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This talk was given by Father O'Rourke at the annual meeting of the National Guild of Catholic Psychiatrists in Chicago on May 13, 1979. A vice-president of the Catholic Hospital Association from 1977-79, he is presently director of the Center for Health Care Ethics at the St. Louis University Medical Center.

1. The Problem

In the United States, suicide is a rather common event. Each year, some 27,000 people (about 13 people per 100,000) choose this manner of death. One specialist in suicide, Dr. Joseph Hirsch of Temple University, states, "I think suicide in this country is a vastly understated problem. In my opinion, the number of actual suicide deaths is probably closer to 60,000 per year."[1] Moreover, the rate of suicide for those under 30 seems to have more than doubled in the past 10 years.

Suicide is usually ranked as the tenth or eleventh cause of death in the United States, and those committing suicide are not always people who seem "to have nothing to live for."[2] Rather, they are often well educated and affluent. Surprisingly, high on the list of those who commit suicide are physicians. The situation in regard to physician suicide was studied by a task force of the American Psychiatric Association.[3] This group concluded that more physicians die each year as a result of suicide than by auto accidents, plane crashes, drownings and homicide combined. The suicide rate for male physicians is about 15 percent above the rate for men in general; however, the rate for female physicians is an astounding three to four times higher than the rate for American women.[4] One out of 50 doctors commits suicide each year and the average age is 48. The highest incidence is among psychiatrists.[5] For psychiatrists, it seems, suicide is at epidemic proportions.

Among psychiatrists, overwork, marital troubles and financial worries are the causes usually put forward for suicide and other psychic disorders, such as drug addiction, alcoholism and depression. Case histories repeatedly describe the doctors as unable to relax, unwilling to take time off from work and unable to enjoy a vacation. Doctors who become ill are described by their psychiatrists as over-achievers who drive hard to be successful and are completely preoccupied with their work.[6]

Other studies indicate that motivation for contemplating suicide may be social as well as personal. Thus suicide may reflect a lack of integration into society, a lack of meaningful social interaction, a lack of participation in the social structure arising from a deprivation of position, wealth or spouse.[7] Social forces alone, however, do not explain nor predict an individual suicide. Other factors, often influential, are negative feelings about one's self and one's world, along with hopelessness and helplessness. Whatever the variety of causes that may be posited for suicide, no single psychological, social or individual theory suffices for its understanding and prevention.[8]

One psychiatrist who has studied suicide and its causes among physicians believes that the cause for the high incidence of suicide among doctors in general, and psychiatrists in particular, may predate their time of crisis. "The answer may lie in character structure: those same neurotic drives and personality traits which may have led these individuals to the study and practice of medicine in the first place. It may well be that their midlife psychiatric illnesses result not so much from the stress of medical practice itself but rather from patterns established prior to medical school. It is a generally accepted impression — although it has not been confirmed by objective testing — that physicians tend to be obsessive-compulsive, accounting for their hard-working over-achieving perfectionism. Their conscientiousness may be the very ingredient which makes them unable to relax or turns them to drugs and alcohol for support. Consequently, such personalities often feel ashamed to seek help if they see themselves failing or breaking down."[9]

II. The Morality of Suicide

The possibility that anyone can make a rational decision to commit suicide is debatable. This debate aside, it is important to be clear, as Novak points out, that the issue is not whether persons who commit suicide are to be morally condemned.[10] No doubt, a great majority of persons who take their own life do so because they are so emotionally disturbed that they act compulsively or at least their perception of objective morality is so distorted by their anguish and depression that their freedom of choice is greatly restricted. Consequently, either their act is not to be evaluated morally, or at least it may be assumed,

unlesss clearly proven otherwise, that they are in good faith and are subjectively guiltless. Indeed, many experts in suicidology seem to take it for granted that suicide is irrational and compulsive.[11]

Whatever the situation in regard to subjective states of people who commit suicide, something more must be said about suicide from an objective viewpoint. Among the Greeks and Romans suicide was both condemned and defended as it was in Eastern cultures.[12] The Epicureans, who considered pleasure and peace of mind the highest human goods, argued that it was better to kill oneself than to endure life if it had become more painful than pleasurable or peaceful. The Stoics, who believed that virtue or self-control was the highest good, argued that it was permissible to kill oneself if suffering or torture might force one to lose self-control or act ignobly, or where a choice had to be made to perish in a shameful way or "die with dignity." Dualists, for example, Platonists (but not like Plato, himself), agnostics, and Manichaeans taught that the soul, which is the real man, is burdened by the body in this life or in many reincarnations; hence suicide might be justified as a laying down of this burden. Even in modern times men and women have been regarded as heroic if they committed suicide for the sake of honor. Recently some Catholic Irishmen and Buddhist Vietnamese have used suicide by self-starvation and self-immolation as a protest against injustice.

However, the monotheistic religions of Judaism, Christianity, and Islam have always opposed suicide because they regard life as God's gift which His creatures are to use as faithful stewards. Because life is a gift over which man does not have absolute but only useful dominion, life should not be destroyed but rather valued and preserved. This principle is one of the fundamental insights of Christian teaching and influences Christian thought in regard to many other medical-moral questions. Moreover, it has been expressed in the ordinary teaching of the Church[13] and is reflected in the refusal of Christian burial to those who knowlingly and freely commit suicide.[14] Thus these monotheistic religions, unlike others, hold that eternal life is not the survival of a disembodied soul, nor endless reincarnation, but resurrected life with God. Consequently, we cannot escape accounting to God for our stewardship of this one life which is given us on earth, nor can we reject the body which will always be part of us.

This Judeo-Christian view of suicide was anticipated by the great Greek philosopher, Plato, who argued that suicide is a rejection of our duty to our body, to the community of which we are a part, and to God Who gave us life. In a very different way, another great philosopher, Kant, argued that suicide is the greatest of crimes because it is man's rejection of morality itself, since man must be his own moral lawgiver. For a person to kill himself or herself is to treat himself or herself as a thing (a means) rather than as a person (an end) in himself or herself.

Today, this classical stand is being reexamined by psychiatrists and theologians. The Protestant ethicist, Joseph Fletcher, has said, "The real issue is whether we can morally justify taking it into our own hands to hasten death for ourselves (suicide) or for others (mercy killing) out of reasons of compassion."[15] Fletcher answers this in terms of his own situation ethics according to which the only command of God is to "act lovingly." This leads Fletcher to an ethics of intention which justifies any means if it is effective for achieving loving ends because "if we will the end, we will the means." Consequently, it appears to him that there are many situations in which persons can will their own death for the good of others (as a war prisoner fearing torture that may cause him to reveal the hiding place of others) or in which we may put others to death out of compassion for their sufferings, assuming that they would want this to be done for them.[16]

Catholic theologians generally reject situationism, but those who hold for the principle of proportion, as developed by Peter Knauer and Joseph Fuchs, argue that the moral law against suicide and euthanasia is not absolute.[17] Thus Daniel Maguire in *Death by Choice* maintains:

> What he (Knauer) means is that the taking of innocent life is wrong if there is no commensurate reason for taking it. . . . At the theoretical level, then, Knauer's ethical theory allows for euthanasia, suicide, or abortion under his dominant rubric or "commensurate reason." He slips out from under the old rule against intentionally taking human innocent life and comes up under the position that commensurate reason is what counts.[18]

Maguire admits that Knauer and others of this persuasion "are not willing to go as far as their theories"; that is, they consider mercy killing and suicide to be wrong because no proportionate good could come from allowing exceptions. But Maguire is willing to follow the theory to its ultimate conclusions, and so are others[19] and he states, "The morality of terminating life, innocent or not, is an open question although it is widely treated as a closed one" (p. 112). Maguire believes termination of life can be moral or immoral according to the circumstances that give it moral meaning. In general, these Christian thinkers believe that to make an absolute rule against suicide is under some circumstances to fail to respond compassionately to useless human suffering or to draw subtle distinctions which indicate the Pharisaic legalistic mentality repudiated by Christ.

I disagree with and reject the principle of proportion because I think it is based upon an interpretation of the principle of double effect that is psychologically unsound. But even if one does consider this a valid method of reaching moral judgment, I find it difficult to agree that suicide could be judged a morally good human action. With Richard McCormick, the most able proponent in the United States of

the theory of proportion, I would agree that the values associated with suicide do not outweigh the values associated with preserving life. Natural reason tells us that if we destroy our own life we destroy the basis for any other value as well as the basis for happiness. Our Christian faith tells us that our hope in God grounds our future. If we give up hope, we challenge God. Moreover, we know that through God's providence even the most painful situations can be endured and may even be extremely important events in the completion of earthly life. As creatures of God we ought to wait on God Who gave us life, because He knows best how to prepare us for the mystery of eternal life with Him. Thus, if we weigh the values, the objective evidence is on the side of life.

III. Some Suggested Solutions

Given the evidence that suicide is a tragedy that seems to affect physicians and especially psychiatrists to an inordinate degree, is there anything that might alleviate or limit this situation?

1. First of all, physicians, especially in their formative years, should be encouraged to develop a healthy lifestyle that will enable them to avoid depression, suicide and other psychiatric difficulties. Even though people have obsessive-compulsive tendencies, it is possible to help them order their lives in a less inhuman manner. Attitudes and priorities can be developed which would help shape a more livable future. Putting family concerns first — for example, actively learning to understand and dialogue with people during the time of medical school and residency — will help toward a more balanced personality.

The negative factors that might be present in a young person, factors which might later dispose for depression or suicide, are not overcome by accident. There must be a concerted effort to develop an understanding, accepting, hopeful character or else the negative factors and neurotic tendencies will predominate. Medical schools might ponder their responsibilites to offer activities, direction and guidance which would enable young physicians to develop a balanced character. Suicide is a problem for physicians in later life, but it is a problem during medical school as well.

Those who are close to medical schools and the dynamics between faculty and students realize that only people with strong egos enter and survive medical school. To be accepted in medical school with 150 vacancies for 4,000 applications means that a person must be intellectually able, industrious, a high achiever, socially acceptable and often a person with leadership qualities. Moreover, the devotion to scientific endeavors during medical school and residency tend to lead to the neglect of more humanizing studies and pastimes. Anatomy, psychology, and histology are necessary subjects leading to the devel-

opment of a skilled physician, but the question of developing the personality through liberal studies must be taken into consideration as well. Having been associated with a medical school for only a short time, I can attest that the concern of many faculty members centers around the lack of vision and balance in the formation of young physicians. Merely hoping that everything will work out all right for the future physician and, at the same time, ignoring his or her human needs, is ridiculous. Do we have to wait until the unhappiness and destruction of human life reach epidemic proportions before some steps are taken to help young physicians develop a balanced character and value system?

Realize that every person has a value system, not only those who proclaim to be Christian or members of some other religion. Even the atheist has a value system; no person acts without one. Hence, the question is not, "Should we help young physicians develop a value system?" but rather, "Are young physicians developing a value system that helps them to cope with the difficulties they will encounter in later life?" Judging from the statistics that we have on depression, alcoholism, drug abuse, and suicide among physicians, I would say that the medical schools and the medical profession in general have cause for concern.

2. If hopelessness and helplessness and the feeling that life is not worth living sum up the motivation for suicide, then developing a Christian spirit of courage and hope is the antidote for this malaise. The qualities of hope and courage enable one to overcome the strenuous and arduous difficulties in life; they enable us to push uphill, fight back, and live with or conquer the difficulties that give rise to sorrow or sadness. Moreover, courage and hope enable us to carry on the daily struggle, day by day, in the face of ennui and boredom, especially that peculiar form of boredom or meaninglessness that seems to overtake people in their forties or fifties. Scripture speaks of this mid-life phenomenon as the "noon day devil."

Developing hope and courage requires more than merely speaking the words. In order to develop hope we need a deep feeling of self-worth, a sound love of self. In order to hope in the face of sorrow or suffering, we have to be convinced that there is something important, something worthwhile, that we will protect or achieve if we overcome the evil that causes our sorrow. Hope is based upon a strong attraction to something good. If the person is not convinced that he or she is good, that the evil or sorrow which he or she now faces is interfering with that personal goodness, then there will be no impetus to transcend or overcome the evil. Jesus told us to love others, *as we love ourselves.* If we don't love ourselves, we will not be able to love others. In the same sense, if we don't love ourselves, we will not have the personal ego-strength to overcome the small and large difficulties

of life. Protecting and preserving our own life will not seem to be important in face of depression or suicidal tendencies if we do not have a deep love for our own being and personhood.

Recently I spoke with a psychologist who works with people contemplating suicide. In the first interview, the rather successful psychologist often asks the patient to draw a picture of his or her own personality. So many times there is a very pathetic and negative self-view; moreover, if God enters the picture it is in a negative manner. To people with suicidal tendencies, God often seems to be Someone Who does not care. Although this experience does not prove conclusively that poor self-image disposes for suicide, at least it confirms our everyday observation that people will not overcome the trials and sorrows of life unless they feel their own lives are worth living and this means they must feel that "they make a difference."

How does one go about developing a strong and healthy self-love? Christian spirituality demonstrates that a balanced, healthy, productive view of self begins from a realization of God's love for us, and develops and is strengthened through a continuing experience of His love. The whole purpose of Christ's coming, the Church, and other realities in salvation history is to show the deep love that God has for each person. God holds you in the palm of His hand and caresses you. He loves you not in spite of your sin but with your sin. If you were the only person in the world, Jesus would have become a human person and redeemed you. The good news that Jesus came to bring is simply this: God loves you more than you will ever imagine. Because of love He brought you into being and His whole purpose in creation is to demonstrate His love for you.

Becoming *aware* of God's love is not an unusual occurrence; the gift of faith is given to many, usually in ordinary ways through the family but often in extraordinary ways as well. Paul on the road to Damascus is the symbol of extraordinary modes of receiving faith, but certainly he is not the only example. But how does one go about *experiencing* faith? How does one deepen the initial awareness; how does one deepen his or her realization of God's love in an intensely personal and transforming manner? The Spirit breathes where He will and the lives and writings of the great saints tell us that no one can force the hand of God. Still we can do things that dispose for the experience of God's love. There are ways that have been followed by people ever since the time of Christ, ways that are not necessarily peculiar to the Christian religion but which have been practiced and recommended by the people who have demonstrated a personal and intense conviction of God's love.

The first step in disposing for the experience of God's love is to "go out into the desert" — to spend some time alone with God, away from the occupations, the worries, the false concerns, the comings and goings, the criticizing and posing, the scheming and planning that fill

so much of our time. In addition, prayer, especially liturgical prayer, attempting to converse with God and reading the Scriptures, will help a person dispose for the experience of God's love. Clearly, the experience will come to different people in different ways, but there are some things that will help dispose for the experience. Some will be "hit" all of a sudden, others will "grow into" the experience; but the experience does not seem to take place unless people are willing to "get away" from everyday concerns for a significant length of time. Does this mean that in order to have a firm and healthy love for self one must be some sort of contemplative? Should the physician or psychiatrist cultivate the mental outlook of a contemplative? Yes, that is my contention. This is the way "you will find your life by losing it"; this is the "pearl of great price"; this is the "seed that falls in the ground and dies and then bears fruit a hundredfold." You don't become a better person by doing more, you become a better person by waiting for God to love you and then as a result of that experience your life and the things you do are transformed. Doing less means doing more, the paradox of Jesus' example and teaching.

Talking about God's love to psychiatrists may seem like a contradiction. After all, if psychiatry has something to offer to people, are only Christians able to offer help through psychiatry to other people? Rather than show that only Christians can be psychiatrists, I am trying to show that theology, the development of faith through reason and experience, does have something to add to psychiatry. Not something to replace it, but something to perfect it. Certainly there are other ways to develop healthy self-love: for example, through positive mental attitudes, group sessions, reflection upon the beauty of life, interest in the fine arts, and other things which take a person "outside of herself." But how can a person find the most total and integrating way to realize the wonder and goodness of human life and the particular personality? Only by becoming more lovingly united with the source and meaning of human life and personal existence, by becoming a closer friend of God, Who is waiting to speak to us in loneliness, quiet and the creative silence of the desert.

3. In our effort to thwart the tendency among physicians toward suicide, an examination of the value structure of physicians would be in order. While there are no comprehensive studies of value structure among physicians and psychiatrists that I have been able to find, there are several hypotheses put forward based upon the experience of at least a few people. Briefly, I would like to present these hypotheses and consider some of their implications.

a. The first hypothesis: physicians are highly intelligent, autonomous scientists who will be able, one day or another, to solve all psychological problems. For this type of person, death is an enemy, the symbol of defeat. Moreover, because the scientific approach can be

hindered by emotion, empathy and sympathy with the suffering patient are luxuries not allowed the "compleat physician." A caricature, perhaps, but some truth contained therein, nonetheless.

How could a person of this mind-set be helped? Personally, I think the proper object of medicine must be explained to people with this mentality. Medicine seeks to cooperate with nature (God) by disposing the human person for cure and healing. But since death is part of human life, then death is part of the natural process, and physicians should consider death a fulfillment of a person's life. By becoming more aware of and supportive of the suffering and dying person, the physician becomes more faithful to his or her profession.[20]

b. The second hypothesis: physicians judge their personal worth either by their scientific achievements, writings and research, or by monetary success in their practice. Certainly research, writing and a decent lifestyle are worthwhile values, but are they top priorities for a person who ministers to others and seeks to be a well-balanced person? The qualities which enable a person to reach out, to help, to understand, to exercise compassion and empathy are much more important than the aforementioned values. Do people who contemplate suicide realize that the values they pursued for so long, and perhaps achieved, are nothing more than a handful of sawdust? Would it help to insist upon more "humane" values as the substratum for a successful physician?

c. The third hypothesis: insofar as psychiatrists are concerned, there seems to be a status problem. First of all, they seem to be on the bottom of the professional ladder;[21] second, psychiatrists seem to have an identity problem, not being exactly sure of the worth of their profession.[22] The first of these problems might be solved if the second could be answered satisfactorily, that is, there would be the potential for a better professional identity if the specific object of psychiatry were better understood. What are psychiatrists supposed to do? Both action and insight therapists seem to be confused as to what they wish to do, and why they wish to do it. Would more time devoted to the proper object of psychiatry help alleviate the problems we have been discussing?

Conclusion:

There are no easy solutions to the problem of suicide among physicians in general and psychiatrists in particular. But if some progress is to be made in limiting this personal and social tragedy, then a start has to be made somewhere. I suggest we consider the education of physicians, their need of a contemplative activity, the prevailing value system among physicians, and the proper object of psychiatry as a human discipline.

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