Physician-Assisted Suicide: Kevorkian, Oregon, and the Arguments in Between

“In the summer of 1989, David Rivlin, a 38-year-old quadriplegic who lived in a nursing home in the Detroit suburb of Farmington Hills, publicly asked to be disconnected from life support. Rivlin's spine had been severed in a surfing accident when he was 19, and a failed spinal operation had left him breathing with a respirator. He faced decades of that kind of life. The Oakland County Prosecutor's Office tried to intervene to stop his death.

Kevorkian decided it was time to act. Rivlin—and others to follow—needed help in dying, he believed. But to make the matter as ethically clean as possible and to minimize abuse and coercion, the patient should "pull the trigger."

It took Kevorkian only a few days to work out the design, sketching on the Formica table in his kitchen: Start an intravenous drip of a harmless saline solution. Have the patient press a button to activate a device to stop the saline solution, start a new drip of thiopental and set off a 60-second timer. The thiopental would put the patient into a deep coma. After a minute, the timer's click would send a lethal dose of potassium chloride through the IV, stopping the heart in minutes. The patient would die of a heart attack while asleep.

Quick, painless and easy.”

-Michael Betzold, Appointment With Dr. Death

The End

On April 13th, 1999 Dr. Jack Kevorkian was convicted of second-degree murder. His victim? Mr. Thomas Youk who, at the time, was suffering from Lou Gehrig’s disease. Lou Gehrig’s disease, incurable by modern medicine, essentially leaves its subjects helpless as they slowly lose control of their muscles and physical functions. Trapped inside their own bodies, Lou Gehrig’s disease patients eventually succumb to their own immobility, usually because they cannot swallow food. Dr. Kevorkian had defended himself in the case, claiming the death was not a murder but a “mercy killing”. His defense was that he had only acted in the wishes of the patient, and had done so only to prevent the needless suffering of Mr. Youk. Even Mr. Youk’s widow and brother defended Dr. Kevorkian at the trial. They pleading with the jury to acquit Kevorkian and stated he was, in fact, acting in Youk’s best wishes. Nonetheless, Kevorkian was found guilty, and was sentenced to 10-25 years in prison.

The Youk case was the culmination of legal and court battles over physician-assisted suicide and euthanasia in Michigan. Kevorkian had tried, unsuccessfully, to push his agenda for years in the Michigan courts. Finally, tiring of the everlasting struggle, Kevorkian in 1998 videotaped the death of Youk. Kevorkian this time stepped outside his normal practice of physician-assisted suicide and instead administered the
lethal injection himself. CBS aired the tape on *Sixty Minutes*, thereby giving prosecutors the evidence they needed to put Kevorkian away. The trial may have been the end of Kevorkian’s crusade for physician-assisted suicide, but it was merely one of many battles over PAS and the law.

**His Beginning**

Jack Kevorkian was born May 28, 1928 in Pontiac, MI. The son of Armenian immigrants, Kevorkian was raised in the Armenian Orthodox religion. Kevorkian quickly realized religion held no deeper meaning for him saying, “I realized that I didn’t believe in their miracles, walking on water, that sort of thing”\(^1\). He also was discovered to be extremely bright and, after getting in trouble for throwing paper-wads in 6th grade, was promoted to junior high. His intellect was well renowned in the neighborhood and they marveled at his abilities. Richard Dakesian, a childhood friend, remarked, “He’s the smartest man I ever knew. I think he was born ahead of his time.”\(^1\)

Kevorkian graduated from the University of Michigan’s Medical School and, as an intern at Henry Ford Hospital, had a moment of inspiration. After running across a terminal cancer patient he had this impression: “The poor wretch stared up at me with yellow eyeballs sunken in their atrophic sockets. Her yellow teeth were ringed by chapping and parched lips to form an involuntary, almost sardonic 'smile' of death. It seemed as though she was pleading for help and death at the same time. Out of sheer empathy alone I could have helped her die with satisfaction. From that moment on, I was sure that doctor-assisted euthanasia and suicide are and always were ethical, no matter what anyone says or thinks”\(^8\). From that moment on Dr. Kevorkian’s career seemed to convey a troubling consistency. His research, practice, and goals were focused almost entirely on the macabre, death, and dying.

Kevorkian’s work began to alarm his fellow associates. Kevorkian began postulating a new practice in which death-row convicts would be used for experimentation before their death. Performed with the consent of the convict, he said the experiments would save millions of dollars in research and would also help find new cures for disease. Similarly, in an article in *Medicine and Law*, “Kevorkian praised Nazi doctors for trying to get some good out of concentration camp deaths by conducting medical experiments.”\(^3\) At Pontiac General Hospital, he began uncontrolled experiments transfusing blood from corpses into live people.

**Kevorkian’s Mission**

Finding resistance in all those undertakings, Kevorkian then turned back to one of his original aims: to end suffering through physician-assisted suicide and euthanasia. After a visit to the Netherlands, where PAS is routinely performed, Kevorkian came back energized. He placed a classified ad in a local newspaper for an ‘obitiatry’. It read: “DEATH COUNSELING – IS SOMEONE IN YOUR FAMILY TERMINALLY ILL? Does he or she wish to die – and with dignity? CALL PHYSICIAN CONSULTANT”. While Kevorkian placed his ad he also attempted to recruit potential patients from local oncologists. Both his ad and recruitment were met with little to no success.

Kevorkian refused to give up, though. He then called the Oakland County Prosecutor’s Office inquiring as to the legality of PAS in Michigan. He was not given an
answer due to Michigan’s lack of having any statute addressing the subject. David Rivlin, who is mentioned in the earlier quotation in this article, then contacted Kevorkian. Rivlin was a quadriplegic living in a nursing home near Kevorkian and was being supported on a respirator. Disabled since age 19, Rivlin had no hope of recovery and was hoping for Kevorkian’s assistance in ending his life. While Rivlin never actually received Kevorkian’s help, he did inspire the doctor to create his infamous “Thanatron”, or “death machine.”

The Thanatron was actually a very simple machine. Constructed with just $30 in garage sale parts, it used a combination of saline solution, thiopental, and potassium chloride. Kevorkian would start an IV line to the patient that would run only saline in to the patient. At the patient’s discretion, they would then push a button that would begin the thiopental. After 60 seconds the patient would be deep in a coma and the potassium chloride would then start, resulting in cardiac arrest and death.

On June 4, 1990 Dr. Jack Kevorkian performed his first physician-assisted suicide. Janet Adkins, a 54-year-old woman with Alzheimer’s, died using the Thanatron. She died in the back of Kevorkian’s 1968 Volkswagen van. Kevorkian was charged with murder. The charges against him were eventually dropped but a Circuit Court Judge ordered him not to aid in any suicides again.

Over the next eight years Kevorkian performed, by some counts, up to 150 physician-assisted suicides. His license was revoked and, then unable to obtain the necessary drugs, he modified his methods to instead use carbon monoxide. He became embroiled in numerous legal matters during this time and was acquitted multiple times in patients’ deaths. He had, in his words, encountered “the enormous force of social, political, and historical inertia which makes it almost impossible to implement seemingly radical change, to bridge the wide gap between rational theory and actual practice.”

After his repeated victories in court, Kevorkian grew understandably confident that he would never be convicted. It was then, because of growing age and impatience, that he decided to force the matter. Tired of waiting for his redemption that may never come, he videotaped his euthanization of Thomas Youk. Kevorkian this time was convicted, effectively ending his crusade.

His conviction did not stop the firestorm of controversy that rages on yet today, though. Kevorkian said, "I have no fear about what I'm doing. I'm here to help anybody who's in distress". He said his methods were "dignified, humane and painless, and the patient can do it in the comfort of their own home at any time they want." State investigator Cathy Svoboda commented, “Dr. Kevorkian does not believe laws should rule or guide morality. (He) maintains that he is law-abiding but cannot agree or condone how law does not represent the consensus of society. He is making every effort to change laws and at the same time fulfill the demands of society.”

The Oregon Death with Dignity Act

Around the same time as the Kevorkian debacle, the state of Oregon was approaching the subject of PAS in a more civil matter. The Oregon Death with Dignity Act was passed in November 1994 and legalized physician-assisted suicide in Oregon. Because of legal problems, however, it was not put into practice until October 27, 1997.
The Act was originally put to vote as a citizen’s initiative and narrowly passed with a 51% yes vote. In an effort to disallow the Act, U.S. Attorney General John Ashcroft implemented an injunction against the bill. However, he had a petition denied in the U.S. Supreme court and the Ninth Circuit Court subsequently lifted the injunction. In November 1997 the citizens of Oregon were again asked to vote, this time they reaffirmed the Act 60% to 40%. It remains legal to this day, although Ashcroft continues his attempt to reverse the measure.

DWDA and the Patient

In order to understand more clearly what is needed to properly carry out the necessary procedures of the Act, it is easiest to walk through the process one step at a time. Firstly, for a patient to be eligible to request a prescription they must be at least 18 years old. They must also be a resident of Oregon and be capable of making their own health care decisions. In this respect they must not be suffering from any psychiatric or psychological disorder. The patient must also be diagnosed with a terminal illness, with terminal illness being defined as one that will likely lead to death within six months. The patient must make at least two oral requests to his/her physician and these requested must be at least 15 days apart from one another. The patient must also provide a written request, signed in the presence of two witnesses.

DWDA and the Physician

Under the law there are detailed provisions that must be met in order to satisfy its requirements. The first, and most important, is the distinction between physician-assisted suicide and physician euthanasia. Under the law, a doctor may prescribe a lethal prescription for a patient, but he/she may NOT actually administer the medication him/herself. On this matter the DWDA is very clear. Of significance is the law’s requirement for the physician to provide a prescription for a barbiturate. In addition to the physician diagnosing the terminal illness, he/she must also make use of a consultant to verify the diagnosis. The physician must also rule out that a patient is suffering from depression or any other mental disorder. After the patient submits his/her requests, the physician must then inform the patient about alternative options for end of life care. This may consist of hospice care, pain control, or any other methodology that might be applicable. The physician must also request that the patient notify his/her next-of-kin of the prescription. This is a request only and the patient is under no obligation to do so. Physicians must report all prescriptions within seven working days and the law guarantees the confidentiality of the physician and the patient. The physician need not be present at the time of the ingestion. On a related note, any health care facility may prohibit its employee from participating in the Act on its premises.

DWDA and the Pharmacist

The Act states, “no health care provider shall be under any duty, whether by contract, by statute, or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner.” In short, no health care worker is obligated to participate in the Act. That being said, a physician is obligated to inform the dispensing pharmacist of the intent of the prescription. If a pharmacist is uncomfortable filling such a prescription presented to him/her, he/she should kindly inform the physician of the issue. The pharmacist may
then refer the physician to another pharmacist, but is under no obligation to do so. If the pharmacist does fill the prescription they must then file a copy with the state registrar. He/she must also record the patient’s name, physician’s name and phone number, the name and quantity of medication dispensed, and the date.

**Kevorkian vs. the DWDA**

In retrospect, the idea of comparing the Jack Kevorkian cases with the concept of legalized physician-assisted suicide was a little shortsighted. While the Kevorkian cases certainly were focused on the ethical notions regarding PAS, there was also a large contingent of the discussion that focused on Kevorkian as a person. Jack Kevorkian, like all genius-madman characters in life, is a difficult person to understand. Kevorkian certainly was fighting for what he believed to be an obvious and unalienable right, but he also had an aspect that was beyond comprehension. Although there certainly is a large gray area of ethics in which PAS may be debated, many times in Kevorkian’s life he seems to be dancing on the side most repulsive to society. Unlike many who would argue for assisted suicide, Kevorkian was a proponent of questionable human experimentation and praised Nazi doctors. This aspect of him may have been both his genius and his undoing, and was that which allowed him to take such drastic measures. That being said, it may still be enlightening to contrast Kevorkian’s patients and measures with those in Oregon.

Of Kevorkian’s patients, only 25% were “terminally ill” as compared to 100% of patients in the Oregon PAS cases. The reasons for this could be numerous. It is obvious that all of the cases in Oregon would be classified this way, considering that it is required and would unlikely be reported otherwise. As for Kevorkian’s patients, much debate was had over the actual severity of his patients’ illnesses. Because some of his patients could potentially have lived indefinitely it was considered questionable whether or not he should have helped these patients. Kevorkian was wholly concerned with ending human suffering, though, and he likely perceived himself to be preventing the eventual suffering regardless of the time frame for their death.

While Oregon requires physicians to refer patients to a consultant to verify the original diagnosis, Kevorkian had no such luxury. Thus, it has been suggested that more than a few of Kevorkian’s patients may have been suffering from depression and that the severity of illness may have not been as severe as originally thought. This lack of accountability should be a major concern whether one is an advocate or not of PAS.

**The Ethical Debate**

In the end, what is done is done and nothing that happened can be changed. Whether you consider Kevorkian a hero or a villain, perhaps the best good that the entire drama brought to us was to encourage discussion on PAS. From the news coverage to books to editorials to picket marches it would have been difficult to miss some of the attention devoted to PAS. In that moment, one was forced to react. One was forced to think. The following represents some of the ethical arguments for and against PAS.

**An Argument Supporting Physician-assisted Suicide**

Death is a much-feared subject in our society. Seldom frankly spoken of and feared intensely by most, death is one of the very few promises this life holds for us. To
die is natural and inevitable; it is as sure as birth and taxes. While we apparently have no qualms speaking of such private things as our sex lives, talk of our deaths remains taboo. We will sometimes discuss our plans with our families, but even that is often overlooked. Seemingly, to discuss our deaths opens up for us the possibility that we will actually die.

With that in mind, it is easy to understand why physician-assisted suicide is so controversial. For those brave enough to speak, for those who feel compelled enough to argue, physician-assisted suicide rarely evokes anything but division. Those wishing to speak out for their beliefs are certainly free to do so, this is a free country after all. The very notion of freedom of speech is grounded in our own all-encompassing ideals of liberty, autonomy, and freedom. With that in mind, we are free to make our own decisions in life. We are free to pursue our loves, our goals, our desires. That very freedom is what drives the push for physician-assisted legalization. No one except those with a terminal illness can understand the pain they go through. No one except those with a terminal illness can understand the suffering they go through. While PAS is not an appropriate choice for everyone, we must respect the rights of those who wish to end their lives on their own terms, and grant them the ability to do so. Only then will they have their freedom.

Many times pet owners are faced with a difficult decision regarding their pet. Faced with their pet’s life of increasing pain and suffering, they must make the choice to have it humanely put to sleep. After the many good years together, after all the enjoyment, after all the bonding, after the entire relationship, they must make the decision to say goodbye. This is not simply an issue of the pet outliving its “usefulness”. This is caring for the animal. This is wishing it no undue harm in this world. In that sense, it is surprising that we do not offer our fellow humans the same courtesy. Now, it is easy to refute this claim, to say that an animal is not the same as a human. That is undeniably true. A human’s life is not the same as a pet’s life. The underlying values, however, still remain. We must value life while we are living. Not living in the sense that a human being is still breathing, but living in the sense that one can truly live. Suffering extends well beyond mere physical pain. Loss of dignity, loss of ability, loss of a life worth living are no reasons at all to continue on in uninterrupted misery. Unabated illness is an untenable situation. Compassion for others dictates this.

There are those who would argue that in the face of legalized assisted suicide, many (the homeless, uninsured, etc) would be coerced into an assisted suicide. While the claim has always seemed to be a farfetched notion, it can now be sufficiently put to rest. With the advent of the DWDA in Oregon, there is now evidence to enlighten us to the possibility of this occurring. Oregon’s report on the demographics of the patients who died as a result of PAS are almost identical to the demographics of the general population deaths. There are slight differences in marital and family status, but there is no evidence to suggest that patients with lower socio-economic status are more likely to participate in PAS.

There are also those who would cite the Hippocratic Oath, noting that it has a prohibition on hastening death. This also seems a bit disingenuous, in that physicians regularly disconnect life-saving respirators and equipment to fulfill a patient’s wishes. It also seems to imply that the Hippocratic Oath is one to be followed in the most literal
terms, verbatim. The Oath is more of a symbol of physician unity than an all-encompassing doctrine.

Finally, legalization of PAS would encourage discussion regarding death and would facilitate more logical solutions to end of life care. It is highly suspected that PAS already occurs secretly in some manner, be it through overdosing of narcotics or another other method. This would help to legalize appropriate physician behavior.

An Argument Against Physician-Assisted Suicide

In our society, we have made our physicians the modern day deities. The doctors are the smartest people, the hardest working, and are the best products of our education system. In all aspects of our health care, we defer to the doctor to make the decision. We may take a recommendation from a nurse, pharmacist, or physician assistant, but only if it’s trivial. This culture we’ve created of doctor worship has imposed upon us the subconscious belief that our doctors are infallible. In that they are infallible, we look to them to make the most difficult decisions for us.

Physician-assisted suicide is a disturbing concept for many reasons, but the most glaring of them is the notion that the doctors doing the diagnosing are always correct. There are many examples of cases in which a patient was left for dead at a hospice organization only to spontaneously recover later on, long after the patient was expected to die. It is well known in the medical community that a prognosis for death is anything but accurate; the actual time of death may occur anywhere from shortly after the prognosis was given to not dying at all. This is not to say that physicians are overwhelmingly incompetent or that they don’t have the best wishes of their patients at heart. This is just to point out the fact that doctors can, and do, make mistakes in not only estimated the course of a disease but also the original diagnosis.

It is well known that depression is a major risk factor for suicide. The rate of depression is estimated to be anywhere from 65-100% in terminally ill patients. With this being said it seems reasonable that physicians would screen patients for depression when they seek PAS. This does, in fact, happen but studies have shown that, of the patients requesting PAS, only 20% were determined to be depressed. This is a frightening disparity and lends to the argument that these patients are not being adequately screened.

Similarly, physicians seem to be underemphasizing the role of alternative end of life care. Programs such as hospice, intensive pain management, dignity psychotherapy, and others are extremely underused. One study showed that, of the patients requesting PAS, only 60% were offered alternatives. Of those, almost half changed their mind about PAS and instead agreed to alternative therapy. How many more lives could have been saved had alternative methods been offered to ALL the patients?

Physician-assisted suicide seeks to normalize suicide and integrate it into our everyday lives. Do we want to live in a world where suicide is viewed casually and as a normal part of life? With increasing physician-assisted suicides, this will only increase the propensity of other, non-ill citizens to also look to suicide as a resource to end their depression. PAS will create a culture of suicidal peoples. This is unacceptable.
PAS does not only promote suicide. It also undermines the sanctity of life. Regardless of one’s religion or culture, our time on this Earth is all we have in this life. We should value and cherish this gift of life that we have. To simply throw away a human life is an act that unequivocally denies this truth. It denies the possibility of miracles and it denies our own value.

Physicians must wrestle with the decision of PAS and their own personal stance on it. Let this be a helpful reminder: The Hippocratic Oath itself, a longstanding ethical tradition of physicians, states that a physician will do no harm. What worse harm could there be than in assisting patients in killing themselves? This in itself serves to illustrate how PAS undermines the integrity of the physician. They would do well to continue this tradition and help patients in living.

Finally, the option of PAS opens us up to a dangerous possibility. In the mainstreaming of PAS, there may be an increasing urge to coerce certain populations (the homeless, uninsured, etc) into seeking PAS. This could happen for monetary reasons, emotional reasons, or social reasons. The bottom line is that, even as unethical as PAS is, it is merely a domino in a hundred other more serious ethical violations.

There are many reasons to oppose PAS, and these are just a select few. The really alarming fact is how much we don’t know about it and what else it may bring.

My Take

In researching this paper, I got the opportunity to examine both points of view in the PAS debate. In doing so, I thought that by the time I was finished writing this paper I would have it all figured out. I would know exactly where I stood on the issue. Now that we have reached the end I realize I still don’t have a concrete opinion. I have written the above opinion essays as if I really believed them, but the truth is that I am still somewhere in the middle; I’m sitting on the fence, so to speak. In looking at this from a personal perspective there are two different viewpoints that one can take. There is the obvious “future pharmacist” opinion. That is relatively obvious in the context of what this term paper is for. There is also the more personal aspect.

Would I want this option for myself? Absolutely. I’m not sure that I would ever want to actually partake in that, but I think it’s safe to say that it’s an option that might be “nice” to have around. The thought of death is scary, yes, but the thought of a seemingly meaningless suffering condition is even more mortifying. In that I am happy being alive, there are certain conditions under which I think we can all agree would be horrific. If I were so unfortunate to be in said situation, I would probably consider it.

Now there’s also the pharmacist’s standpoint. As a pharmacist would I feel comfortable dispensing a prescription for death? I’m not sure. I realize that this creates a certain inconsistency in my reasoning. I, on one hand, say that I would feel comfortable having PAS as an option for me personally. On the other hand, I wouldn’t necessarily feel comfortable taking part in it as a pharmacist. This is somewhat hypocritical on my part, I do realize. I would want it for myself, yet I would not necessarily offer another human being the same courtesy. That is food for thought, I suppose. I will continue to give it the “Dr. Vivian pillow test”.
References

1. Bascom PB, Tolle SW. Responding to requests for physician-assisted suicide: “these are uncharted waters for both of us…” JAMA, 288:91-98. 2002.


