supreme Court had declined to endorse PAS as it had abortion. That year the APA focused on the Northern Territory in Australia, which had legalized euthanasia, requiring a psychiatrist "to confirm only that the patient is not suffering from a clinical depression in respect of the illness."²⁵ In a symposium on psychiatry and euthanasia, several Australian psychiatrists discussed difficulties for the psychiatrist involved and contrasted their law with the Oregon Death with Dignity Act, which did not require psychiatric evaluation and which was held up in court at that time. While Dr. Christopher Ryan of Sydney praised the legislation as "a good first attempt to create an act permitting voluntary euthanasia and warrants close study as a model for similar legislation elsewhere," Dr. David W. Kissane from Melbourne preferred relieving the suffering which prompts requests for euthanasia by palliative care. A psychodynamic palliative care perspective in the same symposium was offered by Francis T. Varghese of Brisbane in his paper, "Euthanasia: The Wish to Die and the Wish to Kill". He examined "the role of counter-transference forming a wish to kill in doctors involved in acceding to such a request (for assisted suicide)".²⁶

This symposium had obviously been prepared before the Australian Parliament overturned the world's first PAS law in March, 1997, almost two months before the APA meeting in May. Four people had already committed suicide in the Northern Territory since the law took effect there in July, 1996.²⁷ One of them, at least, was apparently the victim of an Australian high-tech Kevorkian named Dr. Philip Nitschke who hooked up 66-year-old Bob Dent's intravenous tube to a computer. He is marketing the software and equipment for \$160 and planned a less invasive version using carbon monoxide instead of intravenous administration of a lethal drug.²⁸ With the increasing use of computers by psychiatrists, including assessments, Timothy Leary's first "visible, interactive suicide" in early 1996 may prompt a millennial version of "turning on, tuning in, and dropping out." The former Harvard psychology professor who spawned the hippie drug culture of the 60s was feeling minimal pain from his prostate cancer with his daily pain regimen of 44 cigarettes, 3 cups of coffee, 2 glasses of wine, 1 beer, 1 marijuana joint, 3 Leary biscuits (baked marijuana and cheese), and 12 balloons of nitrous oxide. He was promoting "hi-tech designer dying" via his home page on the web.²⁹

Leary epitomizes the Freudian legacy in many respects, especially his use of dangerous substances. Freud used cocaine extensively and recommended it to others. "I had been the first to recommend the use of

cocaine in 1884, and the recommendation had brought serious reproaches down on me. The misuse of that drug has hastened the death of a dear friend of mine."³⁰ Although he eventually gave up using and promoting cocaine, he remained addicted to cigars which he realized had caused his recurrent throat cancer. He told his physician, Dr. Schur, that he could do no creative work without smoking.³¹ Moreover, he arranged for everyone in his weekly psychoanalytic meetings to have a cigar producing a deadly incense in fulfillment of his "dream of a primeval devil religion with rites that are carried out secretly."³² According to one of his early followers, Max Graf, "there was an atmosphere of the foundation of a religion in that room... Freud's pupils were his apostles... Freud — as the head of a church — banished Adler; he ejected him from the official church. Within the space of a few years, I lived through the whole development of a church history."³³ Many of his followers anticipated and followed his suicidal example, including Tausk, Silberer, Stekel, Rosenthal, Gross, Zweig, and Bettelheim.

Which Religion for the New Millennium?

Freud's atheism and attempt to paganize Judaism by identifying Moses as an Egyptian has reverberated in the contrast between psychiatry and orthodox Judaism. The last APA meeting of the millennium seems to have tilted in favor of the latter as expressed by several noted psychiatrists, with reservations about PAS. The incoming president of the APA wondered why he had been asked to comment on the Pfister address since he had not worked in the area of religion. He recounted the change in his 17-year-old daughter who spent the summer in 1998 in Israel and identified with the wailing wall. In his research for the talk he had unearthed a discovery several hundred years ago by a Catholic priest who would walk around the church to discover the pathological secret of a penitent which would lead to healing when confessed. Freud may have known the same reference when he declared "Confession is liberation and that is cure. The Catholics knew it for centuries, but Victor Hugo had taught me that the poet, too, is a priest, and thus I bodily substituted myself for the confessor."³⁴ Tasman referred to another Jewish psychiatrist, Dr. David Spiegel, crediting him with prolonging the life of terminal breast cancer patients with psychotherapy.

Dr. Spiegel had already stressed his opposition to PAS two years before at the annual meeting of the Academy of Psychosomatic Medicine. His 20 years experience in group therapy with breast cancer patients had focused on helping them find meaning in their lives as they were dying.³⁵ At the 1999 APA meeting he elaborated on his work as one of four

presenters in a symposium entitled "Psychiatric Issues in Desire for Death in Terminally Ill Patients." He said that those requesting PAS were three times as likely to be depressed as terminally ill patients in general. Those who need to maintain emotional control tend to be the most anxious and depressed facing terminal illness, while those who maintain a fighting spirit are least depressed. He teaches a good death but you "don't have to kill them to help them die." Like his admirer, Dr. Tasman, this Stanford University Professor of Psychiatry admits about spirituality "I know very little (and) leave afterlife to others." While his group is comprised of women with various religious backgrounds who sometimes argue about God, he does not get into such discussion and discourages proselytizing.

Another presenter in that symposium has been a speaker at past APA meetings and gave several presentations at this one. Dr. William Breitbart, in his association with the Sloan Kettering Memorial Cancer Institute in New York City has been on the cutting edge of research on palliative care. Beginning as an expert in pain management and symptom relief, he has been challenged to expand his vision by his patients and involvement in a bi-weekly seminar. Among his many published works was a survey of 378 ambulatory HIV patients' attitudes toward PAS in the 1996 *American Journal of Psychiatry*. He found that those who frequently attended religious services were less accepting of PAS for themselves and less likely to support the legalization of PAS. In a workshop on "Spiritual and Ethical Issues in End of Life Care" he acknowledged that religion gives one hope and relieves one of the fear of death. Although 63% of patients want their doctor to talk about spiritual matters, only 10% of physicians actually do so. For the seminar, he had read Victor Frankl's *Man's Search for Meaning* in the suffering in a Nazi concentration camp. After agreeing with a Jewish mother's demand to stop her palliative medication, he repeatedly raised the issue of life's meaning in an attempt to stop the woman's demands that her children kill her. Eventually, she was won over and introduced him to her children as her rabbi. Yet, he admitted, "I'm not a spiritual director", and readily refers patients, including homosexuals dying of AIDS with guilt to a chaplain.

The other two presenters in this symposium, albeit also Jewish, seemed in a different world, where PAS was common among homosexuals dying of AIDS. Robert L. Klitzman, M.D., of Columbia University School of Medicine, reported on 36 HIV positive physicians in New York who overidentified with their homosexual patients dying of AIDS. "My friends are my patients and vice versa... we're part of a family... it's almost as if one of my close friends was passing" were some representative comments from the physicians. A retired internist named Paul received most of his referrals from the Hemlock Society and would give them 15 Second

capsules a month to accumulate a lethal dose. Another doctor invited two patients over for dinner, gave them morphine, benzodiazepines, and wine and held their hand like a close friend while they died. Yet another climbed in bed with the patient after administering a lethal dose and stroked the patient's hair while he died. Klitzman commented negatively only on the latter case regarding the bed routine. He approved PAS with guidelines and considered prayer and ritual important, perhaps fulfilling Freud's dream of a "primeval devil religion with rites that are carried on in secret."

The final presenter reported from the University of San Francisco General Hospital on the Coping Project, sponsored by the National Institute of Mental Health. This first study of men as caregivers was conducted from 1990-96 and was a prospective study of caregiving partners of 140 men with AIDS. The partners were interviewed initially, bimonthly for two years, then one month before their partner's death, and were asked three months later "if they had increased their partner's narcotic and/or sedative-hypnotic medication dose and if so, what had been the objective of the increase, and their comfort with their medication decision". All but one spoke about the death, saying, for example, "I tried to kill him" or "I called the M.D. to find out and then increased the dosage." In what may have been an encouragement of caretaker assisted suicide by the six women researchers, including internist Molly Cooke, an ethicist and PAS expert, 17 of the 140 (12.1%) "received an increase in the use of medications immediately before death intended to hasten death." Fourteen of the 17 actually administered the lethal dose and reported more social support and positive meaning in their caregiving. This was the first study documenting the incidence of intentionally hastened death and concluded, "The decision to hasten death is not rare in this group of men. There is no evidence that it is the result of caregiver distress, poor relationship quality, or intolerable caregiving burden; and it does not cause excessive discomfort in the surviving partner. This study, although small, has implications for the policy debate on assisted suicide."³⁶

This study was clearly meant to support the current effort to legalize PAS in California. It mentioned two references in the *New England Journal of Medicine*, one in 1994 recommending the Oregon death by prescription "that the status quo of private, occasional assistance in dying accomplished by persons with loving connections to the patient, with physician input, is optimal public policy." The second, a 1997 study reported that 53% of physicians caring for people with AIDS in the San Francisco Bay Area had performed at least one PAS. That study recommended a physician propose to such a patient the following: "Many of my patients have asked, when they became extremely ill, if I would ever

give a pill or an injection to help them die. Have you ever thought about this?" Professor Susan Folkman, the presenter of this paper, is associated with the Center for AIDS Prevention Studies at the University of San Francisco Medical Center.

A predecessor of her senior colleague, ethicist Dr. Cooke, had spoken at a meeting of the American Orthopsychiatric Association in San Francisco several years before about preventing diabetes by selective abortion. Dr. Albert Jonsen, S.J., had left his post as president of the Jesuit University of San Francisco and was a bioethicist at the University of California San Francisco Medical Center at the time. I recall appealing to him to counter the Center's support for the 1976 Natural Death Act, but to no avail. He now is a bioethicist at the University of Washington Medical Center and has written a text as a guide for hospital bioethics committees, which have proliferated since the mid-1970s. As the Hippocratic Oath has been either ignored or changed and a humanistic or Freudian religion replaces the Judeo-Christian tradition, ethics committees now operate in most hospitals, which pick the members, who anonymously decide who lives and dies in American hospitals.³⁷

Oregon Leads the Way at the 1999 APA

Although the Australian euthanasia law had been abrogated by the time of the 1999 APA meeting which mentioned some of the problems noticed during its brief existence, the Oregon PAS law had finally begun to operate, much along the lines of a committee decision. The psychiatrist who has been most involved in Oregon made a presentation at the meeting. Linda K. Ganzini, M.D., had co-authored the mental health chapter of *A Guidebook for Health Care Providers*, the instructional manual for the Oregon law, before ever evaluating anyone for PAS. Responding to the many calls after its publication, she confessed that she felt like a fraud. Only four of the 23 requests for PAS in the 11 months ending December 1998 had required psychiatric evaluations, and she had since publication done two of them. The law required that subjects be Oregon residents and wait 15 days to implement the two oral and one written requests. A consultant had to concur that the illness was terminal. No surrogates were allowed. After the deadly prescription was written, death occurred within twenty days. The all-Caucasian subjects were 6.8 times more likely to be divorced than the general population. Eighty percent of them were concerned about potential loss of autonomy and 53% with loss of function, along with other concerns involving being a burden, being inactive, pain, and finances.

For those who believe hospice will obviate PAS, Oregon will shatter such a delusion. 98% of Oregonians have hospice insurance and have the highest rate of deaths in hospices in the country. Of the 11 patients requesting PAS by July, 1998, seven were in hospices. They also objected to being dependent, "intolerable (that) people take care of him", as one expressed. For those who believe that universal health coverage will obviate PAS, Oregon adds to the Dutch experience with its encompassing Oregon Health Plan which includes PAS as a "comfort care" benefit. For those who put their confidence in doctors not to do PAS, over two-thirds of psychiatrists, psychologists, and primary care physicians in Oregon support PAS. For those who think more liberal use of pain medication obviates PAS, Oregon ranks in the top five states for morphine use. Characteristics of those desiring PAS include more education, hopelessness, a dark future, and being less religious. Ganzini referred to a 1996 study by Emanuel indicating that religious patients rely less on PAS. She works at the Veterans' Administration Medical Center in Portland and had requested that no one tape her presentation entitled "Views of Oregon Patients and Their Caregivers on Assisted Suicide".

Ganzini's editorial in the *New England Journal of Medicine*, June 19, 1997, expressed concern that other psychiatrists like herself were not prepared to implement the Oregon law. She noted that psychiatrists rarely work with dying patients and must improve their expertise in order to provide effective consultation. One of their tasks would be to determine whether a patient is competent to choose suicide. Although she deplored the fact that over two-thirds of Dutch psychiatrists favor PAS for mental patients without terminal physical illness, she reported two years later that the same proportion of Oregon psychiatrists favored PAS. Most Oregon psychiatrists were willing in 1997 to evaluate patients' competency under the Death with Dignity Act.³⁸ As she wrote in the Guidebook, a mental competency exam was not required unless the attending or consulting physician believed that the patient may suffer from "a psychiatric or psychological disorder, or depression causing impaired judgment". Then the mental health consultant had to follow two rules, the first, as outlined in the Death with Dignity Act, is to determine the patient's specific capacity to make the decision to hasten death by self-administering a lethal prescription. The second, reflecting a traditional role, is to evaluate for any remediable sources of suffering. The president of the Oregon Psychiatric Association, child psychiatrist Richard H. Angell, M.D., had formed a committee to determine competency standards for individuals who choose PAS, maintaining "It's important for our profession to understand fully the societal demands on ...our practice."³⁹

What looks like a cautious protocol actually unravels as one follows the first known patient to die under the Oregon PAS law. A woman who had been diagnosed with breast cancer 20 years before was having difficulty breathing, but could not get her doctor to give her a lethal prescription. Another doctor also refused. She consulted the suicide advocacy group Compassion in Dying which referred her to another doctor who saw no need to refer her to a psychiatrist or psychologist. Such advocacy groups have been involved in at least two-thirds of the reported suicides. Most of the doctors who eventually assist hardly know the patients. This woman naively exclaimed, "I'm looking forward to it. I will be relieved of all the stress I have." Surrounded by family and doctor, she ingested a lethal dose of barbiturates with syrup washed down with a glass of brandy, fell asleep in five minutes, and died in a half-hour.⁴⁰

Freudian Hell

Would a psychiatric evaluation have forestalled her suicide? Not likely, considering the Freudian legacy as recounted in this article. She had battled cancer for twenty years, as Freud had for seventeen. They both had planned their death and viewed it simply as a relief of all stress. Freud, as a two-year-old had a Catholic nanny who took him to "church services. She implanted in him the ideas of Heaven and Hell, and probably also those of salvation and resurrection. After returning from church the boy used to preach a sermon at home and expound God's doings," according to his official biographer, Ernest Jones.⁴¹ The nanny was sent to jail, but Freud at three on a train trip to Vienna during which he saw his mother nude thought of souls burning in hell when he saw gas jets for the first time through the window.⁴² His mother subsequently gave him no religious training and he later expounded on her statement that with death one simply returns to dust. When he later developed the idea of a death instinct as a reversion to an earlier state, and associating that with his preoccupation with two mothers, he could choose which mother and which doctrine to follow.

At the end of his life, while being threatened by the Nazis who had taken over Austria, he reaffirmed that his real enemy was not the Nazis but, rather the Catholic Church.⁴³ Insofar as his Catholic nanny's doctrine of heaven and hell is ignored, along with the doctrine of purgatory expurgated by Protestants, there is no convincing argument against PAS. Whether one claims no religion as did Freud, or a Universalist humanism as his follower Yarnell, one is already living in hell, which the Pope recently characterized as "the state of those who freely and definitively separate themselves from God, the source of all life and joy." After death it

is "the state of those who definitively reject the Father's mercy, even at the last moment of their life."⁴⁴

Hospice as a Gift of Love

The hospice movement was popularized by Dr. Cicely Saunders, who was trained in a Catholic nursing home run by nuns. She fell in love at different times with two of the men dying and described intense moments together as each glanced at two different crucifixes.⁴⁵ Although the hospice movement that she founded has generally been co-opted by Freudians like Lamers and Klagsbrun, the Catholic spirit of service lives on in hospices run by Mother Theresa's Missionaries of Charity. At the Gift of Love, their AIDS hospice in San Francisco, they accept referrals from everywhere, including San Quentin State Prison and San Francisco General Hospital. One man had been at GOL for two years and after receiving the Anointing was hospitalized at the San Francisco General Hospital, deathly ill. However, he insisted on coming home to die at GOL. Five residents kept vigil with him all night until he died the next morning. All residents are homosexuals with AIDS whose families do not spend much time with them even if close by. The sisters do spend time with them and go looking for them when they are not around. They feel accepted as they are and are given jobs to do in the house of which they are capable. The sisters pray with them if they are willing and for them when they are not. Usually, they return to the sacraments or become baptized and receive the Anointing as soon as they get very sick.

When a resident asks to die, he is told that God has not called him yet and that he has an opportunity to prepare for death, to offer his suffering for his sins and for those on the street who do not have someone to care for them. They invariably accept such advice and do not persist in their request for death. Sister Salome, who spoke with me at GOL on August 23, 1999, administers prescribed medication including narcotics, but usually after two weeks at GOL they are no longer required. Even when they are administered to a dying patient, consent to call a priest is elicited. Non-Catholics accept the blessing of the priest who comes three times a week to celebrate Mass. Arriving at GOL, often from the streets, residents are embittered, but soon with loving care their attitude changes to acceptance and gratitude and a desire to participate in the sacraments. Sometimes there is physical recovery after the anointing, but more often death is accepted with peace, whereas before there was anxiety and fear. Volunteers come from near and far to assist the sisters in caring for the residents, including some discerning a vocation to the priesthood. I met a non-Catholic woman there who volunteers one evening a week after work

inspired by Mother Theresa. She told me that sharing in the Gift of Love always uplifts and makes her happy.

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