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LEGAL ISSUES IN MEDICINE

PHYSICIAN-ASSISTED SUICIDE — MICHIGAN'S TEMPORARY SOLUTION

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LEWIS Thomas has noted that doctors "are as frightened and bewildered by the act of death as everyone else."[1] "Death is shocking, dismaying, even terrifying," Thomas has written. "A dying patient is a kind of freak . . . an offense against nature itself."[1] It is thus not surprising that many physicians have difficulty talking candidly with dying patients and caring for them, a reaction that often results in undermedication for pain and expensive and ineffective overtreatment.

American patients know this, and although death is a culture-wide enemy, many Americans fear the process of dying in an impersonal modern hospital more than death itself. Americans say they want to die at home, quickly, painlessly, and in the company of friends and family. Most, however, die in hospitals, slowly, often in pain, and surrounded by strangers. Discussions of assisted suicide, the publication of self-help suicide books, and fascination with suicide machines are all symptoms of the problem modern medicine has with the dying, rather than solutions.[2,3] The state of Michigan is struggling with this problem in its efforts to stop Jack Kevorkian.

KEVORKIAN AND THE SUICIDE MACHINE

Jack Kevorkian decided to test his suicide machine in Michigan because he was convinced that Michigan had no laws against assisted suicide.[4] This belief was based on his own reading of two Michigan cases, *People* v. *Roberts*[5] and *People* v. *Campbell*.[6] The first is a 1920 case in which Frank Roberts pleaded guilty to the charge of murder for killing his wife, Katie. Katie Roberts was terminally ill, practically helpless, and suffering from multiple sclerosis. At his wife's request, Frank Roberts mixed a quantity of Paris green (which contains arsenic) in a drink and placed it within his wife's reach. Katie Roberts drank the potion with the intention of taking her own life and died a few hours later. After being sentenced to life imprisonment on the basis of his guilty plea, a sentence required under Michigan law for murder "perpetrated by means of poison," Roberts appealed. His primary argument was that since suicide was not a crime in Michigan, there could be no crime of being an accessory before the fact to suicide — that is, since Katie Roberts committed no crime in killing herself, Frank Roberts could have committed no crime in helping her. The Michigan Supreme Court agreed that if there is no crime of suicide there can be no crime of being an accessory to suicide, but Roberts was not charged with being an accessory to suicide, but with murder, to which he pleaded guilty. The court concluded that the facts supported a finding of guilty of murder by poison.

In 1983, the Michigan Court of Appeals dismissed the indictment of Steven Paul Campbell on the charge of murder in connection with the suicide of Kevin Basnaw.[6] On the night of his suicide, Basnaw had been drinking heavily with Campbell. Just two weeks earlier, Campbell had caught Basnaw in bed with Campbell's wife. Basnaw talked about suicide but said he didn't have a gun. Campbell offered to sell him one and ridiculed him. Finally, the men drove to the home of Campbell's parents to get a gun and bullets, after which Campbell left Basnaw at home. The next morning Basnaw was found dead with a self-inflicted wound to the temple. The prosecutor relied on *Roberts* to justify a charge of first-degree murder against Campbell. The appeals court agreed that the case could not be distinguished from *Roberts* but ruled that *Roberts* was no longer good law. The court found that "the term suicide excludes by definition a homicide. Simply put, the defendant here did not kill another person."[6] The court invited the legislature to pass a statute against this type of conduct, which it said laws in other states had characterized as crimes ranging from negligent homicide to voluntary manslaughter, but not murder. The court concluded that Campbell's conduct, although "morally reprehensible," was not "criminal under the present state of the law."

As of May 1, 1993, Kevorkian had been involved in the deaths of 15 people (11 women and 4 men), 2 of whom used his "suicide machine" and 13 of whom used carbon monoxide. The suicide machine consists of three hanging bottles connected to an intravenous line. When the line is in place, it delivers a saline solution. The subject can then push a button that switches to the second bottle, containing the sedative thiopental. A third bottle, containing potassium chloride, is later activated automatically by a timer, and death follows within minutes.

After this method was first used by Janet Adkins in June 1990, I observed that the "suicide machine stands as a hybrid between medical and nonmedical technology" and that if Kevorkian had used a noose or helped Adkins "point a gun at her head and indicated when to pull the trigger, there seems little doubt that he would have been charged with and convicted of manslaughter (the reckless endangerment of another's life), if not murder."[7,8] Kevorkian was in fact charged with murder in the death of Adkins, but the medical trappings of the machine seemed to help persuade the trial judge that Kevorkian's acts were medical in nature — and thus presumptively benign. Relying on *Campbell*, Judge Gerald McNally dismissed all charges, ruling that Adkins had caused her own death and that Michigan had no specific law against assisting a suicide.[7,8]

Murder charges were also brought in connection with the deaths of the second and third persons "assisted" by Kevorkian (Sherry Miller and Marjorie

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Wantz) but were also dismissed (these dismissals are on appeal). On February 5, 1991, a permanent court injunction was issued barring use of the suicide machine. On November 20, 1991, Kevorkian's license to practice medicine in Michigan was suspended, and on April 27, 1993, his license to practice medicine in California was also suspended.

Kevorkian, a pathologist, had trouble starting the intravenous line in Janet Adkins, making five attempts to enter a vein.[4] With his second subject, Sherry Miller, he tried unsuccessfully four times to start the infusion and eventually returned home to get a cylinder of carbon monoxide. Later that same day he was successful in starting an intravenous line in Marjorie Wantz, but thereafter he abandoned the suicide machine and has since relied exclusively on the use of carbon monoxide. On December 15, 1992, the day Kevorkian supplied carbon monoxide to his seventh and eighth subjects (who, like the earlier subjects, were women), Governor John Engler signed Michigan's anti–assisted suicide bill, which was to become effective on March 30, 1993. Kevorkian stepped up his activities, however, and after his list of cases grew quickly to 15, Michigan's legislature made the statute effective immediately (on February 25, 1993) and also clarified the exceptions to the new crime of assistance to suicide.[9]

Michigan's Law against Assisted Suicide

Michigan's new law has two basic provisions. The first establishes a 22-member Commission on Death and Dying, composed of persons recommended by 22 different interest groups in Michigan, including the state's medical society, hospital association, Hemlock Society, and right-to-life organization. This commission has been given 15 months to "develop and submit to the legislature recommendations as to legislation concerning the voluntary self-termination of life."[9]

The second part of the statute temporarily criminalizes assisted suicide (for a maximum of 21 months) and will automatically be repealed 6 months after the commission makes its recommendations to the legislature. The statute states:

(1) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following is guilty of criminal assistance to suicide, a felony punishable by imprisonment for not more than 4 years or by a fine of not more than $2,000.00, or both:
  (a) Provides the physical means by which the other person attempts or commits suicide.
  (b) Participates in a physical act by which the other person attempts or commits suicide.

(2) Subsection (1) shall not apply to withholding or withdrawing medical treatment.

(3) Subsection (1) does not apply to prescribing, dispensing, or administering medications or procedures if the intent is to relieve pain or discomfort and not to cause death, even if the medication or procedure may hasten or increase the risk of death.[9]

This statute is, of course, a direct response to Kevorkian's activities, but it covers other types of assistance in suicide as well. Kevorkian's actions meet the requirements of both parts a and b in that, with knowledge that a person intends to commit suicide, he "provides the physical means" and "participates in [the] physical act." And since his intent is "to cause death," his action does not fall within the exception in subsection 3. A case like that in *Campbell,* in which a person provides a gun and bullets to someone who expresses a desire to kill himself or herself, would be covered by part a, as would the act of providing poison, as in *Roberts.* The statute has been attacked as unconstitutionally interfering with the right of privacy, but given its exceptions, that challenge is unlikely to succeed.[10]

On the surface, the statute might seem to criminalize actions like those described by Timothy Quill in an earlier issue of the *Journal.*[11] Quill prescribed barbiturates to a terminally ill patient with cancer who said she might use them to kill herself at some indeterminate future time.[11,12] However, assuming a Michigan physician writes a prescription for drugs that have a legitimate medical use (but also could be used to commit suicide) with the intent "to relieve pain and discomfort and not to cause death," the physician's action should qualify as an exception under subsection 3.

The existence of a long-term doctor–patient relationship seems necessary to argue such a defense credibly in a case like that described by Quill. This is because making a medical judgment about the appropriateness of a drug prescription requires knowledge of the patient and the patient's condition. Prosecutors must also contend with the fact that unlike the defendants in *Roberts* and *Campbell,* physicians who write prescriptions do not provide the "physical means" to commit suicide, any more than someone who gives a person money to fill the prescription or a car to get it would provide the physical means. All elements of a crime must, of course, be proved to a jury, which must find the physician guilty beyond a reasonable doubt.

The concern that the statute might bar either the withdrawal of life-sustaining medical treatment or the provision of sufficient pain medicine to relieve suffering, even if this would hasten death, is misplaced. Subsections 2 and 3 make it clear that the statute does not apply to withholding or withdrawing medical treatment and that the principle of the double effect provides a legal defense for the prescription, dispensing, or administration of medication for the purpose of relieving pain or discomfort, even if such action does in fact hasten death. These exceptions cover not only health care professionals, but also the families and friends of the patient. It would be a tragedy if physicians failed to provide pain medication out of fear of legal consequences, because "no patient should ever wish for death because of a physician's reluctance to use opioid analgesics."[13]

Distinguishing between Quill and Kevorkian

There is no evidence, other than the language of the new statute, that the Michigan legislature sought to distinguish between actions such as those of Jack Kevorkian and those of Timothy Quill. But in determining what Michigan's permanent statute (if

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any) should look like, the commission should distinguish between these two types of cases. What is at stake is the proper role of the criminal law in medical practice, and Kevorkian seems correct when he asserts that he is "not practicing medicine."[14] Similarly, the American Medical Association (AMA) seems wrong in equating the actions of Kevorkian and Quill and adopting an overly broad and vague definition of physician-assisted suicide to cover them both.

In the AMA's definition, "assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide)."[15] This definition is much broader than that in the new Michigan statute, which does not cover information at all and which requires not only providing the means, but also doing so with the knowledge that another person intends to commit suicide. The AMA, moreover, seems unable or unwilling to distinguish physician-assisted suicide from killing by a physician, saying that both are "contrary to the prohibition against using the tools of medicine to cause a patient's death."[15] The tools of medicine are used all the time with the knowledge that they may cause death, but this is acceptable because the intent is to benefit the patient.

The crucial legal and ethical distinctions lie not just in the nature of the tool but also in the intent of the physician using it.[8] Quill's actions can be compared with those of the gynecology resident described in "It's Over, Debbie,"[16] who gave a lethal injection to a 20-year-old patient with ovarian cancer whom he did not know, who said only, "Let's get this over with." Making this comparison, the New York medical licensing board concluded, "One [Quill] is legally and ethically appropriate, and the other, as reported, is not."[17] Kevorkian intends and ensures the deaths of his subjects.[4] Quill intends to alleviate the pain and suffering of his patients' final weeks or months of life.[11,12]

The Slippery Slope

The most powerful argument against the legislative expansion of the power of physicians to assist patients in suicide is the danger that this greater latitude will result in abuses that disproportionately affect especially vulnerable populations — the poor, the elderly, women, and minorities. In a country that treats the dying as "freaks," already marginalized members of society could be deprived of their human rights by making them appear somehow less than fully human. This is especially true in the context of cost containment and economic constraints.

Kevorkian is fond of describing his detractors as Nazis, but his own actions (and our response to them) require that we examine the Nazi experience carefully. Kevorkian's primary method of inducing death, for example, is carbon monoxide poisoning. This was the method personally chosen by Adolf Hitler at the outset of the Nazi euthanasia program on the advice of his medical advisor, Werner Heyde. Heyde conducted an experiment in 1940 on various ways to kill people and concluded that carbon monoxide gassing was the most humane.[18] Even though it was difficult to see gas poisoning as a medical act, the Nazi physicians nonetheless persisted in stressing that "only doctors should carry out the gassing."[18] It is remarkable how much commentary has been devoted to Kevorkian's suicide machine and how little to his much more frequent use of carbon monoxide gas. There is nothing medical about the latter method, which has no legitimate medical use; nonetheless, some of us seem to accept the idea, as did the Germans, that if a physician performs the act, it must be "medical," and if it is medical, it must be acceptable.

For similar reasons, state-ordered executions in the United States are moving from the gas chamber to lethal injection. Medical organizations throughout the world have quite properly declared that the participation of physicians in executions is unethical.[19] The primary reason is that physicians should not permit their caring profession to be subverted for the nonbeneficent goals of the state. The medicalization of executions makes them appear more humane and thus much more acceptable to society.

The same may be said about assisted suicide. If suicide is assisted by a physician instead of a relative or friend (even using poison gas), society is much more likely to see this assistance as acceptable, even expected. Although proponents currently insist on contemporaneous, competent, voluntary, and informed consent, the terms "physician-assisted suicide" and "euthanasia" are already being used almost interchangeably.[2,10,15] This linkage indicates that it will be as difficult to retain personal consent at the time of death as a prerequisite to physician-assisted death in the United States as it has proved to be in the Netherlands, where almost half of all lethal injections given to incompetent patients are given in cases in which the patient has never expressed a wish for euthanasia.[20] When we decide to rely on substituted judgment, our own definition of another person's best interests, or proxy consent, we quickly move from assisted suicide to direct killing by physicians.[21]

The Challenge for Physicians

The Michigan Medical Society took no position on Michigan's temporary law. As an organization represented on the commission charged with recommending new legislation, it will have to take a position. My own view is that the medical society would do well to support the retention of the law (at least as long as Kevorkian stays in Michigan), although with an amendment that makes it clearer that a physician who writes a prescription for potentially lethal medication for a legitimate medical purpose does not commit an illegal act.[13]

Michigan had to stop Kevorkian. But stopping one aberrant physician is not what the debate over physician-assisted suicide is about. Kevorkian is a symptom

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of a medical care system gone seriously wrong at the end of life. Dying continues to be treated as an "offense against nature,"[1] even though it is as integral a part of nature as birth and life itself.

Kevorkian says, in effect, that medicine cannot change and that society must therefore accept his methods as a reasonable alternative. The Michigan legislature has properly rejected his approach. But the real issues are related to medical practice, not the law, and the challenge Kevorkian presents to modern medicine is real. Physicians must respond by listening to their dying patients, comforting them, providing them with continuity of care and freedom from pain and suffering (even to the extent of prescribing drugs they might use to end their own lives), and bringing hospice care into mainstream medicine. If physicians fail to meet this challenge, society will ultimately embrace the solution that Kevorkian offers by medicalizing suicide the way we have already medicalized death.

References

1. Thomas L. Dying as failure. Ann Am Acad Polit Soc Sci 1980;447:1-4.
2. Cassel CK, Meier DE. Morals and moralism in the debate over euthanasia and assisted suicide. N Engl J Med 1990;323:750-2.
3. Solomon MZ, O'Donnell L, Jennings B, et al. Decisions near the end of life: professional views on life-sustaining treatments. Am J Public Health 1993;83:14-23.
4. Kevorkian J. Prescription: medicide. Buffalo, N.Y.: Prometheus Books, 1991.
5. People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920).
6. People v. Campbell, 335 N.W.2d 27 (Mich. App. 1983).
7. Annas GJ. Killing machines. Hastings Cent Rep 1991;21(2):33-5.
8. *Idem.* Standard of care: the law of American bioethics. New York: Oxford University Press, 1993.
9. Mich. Compiled Laws, sec. 752.1027 (Public Act 3 of 1993).
10. Kamisar Y. Are laws against assisted suicide constitutional? Hastings Cent Rep 1993;23(3):32-41.
11. Quill TE. Death and dignity — a case of individualized decision making. N Engl J Med 1991;324:691-4.
12. *Idem.* Death and dignity: making choices and taking charge. New York: W.W. Norton, 1993.
13. Prescribing practices policy and guidelines. Boston: Board of Registration in Medicine, Commonwealth of Massachusetts, August 1, 1989.
14. Gianelli D. Dr. Kevorkian takes case to Mich. society. American Medical News. October 5, 1992:37.
15. Council on Ethical and Judicial Affairs, American Medical Association. Decisions near the end of life. JAMA 1992;267:2229-33.
16. It's over, Debbie. JAMA 1988;259:272.
17. Foderaro LW. New York will not discipline doctor for his role in suicide. New York Times. August 17, 1991:25.
18. Lifton RJ. The Nazi doctors: medical killing and the psychology of genocide. New York: Basic Books, 1986.
19. Doctors and death row. Lancet 1993;341:209-10.
20. van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. Lancet 1991;338:669-74.
21. Smith GP. All's well that ends well: toward a policy of assisted rational suicide or merely enlightened self-determination? Univ Calif Davis Law Rev 1989;22:275-419.

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Abstracts are being accepted for the "Annual Meeting of the International Society for the Study of the Lumbar Spine," to be held in Seattle, June 21–25, 1994. Deadline for submission is Nov. 15.

Contact ISSLS, Sunnybrook Medical Ctr., Rm. A 309, 2075 Bayview Ave., Toronto, ON M4N 3M5, Canada; or call (416) 480-4833.

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Contact Dr. Josip Hendekovic, ESF, 1 quai Lezay-Marnésia, 67080 Strasbourg Cedex, France; or call (33) 88 76-71-35.

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