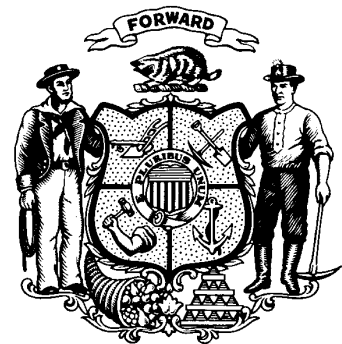


# Right to Die Issues

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# RIGHT TO DIE ISSUES

## I. INTRODUCTION

Oregon voters, on November 8, 1994, approved the ballot question: "Shall law allow terminally ill adult patients voluntary informed choice to obtain physician's prescription for drugs to end life?" By a 51% to 49% margin, voters adopted Measure No. 16, making Oregon the first state to pass a law that allows physician-assisted suicide. A federal court has issued a temporary restraining order against the measure pending a decision on its constitutionality.

Several states, including Wisconsin, have considered measures that would allow physician aid in dying. None has passed. Following the success of the Oregon initiative, the author of a 1993 Wisconsin bill, Representative Frank Boyle, introduced a revised version in the 1995 Legislature (Assembly Bill 174). California and Washington considered, but defeated, initiatives on physician aid in dying, and Michigan and New York appointed commissions to consider the issues. Michigan's commission approved the concept of assisted suicide by a close vote, but New York's commission rejected legalizing it.

More than any other individual, Michigan pathologist Jack Kevorkian has brought the issues of assisted suicide and aid in dying to the public forum. From the time he first assisted a suicide in 1990 to the end of 1994, a total of 21 patients have committed suicide using Kevorkian's equipment. In response to the controversy spawned by Kevorkian's methods, several states passed laws that specifically made assisted suicide a felony.

Right to die issues are those that deal with medical decisions made toward the end of an individual's life. They include the withholding and withdrawal of medical treatment and aid in dying. Aid in dying refers to both assisted suicide and the taking of an individual's life by another party at that person's request. Originally, a right to die only extended to the refusal of medical treatment in the face of a possible death. For many advocates, it has come to mean ending one's life by any means available.

This bulletin discusses the concept of a right to die and the issues of physician aid in dying and assisted suicide. It includes the development of case law regarding withholding and withdrawal of life support systems and a brief description of living will and power of attorney for health care legislation. Arguments for and against aid in dying, its current status and background, and recent legislation are also presented.

## II. ADVANCED DIRECTIVES

Individuals who wish to have some control over the medical treatment provided to them in the future may fill out "advanced directives" that spell out guidelines for medical treatment if they become terminally ill or incapacitated. The two most common types of advanced direc-

tives are “living wills” and “power of attorney for health care”. Under Wisconsin law, execution of either of these directives does not constitute attempted suicide, and health care decisions made pursuant to them do not constitute suicide.

### **Living Wills**

A living will is a declaration made in advance by a competent adult to authorize the withholding or withdrawal of life-sustaining procedures. It directs the treating physician to discontinue or withhold life-sustaining treatment under circumstances allowed by state law and specified in the document.

Chapter 154, Wisconsin Statutes, titled “Natural Death”, allows a competent adult to authorize withdrawal of “life-sustaining procedures” or feeding tubes if the person is in a “terminal condition” or a “persistent vegetative state” as diagnosed by two physicians. Withholding or withdrawal of treatment is not authorized if the attending physician advises it would cause pain or reduce comfort. It is up to the individual to notify the physician that there is a declaration. It must be signed in the presence of two witnesses who will not benefit from the patient’s death and who are not responsible for the patient’s health care. The legal form of the will is contained in Section 154.03 (2).

As is typical in living will legislation, there are provisions that protect health care providers and witnesses from criminal and civil liability. A physician is not liable for refusing to carry out the provisions of the will, but he or she has a professional responsibility to make a good faith attempt to transfer the patient to a physician who will observe the provisions. A declaration does not impede the purchase of life insurance and cannot modify or impair an existing policy. There are also provisions for revocation of the document. The law includes penalties for concealing a declaration and for concealing a revocation of the will.

Chapter 154 was created by 1983 Wisconsin Act 202 and later modified by 1985 Wisconsin Act 199, which changed the definition of “terminal condition”, and 1991 Wisconsin Act 84, which defined “persistent vegetative state”, added provisions on feeding tubes, and made other modifications in the declaration.

### **Power of Attorney for Health Care**

Chapter 155, Wisconsin Statutes, as enacted by 1989 Wisconsin Act 200, created this state’s power of attorney for health care, which allows an adult of sound mind to authorize an agent to make health care decisions if that person should become incapacitated.

Section 155.01 (8), Wisconsin Statutes, defines incapacity as “the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions.” While a living will covers only those persons with a terminal condition or in a persistent vegetative state, a power of at-

torney covers all persons who are incapacitated. Where the provisions of a power of attorney for health care conflict with those of an existing living will, the power of attorney supersedes.

Two physicians or a physician and a psychologist must make the diagnosis of incapacity, before the power of attorney can take effect. The individual exercising power of attorney (the “agent”) may consent to the withholding or withdrawal of a feeding tube if the directive authorizes it, unless the physician advises that the action would cause the patient pain or reduce comfort. The agent must act in the best interests of the patient and may not do anything to end the life of the patient other than withholding or withdrawal of health care.

As in the living will law, health care providers and witnesses are protected from civil or criminal liability for complying with the terms of the document. The statutory language includes penalties for the coercion or intimidation of any person to sign a power of attorney, the concealment or destruction of an existing document, the intentional withholding of knowledge of revocation, and an agent’s acting without voluntary consent of the individual.

Sections 154.13 (3) and 155.70 (8), Wisconsin Statutes, provide failure to file a declaration to physicians with register of probate, under the natural death law, or to execute a power of attorney for health care document “creates no presumption about the intent of any individual with regard to his or her health care decisions”.

### **Federal Patient Self-Determination Act**

The federal government entered the field when the U.S. Congress passed a requirement in the Omnibus Reconciliation Act of 1990 that providers who are reimbursed by Medicare or Medicaid must give patients information on advanced directives upon their admission to a health care facility. Similar requirements also apply to reimbursed palliative care programs, such as hospice care. Under Section 1866 (f) of the Social Security Act, 42 U.S.C. 1395cc, health care providers must supply written information on an individual’s rights to accept or refuse treatment and the provider’s policies regarding those rights. The provider must document whether or not a patient has executed an advanced directive. Providers who cannot, in good conscience, carry out the provisions of a directive must notify the patient.

### **III. CASE LAW AND RIGHT TO DIE ISSUES**

In 1975 there was neither statutory nor case law to sustain the right to refuse, withhold, or withdraw medical treatment from a dying or comatose patient. Today, by way of contrast, courts and legislatures in every state have recognized this right to one degree or another. Statutory law recognizes advanced directives made by individuals and proxy decision makers. Courts in many jurisdictions, including Wisconsin, have extended patient rights to include those who have never been competent.

For the most part, state courts have arrived at a consensus on a number of right to die issues. First, a competent patient has a right to refuse medical treatment even if that refusal would cause death. Second, surrogates ought to be able to make decisions on behalf of once competent patients with or without written directives. Although Missouri and New York adhere to a clear and convincing evidence standard, courts in both states recognize private conversations in place of written directives, if the conversations were explicit enough. Third, patients ought to be allowed to refuse food and fluids in addition to life support systems. Fourth, courts have agreed to extend the right to die to patients in a persistent vegetative state. These patients are not truly terminally ill and may live for decades with proper care and treatment. Fifth, most state courts, except New York, allow withdrawal of life support from patients who were never legally competent, so long as the guardians can demonstrate that the burden of continued treatment for the patient outweighs the interest of the state in preserving life.

Case law governing right to die issues relies or rests upon three legal principles:

1) A competent individual has a right to refuse medical treatment. Under the doctrine of “informed consent”, medical treatment cannot be given unless the patient gives permission. A logical corollary is that the patient has the right not to consent. Informed consent is grounded in a long-standing common law tradition dating back to 18th-century England that recognizes and protects human autonomy and self-determination.

2) A “liberty interest”, derived from the due process clause of the Fourteenth Amendment to the U.S. Constitution, provides constitutional support for informed consent.

3) The right to privacy supports a right to refuse treatment. Privacy rights rely on a stream of U.S. Supreme Court decisions particularly *Griswold v. Connecticut*, 381 U.S. 479 (1969). These cases interpret amendments to the U.S. Constitution, especially the Fifth, Ninth, and Fourteenth Amendments, as protecting an unspoken privacy right broad enough to include a patient’s decision to decline medical treatment under certain circumstances.

The landmark case in right to die law is *In re Quinlan* (70 N.J. 10), decided by the New Jersey Supreme Court in 1976. Karen Quinlan had collapsed after taking a mixture of alcohol and tranquilizers and lapsed into a coma. Her parents requested that she be taken off her respirator, but the hospital refused the request. The court ruled that Karen had a right to refuse treatment on the basis of a constitutional right to privacy. Since she was incompetent, her family or guardian could decide to exercise that right under the circumstances. While the state has an interest in preserving life, the court reasoned, that interest “weakens and the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims.”

The second landmark case is *In re Conroy* (98 N.J. 321), decided by the New Jersey Supreme Court in 1985. The case involved the withdrawal of a nasogastric tube from an elderly patient

with severe mental and physical impairments and a limited life expectancy. The court set three standards for deciding whether to remove life support:

- A “subjective test”, in which the patient’s guardian may exercise “substituted judgment” to refuse treatment when clear and convincing evidence exists that the incompetent patient would refuse treatment if he or she were able to do so.
- The “limited objective test”, which is applied in the absence of clear and convincing evidence when there is trustworthy evidence that the patient would have refused treatment. Life support could be removed, according to the court, “if it is manifest that such action would further the patient’s best interests.”
- The “pure objective test”, which is operable when there is no evidence as to the patient’s desires but the effect of administering life-sustaining treatment would be inhumane due to severe, recurring and unavoidable pain.

The New Jersey court also concluded that any potential distinction between “ordinary” and “extraordinary” medical treatment was not meaningful. Feeding by artificial means is “analytically equivalent” to breathing by means of a respirator.

The *Quinlan* decision spurred interest in living will legislation, with California being the first state to adopt such legislation in 1976. By 1988, a total of 38 states had passed advanced directive laws, and today every state has enacted either a living will or a power of attorney for health care law.

Over the last 20 years, all of the major right to die decisions have been issued by state courts. In *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), the U.S. Supreme Court found: “This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a ‘right to die.’” In the decision written by Chief Justice William Rehnquist, the Court refused to make any general statement on the subject.

Nancy Cruzan had been unconscious since an automobile accident in 1983. When it became clear she was in a persistent vegetative state and would never recover her mental faculties, her parents requested the removal of artificial feeding. The medical facility refused to do so without court approval. A lower court approved the request but was overruled by the Missouri Supreme Court in 1988. A divided court found that there was no “clear and convincing evidence” that she wanted treatment discontinued.

The U.S. Supreme Court upheld the Missouri court by a 5-to-4 vote. It recognized an individual’s right to refuse medical treatment under the common law doctrine of informed consent and that the individual has a protected liberty interest under the Fourteenth Amendment. According to Chief Justice Rehnquist, the Court has never recognized the right to refuse treat-

ment under a generalized right to privacy. For the purposes of the *Cruzan* case, the Supreme Court assumed an individual has a protected right to refuse artificial feeding. However, it upheld Missouri's right to adopt a "clear and convincing evidence" standard of proof for cases that govern the treatment of incompetent persons.

#### IV. WHY IS AID IN DYING AN ISSUE?

While the concept of allowing an individual to die by foregoing medical treatment is established in American law, there is no fundamental recognition of a right to die. The literature on death and dying cites four general reasons for assertion of this right and the increasing attention paid to it:

1) Medical technology can prolong a life or extend the time it takes to die, even in the case of terminal disease. Ironically, medicine's ability to prolong life through surgery, drugs, and machines has also made people more vulnerable to diseases of deterioration. Emergency room medicine, too, has advanced in its ability to keep patients alive. Someone who has lost a major portion of their brain functions, such as Mary Beth Cruzan or Karen Quinlan, can be kept alive for years with respirators and tube feedings with little or no hope of recovery.

2) Not only are people living longer, but many are aware of the consequences of chronic incurable diseases, such as AIDS and Alzheimer's disease, as well as advanced cancers. Some fear the degradation of dependency and the loss of control over their lives. Other fears include becoming a physical, emotional and financial burden on their families.

3) There is a widespread emphasis on individual rights that has gone beyond the right to refuse unwanted life-sustaining medical treatment. Some people are also claiming a right to die as a matter of choice — not necessarily one based on medical prognosis or status of treatment, but emphasizing choice as an ultimate value.

4) In a period when the high cost of medical care is a common topic of discussion, the cost of medical care near the end of life enters the debate. It is estimated that one in every seven medical dollars is spent on patient care in the last six months of life. Many of these dollars may be Medicare and Medicaid dollars provided by taxpayers. A Health Care Financing Administration (HCFA) study, based on 1988 data, estimated that 28% of the Medicare budget is spent in reimbursements for people over age 65 in the last year of life, and the bulk of that is spent in the last 30 days. HCFA data also indicate that Medicare reimbursements are consistently six times higher for decedents than for survivors of hospitalization.

Some researchers have argued that a more widespread use of advanced directives and legalization of physician-assisted suicide might have the side effect of lowering medical costs. Recent research, however, casts doubt on the savings to be gained from cutting off life-sustaining treatment to patients who are in the last months of life. A study published in the

*Journal of the American Geriatrics Society* states: “If hospitals withheld treatment from critically ill patients not expected to survive more than a couple of months, the financial savings would be surprisingly modest.”

Neither of the two studies includes any estimate of the cost to private insurers, dying individuals or their families for late-in-life care, a concern expressed in right to die literature.

To some people, the willingness and ability to confer intense medical care illustrates the value our society places on preserving human life. Others see it as a blind pursuit of doing whatever can be done, because the means are at hand, without regard for the long-term prognosis; the discomfort and the loss of dignity for the individual; or the physical, emotional, and financial turmoil caused for concerned family and friends. Difficulties arise when physicians are fearful of being sued for malpractice if they do not treat patients aggressively or when the patient’s family demands all treatment possible, regardless of effectiveness.

## V. ARGUMENTS FOR AND AGAINST AID IN DYING

The debate over aid in dying generally divides into four issues: individual self-determination or autonomy, patient pain and suffering, medical ethics, and possible social effects. Supporters of voluntary euthanasia tend to make their arguments on the basis of self-determination and individual pain and suffering. Opponents usually argue on the basis of patient protection, medical ethics, religious or moral beliefs, and social effects.

### **Self-Determination**

Self-determination is the ability to make decisions to direct one’s own life, including the choice to die. It extends, proponents argue, to controlling the manner, circumstances, and timing of one’s own death. Individual self-determination already receives recognition in the common law right to refuse medical treatment and the availability of living wills and power of attorney for health care.

For many people approaching the end of their lives, maintaining the quality of life, avoiding undue suffering, and wanting to be remembered at one’s best are values of the utmost importance. Thus, self-determination is seen as a central aspect of human dignity. It includes the most humane way to end one’s life, a right to death with assistance if necessary.

In arguing against the American Medical Association’s opposition to assisted suicide, Drs. Christine K. Cassel and Diane E. Meier contend in *The New England Journal of Medicine*: “The rigid view that physicians should never assist in suicide denies the complexity of the personal meanings life can have in favor of single-minded devotion to its maximal duration.”

Medical ethicist Dan Brock argues that treating active euthanasia as an act of killing a patient and the removal of life support systems as allowing a patient to die is not a useful moral

distinction in cases where both actions can result from requests made by a competent individual. Ordinarily, Brock argues, individuals have a right not to be killed but “the right not to be killed, like other rights, should be waivable when the person makes a competent decision that continued life is no longer wanted or a good, but is instead worse than no life at all.”

Critics argue this particular notion of self-determination tends to be an unlimited, open-ended claim. Hastings Center Director Daniel Callahan asks: “How can self-determination have any limits? Why are not the person’s desires or motives, whatever they be, sufficient?”

While legislation that proposes aid in dying would restrict it to those diagnosed as terminally ill, some supporters of the concept appear to want that aid permitted to anyone who asks for it. For example, none of the first three individuals assisted by Jack Kevorkian could be thought of as terminally ill, although they came to him voluntarily. As the minority report from the Michigan Commission on Death and Dying stated: “Several of the people who died with Jack Kevorkian’s assistance were not facing imminent death, but permanent physical challenges.”

Callahan believes it is a mistake to argue that assisted suicide and voluntary euthanasia are acts of self-determination: “Because they entail the assistance of another, they are essentially a form of concerted communal action, even though the community in question may only be two people. That ceases to make them private acts; they become a form of public action.”

It is further argued by physician Leon Kass that if autonomy means a right to someone else’s assistance in dying “that would impose an obligation on someone else and thereby restrict *his* autonomy.”

Proponents point out the self-determination does not obligate physicians to act contrary to their own moral or professional code. A physician unwilling to act in accordance with a request for death assistance should transfer the patient to another physician.

The American Civil Liberties Union (ACLU) of Michigan, in its attempt to overturn Michigan’s law against assisted suicide, argues that such laws violate a person’s right to privacy and autonomy over one’s own body as protected by the Fourteenth Amendment. In their statement to the Michigan Commission on Death and Dying, the ACLU recognized the state’s interest in protecting and preserving life and its conflict with individual autonomy: “The ACLU believes that these competing interests can and must be harmonized by legalizing aid-in-dying.”

A U.S. District Court judge ruled in *Compassion in Dying v. Washington*, 850 F.Supp. 1454, W.D. Wash. (1994), that the State of Washington’s ban on physician-assisted suicide is unconstitutional because it places an undue burden on the Fourteenth Amendment liberty interests of terminally ill, mentally competent adults. The judge argued that from “a constitutional per-

spective, the court does not believe that a distinction can be drawn between refusing life-sustaining medical treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult.”

The U.S. Supreme Court has not ruled on the issue of assisted suicide. In his concurring opinion in the *Cruzan* case, Justice Anton Scalia equated the termination of life support with suicide. In his view, the request to end Nancy Cruzan’s artificial feeding was, in effect, the assertion of a right to suicide. None of the other justices, concurring or dissenting, made any mention of a right to suicide. While sustaining the Missouri court’s position, Chief Justice Rehnquist remarked that states have an undeniable interest in preservation of human life as evidenced by the number of them that impose criminal penalties for assisted suicide.

### **Pain, Suffering and Patient Welfare**

Proponents argue that there are a number of patients who suffer from intolerable pain and other symptoms that cannot be managed or reduced to a reasonable level. Even when pain control is available, it may not be adequately used by physicians or the patient may be reduced to a semicomatose state by the process. If these patients were judged to be terminally ill and on life support systems, the law would allow withdrawal of the support, but patients who are not terminally ill do not have that same right. Opponents argue that pain can be controlled in most cases without putting patients into a semicomatose state. Under adequate supervision, patients may have control over their own pain medication. Hospice comfort care, they point out, is increasingly available and makes aid in dying unnecessary.

In addition to pain, many patients experience personal suffering that cannot be helped by medical treatment. They may find the prospect of a loss of control or independence unbearable. Others experience loneliness and helplessness. Proponents of assisted suicide contend that society and the medical profession tend to abandon patients for whom there is little hope. Although hospice or comfort care may be helpful, they are not widely available.

Opponents claim verbal requests for aid in dying may conceal a number of other symptoms. A request to die may often be a plea for help, a fear of rejection or abandonment, or made in ignorance of alternatives that could alleviate pain and suffering. A 1991 report by the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) concluded: “There is evidence to suggest that most requests for euthanasia or assisted suicide would be eliminated if patients were guaranteed that their pain and suffering will be eased and their dignity and self-sufficiency promoted.”

Proponents say a person has the right to seek help in ending life, if the decision is a rational one. The key consideration is state of mind. A physician helping a patient who requests assistance with suicide must first determine if the patient is beyond help and not just suffering from

a treatable depression that can be alleviated by therapeutic intervention. Opponents content studies of people who commit suicide or attempt to commit suicide show that nearly all of them suffer from some form of mental illness. Suicide requests, they argue, are seldom rational and have little to do with terminal illness or intense physical pain. Suicide, they also contend, is infrequent among the terminally ill.

One good consequence of permitting death assistance, Brock argues, is that it would benefit a much larger group of people than would use it. Death assistance could be thought of as an insurance policy against being forced to endure a protracted dying process. The Michigan Commission on Death and Dying, in recommending legalization of assisted suicide, concluded that making the option available “. . .under humane, legal conditions may be comforting to the person and may further reduce the incidence of aid-in-dying.”

Giving people a new choice can make them worse off, according to medical researcher David Velleman. In most cases, an individual's existence is a given or fixed condition with which they must cope. Making euthanasia available denies the alternative of staying alive by default. If society is unsympathetic to the ill and handicapped, those who are dependent or severely impaired may feel they have to give up life or at least justify their existence, and “the burden of proof will lie heavily on the patient who thinks that his terminal illness or chronic disability is not a sufficient reason for dying.”

Others point to the possibility of medical mistakes. A patient could be misdiagnosed as terminally ill or a cure may be discovered before the patient dies. One of the commission members and three people who testified before the Michigan Commission on Death and Dying had been diagnosed as being terminally ill, but were still alive several years later.

### **Medical Ethics**

In 1990, the AMA expressed the view that “under no circumstances should a physician intentionally cause death.” Although it would permit passive acts, the AMA strengthened its stance against any type of euthanasia, calling assisted suicide “totally incompatible with the nature and purposes of the healing arts and sciences.”

Opponents of aid in dying argue the physicians' Hippocratic Oath requires them to oppose any act that might endanger a patient's life. It states in part: “[Y]ou will exercise your art solely for the cure of your patients and will give no drug, perform no operation, for a criminal purpose, even if asked, far less suggest it.”

Medicine is intended to treat and care, not to kill, argues Dr. Willard Gaylin. If physicians are licensed to kill they can never again be worthy of respect as healers, comforters, and protectors of life. “Once physicians have a license to kill they have a duty to kill”, contends John

Pickering of the American Bar Association (ABA) Commission on the Legal Problems of the Elderly.

Other physicians argue that the AMA report does not respond to the needs of patients in intense and prolonged pain. One delegate to a 1993 convention argued: "The role of the physician should be to heal as long as they can. When you can heal no longer, give comfort. And when neither is possible and the patient wants to die, be a friend and lend a hand."

After California defeated Proposition 161 in November of 1992, Alexander Morgan Capron, professor of law and medicine at the University of Southern California, felt that the vote should be taken as a warning to the health care system: "Proposition 161's defeat should not obscure the remarkable fact that millions of people are so fearful of how they'll be treated by the health care system when they're very ill that they'd rather be dead." Capron, an opponent of aid in dying, warned that unless physicians paid more attention to the problems of the dying and the gravely ill that sooner or later patients might acquire a legal right to voluntary euthanasia through the ballot box or court decisions.

While supporters of aid in dying point to voluntary euthanasia in the Netherlands as a model, others see a number of dangerous practices, particularly by physicians. Dutch physicians, opponents argue, have gone beyond the point of euthanizing on request. The danger of legalizing aid in dying is that physicians may begin to decide when it is good for someone to die. Even if carefully controlled, there would be little to prevent someone, such as Kevorkian, from setting up practices that specialize in killing patients at their request.

Polling information gathered in Wisconsin and other states indicates that a number of physicians might euthanize patients on request if it was legal. The Medical College of Wisconsin mailed a survey to 2,239 physicians in Wisconsin on the topic of euthanasia and 740 responded on a guarantee of anonymity. The results, published in March 1994, claimed that 30% of the physicians who responded would be willing to perform euthanasia if it were legal. The survey found that 2.2% of the respondents reported having performed euthanasia in the past on patients who had requested it. More than 42% of the respondents agreed with the statement: "Euthanasia should be limited to competent adults who request it as a result of their present situation and prognosis for recovery." Critics of the survey felt it might not have been representative and that it ran counter to the official position taken by professional medical societies.

### **Moral Beliefs and Social Effects**

There are many in this society who oppose assisted suicide from deep religious convictions. To them, human life comes from a supreme being and cannot be justifiably destroyed or taken away, either by an individual who wants to end his or her own life or through assis-

tance by another. A Fall 1991 editorial in *Commonweal* declared that human life is not “merely the possession of the one who bears it. It is an inherited gift, and as such, has meaning not only for oneself but for those who bestowed it, those who have shared it and those who will follow.”

In Brock’s view, we live in a pluralistic society with a strong commitment to religious freedom where “public policy should not be grounded in religious beliefs which many in that society reject.” According to Callahan, it might be impossible, even with a very carefully drawn law, to avoid manipulation or even coercion of dying or extremely ill patients. He notes, “There are many reasons why the death of one person can be of advantage to another. In a society less than pleased to care for those who are costly or burdensome, the social pressures in that direction would be all the stronger.”

Thomas Murray, director of medical ethics at Case Western Reserve University, agrees that assisted death might reduce health care spending but could be misused. “There’s a good chance of inequality in assisted dying, with it being offered most readily to those least able to pay for regular medical care or long-term care.”

Nancy Dubler, a member of the ABA’s Coordinating Group on Bioethics and the Law, refers to voluntary euthanasia as a “social catastrophe” in a society that does not provide universal health care, particularly for the elderly, the poor and minorities. She contends the medical system has not come to terms with needs of the terminally ill and it might be too easy to shunt them aside and grant requests for the end of treatment. “We must recognize that as long as there is no universal health insurance, families and health care institutions can exert a subtle pressure on patients to terminate their lives because of the costs involved in life-sustaining treatments.”

Both opponents and supporters cite euthanasia practices in the Netherlands as an ongoing example of how such practices should work and the dangers inherent in them.

## **VI. EUTHANASIA IN THE NETHERLANDS**

In the Netherlands, under Paragraph 293 of the criminal code, voluntary euthanasia is illegal and punishable by imprisonment and fines: “Any body, who takes the life of another person at the explicit and urgent request of that person, shall be punished with an imprisonment up to 12 years or a fine . . .” Willfully inciting someone to commit suicide or assisting in suicide is also a criminal offense. The agreed upon definition of euthanasia in the Netherlands is the taking of another’s life at the explicit and urgent request of that person. Involuntary taking of a life, no matter how good the reason, is considered manslaughter or murder and not euthanasia.

In practice, Dutch physicians who follow guidelines set by court decisions and the State Commission on Euthanasia are exempt from punishment. First, the patient must take the ini-

tiative in requesting euthanasia and must make that request repeatedly and freely. Second, the patient must be experiencing suffering that cannot be relieved by any other means but death. Third, the physician must consult with another physician who must agree that euthanasia is acceptable in the particular case. Physicians are required to report cases of euthanasia to the medical examiner and to a prosecutor. In November 1993, the Dutch Parliament passed a bill that grants physicians immunity from prosecution if they follow the three guidelines and notification requirement. The new law left Paragraph 293 in effect, and physicians who do not fulfill the three conditions could still be prosecuted.

In 1987, the Netherlands appointed the R Emmelink Commission to study the extent and practices of euthanasia. It gathered information through a random sample of family practitioners and a study of police reports on euthanasia. The commission reported in 1991, that about 1.8% of all deaths (2,300) in a year were by euthanasia, and about 0.3% (400) by assisted suicide. It found that in 0.8% (1,000) of all deaths, drugs were administered that killed a patient under conditions that did not meet the three criteria set by Dutch courts referred to as "life-terminating acts without explicit and persistent request". In cases not following the guidelines, 28% of the patients had expressed a wish to be killed if their situation became "unbearable". Physicians mentioned previous requests as the reason for euthanasia in 17% of the cases that did not follow the guidelines. The commission further found that less than one-third of euthanasia requests were honored and less than 20% of the cases were reported to a prosecutor. The primary reason given for not reporting was to save families from public embarrassment. A study of the commission's report by two Dutch medical researchers found about 20,000 deaths a year where physicians withdrew or withheld medical treatment "neither because the patient so requests, nor because the treatment is futile, but because only limited benefit is to be expected and there are other reasons to withdraw or withhold." In 16% of these deaths, the researchers found "hastening death was the point of the decision", and in another 19% "hastening death was one of the reasons".

Various other studies estimate that anywhere from 4,000 to 20,000 deaths in the Netherlands take place annually through voluntary euthanasia. Supporters of aid in dying in this country cite the Netherlands as a positive experience, while detractors argue that the Netherlands has already started on a path toward more widespread mercy killing. Professor Capron raises the question in this way: "By making euthanasia an accepted practice, the definition opens the way to expanding the categories of patients for whom 'euthanasia' is acceptable for reasons other than voluntariness."

One Dutch physician, cardiologist Richard Fenigsen, argues that voluntary euthanasia should be rejected because it turns out to be not truly voluntary. He states: "In Holland, doctors have tried to coerce patients, and wives have coerced husbands, and husbands wives to

undergo ‘voluntary’ euthanasia.” What is worse, Fenigsen continues, is that for many years “the population of Holland has been subjected to all-intrusive propaganda in favor of death.” This, he contends, has caused many people to think of themselves as a burden to society and to feel obligated to request euthanasia. Furthermore, public opinion polls in the Netherlands indicate an equal support for involuntary (77% approval) as for voluntary euthanasia (76% approval). Fenigsen finds several cases where health care providers have killed patients without their consent and been released by the courts — all with public approval. He argues that in Dutch society there is a “widely shared conviction that people’s lives may be cut short whenever there are good reasons for doing so.”

Proponents argue the potential dangers to society can be minimized by establishing sufficient guidelines. These would include mandated confirmation of diagnosis by a second qualified physician, referral for counseling, mandatory report requirements, and restrictions limiting who would be eligible for aid in dying.

Dr. Timothy Quill, who knowingly provided a long-time leukemia patient with enough barbiturates to take her life, wrote in the *New England Journal of Medicine*: “It’s probably better to have laws with guidelines than to have people operating in secret. At least people would know what to expect. Now, it depends upon the doctors’ values and their willingness to take risks.”

Citing the Netherlands’ experience and that of Nazi Germany, opponents of aid in dying argue that legalizing it would place this society on a “slippery slope” to involuntary euthanasia. Dutch supporters of euthanasia focus on the good of the patient and point out that euthanasia in Germany began on the basis of the health of the nation and not the patient’s wishes. Detractors point out that involuntary euthanasia was introduced in Germany in ways similar to its initiation in the Netherlands. By the time the Nazis came to power, the idea of putting people to death for the good of society had already won public approval.

## VII. CURRENT LAW AND PUBLIC OPINION

With the exception of Oregon, no state has enacted a law that would allow assisted suicide or aid in dying. In the majority of states, assisted suicide is against the law and voluntary euthanasia would be a homicide. There are no definitive court decisions that allow assistance in dying. Washington’s law against assisted suicide has been declared unconstitutional but that decision was overruled on appeal. While there is general public support for the concept of aid in dying, that support has not been translated into specific laws. At the same time, there is evidence that physicians have given patients assistance, and in some cases, actively helped patients die, despite the AMA’s adamant stand against death assistance.

### **Legislative and Legal Status**

While suicide is not illegal, assisting a suicide is against the law in at least 32 states, including Wisconsin. Section 940.12, Wisconsin Statutes, states: "Whoever with intent that another take his or her own life assists such person to commit suicide is guilty of a Class D felony." A Class D felony is punishable by imprisonment not to exceed five years and a fine not to exceed \$10,000, or both. In as many as ten other states, assisted suicide is punishable under the common law.

Some states have enacted language in their advanced directive laws to ensure that they are not interpreted as approving assisted suicide. Illinois' Health Care Surrogate Act, for example, states that the act "is not intended to condone, authorize, or approve mercy killing or assisted suicide." Iowa's living will and durable power of attorney for health care acts each have a similar provision.

While assisted suicide is against the law, there have been very few successful prosecutions. Assisted suicide is a private act done by consent. If Dr. Timothy Quill had not written an article about his experience with a terminal cancer patient, no one would have known he had assisted her. Intent is difficult to prove in such cases. A physician may prescribe a barbiturate and caution the patient about taking an overdose. How does one prove what the physician intended? A search of court decisions reported nationwide indicates that no health care professional has ever been convicted of "causing, inducing, or assisting" in the death of a patient. Dr. Quill was acquitted by a New York grand jury of any wrong doing, and the state medical board refused to suspend his license.

How difficult it has become to convict an individual is indicated by the case of Jack Kevorkian. Even after the legislature passed an interim law against assisted suicide, while a commission studied the matter, Kevorkian continued his practice. Although prosecuted several times, Michigan's lower courts overturned the state's law, and, in one case, a jury found him innocent. Michigan's medical licensing board took away his medical license. While the Michigan Court of Appeals upheld the lower court decisions, the Michigan Supreme Court, in December of 1994, upheld the constitutionality of the interim law, leaving Kevorkian vulnerable to charges on 17 of the suicides he assisted. To date, he has not been prosecuted. The Michigan Legislature, in the meantime, passed another law against assisted suicide which took effect on March 31, 1995. Kevorkian is in the process of appealing to the U.S. Supreme Court.

The courts have not extended the right to die to aid in dying. One federal court declared a Washington's law against assisted suicide unconstitutional, but that decision was overruled by a federal appeals court in March 1995. In a two-to-one decision the court argued: "In the 205 years of our existence no constitutional right to aid in killing oneself has been asserted and

upheld by a court of final jurisdiction.” The court also stated that assisted suicide could not be legally or morally equated with the withholding or withdrawal of medical treatment. A federal district court has upheld New York’s law against assisted suicide (*Quill v. Koppel*, 1994 U.S. Dist. LEXIS 17965), stating “that the type of physician-assisted suicide in this case does not involve a fundamental liberty interest protected by the Due Process Clause in the Fourteenth Amendment.” The Michigan Supreme Court has found that state’s law against assisted suicide constitutional and that assisted suicide is punishable as a felony under the common law through Michigan’s reserve clause (*People v. Kevorkian, Hobbins v. Attorney General*, Docket Nos. 99591, 99674, 99752, 99758, 99759, decided December 13, 1994).

Although Oregon passed the first law that would legalize physician-assisted suicide in a popular referendum, a federal court has suspended the operation of the law. At least six states, including Wisconsin, saw the introduction of bills in 1993 and 1994 to make assisted suicide legal, but none of them passed. Early in 1995, bills to allow assisted suicide, apparently modeled on the Oregon initiative, were introduced in as many as 12 states including Michigan, Colorado, Washington, and Wisconsin.

### **Public Opinion**

Opinion polls seem to indicate public support for some kind of assisted death. A January 1991 Gallop Poll asked: “When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient’s life by some painless means if the patient and his family request it?” Of those responding, 58% felt a person had a right to end life when a disease is incurable. In the same poll, 66% said a person had a right to end life if they were suffering from great pain and there was no hope of recovery. A national Harris Poll in December 1993 showed 73% agreeing that “the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended.”

There are differences in polling results by age. The highest proportion supporting aid in dying appears among the 18- to 34-year-old age group, while those over 65 support it by a much smaller margin. A *Detroit Free Press* poll of Michigan residents asked if they would envision choosing assisted suicide. Of the black respondents, 22% said “yes” and of white respondents 53% said “yes”.

Polling results, however, do not necessarily turn into votes. In 1991, in Washington, and in 1992, in California, initiatives to allow aid in dying, were both voted down by a 54-to-46 margin. Yet, polls taken before the elections indicated that as many as 60% of potential voters approved of the proposal. In Oregon, about 60% of potential voters indicated support in polls but the initiative only passed by a 51-to-49 margin. Despite polls that indicated a majority of those asked might support legalization of assisted suicide, Kevorkian’s supporters in Michi-

gan were unable to gather enough signatures to put the question of assisted suicide on the ballot.

### VIII. LEGISLATION

While bills to legalize assisted suicide were introduced in several states, including Wisconsin in 1993 and 1994, none of them passed. The 1995 Wisconsin bill, the Oregon act and the Hemlock Society model legislation are summarized below.

#### **Wisconsin 1995 Assembly Bill 174 and 1995 Senate Bill 90**

1995 Assembly Bill 174 was introduced on March 2, 1995, by Representatives Frank Boyle and Tammy Baldwin and cosponsored by Senator Fred Risser. It was referred to the Assembly Committee on Health. Senator Risser introduced 1995 Senate Bill 90, a companion bill, with Representatives Boyle and Baldwin as cosponsors, and it was referred to the Senate Committee on Judiciary. These companion bills relate to permitting certain individuals to make written requests for medication for the purpose of ending their lives. Both bills remain in committee and have not yet had a public hearing.

The bills permit a Wisconsin resident who is at least 18 years of age, of sound mind, not incapacitated, to voluntarily request medication from an attending physician to end that person's life. The attending physician is one who is responsible for primary care of the patient making the request and for treatment of the patient's terminal disease.

To make the request the patient must have a terminal disease which reasonable medical judgment finds will cause death within six months. The attending physician must make the diagnosis, and it must be confirmed by a consulting physician who is qualified by specialty or experience to make the diagnosis.

The patient must first make an oral request and then within 15 days make a formal written request using a form described in the bill. After the written request is filed, the patient must make a second oral request for medication. The written request must be signed by three witnesses who are not related to the patient or an heir and who are not financially responsible for the patient's health care. Health care providers serving the patient are not eligible witnesses. The physician may not write the prescription until at least 48 hours after the patient has made a written request.

The attending physician must inform the patient of his or her diagnosis, prognosis, the potential risks and probable result of taking the prescribed medication, and feasible alternatives including comfort care or hospice care, so the patient can make an "informed decision".

The attending physician must inform the patient that he or she may revoke the request at any time and explain the methods of revocation prescribed by the bills. The physician must ask the patient to notify the next of kin, but the patient is not required to do so.

If the attending or the consulting physician believes the patient is suffering from a psychiatric or psychological disorder, the patient must be referred to a psychiatrist or licensed psychologist. The attending physician may not administer the medication unless the psychiatrist or psychologist certifies in writing that the patient is not suffering from a mental disorder, including depression.

There are provisions in the bill that protect health care providers and witnesses from criminal and civil liability. If an attending physician does not carry out the patient's request, the physician is not liable but may be charged with unprofessional conduct if he or she fails to make a good-faith attempt to transfer the patient to a qualified physician who will carry out the request. Requests for medication do not constitute attempted suicide and taking medication under the provisions of the bill does not constitute suicide. A request for medication does not bar the receipt of health care nor admission to a health care facility. The bill also includes penalties for concealing a request, forging a request, or concealing a revocation.

### **The Oregon Death with Dignity Act**

The Oregon Death with Dignity Act was created by Measure No. 16, passed in a statewide referendum. According to an explanatory statement appended to the proposal, the "measure would allow an informed and capable adult resident of Oregon, who is terminally ill and within six months of death, to voluntarily request a prescription for medication to take his or her life."

The patient must make three requests, one of which is in writing. After receiving a request the attending physician must do the following:

- 1) Determine if the patient is terminally ill, capable of making a decision, and has made the request voluntarily.
- 2) Inform the patient of his or her diagnosis and prognosis; the potential risks and results of taking the medication; and alternatives including comfort care, hospice care, and pain control.
- 3) Refer the patient to a consulting physician who is qualified to diagnose the patient's disease for medical confirmation of the diagnosis.
- 4) Refer the patient for counseling by a state-licensed psychiatrist or psychologist, if appropriate.
- 5) Request that the patient notify next of kin.
- 6) Inform the patient that he or she may rescind the request at any time.

The attending or consulting physician may refer the patient for counseling if either one believes the patient is suffering from a mental disorder or depression causing impaired judg-

ment, and the psychiatrist or psychologist must determine that the patient does not suffer from such a disorder before the medication may be prescribed.

At least 15 days must elapse from the original oral request and 48 hours must pass from the time of the written request before giving the medication. The written request must be witnessed by two individuals, one of whom is not related to or an heir of the patient. The patient may rescind the request at any time. Before writing the prescription, the attending physician must verify the patient's request and offer the patient an opportunity to rescind the request.

The act provides immunity from civil or criminal liability for participating physicians and does not require a health care provider to participate in physician-assisted suicide. It also provides penalties for anyone who alters or forges a request, conceals or destroys a rescission, or attempts to induce a patient to request medication. The act does not authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia.

### **Hemlock Society Model Aid-in-Dying Act**

The Hemlock Society is the most prominent organization in this country that advocates legalized aid in dying. The official stance of the society is for voluntary euthanasia as well as assisted suicide. The former director of the society, Derek Humphrey, was the author of the best seller, *Final Exit*, that included recipes for self-administered suicide.

In several respects the Hemlock Society model act is similar to the Oregon Death with Dignity Act. It requires three requests by the patient and a waiting period; a diagnosis and prognosis by two physicians; mental capacity to make a decision; referral to a counselor, if deemed appropriate by either physician; the same informed consent procedure; and the right of the patient to rescind the request at any time.

The model act differs in at least two respects. First, the Oregon Act stipulates that the patient be within six months of death, within reasonable medical judgment. The Hemlock Society model act does not have a six-month provision. The model act "would authorize physician aid-in-dying, both active euthanasia and assisted suicide, at the request of a competent adult patient who is dying of a terminal illness." The Oregon Act does not allow active euthanasia.

The Hemlock Society model act would not require physicians to provide aid but would require them to transfer a patient to another provider. The act would not impair insurance contracts, would not allow "mercy killing", and states that aid in dying does not constitute assisted suicide.

## **IX. CONCLUSION**

Courts and legislatures have accepted a concept of a right to die limited to withholding or withdrawing medical treatment when death seems imminent, treatment futile, or for pa-

tients in a persistent vegetative state. That right may be exercised by advanced directives, individual request, or surrogates. It extends, in some cases, to patients who are currently incompetent and to those who have never been competent.

While public opinion appears to support some form of aid in dying, that approval has not been translated into legislative action. Individual courts at the state and federal level have struck down laws against assisted suicide, but higher courts have overruled these decisions. Voters in Oregon approved a physician-assisted suicide law, but its operation has been suspended pending federal court action. Private acts of assisting suicide and voluntary euthanasia take place, but it is difficult to determine the extent of the practice. Prosecutions are rare.

Ultimately, courts and legislatures will have to decide whether any form of aid in dying is good public policy. If aid in dying is to be allowed, what restrictions and what safeguards should be followed? What are the consequences of allowing aid in dying and what are the consequences of not allowing it? These are among the somber questions which policymakers may encounter while debating aid in dying questions.

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