

Assisted Suicide

BACKGROUND

Physician-assisted suicide came to the forefront of American political debate in June 1990, when Dr. Jack Kevorkian, a pathologist from Royal Oak, helped a 54-year-old woman to commit suicide. The woman, who was diagnosed with Alzheimer's disease, died from a self-administered lethal infusion of intravenous drugs. Since 1990 Dr. Kevorkian—whose medical license was suspended by the state in 1991—claims to have assisted in nearly 100 suicides.

Although many Americans question Dr. Kevorkian's methods, over the years support has grown for physician-assisted suicide.

GLOSSARY

Assisted suicide

Provision by a physician of the means or information to enable a patient to perform his/her own life-ending act; differs from euthanasia in the degree of physician participation.

Euthanasia

The act of bringing about the death of a hopelessly ill and suffering person, for reasons of mercy, in a relatively quick and painless way; generally, a lethal agent is administered to the patient.

Nonvoluntary euthanasia

Euthanasia provided to an incompetent person according to a surrogate's decision.

Passive euthanasia

Euthanasia by such means as withdrawing life support.

Voluntary euthanasia

Euthanasia provided to a competent person at his/her informed request.

- In 1947, 37 percent of Americans supported allowing a doctor to assist a terminally ill, suffering patient to end his/her life.
- In 1973, support was expressed by 40 percent.
- In 1994, 57 percent stated their support.
- In 1997, polls conducted by Gallup, CNN, *USA Today*, and others reveal that general support is in the 69–75 percent range.

The 1994 data revealed, however, that support is not unconditional: Of the 57 percent saying they support physician-assisted suicide, 34 percent premised it on the existence of legal standards regulating the practice. In the Netherlands, voluntary euthanasia is an accepted practice and undergone by 10,000–12,000 people annually; since 1984 Dutch doctors who meet the following criteria in administering it have not been prosecuted:

- The patient explicitly and repeatedly requests euthanasia
- There is no doubt that the patient wishes to die
- There is no prospect of relief for the patient's physical and mental suffering
- All alternative medical care options have been tried or refused by the patient
- The patient's doctor has consulted with another physician

In 1997 the U.S. Supreme Court ruled that physician-assisted suicide is not a constitutional right, which means that each state may permit or prohibit the practice. Since the ruling, only in Oregon has the public voted to legalize physician-assisted suicide. (This was not the first time for Oregon: In 1994, state voters approved an initiative permitting physician-assisted suicide, but a federal appeals court issued an injunction against the law.) Today the Oregon initiative faces its own challenges: The federal Drug Enforcement Administration has

threatened to revoke the drug-dispensing privileges of any physician who abides by the law; the agency has asserted that prescribing medication to assist a patient's suicide is not a legitimate medical purpose and, therefore, would violate the federal Controlled Substances Act.

In Michigan the legal status of physician-assisted suicide is a question with which policymakers and officials have been grappling for years. Following Dr. Kevorkian's participation in several assisted suicides in 1992, a diverse group—the Michigan Commission on Death and Dying—studied the assisted-suicide issue pursuant to a bill that sought to criminalize the act. The commission met for several months and held public hearings, finally taking a nonbinding vote of its membership on supporting a recommendation to the legislature to *decriminalize* assisted suicide under limited and well-defined circumstances. The vote was extremely close; although the measure received the majority of the votes cast, it did not receive a majority of the full membership (eight members voted yes, seven members voted no, and seven abstained).

The commission never officially reported to the legislature because a Michigan court subsequently ruled that the law that created the body was unconstitutional because it had two purposes: banning assisted suicide and establishing a commission to study the issue (the state constitution limits legislation to a single purpose). The Michigan Supreme Court, however, reversed the lower court's opinion and ruled that the 1992 assisted suicide ban does *not* violate the state constitution. Certain legal authorities believe, therefore, that the legislature may not need to pass another law to ban assisted suicide.

Michigan prosecutors repeatedly have failed to convict Dr. Kevorkian, and every year since 1991 lawmakers have introduced legislation to criminalize assisted suicide and make it a felony punishable by imprisonment and/or a fine. The most recent version of the bill calls for up to five years imprisonment and a maximum fine of \$10,000 for assisting a suicide. The bill stipulates that withholding or withdrawing medical treatment would not constitute assisted suicide.

Other pending Michigan legislation would give a competent, terminally ill adult the right to end unbearable pain or suffering through self-administering medication to hasten death, but the measure could take effect unless approved by a majority voting in the November 1998 general election. Pursuant to the recommendation of the former Commission on Death and Dying, this legislation includes strict guidelines.

DISCUSSION

Today in the United States, attempting or committing suicide is not a crime in any state, but *assisted* suicide is a subject of deeply felt social and ethical debate.

On the one hand, many religious and other public leaders who oppose assisted suicide argue that it is immoral on the ground that life is an irreplaceable gift that should not be destroyed by any unnatural act. Opponents also argue that requiring a physician to accede to a patient's demand for aid in dying goes against 2,500 years of medical history and practice and particularly the Hippocratic oath, which reads, "I will give no deadly medicine to anyone if asked . . ."

On the other hand, those who support assisted suicide argue that to prohibit a person from carrying out the decision to end his/her own life is an invasion of privacy, and privacy is a right protected by the U.S. Constitution.

Apart from assisted suicide's moral and philosophical implications, many support or oppose the practice for practical reasons. For example, many proponents maintain that patients whose condition causes them unbearable pain and suffering should have the option to end their distress; they contend that a patient's right to control medical treatment includes the right to request and receive help in ending one's own life.

Opponents argue that unbearable pain and suffering result from medical mismanagement of pain. They believe that physicians and other caregivers are unduly concerned about a patient's becoming addicted to painkilling drugs, and some physicians are not up to date on the most modern techniques available to

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control pain. Opponents also maintain that a patient's right to control treatment should not mean that his/her physician is obligated to actively participate—whether through withholding treatment or prescribing potentially lethal medication—in ending the patient's life. Supporters, believe, however, that doctors should at least be able to choose whether they will participate.

Opponents also insist that there are significant social issues to be considered. For example, they fear that poor or unsophisticated patients could be pressured to request assisted suicide to save money or on the ground that their life has minimal social value. Opponents also point out that people who might gain from another's death could pressure unduly the patient (or encourage the patient's caretakers to do so) to consider suicide as the only option or perhaps as the patient's "duty" in sparing the family additional anguish and financial strain. Opponents also maintain that permitting physicians to assist suicide could cause patients to fear that their doctor might not do his/her best for the patient.

In countering these arguments, supporters suggest that safeguards against improprieties can be built into legislation permitting assisted suicide. For example, rather than disallowing people who have made a thoughtful, careful decision to end their life from doing so, government should regulate the practice to ensure that people who consider the option are

- mentally competent,
- aware of the consequences of their actions,
- able to make the decision without coercion, and
- given every opportunity to change their mind if they so desire.

Supporters also contend that prohibiting assisted suicide prevents patients and their families from making their own choice about the practice.

The debate is further complicated by the question of to whom the assisted-suicide option should be available. Medical ethicists are divided in their opinion about two particular Michigan cases. In one, the pa-

tient chose physician-assisted suicide because of intractable pain, but in her physicians' opinion, she did not have a terminal illness. In the second, a woman confined to a wheelchair by multiple sclerosis and experiencing other motor difficulties opted for physician-assisted suicide; while multiple sclerosis generally is described as a disorder that ends in death after a period of progressively and increasingly severe disability, many medical ethicists and physicians feel this woman's situation had not yet reached the point where suicide was a reasonable choice. Who should decide at what point someone's pain or quality of life has become unbearable?

In both cases, Dr. Kevorkian helped to bring about the patient's death. Many observers believe that his personal willingness to participate in the suicide of both terminally and nonterminally ill patients is detracting from the issue's main point—the patient's right to choose. Many physicians and bioethicists point out that with none of his deceased patients did Dr. Kevorkian have an ongoing relationship that would allow him to ensure that a patient had explored every alternative to death (in some cases he had little more than a day's contact with the patient). Others argue that Dr. Kevorkian has helped bring the assisted suicide issue into the public eye.

As with every end-of-life debate, there are varying degrees of support and opposition when it comes to assisted suicide. And it is clear that the question of assisted suicide—when placed in the context of individual rights, the state's duty to protect its citizens, opinion about the sanctity of human life, principles held by health care providers about their duty to care for their patients, and individual opinion about how one wants one's own life to end—is extremely complex.

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