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Michael J. Roth

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# A FAILED STATUTE, GEOFFREY FEIGER, AND THE PHRENETIC PHYSICIAN: PHYSICIAN-ASSISTED SUICIDE IN MICHIGAN AND A PATIENT-ORIENTED ALTERNATIVE

## I. INTRODUCTION

Since 1988, twenty-one reported instances of suicide conducted with the participation of a physician have occurred in the State of Michigan.<sup>1</sup> Prior to these instances, sources document only nine physicians facing murder charges for assisting in a patient's suicide in the United States.<sup>2</sup> Ironically, the increase in reported physician-assisted suicide cases is at least partially a result of improvements in medical technology.<sup>3</sup> Often, these technological improvements serve to prolong life without regard for improving the quality of life.<sup>4</sup> As such, technology has pushed many patients' lives beyond the traditional threshold of death, but no medical procedure exists to make that prolonged life free of pain.

In response to the drastic increase in reported physician-assisted suicide cases, the Michigan legislature passed a law, effective February 25, 1993,<sup>5</sup> that

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1. The number of suicides is current as of May 14, 1994. See *infra* notes 110-23 and accompanying text.

2. *Juries Kind to Doctors Who Assist*, CAPITAL TIMES, Mar. 17, 1992, at D1. Hemlock Society statistics reveal only ten reported instances of assisted suicide between 1980-1991, half of which occurred in 1991. See Cheryl K. Smith, *What About Legalized Assisted Suicide?*, 8 ISSUES L. & MED. 503, 508 (1993).

3. "Two decades ago, those who were not and could not swallow and digest food, died . . . . Today, various forms of artificial feeding have been developed that are able to keep people metabolically alive for years, even decades." *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 328 (1990) (Brennan, J., dissenting). Justice Brennan is not alone in this observation. A recent article in the *Journal of the American Medical Association* recognized "that the dying process is too often needlessly protracted by medical technology and is consequently marked by incapacitation, intolerable pain, and indignity." American Medical Association Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2229 (1992).

4. "Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues." *Cruzan*, 497 U.S. at 301 (quoting *Rasmussen v. Fleming*, 741 P.2d 674, 678 (Ariz. 1987)) (Brennan, J., dissenting).

5. Michigan's assisted suicide law was to become effective on April 1, 1993. However, because of a marked increase in the reports of physician-assisted suicides, the Michigan legislature voted to make the law effective at an earlier date. Carol J. Castaneda, *Two States Target Kevorkian*, USA TODAY, Feb. 24, 1993, at A3. The pertinent provisions of the statute are:

(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 neither be applicable to nor be deemed to affect any other laws that may be applicable to withholding or withdrawing medical treatment by a licensed health care professional.

(3) A licensed health care professional who administers, prescribes, or dispenses medications or procedures to relieve a person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, is not guilty of assistance to suicide under this section unless the medications or procedures are knowingly and intentionally administered, prescribed, or dispensed to cause death.

MICH. COMP. LAWS § 752.1027 (1)-(3) (1993).

It is essential to note that the statute is only temporary in nature. MICH. COMP. LAWS § 752.1027 (4) provides that the legislature shall repeal the statute six months after the Michigan Commission on Death and Dying, established in the companion statute MICH. COMP. LAWS § 752.1021, makes its recommendation as to what the permanent status of physician-assisted suicide should be in Michigan.

At the time of publication, it was unclear what the Commission's recommendation would be. It was clear, however, that attempting to predict the permanent legal status of physician-assisted suicide was a fruitless effort. The panel was sharply divided as some members favored keeping the statute intact while the remaining members believed the Michigan Constitution provided individuals with an absolute right to receive aid in dying. See, e.g., *Panel Divided on Keeping Ban on Assisted Suicides*, ORLANDO SENTINEL, Dec. 22, 1993, at A14; *Panelists Urge Lifting Ban on Suicide*, CHI. TRIB., Dec. 22, 1993, at A3.

In a similar vein, the Michigan Court of Appeals and Dr. Jack Kevorkian were also seeking to resolve the issue. After the statute's enactment, the State of Michigan filed four charges against Dr. Jack Kevorkian for assisting suicides. Three of the charges were dismissed before trial because the trial court judges believed the statute was unconstitutional. *Judge Orders Kevorkian to be Tried in Assisted Suicide*, L.A. TIMES, Feb. 19, 1994, at A1; David Lawder, *Judge Strikes Down Suicide Law, Charges Against Kevorkian*, REUTERS, Jan. 27, 1994, available in LEXIS, News Library, CURNWS File. The State of Michigan appealed these pretrial judgments and the Michigan Supreme Court ordered immediate consideration by an appellate court. *State v. Kevorkian*, No. SC-98364, 1993 Mich. LEXIS 2986, at \*1 (Mich. Dec. 21, 1993). Although no decision has yet been rendered, the appellate court hearing the case has but two options. The court can either uphold the law or strike it down as unconstitutional. While the Michigan Court of Appeals was considering the rulings of the three district court judges who found the statute unconstitutional, a fourth district court actually held a trial against Dr. Kevorkian. At the time of publication, the attorneys were conducting voir dire. Even though the outcome could not be predicted, there is little doubt that the situation was rife with conflict. Dr. Kevorkian faced the dilemma of being convicted by a jury only to have the appellate court, in a separate action, find the law under which he was prosecuted unconstitutional.

Dr. Jack Kevorkian, often portrayed in the media as a jovial grim reaper, has also offered his hand in "resolving" the issue. After being released from jail in December of 1993, Dr. Kevorkian announced that he and his attorney, Geoffrey Feiger, began a campaign to put a referendum on the November, 1993 ballot that would guarantee an absolute right to physician-assisted suicide within Michigan's boundaries. *Kevorkian Begins Ballot Drive for Suicide Measure*, N.Y. TIMES, Jan. 31, 1994, at A13. If successful, Michigan's Constitution would be amended to read, "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." *Id.* Although public opinion polls suggest that most people in Michigan support such a right, see *infra* notes 261-62, it is nevertheless quite unclear whether such a referendum would succeed. Both California and Washington considered similar referendums that failed even though

prohibits anyone, including a physician, from either causing<sup>6</sup> or assisting<sup>7</sup> in the suicide of a patient. In passing such a law, the Michigan legislature gave great deference to the state's interest in preserving the lives of its citizens.<sup>8</sup> However, in so doing, the legislature ignored the plight of individuals whose lives have been prolonged because of medical advances, yet whose quality of life has not improved.<sup>9</sup>

Physician-assisted suicide is a highly divisive topic. Many patients who face suffering that no medical procedure can alleviate are strongly in favor of exercising their right to self-determination through assisted suicide.<sup>10</sup> Even the

public opinion polls in those states suggested that the referendums should have passed. See *infra* notes 262-63.

Although there are three separate channels of activity attempting to resolve this divisive issue, none appear to be on course. The Michigan Commission on Death and Dying appears to be considering only two diametrically opposed alternatives: keeping the present statute intact, which provides a blanket prohibition on physician-assisted suicide, or recognizing an absolute right, free of governmental regulation, to receive aid in dying. Likewise, the Michigan Court of Appeals will either uphold the statute, the effect of which would be to absolutely prohibit physician-assisted suicide, or it will strike the statute, thus taking physician-assisted suicide outside the reach of Michigan's criminal courts. Dr. Kevorkian's proposed constitutional amendment grants an absolute right to receive aid in dying to competent individuals, while eschewing any form of government regulation. None of these approaches adequately addresses the legitimate, but competing interests that physician-assisted suicide invokes. See *infra* notes 14-17 and accompanying text. For a proposal that is more responsive to the problems posed by physician-assisted suicide, see *infra* section VI.C.

6. See *infra* notes 62-67 and accompanying text.

7. See *infra* notes 68-79 and accompanying text.

8. See *infra* notes 223-38 and accompanying text.

9. The statute would stringently regulate the instances in which individuals, such as those discussed *infra* notes 109-23, could receive aid in dying.

10. The following letter written by a man suffering from lung cancer details a typical example of patient support for self-determination. This letter illustrates an important tenet of this note: Although a strong interest in preserving life exists, the state cannot neglect the incurably suffering patient's interest in personal autonomy.

I like Dr. Jack Kevorkian, the death doctor. Like him a lot. I may, one day soon, hope to do business with him or one of his advocates. I have lung cancer. My pain is controllable now, and I am still able to get around fairly well, but that will change as my cancer progresses. One day I, too, will cry, "Enough!" and plead for help. I can only hope it is available for me . . .

Oh, I've heard the arguments, all of which finally boil down to one of these:

No one has the moral or legal right to end his own life.

If you want to commit suicide, just do it. You don't need a doctor's help.

If you accept the first argument, read no more. The only thing that will change your mind is excruciating pain, for you or for a loved one. I sincerely hope you never hurt that much.

As to the second argument: It sounds easy enough, doesn't it? Just do it! Jump off a bridge. Shoot yourself. Swallow some pills.

I've thought about it. Believe me, I think about it a lot. I've read "Final Exit." I know what kind of pills to take and how many. I've stocked up. I lie in bed and

medical community, formerly ardently opposed to physician-assisted suicide, has

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wonder about pain and nausea and wonder how I will know when it is time to do it. I wonder if I'll have the guts to do it.

The biggest reason I need a doctor's help, I guess, is that I am afraid, terribly afraid, of dying. *I would walk through fire if it would somehow prevent my cancer from killing me. But it won't. And I do not want to walk through the terrible fire of chemotherapy and radiation and rotting internal organs only to die in agony anyway. I need professional help in facing what I must face . . . death.*

One of the women Dr. Kevorkian helped had previously tried—unsuccessfully—to kill herself. She failed, but was lucky in some respects. She didn't destroy her mental faculties. She didn't cripple herself, as so many of those who attempt suicide do. If she had, she might be alive now, experiencing all the anguish she so desperately wanted to escape, hooked up to life-preserving machines and fervently wishing she had died or now had the ability to end her life.

Often, usually late at night, my mind fast-forwards to the time when I must try to take my life. I am calm. I see 60 of the prescription pills I've hoarded sitting on the table. I hold my wife, Clara's hand as I swallow the pills. Then I start crying.

Derek Humphry, the author of "Final Exit," says that pills alone might not do it. He urges readers to enhance the pills by tying a plastic bag around their heads. This combination is almost 100% effective. And you know what? I can't—even in my imagination—tie that plastic bag around my neck. I think I could take the pills I've hoarded. But I just can't see myself tying that bag around my neck.

Humphry says many people have this problem. Now, let me clarify: *I want to avoid the prolonged suffering from lung cancer. I want to die as dignified a death as possible . . . .*

I am not, by the way, some nut who just decided that suicide would be a neat idea. *I have fought my cancer for four years. I have conferred with my doctors all the way and have done what they have told me to do.* Recently, I asked my oncologist how much more chemotherapy I should endure, as the discomfort from each session was getting progressively worse, and the cancer seemed to be accelerating.

He said it was up to me. Some people take chemotherapy right up to the day they die. Others opt to discontinue the treatment and let their doctors do what they can to reduce the pain. I decided to stop chemotherapy.

Here's the point: I made this critical decision only after weighing my doctor's opinion. I leaned heavily on his expertise. Cancer is his specialty. I asked questions. He patiently answered them to the best of his ability, but he left the final decision—should I give up chemotherapy?—to me.

*I would prefer to take this other step, this final step, with similar help from the same experts I now depend on for medical help. I want to ask my doctor questions. I want answers based on his knowledge of cancer, life and death. As with my decision on chemotherapy, I want the decision to end my suffering to be my own, but supported by my doctor's expertise.*

I'll make the decision. I'll even push the lever. But, please, Doctor, help me as much as you can. Perhaps your expertise will lead you to advise, "Don't do it!" Or, "Not now, you have a lot of good days left yet." Good. I want to hear those things. I want the truth. But, please, if the pain is too much and too continuous, give me the equipment and the chemicals to end it with as little stress as possible.

Don Bauer, *An Appreciation of Dr. Kevorkian*, PLAIN DEALER (Cleveland), Feb. 18, 1993, at B11 (emphasis added).

become increasingly sensitive to the suffering patient's predicament.<sup>11</sup> Conversely to the medical community's stance in physician-assisted suicide, the Catholic Church<sup>12</sup> and most state legislatures are staunch proponents of the sanctity of life. Indeed, more than half of the states have statutes prohibiting physician-assisted suicide.<sup>13</sup>

Although several states, including Michigan, make physician-assisted suicide illegal, an absolute ban on assisted suicide does not adequately resolve the issue.<sup>14</sup> The solution to the problem must reflect the conflicting interests implicated by physician-assisted suicide. Conflicting interests exist between the state's interest in preserving life and the individual's interest in privacy and personal autonomy.<sup>15</sup> In addition, competing canons exist which say that physicians are to prolong life yet also strive to relieve suffering.<sup>16</sup> Michigan's absolute ban on physician-assisted suicide fails to adequately balance the issue's competing concerns in two ways. First, the statute gives complete preference to the state's interest in preserving life over the competing concern for the

11. See *infra* notes 255-57 and accompanying text.

12. Kevin O'Rourke, *Catholic Teaching in Regard to Two Prominent "Right to Life Issues": A Historical Theological Study*, ST. LOUIS U. PUB. L. REV. 425 (1992). O'Rourke states that theologians have always viewed suicide as a moral evil. *Id.* at 430.

13. See statutes cited *infra* notes 72-73.

14. See generally L. Paul Hudgins, Comment, *To Live or Die: Creating a Choice of Medically Assisted Suicide in Michigan's Proposed Law*, 8 COOLEY L. REV. 609 (1991) (proposing that "medical treatment" include voluntary, medically-assisted euthanasia as an available form of treatment).

15. See *infra* notes 223-38 and accompanying text.

16. Generally, physicians state a version of the following Hippocratic Oath upon entering the practice of medicine:

To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. *I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death.* Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be [sic] my lot.

STEDMAN'S MEDICAL DICTIONARY 650 (5th ed. 1982) (emphasis added).

individual's right to privacy and autonomy. Second, the statute always gives preference to the physician's role to prolong life over the physician's legitimate competing concern to relieve suffering.<sup>17</sup>

Rather than a law that always prefers one legitimate concern over another, Michigan's assisted suicide law must reflect all conflicting concerns, giving each concern its appropriate weight on a case-by-case basis. The statute proposed in this Note is an alternative to Michigan's absolute ban on physician-assisted suicide and is responsive to the aforementioned interests implicated by physician-assisted suicide.<sup>18</sup>

Section II of this Note will discuss the historical legal treatment of suicide in Greece, the Roman Empire, England, and the United States.<sup>19</sup> Next, Section III will discuss the development of the assisted suicide problem in Michigan.<sup>20</sup> Section III will then explore the status of the law in Michigan.<sup>21</sup> Moreover, Section IV of this Note will distinguish between assisted suicide cases, right-to-die cases, and caused suicide<sup>22</sup> cases to display that a different legal standard is appropriate with application to assisted suicide cases.<sup>23</sup> Section V will explore the Dutch treatment of assisted suicide to show that Michigan can implement a workable system of assisted suicide utilizing stringent governmental control.<sup>24</sup> Lastly, Section VI of this Note will discuss basic policy considerations that justify implementing an exception to Michigan's current assisted suicide statute.<sup>25</sup> Section VI also will provide physicians with an affirmative defense to the Michigan assisted suicide statute followed by hypotheticals that provide a reference for the scope of the defense.<sup>26</sup>

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17. The Michigan statute holds that the state's interest in preserving life is always paramount to self-determination. See statute cited *supra* note 5. By ignoring the dilemma that many suffering patients face, the Michigan statute is unduly harsh. This note provides a statute that is responsive to the conflicting interests implicated by physician-assisted suicide by balancing the interest of individual autonomy against the state's interest in preserving life. See *infra* section VI.C. By approaching the problem in this manner, the proposed statute is more responsive to the pragmatic difficulties of physician-assisted suicide. See *supra* note 10 (quoting Bauer letter). The goal of the statute is to allow suffering individuals who have no medical alternatives for pain alleviation to end their lives with dignity while still preventing the widespread use of physicians as agents of death.

18. See *infra* section VI.C.

19. See *infra* notes 27-79 and accompanying text.

20. See *infra* notes 80-108 and accompanying text.

21. See *infra* notes 109-31 and accompanying text.

22. See *infra* notes 62-67 and accompanying text.

23. See *infra* notes 132-82 and accompanying text.

24. See *infra* notes 183-220 and accompanying text.

25. See *infra* notes 221-65 and accompanying text.

26. See *infra* notes 266-81 and accompanying text.

## II. THE DEVELOPMENT OF ASSISTED SUICIDE LAW

Ancient Greece and Rome viewed an absolute ban on suicide as unreasonable.<sup>27</sup> Both societies recognized suicide as a way to achieve a dignified death.<sup>28</sup> Even the Hippocratic Oath,<sup>29</sup> which dates back to 400 B.C. in ancient Greece, recognizes the physician's obligation to relieve suffering.<sup>30</sup> Moreover, the Hippocratic Oath requires physicians to protect and prolong life.<sup>31</sup> Greeks resolved the conflicting mandates espoused in the Hippocratic Oath in the following manner: physicians were to prolong life when possible, but when a person faced unrelenting suffering, euthanasia<sup>32</sup> was an acceptable method to relieve that suffering.<sup>33</sup>

## A. English Common Law Treatment of Suicide Issues

Later, western cultures did not adhere to the approval of euthanasia evidenced in ancient Rome and Greece.<sup>34</sup> As Christianity spread through the

27. JAMES RACHELS, *THE END OF LIFE* 8 (1986).

28. DEREK HUMPHRY & ANN WICKETT, *THE RIGHT TO DIE* 4-5 (1986). The etymology of "euthanasia" reveals that the word is a compilation of the greek "eu" and "thanatos" which when combined mean "good death." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 786 (1961).

29. See *supra* note 16 (Hippocratic Oath).

30. Marya Mannes, *Euthanasia vs. The Right to Life*, 27 BAYLOR L. REV. 68, 70 (1975).

31. O. RUTH RUSSELL, *FREEDOM TO DIE* 285 (rev. ed. 1977). The Oath provides "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." See *supra* note 16 (Hippocratic Oath). Further, the Oath reads "To please no one will I prescribe a deadly drug, nor give advice which may cause his death." *Id.* Ironically, given the status of medical technology, when physicians prescribe the regimen that is best for patients, they may actually have to administer a deadly drug. See *supra* note 10 (Bauer letter). The conflicting obligations found in the Hippocratic Oath, combined with the tension found in society's interest in preserving life versus individual autonomy, provide the tension which undergirds the issue this note addresses: if and when a physician should be allowed to assist in a suicide. See *infra* section VI.C.

32. Euthanasia is defined as: "The act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy." BLACK'S LAW DICTIONARY 554 (6th ed. 1990). Further, *Black's* defines mercy killing as: "Euthanasia. The affirmative act of bringing about the immediate death allegedly in a painless way and generally administered by one who thinks that the dying person wishes to die because of a terminal or hopeless disease or condition." *Id.* at 988. This note will use "euthanasia" or "mercy killing" when discussing the area encompassing right-to-die cases, assisted suicide cases, and caused suicide cases in general.

33. Greek mythology encouraged those suffering from incurable afflictions to call on the Greek god of death, Thanos, to relieve the person of their misery. Mannes, *supra* note 30, at 70.

34. Ancient Rome and Greece were not alone in their acceptance of suicide as a means to relieve incurable suffering. Both ancient India and Sardinia approved of the practice in cases involving the elderly or chronically ill. Deborah A. Wayne, Note, *Active Voluntary Euthanasia: The Ultimate Act of Care for the Dying*, 37 CLEV. ST. L. REV. 645, 647 (1989).

Western world, the Church forbade suicide for any purpose.<sup>35</sup> By the fourth century A.D., acceptance of suicide had virtually disappeared.<sup>36</sup> Consistent with Christianity's view, English common law reflected the change in attitude regarding suicide.<sup>37</sup> In treating suicide as a form of murder, English common law punished suicide in one of two ways. First, if the deceased/suicidant<sup>38</sup> carried out the suicide to avoid punishment for the commission of a felony or as a result of anger, then the suicidant forfeited all lands and chattels to the king.<sup>39</sup> Second, if the suicide resulted from depression, then the suicidant only forfeited chattels to the king.<sup>40</sup> The land descended to the suicidant's heirs and not to the king.<sup>41</sup> However, regardless of the motive for the suicide, the suicidant received an ignominious burial in which the suicidant was buried at a crossroads with a stake driven through the body and a rock placed on the suicidant's head.<sup>42</sup>

Two rationales prevailed for punishing suicide. First, committing suicide was an offense against God<sup>43</sup> and natural law.<sup>44</sup> Second, committing suicide was

35. Mannes, *supra* note 30, at 72-73. The objection to suicide is grounded in the Sixth Commandment—"Thou Shalt not kill." *Exodus* 20:12. The Church (the Catholic Church) assumed that killings apparently motivated by mercy may instead be motivated by evil. Mannes, *supra* note 30, at 72-73.

36. Waaney, *supra* note 34, at 648.

37. See, e.g., *Hales v. Petit*, 75 Eng. Rep. 387, 399 (C.B. 1565). In *Hales*, Sir James Hales "feloniously and voluntarily drowned himself in a river." *Id.* at 394. Hales committed "a Degree of Murder . . . [as] the killing of himself was prepensed and resolved in his Mind before the Act was done." *Id.* at 399.

38. Unless stated to the contrary, the deceased/suicidant is hereinafter referred to as "suicidant." For purposes of this note, suicidant describes the person who committed suicide.

39. Sue Woolf Brenner, *Undue Influence in the Criminal Law: A Proposed Analysis of the Criminal Offense of "Causing Suicide,"* 47 ALB. L. REV. 62, 64 (1982).

40. *Id.* See also GEORGE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 262 (1970) (describing the method by which chattels escheated to the king in suicide cases).

41. Brenner, *supra* note 39, at 64. If the deceased was insane, then neither lands nor chattels escheated to the king. *Id.* See also William E. Mikell, *Is Suicide Murder?*, 3 COLUM. L. REV. 379 (1903) (offering a concise history of the common law of suicide).

42. WILLIAMS, *supra* note 40, at 257-61. The purpose of ignominious burial was to prevent the body from rising. *Id.* at 259. The last reported burial of this type occurred in London in 1823. *Id.* at 259-60. After 1823, English law abolished the practice because of a growing recognition of the futility in punishing suicide. *State v. Willis*, 121 S.E.2d 854, 855 (N.C. 1961). America thereafter abolished the practice as well. See *infra* text accompanying note 55. Nevertheless, English and American law viewed suicide as the most tragic of sins because it deprived the deceased of the chance for salvation. Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 26 (1985).

43. Kevin O'Rourke describes why Christians view suicide as an offense against God in the following manner:

God gave us the gift of human life to show forth His goodness and love (Gn. 1). We, in turn, show our love for God by respecting and fostering that gift of human life. Although we are called to life beyond human life, we do not disdain the gift of human

an offense against the king because it deprived the king of one of his subjects.<sup>45</sup> Because English common law treated suicide as a crime,<sup>46</sup> it also treated attempted suicide as a crime.<sup>47</sup> The common law punished assisted suicide as well. If one advised another in committing suicide and was present during its commission, English law charged that person as a principal in the suicide.<sup>48</sup> If one advised a person planning to commit suicide, but was not present during its commission, English law charged that person as an accessory before the fact.<sup>49</sup>

### B. American Legal Treatment of Suicide

Early in American history, the legal treatment of suicide varied greatly among the several states.<sup>50</sup> However, no state actively used England's penalty of forfeiture of property.<sup>51</sup> Nevertheless, although no state adopted the English penalty of forfeiture, the suicide laws of the various states differed. Some states held that suicide was not a crime;<sup>52</sup> others held that committing suicide was a

life or reject it to hasten our advance toward eternal life (Lk. 8:11). . . . One way to show our love for God . . . is to prolong human life. Thus it is not an act of responsible human love to willfully and directly end one's own life or the life of another. Christians have always denounced suicide and euthanasia because these acts are considered to be a serious violation of love for God.

O'Rourke, *supra* note 12, at 425.

44. Wainey, *supra* note 34, at 648 (1989). St. Augustine viewed suicide as "intrinsically sinful" because it directly contravened man's survival instinct. *Id.*

45. 4 WILLIAM BLACKSTONE, COMMENTARIES \*188-89. Blackstone noted as well that the punishment for suicide included both forfeiture and ignominious burial because of the practical difficulty in punishing someone already dead. *Id.* at 190.

46. See *supra* note 37 and accompanying text.

47. WILLIAMS, *supra* note 40, at 273-74.

48. Brenner, *supra* note 39, at 66-67. See also Catherine D. Shaffer, Note, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348, 349 (1986) (discussing the historical development of suicide in England).

49. Brenner, *supra* note 39, at 66-67. English courts never convicted a person of this crime. At common law, the sovereign could not punish an accessory before the fact until the sovereign convicted the principal. In the case of suicide, convicting the principal is impossible. *Id.* American law has remedied this problem through statutes that allow the state to prosecute accessories to suicide even in the absence of the principal. Andrew Wolfram, *The Criminal Aspect of Suicide*, 39 DICK. L. REV. 42, 46 (1936).

50. Juliana Reno, Note, *A Little Help From My Friends: The Legal Status of Assisted Suicide*, 25 CREIGHTON L. REV. 1151, 1155-56 (1992) (discussing various states' legal approaches to suicide).

51. Brenner, *supra* note 39, at 65. Massachusetts was the only state to adopt by statute the practice of ignominious burial. The practice fell into disuse in 1823 when the legislature repealed the statute. Reno, *supra* note 50, at 1155. For a discussion of forfeiture, see *supra* notes 40-42 and accompanying text.

52. Royal Circle v. Achterrach, 68 N.E. 492 (Ill. 1903) (holding that one who actually accomplishes suicide is not guilty of attempted suicide or any other crime); State v. Campbell, 251 N.W. 717 (Iowa 1933) (holding that accused who shot deceased while attempting to commit suicide did not commit an unlawful act); May v. Pennell, 64 A. 885 (Me. 1906) (holding that suicide and

felony;<sup>53</sup> while the remaining states held that committing suicide was unlawful, though not a felony.<sup>54</sup> As American law never adopted the penalty of forfeiture, and the English practice of ignominious burial ceased in 1823, suicide carried with it no penalty.<sup>55</sup> Therefore, as time progressed the American states moved away from treating suicide as a crime because they lacked an effective method of punishment.

Although committing suicide is not generally a criminal offense,<sup>56</sup> most states have enacted statutes that criminalize suicide-related offenses such as attempted suicide, caused suicide,<sup>57</sup> and assisted suicide.<sup>58</sup> A brief overview of these areas will give further insight into the complexity of the assisted suicide issue.

### 1. Attempted Suicide

Attempted suicide was at one time a crime, but today states do not criminally sanction a suicide attempt.<sup>59</sup> Although no states have statutes treating

attempted suicide are not criminal offenses); *Darrow v. Family Fund Soc'y*, 22 N.E. 1093 (N.Y. 1889) (stating that suicide is not a crime in New York), *overruled by Shipman v. Protected Home Circle*, 67 N.E. 83 (N.Y. 1903); *Blackburn v. State*, 23 Ohio St. 146 (1872) (holding that suicide can be used as a defense to a murder trial, as suicide is not a crime), *overruled by State v. Staten*, 247 N.E.2d 293 (Ohio 1969); *Sanders v. State*, 112 S.W. 68 (Tex. Crim. App. 1908) (reversing conviction of murder in light of evidence that defendant assisted in suicide), *overruled by Aven v. State*, 277 S.W. 1080 (Tex. Crim. App. 1925).

53. *Burnett v. People*, 68 N.E. 505 (Ill. 1903) (recognizing that suicide is a felony); *State v. Carney*, 55 A. 44 (N.J. 1903) (holding that attempted suicide is an indictable felony).

54. *Pennsylvania Mut. La. Ins. Co. v. Cobbs*, 123 So. 94 (Ala. Ct. App. 1929) (stating that suicide in Alabama is a crime involving moral turpitude); *State v. Levelle*, 13 S.E. 319 (S.C. 1891) (holding that suicide is an unlawful act).

55. Wilbur Larremore, *Suicide as a Crime*, 17 HARV. L. REV. 566 (1904).

56. A few jurisdictions still treat suicide as a common law offense. *See, e.g., Hill v. Nicodemus*, 755 F. Supp. 692 (W.D. Va. 1991) (affirming that suicide remains a common law crime in Virginia although the legislature has rescinded any punishment for suicide), *aff'd*, 979 F.2d 987 (4th Cir. 1992); *Southern Life & Health Ins. Co. v. Wynn*, 194 So. 421 (Ala. Crim. App. 1940) (holding that suicide is a common law felony and is a crime involving moral turpitude); *Commonwealth v. Hicks*, 82 S.W. 265 (Ky. 1904) (recognizing that suicide is a common law crime). Generally however, the lack of criminal punishment for suicide prevents it from being a crime. 1 JOEL P. BISHOP, COMMENTARIES ON THE CRIMINAL LAW 551-52 (4th ed. 1868). No state has a statute making suicide a punishable offense. *See, e.g., State v. Marti*, 290 N.W.2d 570 (Iowa 1980) (recognizing futility in charging person who successfully commits suicide with a crime); *State v. Fuller*, 278 N.W.2d 756 (Neb. 1979) (allowing jury instruction stating that suicide is not a statutory crime in Nebraska).

57. *See infra* notes 62-67 and accompanying text (defining caused suicide).

58. *Reno*, *supra* note 50, at 1155.

59. Six states once made attempted suicide a crime by statute. *See Lawrence T. Hammond, Note, Criminal Law—Attempted Suicide*, 40 N.C. L. REV. 323, 326 (1962) (noting the trend for states to repeal statutes forbidding attempted suicide). *But see State v. Lafayette*, 188 A. 918 (N.J.

attempted suicide as a crime,<sup>60</sup> if a person attempts suicide unsuccessfully and in the process kills another person, the states impose criminal sanctions of different degrees.<sup>61</sup> However, further discussion of attempted suicide is not relevant to the scope of this Note.

## 2. Caused Suicide

The offense of caused suicide arises in two instances. The first scenario occurs when a person by use of force, duress, or deception purposely causes another to commit suicide.<sup>62</sup> The second scenario occurs when a person acting pursuant to the request of an individual seeking death, commits the ultimate act resulting in death.<sup>63</sup> American courts have recognized uniformly that a victim's consent to murder is no defense.<sup>64</sup> Generally, if a person commits the ultimate act resulting in the death of another person, the person committing the act is guilty of murder.<sup>65</sup>

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1937) (holding that attempted suicide is a crime); *accord* State v. Willis, 121 S.E.2d 854 (N.C. 1961) (holding that attempted suicide is a crime).

60. MODEL PENAL CODE § 201.5, at 56 n.10 (Tentative Draft No. 9, 1959) (recognizing that only Oklahoma and Washington had statutes outlawing attempted suicide, both of which have been repealed). It is the best policy not to punish attempted suicide. The threat of punishment will not deter a person contemplating suicide if the attempt is unsuccessful. "There is a certain moral extravagance in imposing criminal punishment on a person who has sought his own self-destruction." WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., CRIMINAL LAW § 7.8, at 649 (2d ed. 1986).

61. State v. Campbell, 251 N.W. 717 (Iowa 1933) (holding that an attempted suicide that kills another is not a crime without showing recklessness); Commonwealth v. Mink, 123 Mass. 422 (1877) (affirming that attempted suicide that kills another is involuntary manslaughter), *overruled* by Commonwealth v. Catalina, 556 N.E.2d 973 (Mass. 1990); State v. Levelle, 13 S.E. 319 (S.C. 1891) (treating attempted suicide that kills another as murder). These cases generally arise when a person sees another trying to commit suicide and attempts to prevent the suicide. In response, the person seeking suicide reacts aggressively toward the person intervening.

62. MODEL PENAL CODE § 210.5(1) at 127 (Proposed Official Draft 1962) provides that a person should be convicted of homicide if that person, by use of force, duress, or deception purposely causes another to commit suicide.

63. State v. Cobb, 625 P.2d 1133 (Kan. 1981) (upholding murder conviction when defendant, at the victim's request, administered a lethal dose of cocaine and shot victim in the head); State v. Fuller, 278 N.W.2d 756 (Neb. 1979) (affirming murder conviction when defendant, acting pursuant to victim's request, collapsed a bag attached to a needle that was inserted in victim's arm); Turner v. State, 108 S.W. 1139 (Tenn. 1908) (upholding murder conviction where defendant shot his married lover at her request). The caused suicide fact pattern is defined for purposes of this note as completely active euthanasia as it relates to mercy killings. See *infra* note 167 and accompanying text.

64. For a general discussion of consent, see LAFAVE & SCOTT, *supra* note 60, § 5.11, at 477-80.

65. See cases cited *supra* note 63. Murder is a slightly overbroad term. Murder, under such circumstances, could entail a charge of first degree murder, second degree murder, voluntary manslaughter, or involuntary manslaughter. However, distinguishing between these types of murder is beyond the scope of this note.

Although in practice jurors are reluctant to convict doctors of murder, in theory criminal liability applies with equal vigor to the physician who causes a patient's death by means of a lethal injection.<sup>66</sup> Notwithstanding the juror apprehension to convict doctors, in certain instances the state should provide a physician who assists a suicide with immunity from a criminal charge. As an example, the criminal law should not expose the physician to criminal liability when the physician assists the suicide of a competent patient experiencing extreme pain that no medical procedure can alleviate.<sup>67</sup> The following discussion provides further insight into the distinguishable characteristics of caused and assisted suicides.

### 3. Assisted Suicide

Caused suicide cases involve a second party who actively participates in the suicide by firing a gun or by injecting the victim with a substance that causes death.<sup>68</sup> In contrast, assisted suicide cases involve a second party who assists the suicidant in committing suicide by either encouraging the suicidant or by providing the means for the commission of the suicide.<sup>69</sup> A small number of jurisdictions have held that assisted suicide is not a crime.<sup>70</sup> However, most state judiciaries from the nineteenth century until early in the twentieth century held that assisted suicide constituted murder.<sup>71</sup> Today by statute, many

66. See *infra* note 111 and accompanying text.

67. The statute proposed in this note would absolve physicians of criminal liability in the extreme circumstances where a patient is competent and there exists no medical procedure, other than the administering of mind altering drugs, that can alleviate the patient's extreme pain. The proposed statute includes several safeguards so as to prevent abuse and to give proper weight to the legitimate state interest in preserving the lives of its citizens. For a more detailed discussion of the statute and its scope, see *infra* section VI.C.

68. See *supra* note 63 and accompanying text (discussing cases involving caused suicide).

69. *People v. Roberts*, 178 N.W. 690 (Mich. 1920) (exemplifying an assisted suicide case where the defendant placed poison within the reach of his wife; she drank the poison and died), *nonacq.* *People v. Campbell* 335 N.W.2d 27 (Mich. Ct. App. 1983). Instances such as that detailed in *Roberts* are active-passive euthanasia cases as discussed in this note. See *infra* notes 169, 175-82 and accompanying text.

70. *Aven v. State*, 277 S.W. 1080 (Tex. Crim. App. 1925) (providing the means of committing suicide is not a crime); *Sanders v. State*, 112 S.W. 68 (Tex. Crim. App. 1908) (providing means of committing suicide is not a crime in absence of deception).

71. *McMahon v. State*, 53 So. 89 (Ala. 1910) (treating suicide as self-murder, court held that defendant who encouraged victim to commit suicide is guilty of murder as a principal); *Burnett v. People*, 68 N.E. 505 (Ill. 1903) (charging defendant with murder where defendant admitted that he and victim both took poison in suicide pact; victim died but defendant survived; although defendant was not convicted, court stated that if there was sufficient evidence, defendant would have been convicted); *Commonwealth v. Hicks*, 82 S.W. 265 (Ky. 1904) (holding that a murder occurs where defendant provides victim with poison even if not present at time of ingestion); *Commonwealth v. Bowen*, 13 Mass. 356 (1816) (upholding a jury instruction that if defendant's advice to commit suicide persuaded the victim to commit suicide, then defendant would be guilty of murder; jury found the defendant not guilty); *People v. Roberts*, 178 N.W. 690 (Mich. 1920) (holding that

jurisdictions treat assisted suicide as an offense apart from murder,<sup>72</sup> while other

defendant is guilty of murder as he provided wife with poison that she ingested without further aid, *nonacq.* *People v. Campbell*, 335 N.W.2d 27 (Mich. Ct. App. 1983); *Blackburn v. State*, 23 Ohio St. 146 (1872) (holding that although suicide is not a crime, furnishing a suicident with the means to commit suicide constitutes murder), *overruled by State v. Staten*, 247 N.E.2d 293 (Ohio 1969); *State v. Jones*, 67 S.E. 160 (S.C. 1910) (affirming defendant's conviction for murder because one who persuades another to commit suicide is guilty of murder if such persuasion causes the suicide).

72. The MODEL PENAL CODE § 210.5(2) at 127 (Proposed Official Draft 1962) states "A person who purposely or knowingly aids or solicits another to commit suicide is guilty of a felony of the second degree, if such suicide occurs, and otherwise of a felony of the third degree." For state statutes that treat assisted suicide as a crime apart from murder or manslaughter, see CAL. PENAL CODE § 401 (West 1993) ("Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony"); DEL. CODE ANN. tit. 11, § 645 (1993) ("A person is guilty of promoting suicide when he intentionally causes or aids another person to attempt suicide, or when he intentionally aids another person to commit suicide."); IND. CODE ANN. § 35-42-1-2 (Burns 1993) ("A person who intentionally causes another human being, by force, duress, or deception, to commit suicide[,] commits causing suicide, a Class B felony."); KAN. STAT. ANN. § 21-3406 (1992) ("Assisting suicide is intentionally advising, encouraging or assisting another in the taking of his own life."); ME. REV. STAT. ANN. tit. 17-A, § 204.1 (West 1993) ("A person is guilty of aiding or soliciting suicide if he intentionally aids or solicits another to commit suicide, and the other commits or attempts suicide."); MICH. COMP. LAWS ANN. § 752.1027 (West 1992) ("A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally . . . provides the physical means by which the other person attempts or commits suicide . . . or participates in a physical act by which the other person attempts or commits suicide, is guilty of criminal assistance to suicide . . ."); MINN. STAT. ANN. § 609.215(1) (West 1993) ("Whoever intentionally advises, encourages, or assists another in taking the other's own life may be sentenced to imprisonment for not more than 15 years or to payment of a fine of not more than \$30,000, or both."); MISS. CODE ANN. § 97-3-49 (1993) ("A person who willfully, or in any manner, advises, encourages, abets, or assists another person to take, or in taking, the latter's life, or in attempting to take the latter's life, is guilty of a felony. . ."); MONT. CODE ANN. § 45-5-105(1) (1993) ("A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide."); NEB. REV. STAT. § 28-307(1) (1992) ("A person commits assisting suicide when, with intent to assist another person in committing suicide, he aids and abets him in committing or attempting to commit suicide."); N.H. REV. STAT. ANN. § 630:4(I) (1993) ("A person is guilty of causing or aiding suicide if he purposely aids or solicits another to commit suicide."); N.J. STAT. ANN. § 2C:11-6 (West 1993) ("A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree."); N.M. STAT. ANN. § 30-2-4 (West 1978 & Supp. 1993) ("Assisting suicide consists of deliberately aiding another in the taking of his own life."); N.Y. PENAL LAW § 120.30 (McKinney 1993) ("A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide."); N.D. CENT. CODE § 12.1-16-04 (1993) ("Any person who intentionally or knowingly aids, abets, facilitates, solicits, or incites another person to commit suicide . . . is guilty of a class C felony."); OKLA. STAT. tit. 21, § 813 (1981 & Supp. 1994) ("Every person who willfully, in any manner, advises, encourages, abets, or assists another person in taking his own life, is guilty of aiding suicide."); 18 PA. CONS. STAT. § 2505(B) (1993) ("A person who intentionally aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide. . ."); S.D. CODIFIED LAWS ANN. § 22-16-37 (1993) ("Any person who intentionally in any manner advises, encourages, abets or assists another in taking his own life is guilty of a Class 6 felony."); WASH. REV. CODE § 9A.36.060(1) (1992) ("A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt

states treat assisted suicide as either homicide or manslaughter.<sup>73</sup>

The fact that a majority of the states criminally sanction assisted suicide is indicative of the state's interest in preserving life.<sup>74</sup> It is this state interest to preserve life which conflicts with the individual's right to privacy and autonomy as outlined in recent Michigan legislation.<sup>75</sup> Certainly in cases in which a second party commits the ultimate act resulting in death (caused suicide), the state's interest in protecting life is paramount to personal autonomy.<sup>76</sup> In such

suicide."); WIS. STAT. § 940.12 (West 1991) ("Whoever with intent that another take his or her own life assists such person to commit suicide is guilty of a Class D felony.");

73. ALASKA STAT. § 11.41.100(a)(1)(B) (1962 & Supp. 1993) ("A person commits the crime of murder in the first degree if with intent to cause the death of another person, the person . . . compels or induces any person to commit suicide through duress or deception."); ALASKA STAT. § 11.41.120(a)(2) (1962 & Supp. 1993) ("A person commits the crime of manslaughter if the person . . . intentionally aids another person to commit suicide."); ARIZ. REV. STAT. ANN. § 13-1103(3) (1993) ("A person commits manslaughter by . . . [i]ntentionally aiding another to commit suicide."); ARK. STAT. ANN. § 5-10-104(a)(2) (1987 & Supp. 1993) ("A person commits manslaughter if . . . [h]e purposely causes or aids another person to commit suicide."); COLO. REV. STAT. § 18-3-104(1)(b) (1993) ("A person commits the crime of manslaughter if . . . such person intentionally causes or aids another person to commit suicide."); CONN. GEN. STAT. § 53a-56(a)(2) (1992) ("A person is guilty of manslaughter in the second degree when . . . he intentionally causes or aids another person, other than by force, duress or deception, to commit suicide."); FLA. STAT. § 782.08 (1993) ("Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter . . ."); HAW. REV. STAT. § 707-702(1)(b) (1993) ("A person commits the offense of manslaughter if . . . [h]e intentionally causes another person to commit suicide."); MO. REV. STAT. § 565.023.1(2) (1992) ("A person commits the crime of voluntary manslaughter if he . . . [k]nowingly assists another in the commission of self-murder."); OR. REV. STAT. § 163.125(1)(b) (1991) ("Criminal homicide constitutes manslaughter in the second degree when . . . [a] person intentionally causes or aids another person to commit suicide."); 18 PA. CONS. STAT. ANN. § 2505(a) (1991) ("A person may be convicted of criminal homicide for causing another to commit suicide only if he intentionally causes such suicide by force, duress or deception.");

74. See generally Philip G. Peters, Jr., *The State's Interest in the Preservation of Life: From Quinlan to Cruzan*, 50 OHIO ST. L.J. 891 (1989) (discussing euthanasia and the great emphasis placed on the state's interest in preserving life absent exigent circumstances that would establish the individual's right to self-determination as paramount to the state's interest).

75. In response to what legislators perceived as an alarming growth in physician-assisted suicides, the Michigan legislature passed a law that bans assisted suicide. Fearing Michigan would become a haven for individual's seeking death, the legislature felt it necessary to pass such a law to protect its citizens. Carol J. Castaneda, *States Fear Kevorkian Fallout*, USA TODAY, Feb. 26, 1993, at A3. Another motive for the legislation was the judicial mandate given by Judge Gilbert in *State ex rel. Thompson v. Kevorkian*. In *Kevorkian*, Judge Gilbert called on the Michigan legislature to pass an assisted suicide law that reflected medical ethics and societal mores. See *infra* note 236 and accompanying text. Further, the *Kevorkian* decision lends support for framing the assisted suicide controversy in terms of balancing the state interest in preserving life against the individual's interest in privacy and autonomy. See *infra* notes 223-24 and accompanying text.

76. "A is guilty of murder if he is actually the agent of B's death, notwithstanding the fact that he acted at B's request—as where A shoots and kills B upon B's insistence that he wants to die now rather than continue to suffer from a serious illness." LAFAVE & SCOTT, *supra* note 60, § 3.8, at 250.

cases a grave danger exists that the second party is not acting at the request of the person suffering, but is acting against the suffering person's will.<sup>77</sup>

More troubling legal, moral, and ethical questions arise when a doctor acts at the request of a suffering person and provides that person with the means to commit suicide (assisted suicide). Here, two conflicts are apparent. First, the state's interest in preserving life is in direct conflict with the patient's right to personal autonomy.<sup>78</sup> Second, the Hippocratic Oath calls on doctors to prolong life which creates a direct conflict with the mandate to relieve suffering.<sup>79</sup> A case analysis of these conflicts follows.

### III. THE PROBLEMATIC STATUS OF THE ASSISTED SUICIDE LAW IN MICHIGAN

Sources reveal only three reported opinions dealing with either assisted suicide or caused suicide in Michigan. The first case is *People v. Roberts*.<sup>80</sup> In *Roberts*, the defendant, at his wife's request, aided her in committing suicide by making a poison called "poison green" and placing it within her reach.<sup>81</sup> Mrs. Roberts drank the poison without any aid from the defendant.<sup>82</sup> The defendant alleged that Mrs. Roberts desired to die because of her incurable suffering, which resulted from a progressed stage of multiple sclerosis.<sup>83</sup> The Michigan Supreme Court held that Mr. Roberts was guilty of first degree

77. Danger of abuse exists not only in caused suicide cases, but also in assisted suicide cases. For example, on February 26, 1993, pro-life activists combed the garbage outside of a home where a physician-assisted suicide had occurred. The activists found a document that suggested that the deceased, Hugh Gale, requested twice that the doctor present remove a mask delivering carbon monoxide from his face. After the first request, Dr. Kevorkian removed the mask. However, after the second request, Mr. Gale allegedly lapsed into unconsciousness and died before Dr. Kevorkian could remove the mask from Mr. Gale's face. Those present at the suicide contend that Mr. Gale made only one request to have the mask removed and that Dr. Kevorkian promptly complied with that request. *Doctor Death Saga Takes a Bizarre Turn*, UPI, Feb. 26, 1993, available in LEXIS, News Library, UPI File. Whatever the actual occurrences, the incident underscores that regulation is essential. This note proposes a solution that gives greater weight to the patient's interest in personal autonomy and privacy than does the current Michigan statute. See *infra* section VI.C.

78. See *infra* notes 223-24 and accompanying text.

79. See *supra* note 16 (Hippocratic Oath).

80. 178 N.W. 690 (Mich. 1920); but cf. *Sanders v. State*, 112 S.W. 68 (Tex. Crim. App. 1908) (holding that no liability attaches to a person who merely supplies the suicidant with the means to accomplish the act); accord *Grace v. State*, 69 S.W. 529 (Tex. Crim. App. 1902) (holding that a jury instruction regarding whether defendant procured a pistol and put the pistol within the reach of the deceased with intent that she should use it in committing suicide is unjustified).

81. *Roberts*, 178 N.W. at 691.

82. *Id.*

83. *Id.* Mrs. Roberts left no documents stating that she wished to die, although she had previously attempted to commit suicide unsuccessfully by ingesting carbolic acid. *Id.*

murder.<sup>84</sup> The court reasoned that because Mr. Roberts aided and abetted Mrs. Roberts in suicide by providing her with poison, Mr. Roberts was guilty of murder by administering poison.<sup>85</sup> Further, the court recognized that the voluntary nature of the suicide did not lessen the severity of the crime in legal terms.<sup>86</sup> Therefore, the Michigan Supreme Court's position firmly favored preservation of life over individual autonomy.

Twenty-eight years after the *Roberts* decision, the Michigan Supreme Court confronted the issue of caused suicide in *People v. Quicksall*.<sup>87</sup> In *Quicksall*, the defendant entered into a suicide pact with his married mistress.<sup>88</sup> The defendant succeeded in inflicting a mortal wound on his mistress, although the wound the defendant inflicted upon himself resulted only in a minor injury.<sup>89</sup> The Michigan Supreme Court upheld the defendant's conviction for murder, thus affirming the *Roberts* decision.<sup>90</sup>

To the extent that it criminalizes caused suicide, the holding in *Quicksall*

84. *People v. Roberts*, 178 N.W. 690, 693 (Mich. 1920). See also *Farrell v. State*, 163 S.W. 768 (Ark. 1914) (upholding conviction of defendant who assisted a person in committing suicide); *Commonwealth v. Hicks*, 82 S.W. 265 (Ky. 1904) (charging defendant with homicide pursuant to assisting a suicide is a valid charge); *Commonwealth v. Bowen*, 13 Mass. 356 (1816) (upholding a jury instruction that if defendant's advice to commit suicide persuaded the victim to commit suicide, then defendant would be guilty of murder; jury found the defendant not guilty); *State v. Jones*, 67 S.E. 160 (S.C. 1910) (upholding jury instruction of murder where defendant assisted another in a suicide).

85. *Roberts*, 178 N.W. at 693. In large part, the court used the reasoning from *Blackburn v. State*, 23 Ohio St. 146 (1872): Suicide is not a crime. "But the real criminal act is administering poison." *Id.* Therefore, the defendant is not an accessory to the suicide, but is a principal in the murder. *Id.*

86. *Roberts*, 178 N.W. at 693. Such reasoning is indicative of assisted suicide cases. See, e.g., *Blackburn v. State*, 23 Ohio St. 148 (1872), *overruled by State v. Staten*, 247 N.E.2d 293 (Ohio 1969). In *Roberts*, the court recognized that "the atrocity of the crime in a moral sense, would be greatly diminished by the fact that [the] suicide was intended." *Roberts*, 178 N.W. at 693. Nevertheless, the court refused to accept this moral rationale as a mitigating circumstance and paradoxically adhered to a rigid separation of law and morality.

87. 33 N.W.2d 904 (Mich. 1948).

88. *Id.* at 905.

89. *Id.*

90. *Id.* at 908. Although the court devotes the opinion to a discussion of alleged trial errors, this case is important for two reasons. First, it restated that Michigan's law regarding assisted suicide was to hold the offense as equivalent to murder. Second, it showed that the state would punish suicides committed absent the moral justifications present in *Roberts* in precisely the same manner. Thus, the rigid separation of law and morality, discussed *supra* note 86, is again exemplified: The Michigan courts convicted a man who relieved his physically infirm wife from suffering of exactly the same crime as a man who killed his married lover. Although morally these instances are diametrically opposed, the Michigan Supreme Court treated the disparate acts as legal equivalents. For a discussion of caused and assisted suicide, see LAFAVE & SCOTT, *supra* note 60, § 7.8, at 651-52.

is sound. The facts of *Quicksall* represent an instance of caused suicide, as the defendant actually committed the ultimate act that resulted in the death of his mistress.<sup>91</sup> In contrast, the facts of *Roberts* reveal that the defendant merely provided his wife with the means to commit suicide. Mr. Roberts did not commit the ultimate act resulting in death.<sup>92</sup> As the distinguishable facts of *Quicksall* and *Roberts* indicate, the law controlling assisted suicide and caused suicide should not be the same. In caused suicide cases the second party actually commits the ultimate act resulting in death,<sup>93</sup> as distinguished from assisted suicide cases, where the second party does not commit the ultimate act resulting in death. Clearly, the second party's involvement in the latter instance is less culpable or less *direct*. In the early 1980s, the Michigan Court of Appeals had the opportunity to remedy this discrepancy between caused and assisted suicides.

In the 1983 case of *People v. Campbell*,<sup>94</sup> the Michigan Court of Appeals explicitly rejected the standard set forth in *Roberts*.<sup>95</sup> In *Campbell*, the defendant and the suicidant were drinking together.<sup>96</sup> The suicidant, severely intoxicated and depressed, expressed a desire to commit suicide.<sup>97</sup> The defendant thereafter encouraged the suicidant and provided him with a gun and shells, with which the suicidant committed suicide after the defendant had left.<sup>98</sup> The appellate court held that the defendant was not guilty of a crime under Michigan law.<sup>99</sup> Resolving the circular justification given in *Roberts* for charging a person who assists a suicide with murder,<sup>100</sup> the court stated that in cases where a suicide occurs, homicide by definition is excluded.<sup>101</sup> Put simply, assisting another to commit suicide is not murder; murder is only

91. See *supra* notes 62-67 and accompanying text (discussing caused suicide).

92. See *supra* notes 80-86 and accompanying text.

93. See *infra* section VI.C for a proposed solution that delineates between caused and assisted suicide cases and is mindful of the individual's right of privacy.

94. *People v. Campbell*, 335 N.W.2d 27 (Mich. Ct. App.), *appeal denied*, 342 N.W.2d 509 (Mich. 1983). The court stated: "We now consider whether the *Roberts* case still represents the law of Michigan, and we find that it does not." *Id.* at 29.

95. *People v. Roberts*, 178 N.W. 690 (Mich. 1920).

96. *Campbell*, 335 N.W.2d at 29.

97. *Id.*

98. *People v. Campbell*, 335 N.W.2d 27, 29 (Mich. Ct. App.), *appeal denied*, 342 N.W.2d 509 (Mich. 1983). The court rejected the notion that the defendant's actions constituted coercion or duress. The court's reasoning focused on this case as one of assisted suicide and not caused suicide. *Id.*

99. *Campbell*, 335 N.W.2d at 31.

100. See *supra* note 86 and accompanying text.

101. *Campbell*, 335 N.W.2d at 30. Therefore, the approach the court takes is that passive participation in suicide is not murder. However active participation in a suicide, such as where the defendant actually pulls the trigger, constitutes homicide.

committed when the defendant performs the ultimate act resulting in death.<sup>102</sup>

The *Campbell* decision is important on two grounds. First, the *Campbell* court expressly recognized that assisted suicide is not treated as homicide in Michigan and could only be punishable if the legislature passed a statute.<sup>103</sup> Second, the court distanced itself from the position taken in *Roberts* and *Quicksall* that the suicidant's physical or emotional condition should not be considered as a mitigating circumstance in assisted suicide cases.<sup>104</sup> Instead, the court recognized that often assisted suicide cases are distinguishable from caused suicide cases on moral grounds, and the law should reflect this difference.<sup>105</sup>

*Campbell* is the most recently published opinion from Michigan regarding assisted suicide. However, the absence of assisted or caused suicide case law after *Campbell* is not evidence that the issue is no longer problematic. In the years following *Campbell*, reports document several instances of physician-caused and physician-assisted suicides in Michigan.<sup>106</sup> As previously stated,

102. See *State v. Bouse*, 264 P.2d 800 (Or. 1953) (holding that a person who aids another in suicide and actually carries out the overt act resulting in death is guilty of murder), *overruled by State v. Fisher*, 376 P.2d 418 (Or. 1962). A more recent decision from California held that a person who aids in suicide as part of a suicide pact and engages in the overt act resulting in death is guilty of aiding and abetting a suicide. *In re Joseph G.*, 667 P.2d 1176 (Cal. 1983). The court confined the holding of the case to the facts as the suicide was brought about by driving a car off a cliff, which posed a simultaneous danger to the victim and defendant. Therefore, the court adhered to its view, stated in *People v. Matlock*, 336 P.2d 505 (Cal. 1959), that active participation in a suicide through strangling the suicidant constituted murder.

103. "We invite [the legislature] to adopt legislation on the subject [of assisted suicide]." *People v. Campbell*, 335 N.W.2d 27, 31 (Mich. Ct. App.), *appeal denied*, 342 N.W.2d 509 (Mich. 1983).

104. *Id.* Nevertheless the *Campbell* court also called on the legislature to pass a law criminalizing assisted suicide because the court found the facts of *Campbell* "morally reprehensible." *Id.* The court impliedly recognized that the law and its attendant penalties should reflect the moral culpability of the defendant. Therefore, in cases where sufficient moral justification exists for the suicide, the court should consider that justification in either absolving guilt or mitigating the sentence. See *supra* note 86 and accompanying text. However, moral justifications require concrete proof as it is far too simple to create moral justifications after the suicide occurs. Hence, the affirmative defense proposed in this note is useful as it respects the patient's desires, but provides sufficient safeguards so as not to be blind to the manipulative potential of the human intellect. See *infra* section VI.C.

105. *Campbell*, 335 N.W.2d at 31.

106. The notion of physician-assisted suicide first drew the nation's attention in 1950. In *State v. Sander*, the state charged a physician with murder for injecting air into the bloodstream of a terminally ill cancer patient. RUSSELL, *supra* note 31, at 105-06. The doctor noted that the patient made incessant demands for the doctor to cause her death. After the doctor succumbed to the patient's influence, the doctor injected air into the patient who died ten minutes thereafter. William J. Baughman et al., *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1205 (1973). Nevertheless, the jury acquitted Dr. Sander after

since 1988 sources detail twenty-one such instances.<sup>107</sup> The phenomenon of physician-assisted suicide takes on added importance as medical technology advances and prolongs the lives of patients while often failing to provide a commensurate improvement in the quality of life.<sup>108</sup>

On May 6, 1988, Dr. Daniel Caraccio injected Juliette Cherry-Sapp, a seventy-four-year-old terminally ill patient suffering from gangrene, heart disease, and kidney failure,<sup>109</sup> with an overdose of potassium chloride.<sup>110</sup> The Wayne County Prosecutor charged Dr. Caraccio with murder and poisoning with intent to kill.<sup>111</sup> Dr. Caraccio pleaded guilty to poisoning with intent to kill and the court sentenced him to five years of probation.<sup>112</sup>

The Caraccio case, where the physician actually injected the patient with potassium chloride, presents a clear case of caused suicide.<sup>113</sup> Although this Note advocates an affirmative defense to Michigan's assisted suicide law, the defense would not extend to Dr. Caraccio's case, because he committed caused suicide by performing the ultimate act resulting in the patient's death.<sup>114</sup> Dr.

determining there was no causal connection between Dr. Sander's act and the death of the patient. Theodore Sachs, Recent Decisions, *Criminal Law—Humanitarian Motive as a Defense to Homicide*, 48 MICH. L. REV. 1197, 1199 (1950). Likewise, in *State v. Montemarano*, a jury acquitted a physician of murder charges after the physician brought on death by injecting potassium chloride into the veins of a comatose patient given two days to live. DEREK HUMPHRY, COMPASSIONATE CRIMES, BROKEN TABOOS 22 (1986). As in *Sander v. State*, the jury found the doctor's act was not the cause of the patient's death even though the patient died minutes after the injection. Wainey, *supra* note 34, at 669.

In 1986, prosecutors charged two doctors with murder in separate instances after the physicians poisoned terminally ill patients. A jury found Dr. Joseph Hassman guilty but the court sentenced Dr. Hassman to only two years probation, a \$10,000 fine, and 400 hours of community service. *Eight Doctors on Euthanasia Charges*, HEMLOCK Q., Jan. 1989, at 6. A jury acquitted Dr. Peter Rosier of murder charges due to lack of causation. Wainey, *supra* note 34, at 670.

107. See *supra* note 1 and accompanying text. Surveys indicate a great disparity between reported and unreported instances of physician-assisted suicide. To date, states have only charged 11 doctors with murder for assisting a suicide; none of the doctors received time in prison. *Juries Kind to Doctors Who Assist*, CAPITAL TIMES (Wash., D.C.), Mar. 17, 1992, at D1. Yet 20% of practicing physicians admit to having assisted a patient in suicide. Richard A. Knox, *One in Five Doctors Say They Assisted a Patient's Death, Survey Finds*, BOSTON GLOBE, Feb. 28, 1992, at A5.

108. See *supra* notes 3-4 and accompanying text.

109. *Doctor Gets Probation; Poisoned Dying Woman*, CHI. TRIB., Apr. 6, 1989, at A3.

110. Joe Swickard, *Euthanasia Case Fuels Ethics Debate*, DETROIT FREE PRESS, Nov. 14, 1988, at A3.

111. *Id.* The American Medical Association characterized Dr. Caraccio's act as "morally and ethically wrong under any circumstances." *Id.* Nevertheless, a member of the American Medical Association's Council of Ethical and Judicial Affairs felt the charge of murder was far too harsh even while recognizing the act was ethically wrong. *Id.*

112. *Doctor Gets Probation; Poisoned Dying Woman*, CHI. TRIB., Apr. 6, 1989, at A3.

113. See *supra* notes 109-10 and accompanying text.

114. See *infra* section VI.C.

Caraccio's act of placing the syringe into the body of the victim and forcing in its lethal contents is analogous to a person, acting at the request of a suicidant, placing a gun at the suicidant's head and pulling the trigger.<sup>115</sup> Although both acts were consensual, consent, as aforementioned, is no defense to homicide.<sup>116</sup> Even if the act is aimed at relieving pain, it is the ultimate act resulting in death which takes it beyond the shelter of the defense advocated in this Note.<sup>117</sup> By committing the ultimate act resulting in death, Dr. Caraccio crossed the line that separates suicide from murder. The affirmative defense offered here applies only to physicians who provide the means of committing suicide, in other words, perform assisted, not caused, suicides. Such stringent parameters are necessary to exclude caused suicide cases, which pose the greatest danger of abuse.

The area of assisted suicide has become most problematic.<sup>118</sup> Disregarding the very different facts giving rise to assisted and caused suicide cases, the Michigan legislature has outlawed both acts subject to the same legal standard.<sup>119</sup> The following discussion details the recent instances of assisted suicide cases in Michigan.

Two years after Dr. Caraccio caused the suicide of an ill patient, a series of twenty physician-assisted suicides, drawing national attention, began in Michigan.<sup>120</sup> All the individuals who committed suicide were ill, although they could not all be classified as terminally ill.<sup>121</sup> Three of the suicides involved individuals who, although chronically ill and in great pain, were not terminally ill.<sup>122</sup> Moreover, seventeen suicides involved individuals who were

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115. See *supra* note 76.

116. *Martin v. Commonwealth*, 37 S.E.2d 43 (Va. 1946) (holding that invitation and consent to perpetration of a murder does not constitute a defense). As for patient consent to life-ending procedures, see J.G. Castel, *Nature and Effects of Consent With Respect to the Right to Life and Right to Physical and Mental Integrity in the Medical Field*, 16 ALBERTA L. REV. 293 (1978) (discussing the effect of a patient's consent to a procedure that ends the patient's life under Canadian law).

117. See *infra* section VI.C.

118. See *infra* notes 122-23.

119. See the Michigan assisted suicide statute cited *supra* note 5.

120. Between July 1, 1990, and April 12, 1994, twenty individuals have committed suicide with the assistance of Dr. Jack Kevorkian in Michigan. See *infra* notes 122-23 and accompanying text.

121. There is no medical definition of a "terminal illness." However, for purposes of this note, "terminal illness" defines an illness that is so progressed that death is more likely than not to occur within twelve months.

122. Janet Adkins, who suffered from a progressed stage of Alzheimer's Disease, was the first person to end her life under the guidance of the Michigan pathologist, Dr. Jack Kevorkian. William E. Schmidt, *Prosecutors Drop Criminal Case Against Doctor Involved in Suicide*, N.Y. TIMES, Dec. 15, 1990, at A10. Dr. Kevorkian's suicide machine was the method used to effectuate the suicide. *Id.* The machine consists of three vials suspended over a metal box holding an electric motor. *Id.* Dr. Kevorkian inserted an intravenous needle into Ms. Adkins. *Id.* Ms. Adkins then pressed a

terminally ill and in great pain.<sup>123</sup> In response to the growing number of

button on the machine, which fed thiopental into her veins. *Id.* The thiopental made Ms. Adkins unconscious. *Id.* Finally, the machine delivered a lethal dose of potassium chloride, causing her heart to stop. *Id.* The prosecution charged Dr. Kevorkian with murder although the prosecution subsequently dropped the charge. *Id.*

Fifteen months after Ms. Adkins's suicide, Dr. Kevorkian assisted in the suicides of two chronically ill women. *Kevorkian Assists Suicide of Another Michigan Woman*, REUTERS, Sept. 26, 1992, available in LEXIS, News Library, CURNWS File. Marjorie Wantz used Dr. Kevorkian's suicide machine while Sherry Miller committed suicide by inhaling carbon monoxide provided by Dr. Kevorkian. *Id.* The prosecution again charged Dr. Kevorkian with murder but subsequently dismissed the case because there existed no statute under which to prosecute Dr. Kevorkian. *Id.* In none of these instances did Dr. Kevorkian commit the ultimate act resulting in death. *Id.* Rather, the suicidant committed the ultimate act by either pushing the button on the suicide machine which triggered the lethal injection or by voluntarily placing a mask over the face in order to inhale the carbon monoxide. *Id.*

123. These seventeen suicides have occurred since May of 1992. All of the suicidants used the carbon monoxide mask Dr. Kevorkian invented and followed the procedure detailed *infra* note 126. See *All Things Considered* (National Public Radio broadcast, May 15, 1992). The individuals who committed suicide using Dr. Kevorkian's carbon monoxide machine are:

- Susan Williams, age 52, committed suicide in May of 1992. Ms. Williams was blind and suffered from severe multiple sclerosis. *All Things Considered* (National Public Radio broadcast, May 15, 1992).
- Lois Frances Hawes, age 52, committed suicide on September 26, 1992. Ms. Hawes suffered from lung and brain cancer and was in extreme pain. *Kevorkian Assists Suicide of Another Michigan Woman*, REUTERS, Sept. 26, 1992, available in LEXIS, News Library, CURNWS File.
- Catherine A. Andreyev, age 46, committed suicide on November 23, 1992. Ms. Andreyev suffered from progressed stages of breast, lung, and bone cancer. *Dr. Kevorkian Assists Suicide of a Breast Cancer Patient*, L.A. TIMES, Nov. 24, 1992, at A16.
- Marguerite Tate, age 70, committed suicide on December 15, 1992. Ms. Tate suffered from amyotrophic lateral sclerosis. *"Suicide Doctor" Aids Three More Deaths*, FACTS ON FILE WORLD NEWS DIGEST, Dec. 21, 1992, at 958 F3.
- Marcella Lawrence, age 67, committed suicide in tandem with Marguerite Tate on December 15, 1992. Ms. Lawrence suffered from heart disease, emphysema, and a failing liver. *"Suicide Doctor" Aids Three More Deaths*, FACTS ON FILE WORLD NEWS DIGEST, Dec. 21, 1992, at 958 F3.
- Jack E. Miller, age 53, committed suicide on January 20, 1993. Mr. Miller was experiencing great pain brought on by metastatic bone cancer and was given merely days to live. *Dr. Death Presides at Ninth Assisted Suicide*, UPI, Jan. 20, 1993, available in LEXIS, News Library, CURNWS File.
- Stanley Ball, age 82, committed suicide on February 4, 1993. Mr. Ball suffered from pancreatic cancer. *Dr. Death Assists in Two More Suicides*, UPI, Feb. 4, 1993, available in LEXIS, News Library, CURNWS File.
- Mary Biernat, 73, committed suicide on February 4, 1993 in tandem with Stanley Ball. Ms. Biernat suffered from progressed stages of breast and bone cancer. *Dr. Death Assists in Two More Suicides*, UPI, Feb. 4, 1993, available in LEXIS, News Library, CURNWS File.
- Elaine Goldbaum, age 47, committed suicide on February 8, 1993. Ms. Goldbaum suffered from multiple sclerosis. *Doctor Death Assists in 13th Suicide*, UPI, Feb. 16,

physician-assisted suicides in the State of Michigan, Governor John Engler<sup>124</sup> signed a bill just hours after the eighth physician-assisted suicide occurred. This bill makes both assisted and caused suicide a criminal offense punishable by four years in prison and a \$2000 fine.<sup>125</sup>

Common to all of the reported physician-assisted suicides in Michigan since 1990 is that the suicidant committed the ultimate act resulting in death.<sup>126</sup> This

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1993, available in LEXIS, News Library, CURNWS File.

- Hugh Gale, age 70, committed suicide on February 15, 1993. Mr. Gale suffered from chronic emphysema and congestive heart failure. *Doctor Death Assists in 13th Suicide*, UPI, Feb. 16, 1993, available in LEXIS, News Library, CURNWS File.
- Jonathon Grenz, age 44, committed suicide on February 18, 1993. Mr. Grenz suffered from throat cancer. Due to the cancer, doctors had removed much of Mr. Grenz's throat and tongue. Carol J. Castaneda & Robert Davis, *As Ban Looms, Kevorkian Helps 2 More Die*, USA TODAY, Feb. 19, 1993, at A3.
- Martha Ruwart, age 41, committed suicide on February 18, 1993 in tandem with Jonathon Grenz. Ms. Ruwart suffered from duodenal cancer and ovarian cancer. Carol J. Castaneda & Robert Davis, *As Ban Looms, Kevorkian Helps 2 More Die*, USA TODAY, Feb. 19, 1993, at A3.
- Ronald Mansur, age 54, committed suicide on May 16, 1993. Mr. Mansur suffered from bone and lung cancer. Nancy Gibbs, *Prescription for Death*, TIME, May 31, 1993, at 34; *Suicide Doctor Present at Seventeenth Suicide*, UPI, Aug. 4, 1993, available in LEXIS, News Library, CURNWS File.
- Thomas Hyde, age 30, committed suicide on August 4, 1993. Mr. Hyde suffered from Lou Gehrig's Disease. *Suicide Doctor Present at Seventeenth Suicide*, UPI, Aug. 4, 1993, available in LEXIS, News Library, CURNWS File.
- Donald O'Keefe, age 73, committed suicide on September 9, 1993. Mr. O'Keefe suffered from bone cancer. *Judge Refuses Removal from Kevorkian*, THE LEGAL INTELLIGENCER, Dec. 23, 1993, at 3.
- Merian Frederick, age 72, committed suicide on October 22, 1993. Ms. Frederick suffered from amyotrophic lateral sclerosis. *Aided-Suicide Law Invalidated Again*, N.Y. TIMES, Jan. 28, 1994, at A17.
- Dr. Ali Khalili, age 61, committed suicide on November 22, 1993. Dr. Khalili suffered from bone cancer. David Lawder, *Judge Strikes Down Suicide Law, Charges Against Kevorkian*, REUTERS, Jan. 27, 1994, available in LEXIS, News Library, CURNWS File.

124. Governor Engler is a Republican from Rosebush, Michigan. The Michigan electorate voted Governor Engler into office in November of 1990 when he defeated incumbent Governor James Blanchard.

125. MICH. COMP. LAWS § 752.1027 (1993). In addition to criminalizing assisted suicide, the Michigan law also criminalizes caused suicide using the same legal standard and penalty. Therefore, the law does not distinguish between the role that Dr. Caraccio played while administering a lethal injection and a physician who merely provides patients with the means for the patients to die by their own hand.

126. The individuals committed the ultimate act resulting in death in one of two ways. If the individuals used the "suicide machine," the individuals merely pushed a button that allowed thiopental and potassium chloride to enter the bloodstream. See Schmidt, *supra* note 122, at A10. If the individuals inhaled carbon monoxide, the individuals would place a mask over their face and then pull a string which would release carbon monoxide from a canister into the mask. *Kevorkian*

is in direct contrast to Dr. Caraccio's involvement.<sup>127</sup> Case law shows that the state has its greatest interest in preserving life in caused suicide cases because the method of death is artificial and the agent causing the death is someone other than the deceased.<sup>128</sup> Such actions should be prohibited because the state's interest in preserving life absolutely overrides individual privacy. However, in assisted suicide cases, a review of case law suggests that the state's interest in preserving life is lessened when compared to the individual's interest in privacy and personal autonomy.<sup>129</sup> In such cases the method of death is artificial, but the agent causing death is the suicidant, not a physician.<sup>130</sup> As such, the law should treat assisted suicide cases with a less stringent standard than caused suicide cases as long as sufficient procedural safeguards are in place to prevent abuse.<sup>131</sup>

The question remains as to what standard should apply to assisted suicide cases. Some commentators suggest that assisted suicide cases should be treated in the same manner as right-to-die cases. The following section critiques the

*Assists Suicide of Another Michigan Woman*, REUTERS, Sept. 26, 1992, available in LEXIS, News Library, CURNWS File.

127. See *supra* notes 109-17 and accompanying text.

128. *State v. Cobb*, 625 P.2d 1133 (Kan. 1981) (upholding murder conviction when defendant, at the victim's request, administered a lethal dose of cocaine and shot victim in the head); *State v. Fuller*, 278 N.W.2d 756 (Neb. 1979) (affirming murder conviction when defendant, acting pursuant to victim's request, collapsed a bag attached to a needle that was inserted in victim's arm); *Turner v. State*, 108 S.W. 1139 (Tenn. 1908) (upholding murder conviction where defendant shot his married lover at her request).

129. See, e.g., *People v. Campbell*, 335 N.W.2d 27, 29 (Mich. Ct. App. 1983) (rejecting notion that assisted suicide is against the law and finding caused suicide cases are exceedingly immoral and reprehensible when compared to assisted suicide cases), *appeal denied*, 342 N.W.2d 510 (Mich. 1983).

130. See *supra* text accompanying notes 69-73. In determining when the state's interest in preserving life overrides the individual's right to self-determination, it is essential to explore the history of American law. Traditionally, the criminal law has punished affirmative criminal acts more severely than negative acts. LAFAVE & SCOTT, *supra* note 60, § 3.2, at 191-200. In caused suicide cases, an affirmative act occurs on the part of the physician that is the ultimate cause of death. Historically, the criminal law treats such actions as equivalent to pulling the trigger of a gun aimed at a person's head. *Id.* at 650. In contrast, the participation of a physician in assisted suicide cases is less culpable. The physician merely provides the means to commit suicide, with the patient providing the ultimate act resulting in death. Such physician involvement is more closely related to right-to-die cases than caused suicide cases. This is so because in both right-to-die and assisted suicide cases, the physician is not the ultimate actor who causes death. See *infra* notes 169-70 and accompanying text. The Supreme Court has recognized that physicians are not criminally liable for participation in right-to-die cases if they follow proper guidelines because the right of personal autonomy overrides the state's interest in preserving life. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). This note advocates that with safeguards even more stringent than those present in right-to-die cases, the right of autonomy can override the state's interest in preserving life in assisted suicide cases. See *infra* section VI.C.

131. See *infra* section VI.C.

position that assisted suicide cases should be treated in the same manner as right-to-die cases and offers a new method of categorizing euthanasia cases.

#### IV. DISTINGUISHING THE RIGHT-TO-DIE FROM ASSISTED SUICIDE CASES

##### A. Background of Right-to-Die Cases

The term "right-to-die" refers to an individual's right to refuse, or have withdrawn, unwanted medical treatment even though the individual will die without the medical treatment.<sup>132</sup> Beginning with the 1976 New Jersey case of *In re Quinlan*, the courts began to recognize that the state's interest in preserving life does not always outweigh the individual's right to privacy.<sup>133</sup> The courts' method to determine whether an individual has the right to die balances the patient's interest of self-determination against the state's interest in preserving life.<sup>134</sup> Using the balancing test of *Quinlan*, courts have recognized the right of people who are terminally ill,<sup>135</sup> whether competent<sup>136</sup> or incompetent,<sup>137</sup> to refuse medical treatment and die.

##### B. *Cruzan v. Director, Missouri Department of Health*

The only Supreme Court case to address the issue of an incompetent's right to die is *Cruzan v. Director, Missouri Department of Health*.<sup>138</sup> In *Cruzan*, the Court reviewed a Missouri Supreme Court ruling that required clear and convincing evidence of an incompetent's wish for withdrawal of life-sustaining medical treatment.<sup>139</sup> Ms. Cruzan had sustained injuries in an automobile accident and remained in a persistent vegetative state for several years.<sup>140</sup> Her parents, recognizing their daughter would not recover, sought to have her

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132. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

133. See *In re Quinlan*, 355 A.2d 647 (N.J. 1976), cert. denied, 429 U.S. 922 (1976).

134. See Peters, *supra* note 74, at 891 n.3 (recognizing that the state's interest in preserving life also includes preventing harm to third parties, protecting medical ethics, and preventing suicide). In *State ex rel. Thompson v. Kevorkian*, the Oakland County Circuit Court used the same balancing test to determine if a right to physician-assisted suicide exists. No. 90-390963-AZ (Mich. Cir. Ct., Feb. 5, 1991). See *infra* notes 223-24 and accompanying text.

135. *Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980).

136. *In re Farrell*, 529 A.2d 404, 407 (N.J. 1987).

137. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 419 (Mass. 1977). In cases where the patient is incompetent, a court is much less likely to find a right to die. *Id.*

138. 497 U.S. 261 (1990).

139. *Id.* at 269.

140. *Id.*

gastrostomy feeding and hydration tube removed, thus ending her life.<sup>141</sup>

The Missouri Supreme Court reviewed the evidence and found that Ms. Cruzan's casual statements regarding her preference to die under certain circumstances were unreliable.<sup>142</sup> The Missouri Supreme Court stated that it would recognize an incompetent's right to die only if clear and convincing evidence showed that the patient, under the circumstances, would prefer death over life.<sup>143</sup> Justice Rehnquist's majority opinion held that the clear and convincing standard set forth by the Missouri court did not violate the Constitution.<sup>144</sup>

The *Cruzan* decision is important for several reasons. Most notably, it is the first and only case in which the Supreme Court has recognized that upon a proper showing of evidence, an incompetent individual can have life-sustaining medical treatment withdrawn. Second, the Supreme Court explicitly recognized that instances may exist in which a person's right to self-determination overrides the state's interest in preserving life.<sup>145</sup> Third, in recognizing that there may be instances in which incompetents could have medical treatment withdrawn, the Court impliedly validated the right of a competent person to refuse medical treatment.<sup>146</sup>

Further, the case is important for what it did not address. The Court recognized that incompetents could have medical treatment withdrawn upon showing by clear and convincing evidence that such would be the incompetent's desire. However, the Court left unclear whether competent persons, experiencing great pain due to illness, may receive a physician's assistance in

141. *Id.* at 267. A gastrostomy feeding and hydration tube is surgically implanted to ease feeding and to further recovery. It is commonly used in cases where a person has been subjected to extensive trauma resulting in coma. *Id.* at 267-68.

142. *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 268 (1990).

143. *Id.*

144. *Id.* at 267.

145. Prior Supreme Court cases recognize that a competent person has a right to refuse unwanted medical treatment. *See, e.g.*, *Jacobson v. Massachusetts*, 197 U.S. 11, 24-25 (1905) (balancing individual's liberty interest against the state's interest in preventing disease after defendant refused to receive a small pox vaccination); *cf. Breithaupt v. Abram*, 352 U.S. 432, 437-38 (1957) (balancing the interests of the individual and the interests of society in determining whether a person's body is immune from search by the state), *nonacq. Graham v. Connor*, 490 U.S. 386 (1989).

146. The Court explicitly held in *Washington v. Harper* that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment. 494 U.S. 210, 218-19 (1990). *See generally Peters, supra* note 74, at 891 (emphasizing an individual's right to privacy).

ending their life.<sup>147</sup>

### C. Determining the Scope of Cruzan

One commentator has suggested that an individual's right to refuse medical treatment is directly equivalent to the right of having a physician assist a suicide.<sup>148</sup> This analysis fails to recognize the disparate fact patterns of right-to-die and assisted suicide cases. The paradigm right-to-die case involves a patient whose life is sustained only by artificial means.<sup>149</sup> In a right-to-die case, patients, or their legal representatives, exercise personal autonomy by simply requesting that an instrument artificially sustaining life be removed. In contrast, the paradigm physician-assisted suicide case involves a patient whose lingering illness is incurable.<sup>150</sup> In the latter case, the patient requests that a physician make available the artificial means to end life prematurely.

In right-to-die cases, no outside agent causes death. Rather, life functions terminate on their own, without any outside catalyst. Conversely, in physician-assisted suicide cases, the introduction of an outside agent is the sole cause of death. Because a physician makes available a substance that artificially induces death, physician-assisted suicide cases by their very nature require more stringent regulation than right-to-die cases.

147. Although the majority opinion did not address this issue, Justice Scalia addressed the issue in concurrence. Justice Scalia stood as the only member of the Court who did not believe that a constitutionally protected interest in refusing unwanted medical treatment exists. Further, Justice Scalia stated that such an act is equivalent to a right to commit suicide and that none of the nation's law suggests that such a right exists. 497 U.S. at 294-95 (1990) (Scalia, J., concurring).

148. Note, *Physician-Assisted Suicide and The Right to Die with Assistance*, 105 HARV. L. REV. 2021 (1992). The author of the Harvard note argues that the standard set forth in *Cruzan* should apply to physician-assisted suicides as well. Correctly stating that the right to die is grounded in the common law doctrine of informed consent and the constitutionally protected due process liberty interest, the author improperly concludes that because the assisted suicide issue also implicates the doctrines of informed consent and individual liberty, the two issues are equivalent. The author fails to recognize that although the issues share common doctrines, the physician-assisted suicide cases involve greatly different facts. Rather than merely withdrawing an artificially imposed medical treatment and allowing nature to take its course, physician-assisted suicides are instances in which the physician makes available to the patient an artificial means to hasten death. Right-to-die cases allow nature to take its course. In contrast, physician-assisted suicide cases frustrate the natural course by introducing an outside agent to hasten death. As such, physician-assisted suicide cases require a more stringent standard to prevent abuse.

149. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986); *In re Estate of Greenspan*, 558 N.E.2d 1194 (Ill. 1990); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626 (Mass. 1986); *Superintendent of Belchertown State Sch. v. Saikewicz*, 30 N.E.2d 417 (Mass. 1977); *In re Farrell*, 529 A.2d 404 (N.J. 1987); *In re Quinlan*, 355 A.2d 647 (N.J. 1976), cert. denied, 420 U.S. 922 (1976).

150. See *supra* note 123 and accompanying text.

To support the contention that stringent regulation is needed in assisted suicide cases, several commentators group right-to-die cases and assisted suicide cases into two separate categories.<sup>151</sup> These commentators focus on the active-passive dichotomy.<sup>152</sup> Active euthanasia<sup>153</sup> refers to steps taken deliberately to hasten death.<sup>154</sup> Cases of passive euthanasia<sup>155</sup> simply allow death to occur naturally; no outside agent causes death.<sup>156</sup> Active euthanasia involves an act of commission,<sup>157</sup> whereas passive euthanasia involves an act of omission.<sup>158</sup> Although the law generally punishes both acts of omission and commission,<sup>159</sup> strong arguments can be made for diverging from this maxim in cases of euthanasia.<sup>160</sup> Some commentators assert that cases of passive euthanasia are more defensible than are cases of active euthanasia. This is so because “[f]rom an ethical or moral point of view, causing something to happen when it can and should be prevented (active euthanasia) is very different from allowing something to happen when there is no moral obligation to prevent it (passive euthanasia).”<sup>161</sup>

Yet, when these commentators explore the active-passive distinction, they merely contemplate two fact patterns. The first is the paradigm right-to-die case.<sup>162</sup> The right-to-die cases are characterized by withdrawal of medical support and allowing death to occur without the influence of technology.<sup>163</sup>

151. See, e.g., Stephen G. Potts, *Looking for the Exit Door: Killing and Caring in Modern Medicine*, 25 HOUS. L. REV. 493 (1988); James Rachels, *Euthanasia, Killing, and Letting Die*, in ETHICAL ISSUES RELATING TO LIFE AND DEATH 148 (J. Ladd ed. 1979); Arthur Walton, *Active and Passive Euthanasia*, 86 ETHICS 343 (1976).

152. See, e.g., Wainey, *supra* note 34, at 650.

153. Active euthanasia cases are equivalent to caused suicide cases as described in this note.

154. See, e.g., Rachels, *supra* note 151, at 148.

155. Passive euthanasia cases are equivalent right-to-die cases for purposes of this note.

156. Rachels, *supra* note 151, at 148.

157. An act of commission is the affirmative “[d]oing or perpetration of a criminal act.” BLACK’S LAW DICTIONARY 272 (6th ed. 1990).

158. Omission is defined as “[t]he intentional or unintentional failure to act which may or may not impose criminal liability depending upon the existence, *vel non*, of a duty to act under the circumstances.” BLACK’S LAW DICTIONARY 1086 (6th ed. 1990).

159. For a general discussion of omission crimes, see LAFAYE & SCOTT, *supra* note 60, § 3.3, at 202-12.

160. George P. Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967) (arguing that because crimes of commission are resultant of acts which cause something to occur and crimes of omission are resultant of permitting something to occur, the law should recognize a difference in the culpability of one who causes and one who merely allows something to occur; cases of passive euthanasia distance one from criminal liability more than cases of active euthanasia).

161. Kevin O’Rourke, *Active and Passive Euthanasia: The Ethical Distinctions*, HOSPITAL PROGRESS, Nov. 1976, at 68.

162. See *supra* note 132 and accompanying text.

163. For a discussion of technology’s role in medicine, see *supra* notes 3-4 and accompanying text.

The second pattern is described as the caused suicide case.<sup>164</sup> Here, the physician or other second party commits the ultimate act that causes death by means of injection or other overt act. The commentators are correct in suggesting that the former case is justifiable as it merely allows an inevitable death to occur naturally, whereas the latter case is not justifiable because affirmative actions with intent to take a life are morally wrong.<sup>165</sup>

The active-passive dichotomy fails to distinguish a third fact pattern. This fact pattern is embodied in the cases of physician-assisted suicide.<sup>166</sup> In these cases, a physician assists in a suicide by making available to the patient the means with which to bring about death. This fact pattern is not an example of passive euthanasia because medical support is not being withdrawn. To the contrary, medicine is being provided to, rather than withdrawn from, the patient. Nor are physician-assisted suicides examples of active euthanasia as the physician does not commit the ultimate act resulting in death. Instead, physician-assisted suicide cases are a hybrid between active and passive euthanasia cases.

A better method of classifying euthanasia cases is to categorize them into three separate groups: (1) completely active euthanasia; (2) active-passive euthanasia; and (3) completely passive euthanasia.<sup>167</sup> Completely active cases are the caused suicide cases.<sup>168</sup> Such cases are "active" in two aspects. First, an external catalyst hastens the patient's death. Second, a second party

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164. For an explanation of caused suicide cases, see *supra* notes 62-67 and accompanying text. The commentators who focus on the active-passive dichotomy treat cases of assisted suicide in the same manner as caused suicide cases. The commentators treat the two as equivalents because of the participation of a second party in the death. What these commentators fail to explore is that beyond the fact that both cases involve a second party, the role of the second party in cases of assisted suicide is far different from the second party's role in caused suicide cases. See *infra* text accompanying notes 168-69 for further discussion of the distinguishing factors of caused and assisted suicide cases.

165. Wainey, *supra* note 34, at 650.

166. For examples of physician-assisted suicides, see *supra* notes 122-23 and accompanying text.

167. Deborah Wainey provides another way of categorizing euthanasia cases. Wainey discusses the voluntary-involuntary-nonvoluntary distinction. Euthanasia is classified as voluntary, involuntary, or nonvoluntary depending on the competency of the patient. Voluntary euthanasia involves a competent person who wishes to die either by withdrawal of life support or by lethal injection administered by a physician. Involuntary euthanasia is carried out against the will or without the consent of the patient. Nonvoluntary euthanasia occurs when a patient is incompetent and a parent or guardian requests the performance. This method of categorizing euthanasia focuses on the state of mind of the patient. Wainey, *supra* note 34, at 652. Distinguishing euthanasia in this manner fails to address the varying roles played by the physician. As the law is focused on the role of the physician, a system which distinguishes not only the patient's desire, but also the physician's actions, is essential. This note proposes such a standard. See *infra* section VI.C.

168. See *supra* notes 62-67, 109-17 and accompanying text.

introduces the external catalyst to the patient. The active-passive cases are the assisted suicide cases.<sup>169</sup> Such cases are "active" in that an external catalyst hastens the patient's death. However, they are "passive" in that no second party introduces the external catalyst to the patient's body; instead, the patient administers the external catalyst by himself. Completely passive cases are the right-to-die cases.<sup>170</sup> Such cases are "passive" in two aspects. First, no external catalyst hastens death. Rather, an external system prolonging life is removed. Second, no second party administers an external catalyst. Instead, death is "catalyzed" merely by allowing life functions to terminate in a natural and independent manner.

As previously discussed, the law treats completely passive and completely active cases of euthanasia quite differently.<sup>171</sup> In completely passive cases, the Supreme Court has recognized that a state can allow a person to refuse medical treatment, even if that withdrawal of treatment results in death.<sup>172</sup> Conversely, in completely active cases, the role of the physician in administering a lethal dose of potassium chloride is correlative to *A* shooting *B* at *B*'s request.<sup>173</sup> The criminal liability in the second case is clear, although American courts, especially lay jurors, are hesitant to punish well-intentioned physicians to the full extent of the law.<sup>174</sup>

The question remains as to what standard should apply to active-passive euthanasia cases.<sup>175</sup> First, as one commentator suggests, active-passive cases could be subject to the standard that governs right-to-die cases.<sup>176</sup> Second, the law could treat active-passive cases in the same manner as completely active cases, thus making both unjustifiable. The Michigan legislature has adopted the second view.<sup>177</sup>

The Michigan statute and the commentator's proposal<sup>178</sup> fail to recognize that physicians' involvement in active-passive cases is clearly distinguishable

169. See *supra* notes 122-23 and accompanying text.

170. See *supra* notes 132-47 and accompanying text.

171. See *supra* notes 142-44 and accompanying text for a discussion of completely passive cases. See *supra* notes 109-17 and accompanying text for a discussion of completely active cases.

172. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 283 (1990).

173. See, e.g., *State v. Cobb*, 625 P.2d 1133 (Kan. 1981) (upholding defendant's conviction of murder after shooting victim in the head at victim's request).

174. See *supra* note 112 and accompanying text.

175. See *infra* section VI.C for a proposed standard that would allow physicians to assist a suicide in carefully regulated circumstances.

176. See, e.g., Note, *Physician Assisted Suicide and the Right to Die With Assistance*, *supra* note 148, at 2021.

177. See the Michigan assisted suicide statute cited *supra* note 5.

178. See *supra* note 148 and accompanying text.

from their involvement in either completely passive or completely active cases. Contrary to completely passive cases, the active-passive physician's involvement is more culpable, as the physician makes available an external catalyst to quicken death. No state law treats an active-passive physician in the same manner as a completely passive physician,<sup>179</sup> although some commentators have urged for such treatment.<sup>180</sup> Yet in relation to completely active cases, the involvement of the active-passive physician is less culpable, as the physician does not commit the ultimate act resulting in death.

Generally, the law punishes people in relation to their involvement in an alleged criminal act.<sup>181</sup> As Michigan law presently stands, the active-passive physician is treated in the same manner as a completely active physician.<sup>182</sup> Michigan can resolve this inconsistency by providing a standard that is particularly suited to judge the active-passive physician. It follows logically that if different standards exist for the completely passive and completely active physician, then different standards should also exist for the active-passive physician. The difficult question is what that standard should be. An examination of Dutch law provides insight to a possible workable standard.

#### V. EUTHANASIA IN THE NETHERLANDS: A LEGAL REALITY

Relevant to this Note's proposal are recent developments in Dutch law pertaining to euthanasia. As this section will outline, the importance of recent events in the Netherlands is two-fold. First, the events demonstrate one country's successful attempt to accept euthanasia and implement it into its legal structure. Second, the events show that a system far more liberal than that which is proposed in this Note can work effectively while preventing a groundswell of abuse. The following section details each of these important observations.

Article 293 of the Dutch Penal Code provides that "[h]e who robs another

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179. See statutes cited *supra* notes 72-73.

180. See, e.g., Note, *Physician-Assisted Suicide and the Right to Die With Assistance*, *supra* note 148, at 2021; Waaney, *supra* note 34, at 652.

181. Consider, for example, a state's sentencing guidelines for murder. As the defendant's level of participation drops from first degree murder to second degree, so also does the likely period of incarceration. Compare MICH. COMP. LAWS § 750.316 with MICH. COMP. LAWS § 750.317 (1993).

182. The Michigan statute subjects a physician who assisted a suicide in the same manner as a physician who caused a suicide. See statute cited *supra* note 5. Another interesting facet about Michigan's assisted suicide law is that it criminalizes *assisting* a suicide. However, there is no criminal sanction for the person who attempts or commits suicide. An exhaustive review of Michigan's criminal law revealed no corollary wherein the choate act (suicide) was not criminalized but the inchoate act (assisting suicide) was.

of life at his express and serious wish, is punished with a prison sentence of at most twelve years . . . ."<sup>183</sup> Article 289 of the Dutch Penal Code provides that a person who deliberately kills another with malice aforethought shall be imprisoned for life or for a temporary sentence of up to twenty years in prison.<sup>184</sup> The punishment for completely active euthanasia is less than the punishment for murder because completely active euthanasia occurs at the request of the victim.<sup>185</sup> Therefore, Dutch law, contrary to American law, recognizes consent as a partial defense to homicide.<sup>186</sup> The Dutch justify recognizing consent as a partial defense on the premise that murder violates both the interests of the person killed and society in general, whereas consensual mercy killing violates only the respect for human life.<sup>187</sup>

The Dutch Penal Code is far less rigid than its American counterpart. The "Penal Code assumes that situations can develop in which overstepping a norm may not be laid to one's charge and gives the judge the possibility and the duty to ascertain what brought this person to this deed in these circumstances."<sup>188</sup> This principle has permitted a line of cases to develop that allows a physician to cause the death of a patient under closely regulated conditions despite the explicit prohibition under Article 293 of the Dutch Penal Code.

In 1950, the Dutch courts first addressed the issue of active-passive euthanasia. The case involved a physician who gave to his ill brother a combination of sleeping pills and pain killers that resulted in the brother's death.<sup>189</sup> The government prosecuted the defendant-doctor pursuant to Article 293 and convicted him as charged.<sup>190</sup> However, the court imposed a very lenient sentence. The defendant-doctor received a one year suspended sentence. The court examined the close relationship between the defendant-doctor and his brother and the progressed stage of the brother's cancer in applying such a

183. Marian H. N. Driessé et al., *Euthanasia and the Law in the Netherlands*, 3 ISSUES L. & MED. 385, 393 (Walter Lagerwey trans., 1988).

184. *Id.* at 386.

185. Helen Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 363 (1954).

186. LAFAYE & SCOTT, *supra* note 60, § 5.11(a), at 477-80. Several European countries other than the Netherlands recognize that homicide pursuant to the victim's request is less culpable than nonconsensual homicide cases. Silving, *supra* note 185, at 363.

187. Driessé, *supra* note 183, at 387. The fact that mercy killing is consensual shows that the interests of the person killed are actually realized only through death. This serves to lessen the interest society has in protecting life and therefore justifies the diminished punishment. Verbatim, *Guidelines for Euthanasia*, 3 ISSUES L. & MED. 429, 437 (1988).

188. Driessé, *supra* note 183, at 390.

189. RUSSELL, *supra* note 31, at 254.

190. Waaney, *supra* note 34, at 655.

relaxed sentence.<sup>191</sup>

It was not until the 1970s that the Dutch government began its slow move toward legalizing completely active euthanasia. In 1971, Dr. Geertruida Postma injected 200 milligrams of morphine into the veins of her seventy-eight-year-old terminally ill mother, who died within minutes.<sup>192</sup> At this time in the Netherlands, doctors commonly gave patients doses of drugs that would alleviate suffering even though the administration of those drugs would also quicken death.<sup>193</sup> Indeed, this was the recognized manner in which to care for terminally ill patients.<sup>194</sup> The court convicted Dr. Postma because she failed to follow the proper course of pain alleviation.<sup>195</sup> She chose instead to administer a fatal injection without first allowing for alleviation of pain. Nevertheless, the court gave her a very lenient sentence of only one week in prison and probation for one year.<sup>196</sup>

The focus of the Dutch court was not on the consequences of Dr. Postma's act, but rather on the intention of her act.<sup>197</sup> The court concentrated on the fact that Dr. Postma caused death before pursuing a course of alleviation. As such, guilt attached to Dr. Postma's actions. However, the court implied that if she had first chosen a course of alleviation which failed to relieve suffering and then administered a lethal injection, then Dr. Postma would not have been

191. In the same year, an American jury acquitted Dr. Hermann Sander of murder charges on facts similar to that of the Dutch case. The jury acquitted on the ground that no causal connection existed between Dr. Sander injecting air into the veins of a patient and the patient's death minutes later. See *supra* note 106 and accompanying text.

192. HUMPHRY & WICKETT, *supra* note 28, at 171-72. Dr. Postma's mother suffered from a cerebral hemorrhage, partial paralysis, speech difficulty, pneumonia, and deafness. On several occasions she asked for aid in dying and had previously attempted suicide unsuccessfully. *Id.*

193. This is known as the doctrine of double effect which provides that where the intention behind the act is good, the action is permissible even if it is known that undesirable consequences may result. SHEILA MCLEAN, *MEDICINE, MORALS AND THE LAW* 52 (1983). "Double effect therefore condones the administration of a lethal injection so long as the intent behind the act is to alleviate suffering rather than to hasten death, even though life is shortened as a secondary effect of the effort to alleviate suffering." Wainey, *supra* note 34, at 651. This doctrine is addressed in the Michigan assisted suicide statute at § 752.1027(3). See statute cited *supra* note 5. Double effect is exemplified by ". . . a person who would refuse an amputation without anesthesia because it would be too painful . . . even though the choice might hasten death." O'Rourke, *supra* note 12, at 430.

194. Wainey, *supra* note 34, at 655-56.

195. *Id.* at 656.

196. Verbatim, *Euthanasia Case Leeuwarden—1973*, 3 ISSUES L. & MED. 439, 442 (Walter Lagerwey trans., 1988) [hereinafter Verbatim, *Leeuwarden*].

197. In so doing, the Dutch court acted well within its role because the flexible Penal Code places a duty on the judge to ascertain the actor's motive under the circumstances and to consider that motive in determining guilt. Driesse, *supra* note 183, at 390.

guilty of a crime.<sup>198</sup> Whatever the trial court's intention, over time the Dutch courts have interpreted the holding to mean that terminally ill patients suffering from unbearable pain have the right to ask their physician to administer a lethal injection to hasten death.<sup>199</sup>

Ten years after the Postma case, the Dutch courts made a dramatic ruling that increased the scope of who may receive aid in dying.<sup>200</sup> Previously, the right included only the terminally ill.<sup>201</sup> However, the Rotterdam court extended the right to receive aid in dying to include non-terminally ill patients as well.<sup>202</sup> This case involved the trial of a defendant-health care volunteer who assisted a woman in suicide.<sup>203</sup> The court offered a standard for avoiding criminal liability in completely active euthanasia cases. The court stated that a person need not be terminally ill to receive aid in dying, but need only be facing unbearable physical pain and emotional suffering that no medical procedure can alleviate.<sup>204</sup> The court noted that criminal liability would attach only if the individual facilitating the suicide failed to follow the guidelines set forth by the court.<sup>205</sup>

Perhaps the most important completely active euthanasia case coming from the Netherlands is that of Dr. Schoonheim.<sup>206</sup> This case involved a seventy-four-year-old patient suffering from multiple sclerosis who requested that her physician help her die. The defendant-doctor administered a lethal dose of morphine. The patient died soon thereafter.<sup>207</sup> The trial court found Dr. Schoonheim guilty of active euthanasia but imposed no sentence.<sup>208</sup> The Court of Appeals reviewed the trial court decision and found Dr. Schoonheim guilty and imposed a prison sentence of two months, with an additional two years of

198. Postma did not "even attempt to pursue this course [of alleviation], [but] instead administer[ed] a lethal dose all at one time." Verbatim, *Leeuwarden*, *supra* note 196, at 441.

199. Wainey, *supra* note 34, at 656.

200. Driesse, *supra* note 183, at 394 (discussing confidential euthanasia case decided by the court at Rotterdam).

201. See *supra* note 198 and accompanying text (discussing the Postma case).

202. Driesse, *supra* note 183, at 394.

203. Peter Diekstra, *Suicide Should Not Always Be Prevented*, in *DEATH AND DYING* 56 (1980) (discussing the Rotterdam case).

204. Wainey, *supra* note 34, at 656 (discussing the Rotterdam case).

205. H.R.G. Feber, *The Vicissitudes of Article 293 of the Penal Code from 1981 to the Present*, 3 *ISSUES L. & MED.* 455, 456 (Walter Lagerwey, trans. 1988) (discussing another confidential case from Rotterdam).

206. Barry A. Bostrom & Walter Lagerwey, *Nota Bene, The High Court of the Hague Case No. 79065, October 21, 1986*, 3 *ISSUES L. & MED.* at 445 (1988) (discussing *Nederlandse Jurisprudentie*).

207. *Id.*

208. *Id.*

probation.<sup>209</sup>

Dr. Schoonheim then appealed the case to the Netherlands' highest court, the Court of the Hague.<sup>210</sup> The Court remanded the case but developed criteria for the trial court to consider in determining the justifiability of euthanasia.<sup>211</sup> The Court focused on three areas: concern for the patient's dignity; to what extent the suffering would increase if the patient remained alive; and to what extent it would be possible to alleviate the suffering.<sup>212</sup>

On remand, the trial court dismissed the case against Dr. Schoonheim.<sup>213</sup> The court said that the realm of euthanasia was most properly left to the medical profession and the patient, not the judiciary.<sup>214</sup> Thus, following proper medical procedure would shield the physician from any liability emanating from Article 293.<sup>215</sup>

While the Netherlands' case law has evolved greatly, until recently, the statutory scheme still made euthanasia a crime punishable by twelve years in prison.<sup>216</sup> However, on February 2, 1993, the major parties in the Dutch parliament backed plans to legalize euthanasia.<sup>217</sup> The new law would permit a physician to be imprisoned for up to twelve years, but only if the physician failed to follow the guidelines set out in the statute. The guidelines codify the common law of the Netherlands.<sup>218</sup>

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209. *Id.*

210. Wainey, *supra* note 34, at 658.

211. *Id.* (discussing the Schoonheim case).

212. *Id.* at 658-59.

213. *Id.* at 658.

214. HUMPHRY & WICKETT, *supra* note 28, at 178.

215. Bostrom & Lagerwey, *supra* note 206, at 445-46.

216. *See supra* note 183 and accompanying text.

217. *Dutch House Approves Controlled Euthanasia*, THE REUTER LIBRARY REPORT, Feb. 2, 1993, available in LEXIS, News Library, CURNWS File.

218. General provisions of the Dutch statute include: Obliging doctors to notify the coroner of all cases of euthanasia and to give a detailed account of the circumstances, based on a 28-point checklist. The main prerequisites for allowing euthanasia are that the patient be terminally ill and suffering from unbearable pain. The statute merely codifies a practice that has been on-going for twenty years. A 1991 survey shows that in the Netherlands alone, doctors assist in 2700 cases of euthanasia per year. This equates to just over two percent of all deaths in the Netherlands per year. *Id.* Such a slim percentage of deaths attributable to euthanasia seems to undermine the "slippery slope" argument posited by those opposed to assisted suicide. The basic premise of the "slippery slope" argument is that if assisted suicide is allowed for the terminally ill, then eventually euthanasia will be used rampantly and for devious purposes. However, if there truly were a "slippery slope" effect, it seems that far more than two percent of the deaths in the Netherlands would be a result of euthanasia. Moreover, the "slippery slope" argument is logically flawed. For, as Cheryl K. Smith succinctly argues, those who oppose assisted suicide

claim that once we allow voluntary assisted suicide for the terminally ill we will

As demonstrated, the importance of the recent events in the Netherlands is two-fold. First, the events demonstrate one country's successful attempt to accept euthanasia and implement it into its legal structure.<sup>219</sup> Second, the events show that a system far more liberal than that which is proposed in this Note can work effectively while preventing a ground-swell of abuse.

The Dutch system not only allows completely passive euthanasia, but also completely active and active-passive cases.<sup>220</sup> The legal structure proposed in this Note assumes that completely passive euthanasia is permissible in light of *Cruzan*, but proposes a legal distinction between active-passive and completely active cases. The following discussion will illuminate why, in stringently regulated circumstances, the law should permit active-passive euthanasia and why completely active cases should never receive legal protection.

## VI. TOWARD A RATIONAL SOCIETY: RECOGNIZING THE BENEFITS FOR PROTECTING PHYSICIAN-ASSISTED SUICIDE

### A. Tensions

Where medical technology serves to frustrate its purpose of improving life, suffering patients should be able to rely on a legal structure that is responsive to the patient's dilemma.<sup>221</sup> However, the issue of assisted suicide is complicated by the tension inherent in the state's interest in preservation of life and the conflicting mandates of the physicians' Hippocratic Oath.<sup>222</sup> These

eventually move the line to encompass involuntary euthanasia and to allow killing persons who are poor, disabled, or otherwise at risk. This ignores the fact that we draw lines and make distinctions regularly. If the [slippery slope] argument were true, then legal abortion should by now have led to legal infanticide.

Cheryl K. Smith, *What About Legalized Assisted Suicide?*, 8 ISSUES L. & MED., 503, 514-15 (1993) (citations omitted).

219. The Dutch government, however, is careful to state that mercy killing remains a criminal offense in the Netherlands. The new law merely sets out a procedure for doctors to report the termination of a patient's life to the authorities. A prosecutor will then decide on a case-by-case basis whether to prosecute the physician. Nevertheless, the practical effect of the new law is to immunize doctors from prosecution if the deceased was terminally ill, suffering unbearable pain, and requested to die. *Dutch Try to Clarify Controversial Euthanasia Law*, THE REUTER LIBRARY REPORT, Feb. 24, 1993, available in LEXIS, News Library, CURNWS File.

220. *Id.* The most salient restriction of the Dutch law is that the patient or the patient's family must request the procedure. This requirement contradicts erroneous reports suggesting that the law legalized non-requested euthanasia. *Id.*

221. The dilemma faced by the suffering patient under current Michigan law is essentially the problem this note attempts to resolve. By allowing physicians to assist in the suicide of a patient under stringently regulated conditions, the proposed statute contained in this note attempts to strike a proper balance between the state's interest in preserving life and the individual's right to personal autonomy. See *infra* section VI.C.

222. See *supra* note 16 (Hippocratic Oath).

tensions become greater as improved medical technology serves to prolong life beyond its traditional threshold while often failing to improve the quality of life.

The paradox of medical technology creates the central question physician-assisted suicide poses: whether patients should have the right to receive a physician's aid in dying. This Note proposes a statute that pays needed attention to suffering patients who are truly the affected parties under Michigan's present law. The proposed statute attempts to resolve the conflict between the individual's right to self-determination and the state's interest in preserving life, while still giving substance to the role of the physician.

### 1. Society's Interest In Preserving Life vs. Individual Interest in Autonomy

In a 1991 Michigan circuit court case dealing with physician-assisted suicide, *People ex rel. Thompson v. Kevorkian*,<sup>223</sup> the court recognized that in contemplating whether a right to assisted suicide exists, the court must weigh the individual's liberty interest and right to privacy against the state's interest in preserving life.<sup>224</sup> At issue in the *Kevorkian* case was whether the state could enjoin Dr. Kevorkian from using his suicide machine.<sup>225</sup> Although the court granted an injunction against Dr. Kevorkian, the decision is important for other reasons. Initially, the court recognized that an individual has a right to refuse medical treatment based on the liberty interest in the Due Process Clause.<sup>226</sup> Next, the court rejected the proposition that the liberty interest recognized in the Due Process Clause applies to cases of physician-assisted suicide.<sup>227</sup> The court reasoned that "[t]he liberty interest in refusing medical treatment flows from decisions involving the State's invasion of the body."<sup>228</sup> The court distinguished *Kevorkian* from right-to-die cases on two grounds. First, *Kevorkian* lacked bodily invasion by the sovereign as was present in *Cruzan*.<sup>229</sup> Second, the necessity of a second party to make available the means to commit suicide in *Kevorkian* contradicted the concept of the right to

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223. No. 90-390963-AZ (Mich. Cir. Ct., Feb. 5, 1991).

224. Verbatim, *State of Michigan in the Circuit Court for the County of Oakland*, 7 ISSUES L. & MED. 107, 116 (1991) [hereinafter Verbatim, *Circuit Court*]. "[T]he determination that a person has a liberty interest under the Due Process Clause does not end the inquiry; whether [Kevorkian's] constitutional rights have been violated must be determined by balancing his liberty interests against the relevant State interest." *Id.* (citing *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990)).

225. *Id.* at 107.

226. *Id.* at 116 (citing *Washington v. Harper*, 494 U.S. 210 (1990)).

227. Verbatim, *Circuit Court*, *supra* note 224, at 117.

228. *Id.* (citing *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 287 (1990) (O'Connor, J., concurring)).

229. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 261-62 (1990).

privacy.<sup>230</sup>

Having identified the individual's interest in this manner, the court concluded that the state's interest in preserving life substantially outweighed the individual's interest in personal autonomy and privacy.<sup>231</sup> To support its conclusion, the court recognized that the state's interest in preserving life also included an interest in protecting third parties.<sup>232</sup> Next, the court reasoned that the state's interest in preserving life is compelling and no constitutionally protected right to commit suicide exists.<sup>233</sup> Finally, the court noted that the practice of physician-assisted suicide is generally rejected in the medical community, and as such the state has an interest in sanctioning such behavior to maintain the integrity of the medical profession.<sup>234</sup>

The central reasoning contained in the opinion seems to fully define the position that physician-assisted suicide contravenes Michigan law.<sup>235</sup> However strong the reasoning was in a pragmatic sense, in conclusion the court ironically moved away from its prior adamant position and recognized the practical difficulty that suffering patients face. In a direct plea to the Michigan legislature, the court stated:

There is reason to condone dying with dignity, but it mandates a controlled environment that can be properly and professionally monitored by competent persons and in a manner that is acceptable to

230. Verbatim, *Circuit Court*, *supra* note 224, at 117. The court stated:

The fact that Dr. Kevorkian is the party to this case and to the proposed procedure evidences that the asserted individual rights at stake are not the rights of privacy and self-determination. The terms "privacy" and "self-determination" belie the participation of another individual; yet this is precisely what Dr. Kevorkian proposes—the right to assist a suicide. The rights of privacy and self-determination do not encompass the right to direct another person to kill or the right of a third person to participate in the killing.

*Id.* at 117-18.

231. *Id.* at 118.

232. *Id.* at 117 (citing *In re Conroy*, 486 A.2d 1209, 1225 (N.J. 1985)).

233. Verbatim, *Circuit Court*, *supra* note 224, at 117 ("There is no constitutionally recognized right to commit suicide. In fact, the power of the State to prohibit suicide is unquestionable."). However, a more complete review of precedent contained in this note finds that the only state to criminally sanction suicide was Massachusetts which repealed its suicide statute in 1823. Although no textual right to commit suicide exists, no statute or constitutional mandate prohibits suicide. See *supra* note 56 and accompanying text.

234. Verbatim, *Circuit Court*, *supra* note 224, at 117. However, recent polls suggest a growing acceptance among physicians for allowing physician-assisted suicide. Although still comprising a minority, twenty percent of physicians surveyed admitted to having assisted a patient in suicide. The trend is toward greater acceptance of assisted suicide in the medical community. Richard A. Knox, *One in Five Doctors Say They Assisted a Patient's Death, Survey Finds*, BOSTON GLOBE, Feb. 28, 1992, at 5.

235. See *supra* note 231 and accompanying text.

society. The need for the medical profession and the State legislature to deal realistically with this critical issue is society's challenge.<sup>236</sup>

Therefore, the court's original position that the state interest automatically outweighs individual privacy rights wavered.<sup>237</sup> Rather than stating which interest is dominant, the court asked the legislature to consider medical ethics and public opinion in resolving the physician-assisted suicide issue. The Michigan statute prohibiting assisted suicide is not responsive to the court's directive to consider medical ethics and societal mores. Michigan's current statute always gives preference to the state's and physician's interest in preserving life. However, the following discussion reveals that assisted suicide is not *per se* antithetical to medical ethics and that the general public favors physician-assisted suicide.<sup>238</sup> Therefore, the court's directive to the legislature does not warrant an absolute preference for the state's interest in preserving life over individual privacy. As such, an alternative statute is necessary.

## 2. Medical Position on Physician-Assisted Suicide

In resolving the conflicting state and individual interests framing the assisted suicide controversy, the conflicting mandates of the Hippocratic Oath must be considered in determining which interest should be paramount.<sup>239</sup> After analyzing the Hippocratic Oath, some commentators suggest that physician-assisted suicide should never be allowed.<sup>240</sup> In pertinent part, the Hippocratic Oath provides: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect . . . . In purity and holiness I will guard my life and my art."<sup>241</sup>

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236. Verbatim, *Circuit Court*, *supra* note 224, at 118.

237. Originally, the court stated that individuals have no privacy rights in cases of physician-assisted suicide. See *supra* note 231 and accompanying text. But in conclusion, the court recognized the plight of suffering patients and called for the legislature and medical community to resolve the issue in a responsible manner. See *supra* text accompanying note 236.

238. See *infra* notes 239-59 and accompanying text.

239. Considering the physician's role is in accord with the *Kevoorkian* opinion. The court stated: "The final interest that is implicated [in physician-assisted suicide cases] is the maintenance of the ethical integrity of the medical profession. . . . Prevailing medical ethical practice rejects physician assisted suicide." Verbatim, *Circuit Court*, *supra* note 224, at 117. *Contra* Richard A. Knox, *One in Five Doctors Say They Assisted a Patient's Death, Survey Finds*, BOSTON GLOBE, Feb. 28, 1992, at 5 (finding a growing number of physicians are assisting patients in suicide).

240. Leon R. Kass, *Neither for Love Nor Money: Why Doctors Must Not Kill*, 94 PUBLIC INTEREST 25, 30 (Winter 1989) (suggesting that physicians should never participate in assisted suicide because it is antithetical to medical ethics), *contra* Timothy E. Quill, *Doctor, I Want to Die. Will You Help Me?*, 270 JAMA 870, 870-873 (1993) (detailing the physician-author's plan for regulating physician-assisted suicide).

241. See *supra* note 16 (Hippocratic Oath).

Relying on the Hippocratic Oath, the American Medical Association (AMA) and a significant portion of the medical community agree that physician-assisted suicide should not be allowed.<sup>242</sup> However, the AMA's position fails to recognize other provisions of the Hippocratic Oath that require the physician to act so as to reduce pain.<sup>243</sup> Ironically, in some instances, if a physician failed to administer a deadly drug, then the physician may actually be exacerbating pain.<sup>244</sup>

Reliance on the Hippocratic Oath to justify banning physician-assisted suicide is unwarranted. A large portion of the legal and medical communities have treated much of the Hippocratic Oath as legally irrelevant. For example, the Hippocratic Oath states: "Nor will I give a woman a pessary to procure an abortion . . . ." <sup>245</sup> Yet *Roe v. Wade*<sup>246</sup> legalized abortion. The myriad of abortion clinics<sup>247</sup> across the United States make it evident that the medical profession performs abortions even in light of the clear prohibition contained in the Hippocratic Oath. If the Hippocratic Oath's abortion provision is ignored due to changing medical philosophies, it is not outrageous to assert that the Oath's prohibition against ending a patient's life is a flexible guideline, not an absolute law.<sup>248</sup>

242. The AMA's position is detailed in the following statement:

The AMA opposes the participation of a physician, voluntarily or involuntarily, in the termination of a patient's life by the administration of any agent or the use of any means to actively terminate a patient's life. . . . The AMA opposes enactment of any type of federal or state legislation that would require a physician to provide the medicines, techniques, or advice necessary for a patient to pursue a course of suicide, or which would require a physician who is unwilling to participate in suicide to refer the patient to a physician who would be so [sic] willing to do so.

AMERICAN MEDICAL ASSOCIATION, AMA POLICY COMPENDIUM §§ 22.005-.006 (1989).

243. "I will follow the method of treatment which, according to my ability and judgment, I consider for the benefit of my patients . . . .", *quoted in* G. Steven Neeley, *Patient Autonomy and State Intervention: Reexamining the State's Purported Interest*, 19 N. KY. L. REV. 235, 241 (1992).

244. Consider for example, the suicides that have occurred in Michigan. In general, those individuals suffering from pain that no medical procedure could alleviate. If they had not committed suicide, their suffering would have continued. Thus, although Dr. Kevorkian's actions would not receive protection under the proposed statute, his actions served to stop pain. *See supra* notes 122-23.

245. *See supra* note 16 (Hippocratic Oath).

246. 410 U.S. 113 (1973).

247. The nation's largest provider of abortion services is Planned Parenthood. With 178 facilities across the nation, Planned Parenthood performs approximately 100,000 of the 1.6 million abortions performed in the United States every year. Marianne Szegedy-Maszak, *Calm, Cold and Beleaguered*, N.Y. TIMES, Aug. 6, 1989, at A64.

248. Nearly half of all medical schools recognize the fact that medical philosophy is not stagnant, but changes as technology and society changes. Evidence of this is portrayed in the contemporary version of the Hippocratic Oath which recognizes that it may be within a physician's power to end a person's life. *See infra* text accompanying note 253.

The fact that physicians often disregard provisions of the Hippocratic Oath lends credence to the assertion that the Oath's mandate "[t]o please no one will I prescribe a deadly drug . . . ." <sup>249</sup> is not an absolute. <sup>250</sup> Modern treatment of the Hippocratic Oath strengthens this contention. A recent survey reveals that only six percent of medical schools require their graduates to swear to uphold the Oath. <sup>251</sup> Nearly half of all other medical schools require their graduates to swear to uphold a contemporary version of the Hippocratic Oath which is more sensitive to the paradox of modern medical technology. <sup>252</sup> The contemporary Hippocratic Oath provides:

I tread with care in matters of life and death. If it is given to me to save a life, all thanks. *But it may also be within my power to take a life*; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play God. <sup>253</sup>

Therefore, just as the state's interest in preserving life does not automatically override the individual's interest in autonomy, neither does the Hippocratic Oath flatly condemn the physician's involvement in assisted suicide. Rather, both tensions require a careful balancing of competing interests. The present state of medical technology and the mores of medical practitioners reveal that the medical community is slowly becoming more receptive to the idea of physician-assisted suicide. In support of this contention, polls suggest that a significant portion of physicians have assisted patients in suicide. <sup>254</sup>

In one nonscientific count, ten out of twelve physicians advocated positions that favored the physician's ability to assist in a suicide of a patient. <sup>255</sup> A more accurate poll revealed that twenty percent of all physicians had assisted in the voluntary suicide of one of their patients. <sup>256</sup> Although this high percentage

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249. See *supra* note 16 (Hippocratic Oath).

250. If one were to assert that the Hippocratic Oath is an absolute, then no doctor could perform an abortion without violating the Oath. It follows that if one provision of the Oath is not an absolute, then other provisions of the Oath may be regarded in the same way.

251. NATIONAL HEMLOCK SOCIETY, HEMLOCK Q., July 1990, at 1.

252. *Id.*

253. *Id.* (emphasis added).

254. See *infra* notes 256-57 and accompanying text.

255. Sidney H. Wanzer, et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844 (1989). "It is not immoral for a physician to assist in the rational suicide of a terminally ill person" say ten of twelve physician-authors. *Id.*

256. Richard A. Knox, *One in Five Doctors Say They Assisted a Patient's Death, Survey Finds*, BOSTON GLOBE, Feb. 28, 1992, at 5 ("[I]t is relatively common for patients to ask a physician's help in committing suicide, and . . . physicians often take action to hasten death."); see also Lawrence K. Altman, *More Physicians Broach Forbidden Subject of Euthanasia*, N.Y. TIMES, Mar. 12, 1991, at C3.

may shock many practicing physicians, some medical professionals believe that there exists a significant number of physicians who secretly practice euthanasia.<sup>257</sup> The cautious recognition among physicians that assisted suicide may at times be permissible should not be surprising, because doctors are in the business of relieving pain and observe, in a very graphic way, the medically incurable suffering many patients encounter.

In *Kevorkian*, Judge Gilbert recognized that death with dignity should be condoned in some instances.<sup>258</sup> Further, Judge Gilbert called on the Michigan legislature to pass a law that is agreeable to both physicians and society.<sup>259</sup> The previous discussion reveals physicians' growing acceptance of physician-assisted suicide. The following discussion explores society's general acceptance of physician-assisted suicide.

### B. Public Support for Physician-Assisted Suicide

The recognition among physicians that assisted suicide may be an acceptable means to end the life of a suffering human being has been even more widely accepted by the general population.<sup>260</sup> A public opinion poll taken after the *Cruzan* decision revealed that a substantial majority of the population favored a patient's right to refuse medical treatment.<sup>261</sup> More importantly, this poll specifically addressed whether physicians should be allowed to assist in the suicide of a patient. Of the 2000 participants, sixty-four percent supported

257. Lawrence K. Altman, *Doctor Says He Gave Patient Drug to Help Her Commit Suicide*, N.Y. TIMES, Mar. 7, 1991, at A1. (revealing that doctor who assisted patient in suicide said that he believed several doctors prescribe medications to suffering patients to facilitate suicide); Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991) (recounting physician-author's role in assisting a patient in suicide); *Doctors Who Help Patients Die; MDs Reveal a Secret Practice: Aiding Suicides, Mercy Killing*, NEWSDAY, Sept. 29, 1991, at 4 (reporting that ten percent of physician-respondents admitted to assisting a patient in suicide). Even physicians formerly opposed to physician-assisted suicide quickly change their position when their families are confronted with the dilemma. For example, Dr. Howard Sudak, a psychiatrist at Pennsylvania Hospital in Philadelphia was selected to speak against physician-assisted suicide at a San Francisco Conference. However, when his mother suffered a debilitating stroke, Dr. Sudak said, "I underwent my own epiphany, like the antiabortionist whose daughter is raped . . . ." Paul Cotton, *Rational Suicide: No Longer 'Crazy'?*, 370 JAMA 797 (1993).

258. Judge Gilbert wrote that "there is reason to condone death with dignity." Verbatim, *Circuit Court*, *supra* note 224, at 118.

259. See *supra* note 236 and accompanying text.

260. See *infra* notes 261-63 and accompanying text.

261. Fifty-nine percent agreed that Nancy Cruzan's parents should have the right to disconnect the food and hydration tube keeping Nancy alive. Only 19% disagreed with such a right. The remaining 22% were undecided. THE HEMLOCK SOCIETY, HEMLOCK Q., July 1990, at 6 (1990 Roper Poll, surveyed by the National Hemlock Society).

assisted suicide if requested by the patient.<sup>262</sup>

One may contend that public opinion polls should not dictate the issue of physician-assisted suicide. However, two states have already given the public the right to determine whether to legalize physician-assisted suicide.<sup>263</sup> Further, Judge Gilbert called on the Michigan legislature to pass a law that not only was cohesive with medical ethics, but also reflected society's view on the issue of physician-assisted suicide.<sup>264</sup> Given the growing acceptance of physician-assisted suicide in both the medical community and the public, the Michigan legislature failed to pass a law that addressed Judge Gilbert's concerns.<sup>265</sup> The following section details an alternative statute that addresses the concerns espoused in *Kevorkian* by respecting the unenviable position of the suffering patient, recognizing the state's interest in preserving life, and furthering societal and medical mores.

### C. A Proposed Statute for Assisted Suicide in Michigan

On February 25, 1993, Michigan's statute prohibiting assisted suicide became law.<sup>266</sup> However, the position of the Michigan legislature and Governor John Engler in banning physician-assisted suicide is not steadfast.<sup>267</sup> The ban is effective until six months after the Michigan Commission on Death and Dying delivers its report to the legislature recommending what the

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262. *Id.* Merely 24% of those polled opposed the idea of physician-assisted suicide, 13% were undecided. See also *Increasing Number of Americans in Favor of Euthanasia*, AGENCE FRANCE PRESSE, Dec. 6, 1993, available in LEXIS, News Library, CURNWS File (reporting a Louis Harris and Associates poll taken between November 11-15, 1993 which revealed that 73% of people polled believed that the law should allow doctors to assist patients in suicide). But see Derek Humphry, *Where Now With the Euthanasia Debate?*, PR NEWSWIRE, Nov. 17, 1992, available in LEXIS, News Library, CURNWS File (stating that 54% of Californians voted "no" on an initiative to change the law to permit terminally ill people to receive aid in dying from their physicians).

263. In Washington and California, initiatives would have legalized physician-assisted suicide and completely active euthanasia whereby the physician could administer a lethal injection to the patient. Both initiatives differed from this note's proposed statute in that they allowed completely active euthanasia and they had far more lax prerequisites allowing a patient to receive aid in dying. See Derek Humphry, *Where Now With the Euthanasia Debate?*, PR NEWSWIRE, Nov. 17, 1992, available in LEXIS, News Library, CURNWS File. For a complete discussion of the California and Washington proposals, see Julia Pugliese, Note, *Don't Ask-Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 HAST. L.J. 1291, 1320-24 (1993).

264. See *supra* note 236 and accompanying text.

265. See statute cited *supra* note 5.

266. *Doctor Death Saga Takes a Bizarre Turn*, UPI, Feb. 26, 1993, available in LEXIS, News Library, CURNWS File.

267. The statute provides that a Commission is to research assisted suicide and then deliver its recommendation as to permanent legislation to the Governor after fifteen months. MICH. COMP. LAWS § 752.1021 (1993).

permanent status of assisted suicide should be in Michigan.<sup>268</sup>

The present statute fails to address the concerns of the most affected parties—the suffering patients. Often, medical progress prolongs a patient's life beyond the traditional threshold of death with no corresponding relief from the pain. As such, Michigan's ban on assisted suicide, although aiming to further a legitimate state interest, subjects hopelessly ill patients to unneeded prolonged suffering. An exception to Michigan's ban on assisted suicide is necessary to properly address the patient's right to personal autonomy and privacy so as to provide an avenue for alleviating the patient's undue suffering.

### 1. A Proposed Statute

#### § 1 *Definitions*

(a) "Attending Physician" means a physician as defined in § 1(c)(i) of this statute who has treated a patient as defined in § 1(d) during the course of illness.

(b) "Illness" refers to the patient's medical condition that is the primary source of the patient's pain.

(c) "Licensed health care professional" means any of the following:

(i) A physician or physician's assistant licensed or authorized to practice under part 170 or 175 of the public health code.

(ii) A registered nurse or licensed practical nurse authorized to practice under part 172 of the public health code.

(iii) A pharmacist licensed under part 177 of the public health code.

(d) "Patient" means a person who engages in an act of voluntary self-termination.

(e) "Public health code" means Act No. 368 of the Public Acts of 1978, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

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268. *Id.* The Michigan Commission on Death and Dying is reportedly due to offer its recommendation in late May of 1993. *Panelists Urge Lifting Ban on Suicide*, CHI. TRIB., Dec. 22, 1993, at A3.

(f) "Self-termination" and "voluntary self-termination" mean conduct by which a person expresses the specific intent to end, and attempts to cause the end of, his or her life, but do not include the administration of medication or medical treatment intended by a person to relieve his or her pain or discomfort, unless that administration is also independently and specifically intended by the person to cause the end of his or her life.

§ 2 *Criminal Causation of Suicide*

Any person who has knowledge that another person intends to attempt to commit suicide and who intentionally participates in a physical act by which the other person attempts or commits suicide is guilty of criminal causation of suicide, a felony punishable by imprisonment in the state prison for life or any term of years.

§ 3 *Criminal Assistance to Suicide*

Any person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally provides the physical means by which the other person attempts or commits suicide is guilty of criminal assistance to suicide, a felony punishable by imprisonment for not more than four years in the state prison or by a fine of not more than \$2000, or both.

§ 4 *Affirmative Defenses*

(a) Sections 2, 3, and 4(b) shall neither be applicable to nor be deemed to affect any other laws that may be applicable to withholding or withdrawing medical treatment by a licensed health care professional.

(b) Section 3 shall not apply to an attending physician who shows by clear and convincing evidence all of the following:

(i) Two independent and disinterested psychiatrists licensed to practice psychiatry in Michigan examined the patient and found the patient to be (1) competent when making the decision to self-terminate and (2) competent until the time of self-termination.

(ii) Two independent and disinterested physicians licensed as such in Michigan examined the patient and found the patient to be in unbearable pain, the likes of which no reasonable

medical procedure or medicine, excluding mind altering drugs, could alleviate, and there exists no reasonable chance for recovery.

(iii) The attending physician, upon the competent patient's request, and only after the examinations required in (i) and (ii) of this subsection, provided the means with which the competent patient induced self-termination and the attending physician did not participate in the ultimate act causing death.

## 2. Proposed Statute Commentary

This statute is an alternative to the Michigan statute effective February 25, 1993.<sup>269</sup> There are significant differences between Michigan's statute and the proposed statute. First, the proposed statute distinguishes the different fact patterns giving rise to caused and assisted suicide cases. As such, it provides different penalties for the two crimes. Section 2 of the proposed statute treats causation of suicide as a crime correlative to homicide<sup>270</sup> or attempted homicide<sup>271</sup> and punishes the offense more harshly than the present statute.<sup>272</sup> Section 3 of the proposed statute treats assistance to suicide as a felony, although the maximum penalty is far less than the maximum penalty for causation of suicide.<sup>273</sup> Thus, the proposed statute reflects the less culpable nature of assisted suicide, an asset Michigan's statute lacks.<sup>274</sup>

Second, the proposed statute is sensitive to the dilemma that incurably suffering patients face under the operative Michigan statute. Because the existing Michigan statute offers competent suffering patients no alternative to a lingering, painful, and undignified death, the proposed statute is an improvement as it allows a physician to provide the means for a competent patient to commit

269. See the Michigan assisted suicide statute cited *supra* note 5 and accompanying text.

270. MICH. COMP. LAWS § 750.316 (1993) ("Murder which is perpetrated by means of poison, lying in wait, or other willful, deliberate, and premeditated killing . . . is murder of the first degree, and shall be punished by imprisonment for life.")

271. MICH. COMP. LAWS. § 750.91 (1993) ("Any person who shall attempt to commit the crime of murder . . . shall be guilty of a felony, punishable by imprisonment in the state prison for life or any term of years.")

272. See statute cited *supra* note 5.

273. See *supra* notes 68-70 and accompanying text for a discussion of the legal differences between caused suicide and assisted suicide.

274. A review of state statutes reveals that the proposed statute is the only statute to distinguish between caused suicide and assisted suicide as defined in this note and to provide a different penalty for each. Several state statutes distinguish suicides by those induced by duress and those that are willful. Most statutes however, treat caused and assisted suicide as equivalents. See statutes cited *supra* notes 72-73.

suicide in very stringently regulated circumstances.

The most important change from the current Michigan statute is the portion of the statute comprising subsections 4(b) (i)-(iii). These subsections allow a suffering patient to determine when the patient will self-terminate pursuant to stringent guidelines.<sup>275</sup> The requirements of the section are quite strict so as to avoid a large increase in physician-assisted suicide.<sup>276</sup> The statute assures maintenance of objectivity and accountability by requiring that two independent psychiatrists determine competency and that two independent physicians verify that the patient is suffering from chronic pain.

It is necessary to recognize that evaluation of pain levels and the reasonableness of medical procedures involve subjective determinations. However, it is the intent of this statute to give an initial presumption in favor of a physician's professional judgment. In the event that the state can present clear and convincing evidence that rebuts the physician's judgment, then the state can proceed with penalizing the physician pursuant to the statute. The statute avoids the danger that one physician closely involved with the patient will make a subjective decision pursuant to the patient's incessant demands when medical procedures may exist to alleviate the pain.<sup>277</sup> Further, by requiring that a

275. No English-speaking country has ever passed a law that would allow physicians to assist in suicides. *Dutch House Approves Controlled Euthanasia*, THE REUTER LIBRARY REPORT, Feb. 2, 1993, available in LEXIS, News Library, CURNWS File. Interestingly, Canada is currently considering such a law. Anthony Boadle, *Canadian Politician Proposes Assisted Suicide Law*, REUTERS, Feb. 16, 1994, available in LEXIS, News Library, CURNWS File. The Netherlands recently passed the world's most lenient policy on mercy killing. *Dutch Try to Clarify Controversial Euthanasia Law*, THE REUTER LIBRARY REPORT, Feb. 24, 1993, available in LEXIS, News Library, CURNWS File. The only voter referendums in this country that would have allowed physician-assisted suicide failed to garnish the necessary voter support. Derek Humphry, *Where Now With the Euthanasia Debate?*, PR NEWSWIRE, Nov. 17, 1992, available in LEXIS, News Library, CURNWS File. Common to the voter referendums and the Dutch policy is that completely active euthanasia would be allowed. The statute proposed in this note would make completely active euthanasia an offense equivalent to first degree murder. See *supra* section VI.C.1. Further, the prerequisites necessary to give a physician legal protection are far more stringent in the statute proposed than either the Dutch law or the two state referendums. See *supra* note 218 for a discussion on the lax requirements of the Dutch law. The requirements of the two state referendums merely require that the patient request to die and be terminally ill. The state referendums and the Dutch law have none of the safeguards present in section 4(b)(i-iii) of the proposed statute.

276. The provisions of section 4(b) must be supported by clear and convincing evidence. Such a heightened standard of proof is warranted because cases of physician-assisted suicide essentially involve a life-ending decision. The Supreme Court "has mandated an intermediate standard of proof—'clear and convincing evidence'—when the individual interests at stake in a state proceeding are both 'particularly important' and 'more substantial than mere loss of money.'" *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 282 (1990) (citing *Santosky v. Kramer*, 455 U.S. 745, 746 (1982) (quoting *Addington v. Texas*, 441 U.S. 418, 424 (1979))).

277. See *supra* note 107 and accompanying text.

physician making available the means for the patient to self-terminate also be a physician who has offered care to the patient during the illness, the statute avoids the danger of doctors specializing in, and profiting from, assisted suicide.<sup>278</sup>

Section 4(b) does not require that a physician make a determination as to life expectancy. The statute is drafted in this way because such determinations are quite speculative.<sup>279</sup> Rather, the physician need only determine that the patient is suffering from extreme pain that no medical procedure can alleviate and there is no reasonable hope for recovery. Generally, a finding that a patient is suffering from extreme and unrelenting pain will correlate with a short life expectancy. However, setting forth the test in the manner described addresses the issue of foremost concern—the pain the patient is experiencing—in the most direct way.

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278. This would prevent physicians such as Dr. Kevorkian from assisting a suicide. As the following letter written by Dr. Kevorkian to the Michigan Department of Licensing and Regulation indicates, Dr. Kevorkian intends to specialize in assisted suicide:

My purpose is to inform the Department that *I have begun a unique medical practice: to assist the rational suicide of patients* who are suffering from imminently terminal illness, severely crippling or painful disease or deformity or trauma, and who, on their own, have decided that the quality of life for them has degenerated to intolerable levels.

Verbatim, *Circuit Court, supra* note 224, at 110 (quoting letter from Dr. Kevorkian, dated Jan. 24, 1990) (emphasis added).

279. The suicides of Lois Frances Hawes and Jack Elmer Miller exemplify the speculative nature of life expectancies. Doctors gave Ms. Hawes three months to live when they diagnosed her with lung cancer in April, 1992. She exceeded this expectancy by five months and in September of 1992, while suffering from excruciating pain, Dr. Kevorkian provided her with carbon monoxide so she could end her life. *Kevorkian Assists Suicide of Another Michigan Woman*, REUTERS, Sept. 26, 1992, available in LEXIS, News Library, CURNWS File. Doctors gave Mr. Miller only days to live after he received treatment for metastatic bone cancer. More than two weeks later, Mr. Miller was still alive but suffering from extreme pain notwithstanding the massive doses of morphine the doctors administered to him. Mr. Miller enlisted the services of Dr. Kevorkian and ended his life by inhaling carbon monoxide. *Dr. Death Presides at Ninth Assisted Suicide*, UPI, Jan. 20, 1993, available in LEXIS, News Library, CURNWS File.

It has been argued that there always exists some medicine that has the ability to relieve a patient's pain, no matter how severe that pain. Often, people point to the availability of morphine as a medicine that would make the affirmative defense proposed in this note obsolete as it is "a reliable, effective analgesic for almost every type of pain . . ." STEDMAN'S MEDICAL DICTIONARY 888 (5th ed. 1982). Two important points must be made regarding such drugs. First, drugs such as morphine are highly mind altering, often creating incoherence in those individuals who use them. The affirmative defense offered in this note excludes such mind altering drugs from the required pain alleviation procedures because the statute's goal is to provide a dignified death. Second, as exemplified by Mr. Miller's battle with cancer, morphine in fact does not allay pain in every instance. Rather, instances will arise in which morphine or other similar drugs will not relieve pain because of the extreme severity of that pain or because of "repeated administration [that] leads to the development of tolerance . . ." *Id.*

The requirement in section 4(b) of the proposed statute that the patient be competent and commit suicide by the patient's own act necessarily requires that the patient be conscious, alert, and physically able to commit the ultimate act resulting in death. As such, Michigan's Living Will Statute does not apply insofar as it allows competent individuals to arrange for the terms of their death in the event of incompetency. It is essential to the section 4(b) provision that the patient be competent and commit the ultimate act resulting in death. Although these requirements will prevent incompetent individuals from ending their lives, there is an overriding need to prevent abuse, such as the danger posed by cases of involuntary euthanasia. Further, patients must die by their own hand; if the physician committed the ultimate act causing death, that act equates to causation of suicide, an offense equivalent to homicide under the proposed statute.<sup>280</sup>

To further define the scope of the proposed statute, consider the following hypothetical.

*A* is a sensitive, competent, and alert patient suffering from a benign growth in her throat that is slowly strangling *A* to death. Because of the large size of the tumor and its peculiar position within the esophagus, no medical procedure exists that can either halt the growth of the tumor, remove the tumor, or provide an alternative channel for breathing. The attending physician *B* has administered several pain killing drugs, none of which have alleviated the pain caused by the large tumor. *A* requests that physician *B* provide her with the means to self-terminate. Physician *B* arranges for the independent examination by two disinterested psychiatrists to determine *A*'s competency. Both find that *A* is competent. Physician *B* places the psychiatrists' reports into *A*'s medical file. Next, Physician *B* arranges for the independent examination by two disinterested physicians to determine whether *A* is suffering from extreme pain that no medical procedure can alleviate and that no reasonable hope for *A*'s recovery exists. Both physicians find *A* is in unbearable pain that cannot be alleviated and that no reasonable hope for recovery exists. Physician *B* places the physicians' reports into *A*'s medical file. Physician *B* then counsels *A* as to the findings and *A*'s options. *A*, being competent, requests that physician *B* make available the means for *A* to self-terminate. Physician *B* puts a mask and carbon monoxide tank within the reach of *A*. *A* places the mask over her face and pulls a string, releasing the carbon monoxide from the tank and into the mask. After several minutes of inhaling the carbon monoxide, *A* dies.

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280. See *supra* notes 109-17 and accompanying text.

Under the proposed statute, the state should not charge physician *B* with criminal assistance of suicide. Physician *B* followed every provision of section 4(b), thus satisfying the procedural safeguards that are intact to prevent abuse.

However, other cases may not be so clear. For example, if the facts are the same as the above hypothetical except one of the physicians finds that a reasonable medical procedure is available that could provide an alternate channel for breathing, then physician *B* could not provide *A* with the means to commit suicide until attempting that procedure. If the attempt succeeded and alleviated *A*'s pain, then physician *B* could not provide *A* with the means to commit suicide. This example demonstrates that a physician must pursue all reasonable means of pain alleviation and treatment before assisting in a suicide.

Further, if all the facts are the same as the original example except physician *C*, a doctor who has not treated *A* for the tumor, provides the means to commit suicide, then the state could prosecute physician *C* pursuant to section 3 of the proposed statute. Physician *C* cannot use the statute's affirmative defense because physician *C* did not treat *A* for her tumor, thus failing to qualify as an attending physician as required in section 4(b)(iii) of the statute.

Although the above examples are illustrative and not exhaustive of the proposed statute's scope, the important requirements of the statute are detailed. First, patients must be competent and voluntarily avail themselves of the statutory provision allowing assisted suicide. Second, the physicians must follow the statutory provisions to the letter; if any reasonable alternatives exist to alleviate pain, the physician must pursue those alternatives before assisting in a suicide. Finally, after all alternatives to alleviate the pain are exhausted, the only physician who may make available the means to effectuate self-termination is a physician who cared for the patient during the patient's illness. A statute drafted in this manner prevents a large increase in assisted suicide cases while allowing those patients suffering from the most extreme pain to end their suffering in a dignified way.

## VII. CONCLUSION

Assisted suicide has been a crime since the English common law. Indeed, in many instances it is justifiable for a court to sanction individuals assisting a suicide. However, given current developments in medical technology, patients often face prolonged lives of incurable pain and suffering. These suffering patients best realize that the law should accommodate their unenviable position. As well, much of the public recognizes that stringently regulated assisted suicide is a desirable alternative to the current state of Michigan's law. In light of these facts, the medical profession has become more receptive to the idea of physician-assisted suicide. However, Michigan's assisted suicide statute does

not reflect these developments. It is time for the Michigan legislature to consider a tightly drawn statute that recognizes the difference between assisted suicide and caused suicide and permits physician-assisted suicide in highly regulated instances. The proposed statute in this Note provides such a workable alternative to the current law in Michigan.<sup>281</sup>

Michael J. Roth

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281. As this issue went to the printer, the Michigan Court of Appeals struck the assisted suicide statute as unconstitutional. The court ruled that the statute was improperly enacted because the purpose of the statute was not clearly stated in its title. *All Things Considered* (National Public Radio Broadcast, May 12, 1994). The court fell short of saying, however, that assisted suicide itself is constitutionally protected. *Id.* This decision came just days after a Michigan jury acquitted Dr. Kevorkian of assisted suicide. Charles Krauthammer, *Judicially Assisted Suicide*, WASH. POST, May 13, 1994, at A23. The jurors' reluctance in convicting Dr. Kevorkian is consistent with other cases in which doctors have been charged with murder for hastening a patient's death. *See supra* note 106. Further evidence that support for physician-assisted suicide is increasing is embodied in a recent U.S. District Court decision from Washington in which Washington's 140-year-old assisted suicide statute was stricken as a deprivation of individual liberty. Krauthammer, *supra*.

The effect of these events is to again challenge the Michigan legislature to enact a statute, using constitutionally appropriate procedures, that does not abridge individual liberty. The statute and accompanying argument set forth in this note may guide the Michigan legislature.