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Angels or Demons?

Dr. Kevorkian and Physician-Assisted Suicide

Physician-assisted suicide is a hotly debated topic in medical ethics, and very multi-faceted. Of primary interest are the concerns of the health care profession, but there are certainly social, political, economic, and religious concerns also. Dr. Jack Kevorkian and his case are a classic presentation of the “right to die” dilemma. Some people, patients and physicians alike, believe that in the face of a terminal or debilitating diagnosis, it is the prerogative of the affected to request a controlled, humane death. However, physicians take the Hippocratic Oath, binding them to the preservation of life. Physician-assisted suicide clearly breaks this promise and is, by definition, first-degree murder.

Dr. Jacob Kevorkian was a Michigan-based physician who, early in his career, earned the nickname “Dr. Death;” death intrigued him. Kevorkian first did research involving dying patients during his residency and then tried persistently to garner approval for live dissections on death-row inmates. His research was decidedly not conventional and most of his endeavors were rejected by his superiors in the medical community. A general disgust for the hypocrisy of the medical profession and society at large festered within Dr. Kevorkian for almost the entire duration of his career.

When his mother was diagnosed with, and subsequently died from, stomach cancer, Kevorkian realized his life's mission. The doctors' treatment of his mother infuriated him: they did everything in their power to keep her alive, despite the knowledge that she was essentially terminal. They refused to increase her morphine dosage to ease the pain and, in Jack Kevorkian's eyes, prolonged and exacerbated her suffering. Her death came as a relief to him. From that moment, he began seriously questioning medical ethics.

During the 1980's, there were around 10,000 cases of physician-administered euthanasia in The Netherlands each year. While illegal, it was a tolerated practice in general society (Nicol, 140). This was intriguing to Kevorkian, and he visited the country in 1986. Then, in 1989, he learned of a quadriplegic who had requested to be taken off of his respirator. Dr. Kevorkian visited David Rivlin to ask about his decision. Rivlin was tired of not being able to function on his own so he fought for a court order demanding that he be "unplugged." In his biography of Dr. Kevorkian, Neal Nichol states, "Jack thought that taking him off his respirator was a cruel way for him to die; he determined to find a better way to help people like Rivlin carry out their own wishes. What he came up with was a suicide machine" (143).

Nichol outlines mechanisms of the invention:

1. Dr Kevorkian would begin the saline IV drip.
2. The patient would flip a switch, which would do two things: First, it would start a solution of Seconal flowing, which would sedate the patient within 20 seconds, and second, it would start a winding process with the chain that acted as a timer. When the chain was fully wrapped around the mandrel, it would trigger the start of the flow of potassium chloride [to interrupt the body's electrical signals and stop the heart]. The patient was fully unconscious at this stage.

With the thanatron/mercitron [Kevorkian's name for the device], death would be fast, absolutely painless – and self-induced. (143-144)

Kevorkian did set up “parameters for use” of his machine, and any other methods of assisted suicide. Nicol summarizes that “the patient must be adamant, incurable, suffering and terminal... only a physician should be allowed to conduct this service, and it should be done free of charge” (145). Dr. Kevorkian did take into account ethical considerations in the use of his machine. He believed that patient autonomy should be the priority and that in preserving life at all costs, physicians were overriding that right. In order to control potential abuses of the system, Kevorkian also maintained that “medicide” should be a specialty, not a general practice by any physician, and that they doctor should be salaried to avoid any monetary motivation for performing a greater number of procedures.

His first “client” was a woman with Alzheimer's disease named Janet Adkins. He called the police after completing the procedure, was arrested, and then released. When the case became public, the Alzheimer's Association made the distinction between assisted suicide and treatment withdrawal: “When treatment is withheld or withdrawn, the intent is not to kill but to unburden the person from a technological assault on natural death... the refusal or withdrawal of any and all medical treatment is a moral and legal right for all competent Americans of age” (Nicol 153). This, to Kevorkian, was inhumane and much like the circumstance of David Rivlin, the patient who had originally started him on his quest. He didn't see the morality of a long and painful death when there were swifter, more comfortable options.

At the time of Kevorkian's first case, there was no law against assisted suicide. The first charges in June of 1990 were dropped. Before he was convicted of second-degree murder in March of 1999, Jack Kevorkian was tried for at least eight different cases, but never served more than 18 days in jail. His medical license was suspended in 1991 and then the American Medical Association declared him a danger to society, a temporary ban on assisted suicide in Michigan went into effect early in 1993, the Michigan Supreme Court upheld the law as constitutional, and CBS aired their special showing of his tape.

The tape was a recording of Jack Kevorkian's final act of assisted suicide. The patient was a man with Amyotrophic Lateral Sclerosis, or Lou Gehrig's disease. It is a "progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord" (ALS.org) and is incurable. The sufferer eventually dies of suffocation. Tom Youk was a 52-year-old man who had fought against ALS for two years and had finally reached a state of unbearable agony. He sought out Dr. Kevorkian as a last resort when his physicians couldn't, and wouldn't, do anything but treat for anxiety and pain management. Kevorkian agreed to help Youk, but there was one critical difference between this case and the doctor's previous clients: due to his extreme nervous dysfunction, Youk would not be able to "flip the switch." Instead, Kevorkian would be required to actually administer a lethal injection. Before his death, Youk consented to both his killing and the airing of the procedure, as Dr. Kevorkian specifically intended to make an example of Youk by nationally broadcasting the euthanasia.

At 70 years old and having assisted over 130 patients in suicides, Jack Kevorkian was incarcerated in a Michigan State prison with the sentence of 10 – 25 years. The trial

for Youk's murder had only lasted a day and a half and Kevorkian was his own representation (Nicol 218). In his statements he claimed that it was his duty as a physician to kill Tom Youk, he did not do it out of malicious intent; the CBS special was intended to make a dramatic case for euthanasia and bring it to the forefront of public awareness. Partially due to rapidly declining health, in 2007 Kevorkian was paroled "on a promise not to help anyone else commit suicide" (Hechtkopf).

"Dr. Death" truly believed in what he was doing: relieving suffering people of their otherwise inescapable pain. He published a book in 1991 titled *Prescription Medicide: The Goodness of Planned Death* and made numerous television appearances to talk publicize his ideas. Somewhat egotistically, he even compared himself to Mahatma Gandhi, Martin Luther King, Jr., and Albert Einstein (Pence 98). Kevorkian accepted no payment for his services, negating any economic motivation.

While a large majority of the medical community at the time rejected Kevorkian's ideas and he was banned from practicing medicine in both Michigan and California, the doctor did garner support from some groups both within and outside of the healthcare profession. The Physicians for Mercy publicly supported him, beginning in 1995. Also around this time, the Movement to Ensure the Right to Choose for Yourself (MERCY) petitioned Michigan courts for a constitutional amendment: "The right of competent adults, who are incapacitated by incurable medical conditions, to voluntarily request and receive medical assistance with respect to whether or not their lives continue, shall not be restrained or abridged (Nicol 196)." Some Presbyterian and Unitarian churches supported Kevorkian's actions as well. In April of 2000, while still serving his sentence, he was

awarded the Gleitsman Foundation Citizen Activist Award for his work against social injustice.

Family members of the deceased were not forgotten. Jack Kevorkian actually arranged a meeting of some of his clients' relatives, who formed close ties and called themselves "The Survivors" (Nicol 178). They all supported each other in the time period immediately following the assisted suicide. Comfort for them came in the knowledge that they had helped a loved one end his or her suffering. For many people, pursuing a quick and pain-free death in the face of terminal illness was much easier to cope with than watching a spouse, sibling, parent, child, or friend slowly deteriorate.

To date, Physician-Assisted Suicide is a legal practice in only a few places: Luxembourg, The Netherlands, Belgium, Germany, Switzerland, the state of Washington, Montana, and Oregon. The Supreme Court case *Washington v. Glucksberg* in 1997 gave individual states the right to either legalize or ban physician-assisted suicide. Soon after this ruling, the "Death with Dignity Act" was enacted in Oregon, with a 51 – 49% affirmative vote. As written in the law, patients may request a lethal prescription from their physician if they meet the following criteria:

1. They are an adult, aged 18 years or older;
2. They are a resident of Oregon;
3. They are "capable," or able to make and communicate their desires;
4. They have been diagnosed with a terminal illness that leaves them with less than six months of life remaining.

The request must be made twice, with a 15 day interim and be accompanied by a written request signed by two witnesses, a confirmation of the diagnosis, and a psychiatric evaluation. (Oregon.gov)

There are important ethical questions to ask in the debate about physician-assisted suicide. For one, is it always wrong to kill? Murder is a punishable felony in the United States legal code. Secondly, is obeying someone else's wishes morally justified? The difference between "killing" and "letting die" needs to be specified, as do the meanings of mercy and autonomy. Can the service of expediting death be a part of a doctor's job description? A line from the Hippocratic Oath reads, "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect." When is it ok to break this promise?

Assisted death comes in two forms. Euthanasia, as popularly understood, is active and involves administration of the lethal agent by someone other than the patient. This was seen in the Thomas Youk case with Dr. Kevorkian. Physician-assisted suicide is "provision of the means of death" (Kamm 28), the way that Kevorkian traditionally dealt with his clients. The physician is not actively killing the patient, instead providing the means for the patient to take their own life. It still involves an action with intent to cause death, but it is indirect. Then there is "allowing to die," which isn't categorized with assisted death. The withdrawal of medical treatment resulting in patient death is only omission, allowing the fatal disease to run its course.

As stated by the Alzheimer's Association in response to the death of Janet Adkins, any patient has the right to refuse medical treatment. A key concept of the physician-assisted suicide debate is that of patient autonomy, which refers to "the

capability and right of patients to control the course of their own medical treatment and participate in the treatment decision-making process” (ascensionhealth.org). This can be as simple as deciding to not take an antibiotic for an infection or as devastating as declining to be placed on a respirator.

The argument in favor of physician-assisted suicide relies heavily on the concept of autonomy. Rosamond Rhodes, in her justification for PAS, says that, “Respect for another individual’s autonomy is the most fundamental of all moral principles” (169). In her view, the beneficence written into medical codes binds a physician to get involved with the alleviation of a patient’s suffering when specifically requested. She also claims that “assisting in suicide and practicing euthanasia are exceptions to the standard requirements of morality which forbid killing” (172). Society, in her view, recognizes this and thus physicians are released from culpability. Dr. David Brock also supports the “self-determination” that supports PAS, in that “a central aspect of human dignity and the moral worth of persons lies in individuals’ capacity to direct their lives” (89). In general, people do not want to suffer and feel the need to maintain their dignity until the very end. The moral obligation of a physician is not to dissuade the patient from seeking a controlled death. Those in support of PAS insist that the moral obligations of the physician are to ensure that the patient is first well-informed about all possible treatment options, and then to use their knowledge and skills to carry out assisted suicide effectively.

However, the other side of the debate argues that it goes beyond patient autonomy to request help from a physician in ending one’s life. Another person must get involved and their morality is also compromised. In the case of a physician, assisting in suicide

compromises the integrity of their profession. The highest values of medicine are “the preservation of life and the alleviation of suffering” (Byock 109). Bernard Braumin writes that a physician “must not deliberately endanger others under the guise of doing medicine” and that he or she “is to be always a champion of life and health in every context” (179). It is against the ethos of practicing medicine to be the direct cause of a patient’s death. The American Medical Association has made the claim that the integrity of the medical profession would be severely threatened by the legalization of physician-assisted suicide (Pence 101). Public trust in the healthcare system would be eroded and the hospital would go from a place where sick people went to get better to a place where sick people went to die. “I view a person’s decision to end life as a personal, existential choice... Patients who want to kill themselves should do so in their homes,” writes Michael Teitelman (220).

As seen with Oregon and with Dr. Kevorkian, there are “safeguards” written into the laws permitting assisted suicide. Restricting authorization to licensed physicians is a way in which these safeguards might be best kept. Medical professionals are, in theory, the least likely to abuse the power granted to them. However, doctors are human beings as well; there are bound to be instances in which the physician forcibly makes the decision for his patient, possibly for some personal gain. Nearly one-third of euthanasia procedures done in The Netherlands are involuntary (Callahan 81). Daniel Callahan shares his thoughts on the possibility of corruption: “It is not within the power of medicine... to master life and death and to control nature. It *ought* never to be within the moral power of medicine to use its skills to bring about death.” (85)

The many other dimensions – political, social, religious, etc. – to this debate make the issue even more controversial. There will never be a consensus on whether physician-assisted suicide should be condoned as ethically acceptable. Dr. Kevorkian was a leading example of how PAS might work and “help” those seeking it, but his work was considered morally reprehensible by his colleagues and much of society. As long as *Washington v. Gluckberg* allows individual states the ability to legalize physician-assisted suicide, the United States will be confronted with this debate.

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