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An Opportunity Lost: The Failure of the Michigan Commission on Death and Dying

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The Michigan Commission on Death and Dying was created to advise the state legislature on the politically volatile question of assisted suicide. Proposals were considered to allow assisted suicide with safeguards, and to continue the state's temporary absolute ban. Because of the political composition of the Commission, however, no consensus was reached, and the opportunity to enact humane but careful legislation seems to have passed. This paper examines the proposals the Commission considered, the alliances reflected in the voting, and some problems the Commission failed to address.

With the election Nov '94 and the December ruling by the Michigan Supreme Court in various lawsuits involving Dr. Jack Kevorkian and others,¹ it appears that the absolute, but temporary², prohibition on assisted suicide enacted by the Michigan legislature well over two years ago in order to give itself time to study the question has now become permanent. The Court has ruled that assisting suicide is in Michigan a common law felony which may in certain circumstances be prosecuted as murder. Though public and medical opinion seem clearly to favor some form of humane relief,³ in the new state legislature those opposing assisted suicide are evidently stronger than in the old⁴, and the Court's ruling will evidently be allowed to stand as Michigan law. Thoughtful, balanced legislation which would provide relief of suffering while avoiding certain dangers seen by some, is evidently not likely to be enacted or even brought to the floor. Thus a brief window of opportunity to rationalize Michigan law, which opened with the creation early in 1993 of the Michigan Commission on Death and Dying, appears to have closed, if not irrevocably at least for the foreseeable future. The reasons for this are no doubt many, but perhaps some of the blame can be laid to

the working of the Commission itself. Created to guide the legislature on this controversial and emotionally-charged issue, the Commission's 22 members failed to arrive at a consensus position, and instead of offering clear guidance, produced three proposals, none of which received more than nine votes. Even more serious from the point of view of those favoring at least some right to assisted suicide, none of the three proposals could be taken seriously as the basis for possible legislation; only one actually recommended decriminalizing assisted suicide, and this was so covered with qualifications and restrictions as to raise questions whether it would be more likely to enable those in need to take advantage of the right, or to discourage them from doing so.

This paper is an analysis of the commission's proposals and of the shifting alliances of its members as reflected in the voting. If there is a moral to be drawn from this, it is that politically designed commissions are no more likely than legislatures themselves to arrive at reasonable and humane solutions to emotionally powerful problems. The Death and Dying Commission was composed not of experts but of political constituencies pushing what turned out to be incompatible agendas; created to buy time and propose a solution which might to some extent get the legislature off the hook, the Commission effectively nullified itself because its member groups were more interested in defending their constituencies or points of view than in reaching a workable solution.

The Problem Illustrated

Before turning to the Commission, it might be useful to call attention to two stories reported in the press while the Commission was doing its work.

In July 1994 the *NY Times* reported that an 85-year old woman in Vermont had committed suicide by starving herself to death. Though in good health, as the *Times* put it, her eyesight had begun to fail and she had undergone difficult bladder surgery followed by colon surgery, incontinence and pneumonia. She celebrated her 85th birthday, made a last meal of birthday cake, and then refused all further nutrition. Her physician attended with morphine as necessary for discomfort; she died peacefully in her sleep after 6 days of fasting. The *Times* gave her story nearly 10 column inches (*NY Times*, July 20 1994).⁵

Mrs. Eddy was luckier, or cleverer, than many of the AIDS victims studied by a researcher in Vancouver, B.C. He found that half of the 34 assisted suicides he was able to identify were botched. In five cases the victims were unsuccessfully suffocated; in another an attempt was made to slit the victim's wrists with a razor blade; in two cases heroin was injected unsuccessfully; in another case, massive doses of morphine, "a month's supply," were given over a period of four days before death occurred. Similar reports surface elsewhere. "One ethicist told of a man in Illinois who tried to smother his lover with a pillow but ended up asphyxiating him just enough to destroy most of his brain's functions. A New York doctor told of a friend who tried to kill himself by overdosing on his TB medication. He tried a second time on Darvon, and failed again." (NY Times, June 14, 1994)

Mrs. Eddy's son is a medical doctor who wrote up his mother's death in the *Journal of the American Medical Association* (Eddy, 1994). It seems that his mother was sicker than the *Times'* report acknowledged. "She developed oral thrush, apparently due to the antibiotic treatment for her diarrhea, and her antidepressants got out of balance . . . she became anemic, which was treated with iron, which made her nauseated. She could not eat, she got weak, her skin itched, and her body ached . . . they found a lump in her breast and atrial fibrillation." After a cholecystectomy, Mrs. Eddy needed second surgery for rectal prolapse. "She especially hated the thought of more surgery and the intense postoperative fatigue. On the other hand the prolapse was very painful . . . She knew that she could not possibly walk . . . again unless it was fixed . . . Her main concern was to avoid incontinence." Mrs. Eddy decided to have the rectal surgery, which left her "totally incontinent 'at both ends,' as she put it. She was bedridden, anemic, exhausted, nauseated, achy, itchy . . . her eyesight had begun to fail . . . she could no longer read."

Mrs. Eddy and her son discussed *Final Exit* and found it of little use: "Patients can rarely get the pills, especially . . . in a nursing home . . . Anyone who provides the pills . . . can be arrested . . . Even if . . . the pills are available, they can be difficult to take, especially by the frail. Most likely, my mother would fall asleep before she could swallow the full dose . . ."

Starvation turns out to be the only solution. In a passage quoted in the *Times*, Dr. Eddy celebrates his mother's death: "Without hoarding pills, without making me a criminal, without putting a bag over her head, and without huddling in a van with a carbon monoxide machine, she had found a way to bring her life gracefully to a close," he wrote. "This death was not a sad death, it was a happy death. It did not come after years of decline, lost vitality, and loneliness, it came at the right time."

Dr. Eddy's reference to a van with a carbon monoxide machine is of course an allusion to Dr. Kevorkian, who had recently been acquitted by a Michigan jury of the felony of "assistance to suicide" in the death of Thomas Hyde, a victim of advanced amyotrophic lateral sclerosis. Dr. Kevorkian had admitted to placing, in his van, a mask connected to a carbon monoxide machine over Hyde's face and putting in Hyde's hand the string by which the machine is operated.⁶

Mrs. Eddy's death and the botched attempts of the AIDS victims provide real-life counterpoint to the opinion of the famous anti-establishment psychiatrist, Dr. Thomas Szasz. Writing in the libertarian magazine *Reason* (Szasz, 1994), Szasz castigates Dr. Kevorkian as "dangerous," "ominous," "a threat," impugns Kevorkian's "purported compassion," and remarkably implicates Kevorkian as a participant in what Szasz calls "medicine's war on freedom and self-determination." The threat is not that doctors wish to kill people, but that they wish to control the means by which this is to be done. But Szasz stops short of advocating that because their motive is self-aggrandizement, not compassion, doctors must be prevented from assisting in suicide. His solution is the free market. "[T]he fact is that neither killing another, nor killing oneself, nor helping a person kill himself requires medical expertise," Szasz writes. "Giving a person a drug to help him commit suicide is like giving him liquor to help him become drunk . . . Judging by published reports, the persons whom Kevorkian has 'assisted' could have ingested a fatal dose of a lethal drug, had they access to such a drug and the courage to use it. The fact that drugs used for committing suicide are now available by prescription only is a cultural-legal artifact. Prior to 1914, lethal drugs, like other consumer products, were available on the free market." (Szasz, 1994) Whether doctors could safely

be allowed to administer these drugs or at least advise on their use without jeopardizing everyone's freedom, Dr. Szasz does not say. Surprisingly, he fails to mention self-starvation as a method of free market self-help even simpler than drugs.

The Commission

The Michigan Commission on Death and Dying was established by the state legislature to guide it in its deliberations on the problem presented to it by Dr. Kevorkian. The legislation⁷ which established the Commission also created the felony of "assistance to suicide." The membership of the commission was established by the statute, and consisted of 22 organizations (see Appendix) which have an interest in the question. Religious groups were conspicuously omitted, though a Roman Catholic priest served as representative of a secular organization.⁸ Each organization, among them the Michigan Association of Suicidology, an anti-suicide group claiming "approximately seventy-five members," ("Report," Appendix A, position statement of Michigan Association of Suicidology) had one vote. Though created with fairness and breadth in mind, the composition of the Commission did not in the end please everyone, notably certain disability advocates, some of whom tend to regard assisted suicide as a method of disposing of the unvalued disabled, and who proposed via picketing and disruption⁹ that the entire Commission membership be replaced by people with disabilities (*NY Times*, Mar. 6, 1994; *American Medical News*, Ap. 11 1994, pg. 11). Not all the member groups took a position, notably two of the most influential, the Michigan State Medical Society and the Prosecuting Attorneys Association, both of whom cited disagreement among their members as the reason not to commit themselves.¹⁰ (The representative of the state Medical Society, who was also the Commission's chair, abstained on all votes; however the Prosecuting attorneys allowed their representative to vote his conscience, which he did against the proposal decriminalizing "aid-in-dying" and for the proposal to make the prohibition permanent). The work of the Commission proceeded in the usual manner: open meeting, public forums and presentations, scrutiny of documents, subcommittee reports etc.¹¹ But the principle on which the Commission's

membership was determined and the inability of influential member organizations to take a position virtually guaranteed that the Commission would be deadlocked, as it was.

The Commission did reach consensus on several points, none more important than that some public policy was required. The relevant statement is worth quoting in full. **"A significant conclusion reached by the Commission is that some permanent policy regarding assisted suicide should be enacted by the Legislature. The Commission views the current situation, whereby the ban on assisting suicide is scheduled to sunset six months after this report is issued, as untenable. There have been proponents speaking before the Commission who have favored this "No law" option. The Commission felt very strongly that this option would be irresponsible as a matter of public policy and would create tremendous confusion for the people of the state. A motion was made and approved . . . to eliminate the "No law" option as an advisable recommendation to the Legislature." ("Report," Part II. Bold type in original.)**

In addition, the Commission unanimously endorsed 13 "points of consensus" ranging from public education on advance health care directives, to easing access to pain medication.¹²

The Votes

The Commission considered three proposals on the question of assisted suicide. The first, recommending decriminalization with safeguards, and including a model "death with dignity" act, received only 9 votes of the 22 member Commission. Seven members voted against and 6 either were absent or abstained. The second proposal, "Procedural Safeguards," neither endorsed nor opposed decriminalization, but recommended a set of safeguards should the Legislature decide to decriminalize. This also received 9 votes, of whom only 4 had voted for proposal one; five members voted against and 8 were not present or abstained. Finally, there was a third report, "opposing legalized assisted suicide;" this received 5 votes for, 9 against, the others absent or abstaining.

The same five votes cast in favor of the proposal opposing legalization, also were cast against the proposal to decriminalize. There were the "hard-core" votes opposed to legalization. They

were the suicidology group, the Council for Independent Living, the Head Injury Survivor's Council, The Prosecutors' Association representative, and Right to Life, the anti-abortion group.

The other two votes against decriminalization-with-safeguards came from the osteopathic physicians and surgeons association, and the Michigan Hospice Organization. Both of these groups abstained on the second and third proposals. Hospice explained this seemingly inconsistent position as follows: "Rather than supporting legislation dealing with assisted suicide, the MHO supports legislation which requires education to address pain and symptom control and wholistic, supportive care for those with terminal illness and their families." MHO pointed out that the 13-point consensus statement contains much of their position. ("Report," Appendix). It would seem, nonetheless, that to oppose decriminalization is, at least by implication, to favor continuing at least some form of prohibition.

There was a bloc of nine organizations that voted yes for the first proposal, decriminalization-with-safeguards, and against the third, to oppose legalization. No other organization voted either for the first nor against the third; these nine organizations thus constituted a consistent plurality on the commission in favor of liberalizing the law, a plurality which, however, was unable to attract the three additional votes needed to become a majority. They are: the Civil Liberties Union (ACLU), Health Care Association, Hemlock, the associations representing nurses, psychiatrists,¹³ psychologists, and social workers, the Senior Advocates Council¹⁴ and the State Bar.¹⁵

The most interesting proposal in some ways was the second, the procedural safeguards proposal, which neither endorsed nor opposed assisted suicide but recommended safeguards should the Legislature decide to decriminalize. This report was largely the work of advocates for the disabled. The disability community struggled with the problem of assistance to suicide, but was unable to reconcile the promise of offering to the disabled greater control over their own lives with the fear of reinforced social stereotypes and negative valuations of disabled people. Thus both the head injuries group and the independent living council formed part of the hard core opposition to assisted suicide, both groups opposing decriminalization and supporting continuation

of the ban, while the long-term care group and the retarded citizens group (ARC-Michigan) took no position on either decriminalization or permanent prohibition. The Council for Independent Living explained its position in a statement describing its aim as "to facilitate the unity and empowerment of people with disabilities." This they explain as "self-determination and having both the right and the opportunity to make decisions about the issues that affect one's life." They pointed out that assisted suicide could be regarded as a form of self-determination, but feared that a public policy allowing it as an option will reinforce stereotypes which work against disabled people. "These advocates feel that by permitting some form of assisted suicide available only to people with disabilities and chronic illness, the Michigan legislature will both provide a subtle coercion for people with disabilities and chronic illness to end their lives and open the door to active euthanasia in which the decision to end an individual's life is made by the medical establishment or dictated by social norms." ("Report," Appendix A)

Proposal two recommended safeguards without either endorsing or rejecting assisted suicide. Three of the five hard-core pro-ban groups (suicidology, independent living, head injury) voted yes on proposal two. This position is at least consistent: no decriminalization, continuation of the ban, but safeguards should decriminalization be adopted. Of the other two hard-core groups, Right to Life Michigan (RLM) voted against proposal two and the prosecuting attorneys abstained, each perhaps fearing that a yes vote could implicitly be seen as endorsing assisted suicide.¹⁶ By isolating itself from its allies in the disability community, RLM demonstrated its more categorical opposition to assisted suicide. The other two groups who voted no on decriminalization, hospice and the osteopaths, abstained on continuing the present ban; the osteopaths also abstained on proposal two, but Hospice voted yes.

The plurality decriminalization alliance split on proposal two: the ACLU, Hemlock, the psychiatrists, and the state bar joined RLM and voted no, the health care association, nurses, social workers and Senior advocates voted yes, and the psychologists abstained. The other five yes votes on proposal two came from three of the hard-core opponents of assisted suicide, plus Hospice and Better Care (the long-term care advocacy group). Both these

groups abstained on continuing the ban; Hospice voted against, Better Care abstained, on decriminalization.

These shifting coalitions, and the reasons for the votes, indicate the difficulty of reaching consensus. First, fully five of the 22 members either abstained or were not present for all three votes; no explanation is given in the report why certain groups were absent from the voting. Two groups (Better Care and the osteopaths) abstained on two of the votes, and three other groups (Hospice, psychiatrists, prosecutors) abstained once. Thus ten groups were unable to reach a position on at least one of three proposals. Second, apart from the five total abstainers, no more than four organizations adopted common positions on all three votes: health care, nurses, seniors and social workers voted yes on 1 and 2, no on 3; ACLU, Hemlock, psychiatrists and the state bar voted yes on 1, no on 2 and 3. Another set of three organizations voted no on 1, yes on 1 and 2: suicidology, independent living, and head injuries. That is to say, of the 17 groups voting on at least one proposal, no more than 4 voted the same way on all three proposals. (This does not of course take into account unreported straw votes and other informal measures of viewpoint).

in table form:

1	2	3	
Y	Y	N	health care, nurses, seniors, social work
Y	N	N	ACLU, Hemlock, psychiatrists, state Bar
N	Y	Y	suicidology, independent living, head injuries
N	N	Y	Right to Life
A	Y	A	Better Care
N	A	A	osteopaths
N	Y	A	Hospice
Y	A	N	psychologists
N	A	Y	prosecutors

Of course the second proposal complicated matters, splitting both the 9 member pro group and the 5 member anti group. Ironically Right to Life joined the most liberal groups, ACLU and Hemlock, in voting against proposal two. However the second proposal was in a sense the common ground proposal, neither

endorsing nor rejecting assisted suicide but specifying what everyone had agreed on in principle already, the need for legislation with safeguards and conditions. That even this proposal fared no better than the others, gaining only 9 of a possible 22 votes, is significant. Though all favor some kind of legislation, some who are opposed to decriminalization will not consider safeguards even hypothetically; some who favor decriminalization oppose safeguards they regard as unduly burdensome; others so fear abuse that the safeguards they endorse would make the decriminalization almost worthless.

Procedural Safeguards

Since the clear middle-ground position is decriminalization with safeguards, I shall next examine the safeguards developed in the first two proposals. There are some differences between the two proposals but it is difficult to say which set of safeguards is stricter. I shall quote from the summary of the decriminalization proposal, the "death with dignity" act:

"Only persons who have a terminal condition (an incurable or irreversible condition which would likely result in death within six months) or a condition involving irreversible suffering (an irreversible, progressive, debilitating or degenerative disease with unbearable or unacceptable suffering emanating from a physical condition) would qualify for aid-in-dying. Someone suffering from a solely psychological condition (such as situational depression) would NOT be eligible.

"Before any aid-in-dying is given, a person must. . .

- Record an official request for assistance, witnessed by two unrelated, disinterested persons.
- Be examined and counseled by two physicians to determine if the person has an eligible condition and to explore all possible alternatives . . .
- Be examined by a psychiatrist or psychologist, to determine the person's mental competence.
- Be counseled by a social worker to explore social service and support services which might assist the person in living in comfort and dignity.

- Be counseled by a professional in pain management or a certified hospice professional, where appropriate, to explore options that might alleviate suffering.
- Have compliance with this process certified by the probate court.
- Make two further direct requests for aid-in-dying to the attending physician witnessed by two unrelated, disinterested persons, with a waiting period of 7 days between the requests."

I am not, as the humor columnist says, making this up; this is the proposal supported by the ACLU and Hemlock, the Commission's most ardent proponents of decriminalization. The alternative "procedural safeguards" proposal, developed by the Council for Independent Living and ARC-Michigan (retarded citizens), though explicitly written to protect disabled people whose lives are said to be put in jeopardy by decriminalization of assisted suicide, is in some ways more liberal, but in other ways stricter, than the decriminalization model statute. (The title of the alternative proposal is revealing: "Procedural Safeguards against the Exploitation of Personal Autonomy and Vulnerability in the Decision to Terminate One's Life".)¹⁷ Eligibility is based on "irreversible suffering from a physical condition at a level which the individual finds unbearable." This delightfully vague statement seems to allow more opportunity for the individual to decide how much suffering is enough, compared with the decriminalization proposal which says the suffering must "emanate" from a physical condition as described. Under procedures, in addition to the patient's assertion of his/her request witnessed by two impartial witnesses, there are four required consultations. Before each consultation the patient must "reaffirm his or her intent to continue with the process." This is to be done (each time!) by completing a form whose content is specified. Before each consultation the patient must also request a "treatment summary" be sent to the consulting professional.

The consultations are with a physician who not only verifies the condition but is given several other powers and responsibilities including "to document barriers, including financial barriers, which prevent the individual from accessing identified health care interventions"; a social worker, a mental health worker, and

"at least one other expert who could provide meaningful support and assistance to ameliorate the unbearable suffering of the individual [including hospice] . . ." The mental health worker is required to call in a second professional if necessary to assess competence; absolute power is given to the mental health workers to terminate the process if "impaired judgment" is discovered (the document does not say what to do if the mental health workers disagree about this, nor does it say whether the patient adjudged impaired may dismiss the mental health worker and choose another).

To assure that no stone is left unturned in exploring alternatives to suicide, the proposal also mandates what seem to be a whole series of further referrals: "In addition to performing the tasks specified, *each* [emphasis added] of the consulting professionals will be responsible to offer a referral to a 'Personal Advocate,' [not defined] whose role it will be to assist the individual in accessing those support services which the individual chooses to pursue."

When all of these consultation are completed, the Probate court then has an oversight role "to ensure compliance with the procedures."

Whether it is possible, not to say ethical and moral, to construct legislation whose restrictions are so onerous as to discourage people from using its provisions, is a question for philosophers and legal theorists. Questions of unconscionable conditions aside, it remains to be seen who would be eligible for the aid-in-dying privilege, and for what it would be that they are eligible. One can appreciate that under both proposals eligibility is not restricted to those with terminal conditions suffering unmanageable pain, but extends to those with degenerative diseases and "unacceptable" suffering, a term not defined other than by implication to exclude "a solely psychological condition." Would Mrs. Eddy be eligible? Would all of the AIDS victims? The promising vagueness of both the first and second proposals cannot be said to exclude that they might, though doctors fearing prosecution might prudently hesitate to certify them as eligible under the certification requirements. I would suggest however that any "eligibility" criteria failing to meet the Mrs. Eddy test—a test based simply on the premise that someone who is going to kill herself

anyway ought to have the right to be helped by her physician, without the physician being put at risk of criminal prosecution—is unsatisfactory.

More interesting is the question of what are the benefits for which beneficiaries of the legislation would be eligible. After publication of the Commission's report its chair, Howard Brody, a medical doctor who is also a thoughtful and respected professor of philosophy, published an article (Brody, 1994) expressing his disappointment. It was not the Commission's inability to offer guidance to the legislature that troubled him, but the lack of philosophical analysis in the Commission's three proposals. Citing recently published work, Brody pointed out two alternative methods of terminating life, both based on hospice techniques: Mrs. Eddy's route, refusal of nutrition with medical support; and "barbiturate coma," used to assist patients who fail to respond to more routine pain management, in which patients are rendered comatose until death occurs, often in a matter of hours. The question is whether either of these methods ought to be regarded as the "aid-in-dying" to which the proposals' procedural safeguards would apply. If so, then these two techniques, which are presumptively legal even under the absolute ban, would be subject to restrictive conditions which might make them unavailable in many cases. If not, then the procedural safeguards would protect people very largely from lethal injections and effective crudities such as back-of-the-van carbon monoxide, which in any case Dr. Kevorkian has resorted to only since the cancellation of his medical license removed his access to lethal drugs. (Kevorkian's original "suicide machine" provided a self-injected lethal dose of potassium chloride. Access to this or similar apparatus would be regulated under the procedural safeguards.)

A month after the release of the Commission's report, Dr. Brody and five co-authors published, in the prestigious *New England Journal of Medicine*, a proposal for regulating physician-assisted death (Miller, F. G, et al, 1994). The centerpiece of the proposal is mandatory counselling with a trained "palliative care specialist." No other counselling is required. The function of this consultant is partly medical but also partly judicial, as he or she is given appealable veto power over the decision (the consultant's veto can be appealed to a "palliative care committee," whose decision

is final). There are at least two difficulties with the scheme: it is not clear on what grounds other than non-voluntariness the consultant could exercise the veto,¹⁸ nor does the proposal discuss the problem of "forum shopping," ie, how patients could be prevented from selecting consultants known to be favorable to patient's expressed wishes. These difficulties aside however the scheme seems humane and workable with minimum intrusions and burdens, though its quasi-judicial apparatus would clearly not satisfy those proponents of assisted suicide who wish to see no outside interference on the exercise of the right to die. There is no evidence in the Michigan Commission report that such a proposal was even considered by the Commission.

Conclusion

Because of the activism and propagandizing of Dr. Kevorkian, and its mixture of labor union liberalism, human rights activism, and Right to Life religious conservatism, Michigan is doubtless among the most advanced¹⁹ of the states in discussion of assisted suicide, so it might have been hoped that the appointment of a commission to recommend approaches to the problem would have led to some humane resolution which, if not satisfactory to everyone, would be accepted by all but the most unyielding. Establishment of a commission could be seen as a legitimate and even statesmanlike maneuver by a legislature anxious to obtain some distance from the emotional issue and searching for a relatively objective point of view. The failure of the Commission not only to agree on a reasonable proposal but even to lay out fairly the dimensions of the issue and present the plausible alternative solutions, has disappointed those who may have entertained such hopes, and the recent election, coupled with the Supreme Court decision, has apparently assured that these who oppose any decriminalization will carry the day. Opponents see assisted suicide as a piece with euthanasia and abortion, which they regard as the great moral evils of our culture. Proponents of decriminalization seem to lack the moral vigor focused on other human rights issues. Disability advocates, adept at media manipulation, regard decriminalization as suspicious and possibly dangerous (Miller, P. S., 1993). Minorities, who were not present on the Commission

(no members and only two alternates were black) also distrust decriminalization and appeared before it to express their opposition.²⁰ The medical profession is not only split but worried, and unlikely to go much beyond its current neutral position.

Since Dr. Kevorkian was acquitted under the former statute, those who are opposed in principle to any decriminalization will have to solve the problem of jury nullification, so it is unclear that the Legislature would gain anything were it to reenact the former ban. But any legislation purporting to clarify the status of assisted suicide short of an outright ban is likely to be subjected not only to restrictive procedural conditions but to tight definitions limiting who is eligible for the assistance and the kind of medical procedures that are allowed; this could end up criminalizing, or encumbering with procedural safeguards, procedures such as barbiturate coma and even assistance in refusal of nutrition which are presumptively legal and in principle available even under the current prohibition. If that is the outcome, the failure of the Commission will mean more than an opportunity missed to provide relief to those in need; it will also mean that relief has been taken away from sufferers who might have been entitled to it.

APPENDIX I: MEMBERS OF THE COMMISSION**Michigan Commission on Death and Dying
Members and Alternate Members and Officers**

Howard Brody, Chairperson
Elsa Shartsis, Vice Chairperson
Deborah Cummings, Secretary

American Association of Retired Persons

Mable Meites, Member

Mary Alice Shulman, Alternate Member

American Civil Liberties Union of Michigan

Elsa Shartsis, Member

Ronald Bishop, Alternate Member

Citizens For Better Care

Marie P. Iverson, Member

Susan Titus, Alternate Member

Health Care Association of Michigan

Wanda Baad, Member

Helen Wentz, Alternate Member

Hemlock of Michigan

Daniel C. Devine, Member

Shaw Livermore, Alternate Member

Michigan Association for Retarded Citizens

Robert D. Aranosian, Member

Marjorie J. Mitchell, Alternate Member

**Michigan Association of Osteopathic Physicians &
Surgeons**

Joseph A. Balog, Member

Melvin Linden, Alternate Member

Michigan Association of Suicidology

Kenneth T. Morris, Member

Alton Kirk, Alternate Member

Michigan Council on Independent Living

Penny Crawley, Member

John Sanford, Alternate Member

Michigan Head Injury Survivor's Council

Diane Kempen, Member

Benjamin Bolger, Alternate Member

Michigan Hospice Organization

Sue Wierengo, Member

Barbara Kowalski, Alternate Member

Michigan Hospital Association

Lisa Vandecaveye, Member

John Lore, Alternate Member

Michigan Nonprofit Homes Association

Thomas F. Schindler, Member

Ethel Stears, Alternate Member

Michigan Nurses Association

Margaret L. Campbell, Member

Denise Jacob, Alternate Member

Michigan Psychiatric Society

Arles Stern, Member

Michigan Psychological Association

Charles Clark, Member

Judith Kovach, Alternate Member

Michigan Senior Advocates Council

Larmer King, Member

Mary Payne, Alternate Member

Michigan State Medical Society

Howard A. Brody, Member

Thomas Payne, Alternate Member

National Association of Social Workers, Michigan Division

Deborah Cummings, Member

Peter D. Weidenarr, Alternate Member

Right to Life of Michigan, Inc.

Edward Rivet II, Member

Bernard Dobranski, Alternate Member

State Bar of Michigan

John D. O'Hair, Member

Martin L. Kotch, Alternate Member

Prosecuting Attorneys Association of Michigan

Patrick M. Shannon, Member

Richard Thompson, Alternate Member

APPENDIX II: PUBLIC ACT NO. 3, PUBLIC ACTS
OF 1993
STATE OF MICHIGAN

Sec 7. (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.
- (4) This section shall take effect February 25, 1993.
- (5) This section is repealed effective 6 months after the date the commission makes its recommendations to the legislature pursuant to section 4.

Section 2. This amendatory act shall take effect February 25, 1993.

This act is ordered to take immediate effect.

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Notes

1. Mich vs. Kevorkian, (___Mich___), Mich. Supreme Court, five cases decided Dec. 13, 1994. Three of the cases involved lower court decisions rejecting various prosecutions of Dr. Kevorkian; these prosecutions were effectively reinstated by the Michigan Supreme Court. The other two cases were suits for declaratory relief brought by petitioners alleging terminal illness and asking for the right to obtain suicide assistance. These petitions were rejected.
2. The felony of "assistance to suicide" was created with an expiration foreseen to thwart Dr. Kevorkian while the Commission deliberated. Before its presumed expiration, the statute had been declared unconstitutional for technical reasons by four Michigan courts, but the Michigan Supreme Court, stayed the Appeals Court orders and then reversed. It was widely reported in November that the prohibition had indeed expired as scheduled, but the legal situation was at that point far from clear. The legislation creating the Commission and enacting the temporary ban required the Commission to report "within 15 months after the effective date of this act," ie, by May 23 1994. The section (#7) prohibiting "assistance to suicide" "is repealed effective 6 months after the commission makes its recommendations to the legislature." Because of the legal challenges and court rulings, the report issued by the commission dated 6 June may or may not be the report required by the statute to set the six-month clock running. The report itself was not issued as a document of the state of Michigan, but was published by the Michigan State Medical Society. In overturning lower court decisions and holding that the statute was not unconstitutional, the Michigan Supreme court failed to address the question (presumably made irrelevant by its ruling) whether the temporary ban had even expired.
3. A recent *Detroit News* poll revealed that 57% of Michigan residents favor allowing assisted suicide under some restrictions, while 9% favor allowing it without restrictions. Only 30% favored an absolute ban. According to a letter in the *New England Journal of Medicine* (331:812–813, Sept 22 '94) a survey of Michigan physicians showed that 41% of physicians favored allowing assisted suicide under some circumstances, 17% favored keeping it illegal, and 37% preferred to have no legislation on the subject.
4. In the lame duck legislative session which ended in Dec. 1994, majorities in each house voted for a permanent absolute ban, but the two houses failed to

agree on whether the question should be put to a vote of the people, and the legislation died with the session. The legislature elected in 1994 is slightly more conservative (ie, Republican) than its predecessor.

5. The headline reads "A Woman Charts an Unusual Route to Death."
6. *People v. Kevorkian*, Detroit Recorder's Court, #93-10158. The jury verdict of acquittal was returned May 2 after a five-day trial. Thomas Hyde was the 17th of the patients helped to die by Kevorkian since 1990 (as of June 27, 1995).
7. State of Michigan 87th Legislature, Public Act #3 of 1993, approved Feb. 25 1993.
8. The Nonprofit Homes Association, which abstained on all three proposals. However their representative was said to be active in discussion.
9. From the *Times*: "The commission's vote was delayed for several hours when more than a dozen members of Adapt, a group advocating rights for the disabled, burst into the conference room in motorized wheelchairs, carrying signs saying 'Extermination without representation' and 'Hey-hey, ho-ho, this commissions has got to go!'"
10. In May 1994 the Michigan State Medical Society rejected attempts to put it on record either for or against a ban on physician assisted suicide, voting 85-32 to take no position. The MSMS had only the year before become the first state medical society in the nation to change its position from anti-assisted suicide to neutral (*American Medical News* Ap. 11, 1994). The neutral policy calls for physicians to exhaust every alternative before resorting to assisting suicide (*Kalamazoo Gazette*, May 8 1994). This position is interpreted by some as affirming the individual physician's right to follow his or her conscience; protecting the privacy of the doctor-patient relationship seems to be the major concern of state medical societies. Outgoing MSMS president Gilbert Bluhm was quoted as saying that doctors need to make up their minds on the issue. However American Medical Association Chair Lonnie Bristow of San Pablo Calif has already made up his mind: "It is not ethical for physicians to take part in that kind of activity. . . . abuses will occur." (*American Medical News*, May 16 1994). The national AMA has recently strengthened its position, calling assisted suicide "totally incompatible" with the ends of medicine.
 In May 1994 the Oregon Medical Association was also unable to take a position on the ballot initiative to be voted on in November. The Association split virtually equally three ways: for, against, and "let the public decide." However the Association "declined to reaffirm" the national AMA position opposing the participation of physicians in ending a patient's life. (*American Medical News*, May 16, 1994). And a recent study of doctors in Washington state showed equally deep divisions (*NY Times*, July 17, 1994). (The Oregon initiative allowing assisted suicide in certain narrowly defined cases was enacted by a small margin).
11. The full commission met 11 times at the state capital, and held 6 public forums at cities across the state. One procedural and five policy subcommit-

- tees were organized; these latter reported by Dec. 20, 1993. Three drafting committees reported at the meeting of Feb. 3, 1994. As a point of interest here, information was provided on the situation in the Netherlands by Dr. Herbert Cohen and Mrs. Jean Tromp Meesters of that country, and by Dr. Charles Gomez of Virginia, who has published a book on euthanasia in Holland. Additionally, I. John Keown of Queen's College and Ms. Demetra Pappas provided information on the Feb. 1994 report (firmly opposing assisted suicide) of the Select Committee of the British House of Lords.
12. Michigan has now enacted into law certain measures designed to remove some of the obstacles to access to pain relief.
 13. The position of the Michigan Psychiatric Association appears to be stronger than the vote suggests. According to a letter published as part of the commission report, the Council of the MPS voted "Yes on removing the ban; *abstain* on allowing physician-approved physician-assisted suicide; *no* on allowing assisted suicide with counselling and 'safeguards.'" This appears to mean that the MPA either favors an absence of legislation (contrary to the implication in the report that there was consensus on the need for legislation), or legislation enabling assisted suicide but not imposing safeguards. The letter from the MPA Council was provoked by its delegate voting contrary to her instructions. The Council removed its delegate and asked the Commission to change its vote.
 14. A sub-group of seniors was also represented by Citizens for Better Care, which describes itself as "a state wide consumer advocacy organization concerned with the quality of life and the quality of care for the residents of long term care facilities . . ." Its position was that "decriminalizing assisted suicide WITHOUT assuring that those who choose to end their lives are aware of services which may be available would be wrong." ("Report," Appendix A). This led it to abstain on proposals both to decriminalize and to continue the ban, and to support only the second proposal, safeguards without recommendation. In contrast, the Senior Advocates Council voted yes on both the first and second proposals and no on the third.
 15. Whose representative, John O'Hair, was himself a prosecutor who had prosecuted Dr. Kevorkian, though expressing personal opposition to the prohibition on assisted suicide. He was said to be a leader among the decriminalization group.
 16. Right to Life Michigan's statement fails to address the second proposal.
 17. This proposal first attempts to address the fear of active euthanasia; it does so by what its summary calls "a definition of assistance with self-termination" to prevent active euthanasia: "Definition. The actual act which ends an individual's life must be carried out by the individual." However no definition of "actual act" nor of "carried out" is provided, and the distinction may seem hazy at best. Dr. Kevorkian placed the string to the CO machine in Thomas Hyde's hand. If Hyde then tried to pull the string but failed due to his ALS, then under the proposal one would have to say either that the correct procedure by Kevorkian would be to stop the intervention, detach

Hyde from the machine and send him home; or, if this seems unpalatable, that once Hyde had begun the act, or even attempted to begin the act, then the "actual act" requirement is satisfied, and Kevorkian is free to complete the string pulling. One can imagine similar hair-splitting with regard to injections; one can also imagine prosecutions turning on whether Hyde had tried sufficiently to begin the act, or whether his failure to complete the pull amounted to a change of mind. (If the latter, a willing but unable patient could never obtain relief).

It may be noted that as a philosophical question, whether passive acts such as refusal to eat are "acts" or merely "not doings" is probably an undecidable question. Thus if "an actual act carried out by the individual" is required to trigger the safeguards, it could be argued that a person who proposes to starve himself to death is not covered by the safeguards even if he requires the assistance of a physician to provide comfort and pain relief.

18. Dr. Brody has informed me by letter that the intent is that the palliative care physician determine whether the patient has a medical condition justifying assisted suicide.
19. Several states have held referenda, and a commission in New York state has issued a report which opposes legalization. One main objection was that suicide would be granted inappropriately by doctors who are untrained to recognize or treat depression (*NY Times*, May 26, 1994, pg. 1). Assisting someone to commit suicide is manslaughter in New York. The NY statute is being challenged in Federal court, *Quill v. Koppell*, 94 Civ. 5321. The plaintiff is the physician whose essay describing how he administered a fatal injection to a patient provoked both controversy and a criminal investigation (*National Law Jnl*, Aug. 1 '94, pg A8).
20. One black witness was quoted as saying "I took an unscientific survey at my local working class bar . . . They said, 'Wilbur, we don't even trust doctors to keep us alive!'" *NY Times*, Mar. 6, 1994.

This paper is a revised and updated version of a report made to the 10th International Conference of the World Federation of Right to Die Societies, held in Bath, England, 7-10 Sept. 1994; I am grateful to the organizers for the invitation to speak. The earlier version was read to the Center for the Study of Ethics in Society, Western Michigan University, Sept. 21, 1994, and has been published by the Center (Papers Published by the Center, vol. 8 no. 1). In preparing the paper I have had the benefit of conversation with three members of the Michigan Commission on Death and Dying: Howard Brody, MD, PhD; Fr. Thomas Schindler, PhD; Elsa Shartsis, JD. They are not of course responsible for the opinions expressed nor for any errors I may have made.