
Volume 1

Issue 3 *Spring 1997: Symposium - Physician-Assisted
Suicide*

Article 5

Physician-Assisted Suicide: Misconceptions and Implications From a Physician's Perspective

Cory Franklin M.D.

Follow this and additional works at: <https://via.library.depaul.edu/jhcl>

Recommended Citation

Cory Franklin M.D., *Physician-Assisted Suicide: Misconceptions and Implications From a Physician's Perspective*, 1 DePaul J. Health Care L. 579 (1997)

Available at: <https://via.library.depaul.edu/jhcl/vol1/iss3/5>

This Article is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Journal of Health Care Law by an authorized editor of Via Sapientiae. For more information, please contact wsulliv6@depaul.edu, c.mcclure@depaul.edu.

PHYSICIAN-ASSISTED SUICIDE: MISCONCEPTIONS AND IMPLICATIONS FROM A PHYSICIAN'S PERSPECTIVE

*Cory Franklin, M.D.**

INTRODUCTION

Within the past twenty years, physician-assisted suicide (PAS) has evolved from a fringe debate among a radical few, to a major topic of consciousness among Americans. Evidence of this change is visible from the growing media attention regarding the benefits and consequences of PAS, as well as the willingness of a significant portion of the voting public to accept the concept as a ballot issue.¹ Further evidence of this change is the decision by the United States Supreme Court on PAS cases from the states of Washington and New York, as well as the Court's tacit acceptance of an Oregon statute authorizing physician-assisted suicide.² Despite the Court's decision, PAS and its relation to patient autonomy, just as abortion and its relation to privacy, is an issue that will continue to be debated in the near future.³

*Director, Division of Critical Care Medicine, Cook County Hospital; Professor of Medicine, Finch University of Health Sciences/The Chicago Medical School. B.S., Northwestern University, 1973; M.D., Northwestern University, 1977.

¹In the last five years, referenda in Washington and California were narrowly defeated before voters accepted a similar referendum in Oregon in 1994.

²*Compassion in Dying v. State of Washington*, 79 F. 3d 790 (9th Cir. 1996) (en banc) *rev'd sub nom* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (considering RCW 9A.36.060 (West 1991)); *Quill v. Vacco*, 80 F. 3d 716 (2nd Cir. 1996) *rev'd* 117 S. Ct. 2293 (1997) (considering N.Y. PENAL § 125.15 (Consol. 1967)); rejecting the review of OR. REV. STAT. 127.800-995 (1995).

³Janet Firshein, *U.S. Supreme Court Rules Against Physician-Assisted Suicide*, 350 LANCET 40 (1997) ("...the moral question of physician-assisted suicide has not been put to rest. The justices made clear that states have the right to ban assisted suicide, but they also left open the possibility that states may legalize the practice if they wish").

The dramatic change in the willingness of the populace to reassess PAS is the result of a number of developments.⁴ Perhaps least obvious, yet important, is the growing secularization of American society since World War II, which has reduced the religious stigma attached to suicide. For centuries in Europe and North America, suicide was regarded as a sinful, and even criminal act against the state. In fact, in 1816, a United States Supreme Court Justice described how the English system buried the body of a suicide victim in infamy and forfeited his property to the Crown. In the latter half of the twentieth century, the waning influence of religion on society's consideration of suicide has led to destigmatization of the act. Today, when the suicide of a prominent individual is publicized, it is likely to be reported in the context of a medical problem, such as depression or stress.⁵

For some libertarians, suicide has been hailed as the ultimate expression of individuality. This is best exemplified by The Hemlock Society, an organization that supports the individual's right to suicide and has seen a remarkable increase in its membership in the last decade, reflecting in large part, to the writings of its founder, Derek Humphry. In 1991, Humphry's book, *FINAL EXIT*, rose to number one on the *New York Times* best-seller list for hardcover advice books and remained there for four months, eventually selling over 500,000 copies.

Even as suicide became destigmatized in the lay community, the medical community played a prominent role in the reconsideration of physician involvement in PAS.⁶ Over the past decade, several prominent medical journals have published articles by leading physician-ethicists who support PAS, a development which would have been unexpected two

⁴See A. ALVAREZ, *THE SAVAGE GOD: A STUDY OF SUICIDE* (1971).

⁵*Troubling Death Brings Plea for Respect, Not Sensation* read a N.Y. TIMES headline after the suicide of a prominent author.

⁶See generally, *Task Force on Physician-Assisted Suicide of the Society for Health and Human Values, Physician-Assisted Suicide: Toward a Comprehensive Understanding*, 70 ACAD. MED. 583, 583-590 (1995); Marcia Angell, *The Supreme Court and Physician-Assisted Suicide -- The Ultimate Right*, 336 NEW ENG. J. MED. 50, 50-53 (1997); Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 NEW ENG. J. MED. 54, 54-58 (1997).

decades ago.⁷ Coinciding with the development of prominent physicians publicly supporting changes in the law, recent surveys have suggested that rank and file nurses and physicians have increasingly accepted "pro" PAS approaches.⁸

With the continuing public attention on this issue, it is difficult to determine whether the attitude of medical professionals influences society or if medical attitudes are simply a reflection of a changing society. This question is difficult to answer. Nevertheless, the extent of this dramatic shift in professional opinion should not be underestimated. With these thoughts in mind, the experience of the Netherlands, where PAS has been decriminalized, is instructive.⁹ In the 1970s, half of the Dutch physicians polled believed physicians should not administer lethal injections.¹⁰ A quarter of a century later, a study showed nearly 9 percent were against euthanasia; when polled regarding whether their views had changed during the course of their careers, 61 percent indicated they had changed their views, most becoming less opposed to euthanasia.¹¹

Another development in the increasing acceptance of PAS has been the well-publicized experience of Dr. Jack Kevorkian, a retired pathologist acquitted three times in the last five years on charges of assisted suicide in Michigan.¹² The media has extensively covered his trials and his admitted involvement in at least forty-five physician-assisted suicides.¹³ Kevorkian and his attorney, Geoffrey Feiger, have used this prominent media attention to promulgate their pro-PAS position.¹⁴

⁷Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 119, 119-122 (1994); Timothy E. Quill et al., *Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1380-1384 (1996).

⁸Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303, 303-309 (1996); D. A. Ash, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 NEW ENG. J. MED. 1374, 1374-1379 (1996).

⁹Paul J. van der Mass et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669, 669-674 (1991).

¹⁰*Id.*

¹¹*Id.*

¹²*Patient of Kevorkian is Found Dead in a Motel*, N.Y. TIMES, Oct. 10, 1997, at A19.

¹³*Kevorkian Lawyer Hired in Death Case*, N.Y. TIMES, June 28, 1997, at § 1, at 10.

¹⁴Rogers Worthington, *Suicide Doctor Finally to Have Day in Court*, CHI. TRIB., Aug. 18, 1993, at 2.

Much of the public exposure to PAS is based on the media reports of Kevorkian, the Hemlock Society, and the Dutch experience. Unfortunately, when the media informs the public, certain misconceptions about PAS are advanced. This article discusses and analyzes the most common misconceptions of PAS which are:

- (1) intractable pain is the primary motivating reason why people request PAS;
- (2) only few people will actually have the PAS option; and
- (3) PAS can be easily regulated.

After examining these misconceptions more thoroughly, this article will conclude with a physician's perspective on the future of PAS.

MISCONCEPTION ONE: INTRACTABLE PAIN IS THE PRIMARY MOTIVATING FORCE FOR PEOPLE TO REQUEST PAS

Most examples of patients requesting PAS portray a patient with unremitting pain. There is little doubt that the medical community has had a long history of under treating the pain of terminally ill patients.¹⁵ Yet, in the context of PAS, a patient whose pain cannot be treated is the exception rather than the rule.¹⁶ Experience with PAS in the Netherlands indicates that pain was the sole reason for requesting euthanasia in only five percent of cases, while the most common reason (57 percent) for requesting PAS in the Netherlands was the loss of dignity.¹⁷ Of those patients requesting PAS, 85 percent withdrew their requests after receiving adequate symptom control.¹⁸ Likewise, a significant number of Kevorkian's patients who suffered from debilitating symptoms did not suffer intractable pain. In

¹⁵Edward N. Brandt, Jr., M.D., Ph.D, *Relief of Pain, the Physician's Formidable Challenge*, 98 PUB. HEALTH REP. 201, 201-202 (May/June 1983).

¹⁶Transcript of the Report of the Council on Ethical and Judicial Affairs of the American Medical Association, 10 ISSUES L. & MED. 91 (1994).

¹⁷Margaret A. Somerville, *The Song of Death: The Lyrics of Euthanasia*, 9 J. CONTEMP. HEALTH L. & POL'Y 1, 28 (Spring 1993).

¹⁸*Id.*

1996, Kevorkian's last acquittal came despite his own testimony that he did not mean to kill one of his patients, but rather, merely desired to relieve her suffering.¹⁹ This assertion came in the face of undisputed testimony that his method was to have the patient breathe carbon monoxide, an agent with no analgesic or therapeutic properties and only one possible result, death.²⁰

Most of the public is unaware of the major medical advances made over the past twenty years in the area of patient pain control. In some respects, no area of medicine, with the possible exceptions of genetics and transplantation, has experienced greater progress. Pain control is now part of many specialties including anesthesia, neurology, oncology, and geriatrics. Past concerns over respiratory depression resulting from pain medication have been nearly eliminated, thereby altering arguments concerning assisted suicide and the doctrine of "double effect." Experts in pain control currently indicate that 95 percent of patients with intractable pain can experience relief without intolerable sedation.²¹ While this still presents a moral dilemma for the five percent who cannot obtain relief, the statistics, nevertheless, suggest most patients with intractable pain need not resort to suicide.²²

MISCONCEPTION TWO: ASSISTED SUICIDE WILL ONLY BE AN OPTION FOR A SMALL NUMBER OF PATIENTS

The Dutch, like many proponents of PAS, view the procedure as being appropriate for only a small number of patients, and therefore, fears of abuse are overblown. The analysis of PAS in the Netherlands indicates 2.1 percent of all deaths were associated with physician intervention.²³

¹⁹Kevorkian, *Exploiting Exemption in Suicide Law, Testifies on the Pain that His Efforts End*, N.Y. TIMES, Mar. 2, 1996, at § 1, at 20.

²⁰Id.; Rogers Worthington, *Mercy Motivated Me, Kevorkian Tells Court*, CHL TRIB., Apr. 28, 1994, at 3.

²¹Pain, MED. & HEALTH (Faulkner & Gray, Inc.), Oct. 21, 1996, at 41.

²²Foley, *supra* note 6; see, e.g., Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. PAIN SYMPTOM MGT. 289, 289-297 (1991).

²³*Euthanasia Bill Narrowly Clears Dutch Parliament*, CHL TRIB., Dec. 1, 1993, at 6.

Applying this percentage to the number of deaths in the United States, approximately 50,000 deaths per year would be assisted by a physician, a number greater than the total deaths resulting from motor vehicle accidents per year. The experience of Kevorkian supports this extrapolation because Kevorkian himself admitted intervention in at least forty-five physician-assisted suicides, a significant number for a single physician in less than a decade. No doubt, Kevorkian would counter by saying his experience is so extensive because he is the only practitioner willing to perform PAS. Yet, if one considers the large number of requests Kevorkian declines, it seems reasonable that the number of patients who desire PAS in the United States may exceed ten thousand.

MISCONCEPTION THREE: PAS CAN BE EASILY REGULATED

One of the most compelling arguments against PAS is the irreversible abuses which can occur. The New York Court of Appeals, while recognizing this argument, nonetheless countered the objection by stating governmental regulations can adequately minimize the possibility of abuse.²⁴ Physicians in favor of PAS often refer to establishing a comprehensive system of documentation, reporting, and reviewing PAS deaths. However, despite the fact any such system would insert government regulation into the process, a notion Kevorkian and his supporters vehemently oppose there are a number of theoretical and practical problems with any physician-controlled system.

According to proponents of PAS, the two criteria a patient should satisfy are: the patient must have a terminal illness, and be depressed. Yet, in the Netherlands and the Kevorkian trials, patients frequently met neither criteria for terminal illness.²⁵ Similar problems arise when consulting requirements are imposed to rule out depression because the diagnosis is a subjective one which can rarely be made according to definite standards. There is little doubt an expert opinion will conform to any patient's desires.

²⁴Washington v. Glucksberg, 1997 U.S. LEXIS 4039, 4049; 117 S. Ct. 2258 (1997).

²⁵*All Things Considered: Kevorkian Returns to Courtroom for Defense Testimony* (National Public Radio broadcast, April 24, 1996); Thomas Maier, *Autopsies Challenge Mission of Kevorkian*, THE TIMES UNION, Sept. 12, 1996, at A1.

This truism has the inevitable effect of rendering consultation requirements a meaningless *pro forma* exercise since the patient and physician will generally select the consultant. Indeed, one of the telling moments of the final Kevorkian trial occurred when psychiatrists for both parties looked at identical facts and argued diametrically opposite conclusions on whether the patient was clinically depressed.²⁶

Similarly, reporting requirements mandated by law would be little more than a bureaucratic exercise. Although all physician-assisted suicides are subject to a reporting requirement in the Netherlands, a recent study indicated fewer than half were actually recorded.²⁷ The study further indicated that prosecution and punishment were essentially absent for failure to record or report irregularities.²⁸ It should be noted, although most physician proposals to decriminalize PAS in the United States include reporting requirements, none of the proposals currently proffered suggest appropriate penalties if guidelines are violated. Since the likelihood of conviction for PAS is small, even though the practice is illegal, it would be hard to imagine if the practice was decriminalized that anyone would be sanctioned for simply not reporting. Essentially, if PAS was legalized, many of the purported safeguards could be skirted.

**MISCONCEPTION FOUR:
THE 1990 UNITED STATES SUPREME COURT
DECISION IN THE CASE OF NANCY CRUZAN
SUPPORTED THE RIGHT TO DIE**

A landmark in American bioethics was the decision in *Cruzan v. Director of Missouri Department of Health*.²⁹ *Cruzan* was the first case involving the termination of nutrition and hydration to reach the United States Supreme Court. Since *Cruzan* was ultimately allowed to die by removing

²⁶*Id.*

²⁷Gerrit van der Wall et al., *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 NEW ENGL. J. MED. 1706, 1706-1710 (1996).

²⁸*Id.*

²⁹*Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 110 S. Ct. 2841 (1990).

her feeding tube, the *Cruzan* decision has been frequently cited in support of a patient's right to die.³⁰

The majority in *Cruzan* specifically declined to address certain issues concerning the right to die, and instead, chose only to rule on the narrow issue of whether a state could restrict life-ending decisions. While the *Cruzan* decision left open the option for patients to refuse hydration and nutrition,³¹ and granted states latitude making their own rules, the Court remained silent on whether the patient could die by lethal injection rather than die inevitably over several days.³² Because of the finality of the Act and the certainty of death once feeding and hydration are terminated, obvious tensions arise when considering hastening death. Any legal prohibition must be based on ethical primacy rather than practical concerns.

In 1993, England's Law Lords ruled on a case similar to *Cruzan* and recognized that the refusal of hydration and nutrition implicated the question of lethal injection.³³ In contrast to the United States Supreme Court, the British Court deliberately rejected euthanasia as a solution.³⁴

MISCONCEPTION FIVE: KEVORKIAN IS THE WRONG PERSON FOR THE RIGHT CAUSE

Ironically, many in the PAS movement and most of the academic medical community have shunned Kevorkian, viewing him as the wrong man for the right cause.³⁵ Kevorkian, exacerbating his situation by wearing

³⁰Compassion in Dying v. Washington, 79 F.3d 790, 813 (1996) (en banc) *rev'd sub nom* Washington v. Glucksberg, 117 S. Ct. 2258 (1997) (considering RCW 9A.36.050 (West 1991)).

³¹*Cruzan*, 497 U.S. at 288.

³²*Id.* at 292.

³³See also *Euthanasia in Britain; Report of House of Lords Select Committee on Medical Ethics*, 25 HASTINGS CENTER REP. 51 (1995); C. Franklin, *Elm Road and Hillsborough: Tragedy, the Law and Medicine*, 19 INTENSIVE CARE MED. 307, 307-308 (1993).

³⁴*Euthanasia in Britain*, *supra* note 33.

³⁵Alan A. Stone, *Physician-Assisted Suicide and Psychiatric Profession*, 13 HARVARD MENTAL HEALTH LETTER 4 (Jan. 1997).

outrageous colonial costumes to the courtroom, directed several defiant outbursts at the judge and prosecutor.³⁶

Kevorkian's career before the PAS controversy is charitably characterized as undistinguished. Most of his writings were rejected by mainstream medical journals; however, his penchant for tweaking authority and lust for publicity were suddenly successful in landing him on the front pages of national magazines and newspapers. While Kevorkian detractors such as Timothy Quill speak on the purity of the patient-physician relationship, Kevorkian demonstrates how a physician's ulterior motives, in this case the desire for the public spotlight, may complicate the process of physician-assisted suicide and how these motives test the limitations of decriminalization.³⁷ However, this situation does not illustrate how Kevorkian is "the wrong man for the right cause," but rather, how he can easily be considered the "right man for the wrong cause." Quite simply, Kevorkian is the perfect illustration of a self-serving physician granted relative, yet erroneous, immunity.

CONCLUSION

These misconceptions should give pause to those who are undecided on whether to decriminalize PAS. In the final analysis, the question of PAS becomes an issue of patient autonomy. Proponents of the patient's unrestricted right to choose PAS, including such strange bed-fellows as Kevorkian and Quill, are ultimately undeterred by arguments concerning the abuse of the system or the possible corruption of professional ethics.³⁸ They argue that patient autonomy is sacrosanct and should not be violated, yet they do not consider the implications of this approach if PAS is legalized. If patient autonomy is the overriding principle, it is difficult to envision how we will be able to deny PAS to those who are neither sick, nor in physical pain. How will courts justify exempting the spurned eighteen-year-old, the executive who failed to obtain a job promotion, or

³⁶*Kevorkian Dresses as Jefferson at New Trial*, THE BOSTON GLOBE, Apr. 2, 1996, at National/Foreign, p.8.

³⁷Quill, *supra* note 7.

³⁸See generally, David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 NEW ENG. J. MED. 663, 663-667 (1996).

the housewife who lost the household savings at the casino if such "patients" deem it appropriate and request assistance from a physician?

Other questions must also be addressed. If PAS is decriminalized, it then becomes a time-consuming service for which physicians will inevitably charge. What will we do for those without insurance or the finances to afford the procedure? Will government funding be necessary to eliminate the possibility of a two-tiered system for PAS? Will physicians who perform PAS become paid agents of the government? The implications are obvious and quite extensive.

Indisputably, there are many difficult cases of terminally ill and near-death patients who request assistance from their physicians to die. Without question, care for the dying has not received the attention it deserves from the medical community, but this is slowly changing.

In most situations, physicians have a range of options for prescribing medications and obtaining referrals from those trained in caring for the terminally ill. There will always be some "gray zones" regarding how much help a physician can and should give to hasten the dying process. When attention is paid to the actual experiences of Kevorkian and the Dutch physicians, and when common misconceptions are clarified, it is clear the implications of decriminalizing PAS will reach far beyond those gray-zone cases and will inevitably have a profound effect on society. In areas of gray-zone behavior, where the effect on society can be portentous, the role of the law should be to establish a bright line. To adequately protect from abuses and establish this guiding bright line, PAS should not be decriminalized.