On Death, Suicide, and Accelerated Life

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Out of nothing (0) emerges something (1) from which emerges nothing (0).

The dance of 0's and 1's choreographing and evolving, glorious, is!

Sapient homos dance in ephemera.

Introduction: Physicians and Death: A Lethal Struggle?

What is the natural enemy of physicians? Death? Suffering? Both? No, it cannot be both, as death ends suffering, and where there is suffering, there is life!

The Hippocratic Oath dictates that the physician will help the sick and do no harm intentionally. Whenever possible, the physician should alleviate the suffering of the living. But what if the alleviation can come only from ending life? Is that doing harm or good? Except for suicide, one does not have control over one's own death. It is up to others, especially the caregivers – doctors, nurses, family, friends to deal with inevitable death, especially in the late stages of life. Thus it is often up to us, physicians, to make the decision whether to allow the patient's dying!

I treated a patient who had attempted suicide because her helplessness at a virulent metastatic breast cancer (Leigh, 1974). With the patient, psychotherapy helped to gain a sense of psychological control over her malignancy, together with a full bottle of "exit pills" she could use if needed. She died "fighting in her boots" without needing the exit pills. But what if she decided to use them? It was important for her to have that choice, the sense of control over her own life.

1. Suicide

Many factors must be considered in evaluating suicide and the paths leading to it at different levels, individual, immediate environment, and macro-environment including subculture, culture, and society in general.

i. Social & Cultural Factors

Emile Durkheim, a French sociologist, described in his classic book *Le Suicide (1897)* four types of suicide the incidence of which may be determined by sociological factors.

A. *Egoistic suicide*, more prevalent in individualistic, Protestant countries in Europe, was considered to result from a sense of failure in achieving individual aspirations in an environment where there is not much social support or cohesion. Egoistic suicide was considered more prevalent in unmarried men.
B. *Altruistic Suicide* was considered to result from excessive social integration where persons were not as important as the society and were expected to sacrifice themselves, as in a soldier sacrificing self by throwing himself over a grenade to save his buddies, or old Japanese *hara-kiri.*
C. *Anomic suicide,* caused by a sense of lack of definition of self (*anomie)* which may result from rapid social change including sudden disappearance of an activity or purpose that gave meaning to the individual, including loss of a job or even success in achieving a goal, e.g., passing an important exam. Suicide rate is higher at times of peace than war, probably because at times of war there is an imperative (and struggle) for survival. This sense of lack of definition of self is a common experience of many suicidal patients I have seen.
D. *Fatalistic suicide* was considered to occur in severely oppressive societies where the individual would rather die than live. This might occur in certain prisons. The oppression may be psychological and physical, e.g., pain, where patients feel death is preferable to continuing the unbearable life.

In the modern era and especially in multicultural societies, these sociological considerations are not confined to particular regions or cultures, but can be found in individuals' personal social contexts, e.g., family's expectations of success or failure, presence or absence of social support (spouse, friends, communities, etc.).
It is well known that suicide rates are higher in socially isolated individuals. While completed suicide is more common in men, suicide attempts are more common in women. Older age was considered to be a risk factor for suicide, but now teenage suicide is also increasing.

Access to means of suicide is also important, particularly lethal weapons such as guns, and lethal drugs such as fentanyl that may cause "accidental" suicides.

ii. Personal, Psychological, and Biological Factors

A person born into a society brings one's own constitution, consisting of genes in the form of DNA and the results of epigenetic and embryonic/fetal development.

Family history of suicide and depression may shed light concerning *genetic* suicide risk as well as the *memetic* family subculture (Leigh, 2010), e.g., was talk of suicide commonplace (e.g., I'll kill myself if ….) or a taboo? Interaction with family religion, etc. Does suicide exist in the mind as an option? Some families have the memetic subculture of *somatization* of anxiety and depression, thus the *help seeking behavior* may be complaints of pain (e.g., headache, heartburn, muscle pain, etc.) rather than depression. This may result in unchecked progression of depression leading to limit of tolerance (of psychological pain of depression) and fatalistic suicide.

Psychiatric Illnesses, especially *Bipolar Disorders, Major Depression,* and *Schizophrenia* are associated with increased risk of suicide and call for effective evaluation and management of suicidal thoughts and impulses. *Post-traumatic Stress Disorder (PTSD)* can manifest symptoms of any major psychiatric illness including suicidality. *Substance use* also contributes to the risk of suicide both by increasing impulsiveness through cortical disinhibition as well as accidental overdose.

A question that I find very useful in understanding the intent of a patient with suicide attempt is "What would have happened if you had died?"

Common answer types include:

a. "My Mom (or Dad, or family) would be sad" "He (or she or parent) will be sorry!"
b. "I would be relieved of this pain"
c. " I'd be in Heaven" " I'd be in Hell"

These answers may provide clues to treatment of the specific suicidality. In the case of type "a" above, situational relationship issues with a significant other may require attention, or a supportive person ("My Mom would be sad") could reduce a patient's suicidal urge. For type "b", medications to relieve physical pain or antidepressants for the pain of depression may be indicated. For type "c", further

evaluation is indicated concerning the need for comfort ("Heaven") or punishment ("Hell") and psychotherapy may be indicated. For some religious patients, the clergy might be mobilized.

Another question I find useful is, "What do you see yourself doing in 1 year?"

a. "I'd be in college." "I think I would feel a bit more stable"
b. "I don't know." "Maybe I would be dead."

Type "a" answers that imply some hope for the future auger well, and one can be assured that there is no immediate danger of suicide.

Type "b" answers indicate that there is either no sense of the future or a pessimistic one, and one should take these answers as a *cry for help.* Immediate further evaluation and treatment, including possible hospitalization should be considered for these patients.

So far, I discussed the evaluation and management/treatment of suicidal patients. But do all suicidal patients require treatment?

2. Suicide as a Right

Suicide had been criminalized in the Western Culture, largely due to religious dogma. Often the penalty for suicide attempt was death! In *Savage God, A Study in Suicide by* A. Alvarez (19 71), there is a vivid description of how a man who attempted suicide by cutting his throat, was condemned to die by hanging. But when they tried to hang him, the deep cut to the throat in the suicide attempt opened up the trachea and he would not die of asphyxiation. They had to patch the throat and neck with cloth to finally hang him!

Suicide is no longer criminalized in most modern societies, but it is still generally considered unacceptable and to be prevented. Suicidality (or homicidal ideation) is a criterion by which almost all states in the U.S. provide for forcible incarceration in mental hospitals. It is quite understandable that homicide, a

crime, should be prevented, but should suicide, taking one's own life, be forcibly prevented by society?

Modern view of a person's autonomy should certainly include the right to complete control of one's body, including suicide as long as the person has the capacity to make the decision. Suicidality per se should not be sufficient reason to be declared incompetent!
In fact, many states in the US and countries like the Netherlands permit suicide under certain conditions. Should there be complete freedom for suicide without any conditions?

In fact, if one is determined to suicide, no law can prevent them from completing the act. One can simply jump off a tall building, jump off a bridge, etc. One might argue that the simple fact that a person's suicidal intentions came to the attention of others means that the person, at some level, wants help to alleviate the suffering that led to their suicidality. This was the case with the suicidal, terminal cancer patient I mentioned at the beginning. The patient maintained a sense of autonomy and control over her life with a full bottle of "exit pills" I had prescribed. She eventually died of cancer without using them.
A mobilization of help by family and professionals is certainly indicated in these cases of "cry for help".

It is time to *de-pathologize and de-criminalize* suicide. A person who suicides *dies of* suicide, not *commits* suicide. In a study of death by suicide in a community during a 3 year period, it was found that about two thirds of the suicides had no psychiatric diagnoses (Ramsinghani, 2015) Though some of the suicides may have had undiagnosed psychiatric illness, it is clear that many persons without psychiatric diagnoses die of suicide.

For persons who have decisional competence but unable to carry out the decision to suicide due to physical incapacity or other obstacles, should suicide still be available through the assistance of others, e.g., physicians, family, etc.?

3. Death as a Part of Life

Death is a natural part of biological life just as birth is. It is only with the advent of modern medicine that prevents and treats pathologies that "fighting death", especially by physicians, became possible. Hippocratic "Do No Harm" was especially apropos at a time when much of what a physician could do was actually do harm by prescribing at best useless "medicine" or often nonbeneficial toxic substances. Now that physicians can "do a lot" to fight death, is it unconscionable for a patient to wish to die? Despite the valiant fights of physicians, patients still have a habit of dying as the disease or aging process eventually gain the upper hand.

There has been a self-correction to the overzealousness in fighting death through movements toward such movements as the hospice and 'Death with Dignity". Advance directives and directions concerning disposal of remains are steps to enhance persons' choices concerning their death.

What is the proper place of death in a changing world? While it may be accepted as a part of life, we are actually developing more and more control over death – when, how, and *if* it will occur. Masserman (1954) posited that a sense of immortality was one of *Ur-delusions (or beliefs)*, an assumption without which one cannot live ordinary lives. With increase in longevity owing largely to modern medicine, there is reason to believe that this sense of immortality is also increasing. Furthermore, with the advent of digitization, virtual reality, etc., it might even be possible to achieve a form of immortality. Could one eventually digitize their brain and "jump" into a digitized, virtual world? According to one scientific theory (Overbye, 2022; Susskind, 1995), we might actually be already holograms!

So, death might potentially be optional, and thus a *choice.*

4. Death Penalty or Accelerated Life

While suicide had been widely condemned and criminalized around the world, *death penalty*, actual killing of a person has been widely accepted and practiced. From the time of Hammurabi Code of Laws (1750-1755 BCE), a sense of justice based on the *lex talionis* or "an eye for an eye" principle called for death for murderers and other serious criminals.

Should the State have the *right to kill persons for cause* while an individual does not have the right to exercise their autonomy to suicide?

Death penalty has now become controversial, and many nations no longer practice it. Does a sense of *justice*, however, call for death rather than life imprisonment for intentional mass murderers? How about protecting the society from potential serial killers and mass murderers who might escape the prison? Why should the taxpayers support a young murderer by providing food and shelter in protected prison for decades of their remaining life?

If autonomy means that death is a *choice*, it seems fair that a criminal sentenced to life imprisonment should be able to choose to *accelerate their life to the end point, i.e., death.*

5. "Good" or "Appropriate" Death

In this early part of the 21st century, biological human life is till finite and death remains inevitable for most people. The *how and when* of death, however, are becoming more and more matters of choice. So, is there a good time and good way of dying?

The concept of *Appropriate Death* (Weisman, 1970) emphasizes the personal beliefs and life style of the individual, and counsels that each individual comes to terms with an appropriate death for them. For example, an appropriate death might be fighting the

disease and “dying in one’s boots”, or it might be comfort care in a hospice setting, or a planned suicide/euthanasia in the presence of loved ones.

Epilogue

I conceptualize the cosmos as a nexus of curvilinear, evolving, expanding, contracting, permutations and combinations of relationships as can be inscribed as a dance of the ultimate information particles/waves, i.e., zeroes (0) and ones (1) on the surface of or within the cosmos. Everything including nothing is an ephemeral combinations of a series of 0’s and 1’s, which sometimes form complex series of equations, you and me. Life and death are but a slice of this cosmic dance. Of course, given enough time/space/surface, even exotic combinations (you and me) would surely recur (with or without memory, another equation).

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