Gerald Faverman, Ph.D. • *Chairman of the Board*
Robert J. Kleine • *Editor*
April 3, 1992

Public Sector Reports

PUBLIC POLICY ADVISOR

Assisted Suicide

by Frances L. Faverman

Every two years Public Sector Consultants publishes Michigan in Brief: An Issues Handbook. *The 1992–93 edition is in preparation and will be available in September. Although the book contains a considerable amount of information about the state's political and economic history, the branches of state government, the state budget process, and regional and statewide demographic and economic information, its principal focus is an objective discussion of the public policy issues currently or anticipated to be highly visible.*

The upcoming edition of Michigan in Brief *will feature discussion of some seventy current issues: One is assisted suicide. Because this subject is much in the news right now and is receiving considerable legislative attention, we think our readers will be interested in this preview of the book's section on this particular topic.*

BACKGROUND

Assisted suicide became a widely debated topic in Michigan when a physician assisted the suicide of Janet Atkins in June 1990. The participation of Dr. Jack Kevorkian, a pathologist from Royal Oak, and his subsequent arrest on murder charges brought the issue to the forefront of public consciousness and galvanized opinion.

To better understand this issue, some definitions are in order. The following are set forth by the Council on Ethical and Judicial Affairs of the American Medical Association: *Euthanasia* is "the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy. . . . The term [signifies] the medical administration of a lethal agent to a patient for the purpose of relieving the patient's intolerable and incurable suffering"; *voluntary euthanasia* is "euthanasia . . . provided to a competent person upon his or her informed request"; *nonvoluntary euthanasia* is "the provision of euthanasia to an incompetent person according to a surrogate's decision"; *assisted suicide* occurs when a physician provides the means or information to enable the patient to perform his or her own life-ending act. The principal difference between euthanasia and assisted suicide, maintains the council, is the degree of physician participation.

Another distinction to keep in mind is the difference between the various forms of euthanasia and the *right to die*. The right to die depends upon a patient's decision to refuse a medical treatment and does not involve physician participation beyond agreeing to the patient's wishes, whereas all forms of euthanasia involve physician participation in administering a lethal drug.

Nowhere in the world is euthanasia currently endorsed by specific statute. Nevertheless, since 1984 physicians in the Netherlands have not been prosecuted for administering euthanasia to patients who meet specific criteria: (1) the patient explicitly and repeatedly requests euthanasia; (2) there is no doubt that the patient wishes to die; (3) there is no prospect of relief for the patient's physical and mental suffering; (4) all the alternative medical care options have been tried or refused by the patient; and (5) the patient's doctor has

Public Sector Consultants, Inc.
Knapp's Centre • 300 S. Washington Sq. • Suite 401
Lansing, MI 48933-2134 • (517) 484-4954

consulted with another physician. An estimated five thousand to ten thousand patients undergo euthanasia each year in the Netherlands.

Although assisted suicide is a crime in approximately thirty states and territories of the United States, there is virtually no reliable information about the extent to which it is practiced. A 1986 *Columbia Law Review* article indicates that the frequency of assisted suicide appears to be increasing but under secrecy and concealment so that those involved do not face criminal liability for their assistance. Colorado and Indiana have statutes specifically declaring assisted suicide to be a unique offense; in several other states persons may face prosecution on charges ranging from facilitating the act (as did Dr. Kevorkian) to manslaughter to first-degree murder. In Michigan there is no statute governing assisted suicide; the one case prosecuted (in 1991) was pressed under the state's second-degree murder law, and the defendant (Bernard Harper) was acquitted.[1]

Several pieces of legislation dealing with assisted suicide and related issues currently are pending in Michigan. Senate Bills 31–32, introduced by Frederick Dillingham (R-Fowlerville) and others, would deem assisted suicide a felony punishable by a maximum prison term of four years and fine of $2,000, or both, and hold as attempted murder any act that intentionally or knowingly causes through force or duress a person to attempt or to commit suicide. The bills also specify that the following are *not* assistance to suicide unless done with the intention of causing death: (1) withdrawing or withholding medical treatment in response to the request of a competent adult or the adult's designee and (2) administering medications or performing procedures that may cause or increase the patient's risk of death. SBs 31–32, which are identical to HBs 4039 and 4038, introduced by Nick Ciaramitaro (D-Roseville), have passed the Senate and are in the House Committee on Judiciary. The House bills also are in this committee.

Another bill, HB 5415, introduced by Representative Ted Wallace (D-Detroit), would allow a patient to request *aid in dying*. This legislation, currently in the House Committee on Judiciary, prescribes the circumstances under which a patient could request such aid, specifies several conditions that must be met before the aid may be granted, requires the procedure to be videotaped, and requires that on the November 1992 general election ballot there be a proposal to adopt a Death with Dignity Act.

Still another approach is reflected in identical bills—HB 4501 introduced by Representative Thomas G. Power (R-Traverse City) and others, and SB 149, introduced by Senator David Honigman (R-West Bloomfield) and others. An eighteen-member commission on death and dying would be created and have two years to study the issue and forward recommendations to the legislature. Among the several matters the commission would address are (1) current data on suicide in Michigan; (2) causes of suicide, including the role of alcohol and other drugs, age, disease, and disability; (3) current state law regarding suicide, including the status of persons who assist; and (4) current law in other states and the effect on suicide rates. Both bills, introduced in 1991, are in committee in their respective houses (HB 4501 in the Committee on Judiciary and SB 149 in the Committee on Family Law, Criminal Law, and Corrections).

Finally, a special House Subcommittee on Death and Dying, appointed in 1991 by the chairman of the House Committee on Judiciary and chaired by Representative H. Lynn Jondahl (D-Okemos), is holding public hearings and is scheduled to report in late spring.

---

1 Judge James Sheehy, Oakland County Circuit Court, ruled that Dr. Kevorkian should be bound over for trial on charges filed by the Oakland County prosecutor, Richard Thompson. This case involves his participation in the assisted suicide of Margery Wantz and Sherry Miller on October 23, 1991. The judge's ruling is being appealed by attorneys for Dr. Kevorkian. At this time no trial date has been set.

VIEWPOINTS

Historically, attitudes toward suicide in Western culture have ranged from the view expressed by Seneca (4 BC?–65 AD), the Roman Stoic, philosopher, and tutor to Nero, who said, "As I choose the ship in which I sail, and the house I will inhabit, so I will choose the death by which I will leave life," to that expressed by William Blackstone, the great English jurist, when he explained that the reason a suicide's body was dishonored by being buried in an unmarked grave at a crossroads at midnight and the person's lands and goods were forfeited to the king was because by committing suicide the person had deprived the king of a subject. Exceptions to this principle of English common law were "weariness of life or impatience of pain"; then only the person's goods were forfeit. Seneca's statement may be said to represent fairly the view that one's life belongs inalienably to one's self, and it is entirely within the legitimate exercise of individual autonomy to accept the responsibility for ending it. Blackstone's famous *Commentaries* express the view that the individual's life is of paramount importance and that the state is justified in deterring the act of suicide through penalties designed to strike terror into the hearts of individuals; in short, he believed that suicide is as much an act of harm toward the state as is treason.

Today, in the United States attempting or committing suicide is not a crime in any state. But the picture is very different regarding assisting someone else's suicide; some people say that the current debate about assisted suicide reflects the social and ethical confusion surrounding the entire discussion of the end of life. With the exception of the states of Washington (where voters defeated a referendum on the question of permitting physician-assisted suicide by 56 to 44 percent) and California (where a petition drive to put approval of death with dignity legislation on the ballot in 1990 failed to gather enough signatures) there probably is no state where the debate is more intense than in Michigan.

Polls in February 1992 by the *Detroit Free Press* show that a majority (58 percent) of those queried favor permitting physician-assisted suicide and have no problems with the actions of Dr. Kevorkian, who assisted two women in their suicides in October. Support for assisted suicide is strongest among the elderly and persons with a terminal illness.

Many of the arguments in support of or opposition to assisted suicide are the same as those for and against legalized euthanasia. Supporters maintain that patients whose conditions cause them unbearable suffering should have the option of ending their distress, and the right of a patient to control medical treatment includes the right to request and receive help in ending one's life.

Opponents argue that unbearable pain and suffering are more a function of medical mismanagement of pain than of the disease process; they particularly target unwarranted physician concern that patients will become addicted to pain-killing drugs and the failure of some physicians to take advantage of the most modern techniques available to control pain. Opponents also maintain that the issue of the patient's right to control treatment does not include the right to demand that one's physician actively participate in ending one's life.

Furthermore, opponents insist that there are significant social issues to be considered. For example, they fear that poor, minority, or unsophisticated patients could be encouraged to request assisted suicide in the name of cost benefits and on the ground that their lives have minimal social value. Opponents also point out that persons with an interest in another's death could unduly pressure the patient (or encourage the patient's caretakers to exert pressure) to consider suicide as the only option or perhaps as the patient's "duty" so as to spare the family additional anguish and financial strain. Moreover, opponents maintain that permitting physicians to assist suicide also could cause patients to fear that their physician might not do his or her best for the patient. (Supporters contend that safeguards against improprieties can be built into legislation permitting assisted suicide.) Finally, opponents argue that requiring a physician to accede to a patient's demand for aid in dying goes against twenty-five hundred years of medical history and practice, particularly the Hippocratic oath.

The enormous popularity of the book, *Final Exit*, by Derek Humphry, founder of the Hemlock Society, suggests that people want to be able to control the ending of their lives. Nevertheless, the society, while

endorsing suicide as a legitimate choice for individuals in certain situations, does not support the activities of Dr. Kevorkian, the most outspoken proponent of physician involvement in assisted suicide in Michigan.

A further complication in the debate about assisted suicide in Michigan is the question of to whom such an option should be made available. House Bill 5415 would restrict aid in dying to mentally competent persons aged 18 or older. House Bill 4391 would give *living wills* stature in law, allowing a person to direct whether life-support procedures should be withheld, withdrawn, or continued in the event of terminal illness or a persistent vegetative state. Current law allows a patient to appoint another person to make decisions about the patient's medical treatment (the authority is vested in the *durable power of attorney for health care*) when or if the patient becomes incapable of making such decisions. A new question then arises: Should the surrogate be able to make a decision for assisted suicide for someone or should this option be available only to persons able to make their own decisions?

A third question deals with the nature of a person's illness. Medical ethicists are divided in their opinion about the Wantz and Miller cases in Michigan. In one the patient chose physician-assisted suicide because of intractable pain, but in the opinion of her physicians, she did not have a terminal illness; in fact, a medical examiner opined that she did not even have intractable pain. 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 when someone's pain or quality of life has become unbearable? Physicians? Patients? Courts? Ethicists? Politicians? Clergy?

Religious organizations differ in their view of assisted suicide. The Michigan Catholic Conference is on record as opposing it. A consortium of Jewish and Christian theological scholars recently declared that if the right to request assistance in ending one's life is grounded in respect for the autonomy of the individual, then there is no basis for limiting its exercise to those certified as terminally ill and mentally competent, for to deny anyone the right to exercise autonomy is illogical. It also is their view that the state, except when exercising power to protect its citizens and to punish evildoers, cannot assume ultimate power over human life, for to do so would be to fail to respect the right to life from which human beings cannot be separated.

The Michigan Hospice Organization does not view assisted suicide as a part of hospice care. (Hospice care is devoted to enabling the patient to die in comfort and dignity; hospice assists terminally ill patients with pain control and provides them and their families with support services. The association is aware, however, of the potential for conflict between provisions of the assisted suicide bills and current law allowing patients to decline or discontinue medical treatment. Right to Life of Michigan and the National Council for the Rights of the Disabled oppose assisted suicide. In a statement adopted by its board of directors in September 1990, the Michigan State Medical Society went on record as opposing euthanasia while indicating that "assisted suicide represents a moral gray zone." The society urged physicians to become more aware of patient concerns and to address the issue of humane and compassionate care for the dying.

Proponents of assisted suicide fear that legislation such as SBs 31–32 would go too far in the direction of limiting individual rights; the bills appear to be so broadly written that acts that many would see as compassionate could become grounds for being charged with a felony should a rigorous prosecutor happen to become aware of the situation. For example, a husband who leaves a bottle of pain pills within reach of his terminally ill wife of many years and who then leaves the room for a few minutes could be charged with a felony for aiding her in attempting to commit suicide if she were to take several pills; to avoid a charge of attempted murder under the provisions of SBs 31–32, he would have to provide clear and convincing evidence of knowledge of his wife's intent to commit suicide.

Proponents of the legislation to create a commission on death and dying feel that more time is needed to study the issue and to resolve conflicts between legislation to regulate assisted suicide and existing law governing the right to die.

It is clear that the question of assisted suicide—when placed in the context of the rights of individuals, the duty of the state to protect its citizens, the beliefs of individuals and groups about the sanctity of human life, the principles held by health care providers about their duty to care for their patients, and the opinions of individuals about how they want their lives to end—is extremely complex. It will not be easily resolved, and it will not go away.

Frances L. Faverman is a Senior Consultant for Health Policy at Public Sector Consultants. She is editor of the Health Policy Bulletin, *a researcher/writer for the Health Legislation Analysis Service, and follows state and federal developments on health policy issues. She is a graduate of Boston University and has done graduate work at Michigan State University. She recently was appointed to the Medical Rehabilitation Center Advisory Council of the Mid Michigan Rehabilitation Institute.*

PUBLIC SECTOR CONSULTANTS publishes **Public Sector Reports** and the **Health Legislation Analysis Service**, which includes the ***Health Policy Bulletin*** and the ***Health Care Legislation Abstracts***; offers strategic and tactical counsel and issue management for retainer clients; undertakes specialized research studies; provides public relations and meeting and conferences planning services; and, through its textbook division, produces research and reference works, including ***Michigan in Brief: An Issues Handbook*** and ***The Michigan Government Directory***.