



Brief 15-15

Wisconsin Briefs

from the Legislative Reference Bureau

September 2015

RIGHT-TO-DIE LEGISLATION AND LAWS

On November 1, 2014, a 29-year-old woman named Brittany Maynard died in Portland, Oregon. Maynard had been diagnosed with terminal brain cancer, that she was told, would take her life within six months. Her death came after she took a lethal dose of medication prescribed to her by a doctor for the purpose of ending her life under Oregon's Death With Dignity Act. Maynard had moved from her home state of California to become a resident of Oregon, which is a requirement of the act. Before her death, she had become an active campaigner for right-to-die laws and had garnered attention from national media outlets. Much younger than the median age of a terminally ill person who chooses to die by Oregon's law, she became the face of an issue that originally made headlines in the early 1990s. Now, as then, Wisconsin legislators have responded to the national debate; two bills introduced this session would allow terminally ill people to end their lives through doctor-prescribed medication.

Wisconsin law already has "right-to-die" provisions in the statutes; however, they differ substantially from the current popular definition of that term. Chapter 154 allows for advanced directives, including a Declaration to Physicians that authorizes the withholding or withdrawal of feeding tubes and other life-sustaining procedures from a patient when two physicians have personally examined and certified in writing that the patient has a terminal condition or is in a permanent vegetative state (§ 154.02 to 154.15). The law clarifies that such an action does not constitute suicide, cannot affect a life insurance policy, and cannot be required as a condition for health insurance. However, Section 154.11

(6), Wisconsin Statutes, states: "Nothing in this subchapter condones, authorizes or permits any affirmative or deliberate act to end life other than to permit the natural process of dying." Similar provisions relating to do-not-resuscitate orders exist in the same chapter. Chapter 155 of the statutes governs power of attorney for health care, which is when a person can be designated to act for a patient who has been incapacitated and to execute the patient's desire to withhold or withdraw life-sustaining procedures. These types of "living will" issues have been debated and amended since the 1980s, but deal generally with the natural process of dying and not with any action on the part of a medical provider to assist in deliberately causing a patient's death. Physician-assisted suicide laws involve medical professionals facilitating the death of a person and add a new dimension to the argument over an individual's "right to die."

PRIOR WISCONSIN LEGISLATION

The national debate on the right to die came to forefront in the early 1990s when Dr. Jack Kevorkian made a public practice of helping his patients end their lives, which violated Michigan's law against physician-assisted suicide. In Wisconsin, state Representative Frank Boyle introduced 1993 Assembly Bill 755 in the midst of the controversy; at the time, Kevorkian was experiencing success with his court cases and a federal judge had overruled the Michigan law for the first time. Representative Boyle noted that the state needed a "compassionate process" for people facing end-of-life decisions. The bill, which was referred to as both "aid-in-dying" and "Death with Dignity," provided for a

person to execute a directive requesting that his or her attending physician administer a "medical procedure" to end his or her life in a "painless, humane and dignified manner." The directive would have had to be signed by a mental health professional, and the requester documented as suffering from an incurable condition that would cause death within six months and having certain physical pain. The requester would be provided with counseling, and the decision to administer aid in dying would have been reviewed by two members of a three-member committee. If these and several other conditions were met, then 14 days after the directive was executed, the requester having twice more communicated a desire that it be carried out, the procedure could be administered. A hearing held on the bill in December 1993 drew hundreds of people, and the bill never made it out of committee for the 1993 session.

Representative Boyle's bill was not the first time a Wisconsin legislator introduced a provision on the subject. In 1975, state Representative Lloyd Barbee introduced Assembly Bill 1207, "establishing a right to die." The bill contained no specifics about what type of method could be used, and no safeguards were established to prevent any type of coercion by other parties. The bill proposed allowing anyone to request that any other person 14 years old or older cause the requester's death. Children between 7 and 18 years of age would have to notify their parents but did not need permission from them to make the request. A married person was required to notify his or her spouse but did not need that spouse's permission. The bill died in committee without a hearing.

In May 1994, a federal judge ruled a Washington ban on physician-assisted suicide unconstitutional. In November 1994, a citizens' initiative was passed in Oregon called the Death With Dignity Act, allowing residents of the state who are terminally ill to end their lives by use of lethal medications prescribed by a physician. However,

an injunction prevented the act from immediately taking effect. Based on the passage in Oregon, Representative Boyle reintroduced his bill in Wisconsin, revised under the guide of the Oregon initiative and in consultation with members of the Hemlock Society, an organization that lobbied for right-to-die laws locally and nationally. The bill also closely followed the advanced directive provisions already established in Chapter 154. 1995 Assembly Bill 174 provided that a person "who [was] of sound mind and not incapacitated," was at least 18 years old and a Wisconsin resident, and had a "terminal disease" could make a written request to his or her doctor "for medication for the purpose of ending his or her life in a humane and dignified manner." Unlike the 1993 version, this bill made no mention of physical pain.

The bill established several specific steps that needed to be followed before the request could be completed, which are very similar to provisions in the current legislation. The first step was that the person who wished to die had to make the request for medication orally, and then, not less than 15 days later, in writing in front of three witnesses. Witnesses could not be related by blood to the requester, have interests in the estate of the requester, or have responsibility for the requester's health care. At least two doctors would be involved in the process, an attending physician and a consulting physician. The attending physician was responsible for determining whether the patient met the statutory requirements for such a request. The consulting physician was tasked with confirming the attending physician's diagnosis and determination. An attending physician who refused to comply with the patient's request was required to make a good faith effort to transfer the patient's case to a doctor that would comply.

The form of the request followed the Oregon act closely. Titled "Request for Medication to End My Life in a Humane and Dignified Manner," it contained a number of clauses confirming that the patient was of

sound mind, was suffering from a diagnosed terminal disease, had been fully informed of all aspects related to his or her medical care and options, and finally that “I understand the full import of this request and I expect to die when I take the medication to be prescribed. I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.”

A companion bill, 1995 Senate Bill 90, was introduced by state Senator Fred Risser on the same day as the assembly bill. The senate bill received a hearing in March 1996, one year after its introduction, but never left committee. Over the course of seven more sessions, Representative Boyle, Senator Risser, and various coauthors and cosponsors would introduce companion bills attempting to create Chapter 156 of the Wisconsin Statutes, “Death With Dignity,” outlining essentially the same procedure as the 1995 bills. 1997 Senate Bill 27 and Assembly Bill 32 each received hearings, but never got out of committee. The senate hearing was held five days before the injunction was lifted on the Oregon Act passed in 1994. In November 1997, 60 percent of Oregon voters voted to confirm the law. Wisconsin bills introduced from the 1999 session to the 2005 session never received a hearing. In January 2008, 2007 Senate Bill 151 received a public hearing but never left committee.

ACTION IN OTHER STATES

In November 2008, Washington State also passed an initiative called the Death With Dignity Act. It is similar to Oregon’s law in that it allows the terminally ill (people with less than six months to live) to end their lives with requested medication, requires participants to be residents of the state, and follows strict reporting requirements. The law went into effect in March 2009.

On December 31, 2009, the supreme court of Montana issued its opinion in the case of *Robert Baxter v. State of Montana*. Baxter, a terminal leukemia patient, wanted the option

to self-administer a lethal dose of medication prescribed by a doctor. The court found that this type of physician aid in dying was not against public policy under Montana law, writing:

A physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician-patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient’s subsequent private decision whether to take the medicine does not breach public peace or endanger others.

The court’s decision cited Montana’s Rights of the Terminally Ill Act, as well as statutory language about consent.

The state of Vermont passed legislation titled the Patient Choice and Control at the End of Life Act in 2013. The bill was introduced in February and passing both houses of the legislature after lengthy debate, enacted in May. The law contains many of the same elements of the Oregon and Washington initiatives, including oral and written requests, verification of residency, the requirement of a second opinion, the participation of physician, and a diagnosis of a terminal illness causing death in six months. The patient would request a prescription for a lethal dose of medication that he or she would self-administer. A strict, step-by-step process is to be followed until 2016, when the process will sunset and a new law will provide protection to patients and doctors looking to use this option. Section 5292 of the act states: “Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient’s life by lethal

injection, mercy killing, or active euthanasia. Action taken in accordance with this chapter shall not be construed for any purpose to constitute suicide, assisted suicide, mercy killing, or homicide under the law."

A state judge in New Mexico ruled in January 2014 that state residents had a constitutional right to "aid in dying." The suit was brought by a woman with cancer whose two doctors argued that they should be able to provide her with prescription medication without being prosecuted under a state law which classes assisting in a suicide as a felony. The case has been appealed by the state's attorney general and arguments were heard in January 2015 by a three-judge panel. A decision in the case is pending as of this publication.

CURRENT WISCONSIN LEGISLATION

2015 Senate Bill 28, introduced on February 11, and companion Assembly Bill 67, introduced on March 3, relate to permitting certain individuals to make requests for medication for the purpose of ending their lives. The bills were introduced early in 2015, not long after Brittany Maynard ended her own life in Oregon and brought renewed attention to the issue of physician-assisted suicide. Both bills are redrafts of 2007 Assembly Bill 298, updated to reflect current law and follow the form of already-established state law on advanced directives. The proposed legislation would create Chapter 156 of the statutes, this time called "Compassionate Choices." It provides a very specific process by which a resident of Wisconsin, at least 18 years old and with a terminal disease, could request medication from an attending physician in order to end the requester's life. A terminal disease is defined in the bills as one that is incurable and irreversible, is medically confirmed, and will cause death within six months. It is significantly different from the definition of a "terminal condition" in Chapter 154, which

is "an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death."

The bills apply to those who have residence in Wisconsin. "Residence" is defined under Section 46.27 (1) (d), Wisconsin Statutes, as "the voluntary concurrence of physical presence with intent to remain in a place of fixed habitation." Like Oregon's law, there is no minimum residency requirement. Oregon law only requires a patient to adequately establish residence to his or her attending physician. Similarly, Washington and Vermont restrict their laws to residents, but residency can be demonstrated by possession of a state driver's license, voter registration, or evidence that a person owns or leases property in the state.

The legislation proposed in Wisconsin provides language for an authorization form, which would be distributed by the Department of Health Services. It reads very similarly to the language used in the bills introduced since 1995. It includes statements that the requester is of sound mind; has been fully informed of risks, results, and alternatives; is making the request voluntarily; and accepts full moral responsibility for his or her actions. A patient is not required to notify next of kin about his or her request. The bill provides for a patient to revoke his or her request by destroying the written request, writing a signed statement, or orally revoking the request in front of two witnesses or the physician.

Under the proposals, a patient makes an oral request for medication to his or her physician and provides a written request not less than 15 days later, after a consulting physician has completed an examination and report. The written request requires three witnesses, and as with prior legislation these witnesses cannot be related by blood, marriage, or adoption; cannot have a claim on the estate of request;

cannot be directly financially responsible for the requester's health care; and cannot be a health care provider serving the requester, other than a chaplain or a social worker. The legislation also requires one witness to be a residents' advocate designated by the Board on Aging and Long-Term Care if the requester is a nursing home resident. Then a second oral request must be made to the physician. At least 48 hours must pass after the second request before the physician can prescribe the medication.

Under proposed Section 156.05, a requester must make an informed decision, defined as "a decision by an individual to request and obtain a prescription for medication so as to end his or her life in a humane and dignified manner that is based on an appreciation of the relevant facts and is made after having been fully informed by the attending physician" of the medical diagnosis, prognosis, risks of the medication, probable result of taking the medication, and feasible alternatives to ending his or her life.

The bills provide doctors and health care providers with immunity unless they fail to act in good faith on all the steps provided for in the proposed law. A doctor who chooses not to participate in the process must make an effort to transfer the patient to a physician who will. The bills provide penalties of up to \$10,000 in fines and 10 years in prison for falsifying requests or concealing knowledge of a revocation.

The general provisions of the bills, explicitly states that the request for medication and the taking of the medication does not constitute suicide under Wisconsin law. Life insurance would not be affected unless the requester has acted independently of the request. Health care plans could not require any person to make the request, and the request would not bar a person from receiving health care. These clauses are meant to provide additional safeguards for those who may feel pressured to end their lives out of financial

concerns. One of the main concerns about this type of law is that it may lead people to end their lives in order to relieve others of the burden of caring for them emotionally and financially. The clauses related to health insurance and designating unrelated witnesses are meant to allay this concern.

The bills also state, "Nothing in this chapter may be construed to condone, authorize, approve, or permit any affirmative or deliberate act to end life other than through taking medication that is prescribed under a request for medication as provided in this chapter."

STATUS OF LEGISLATION AROUND THE COUNTRY

Both Wisconsin bills are currently in committee; no public hearings have been scheduled. California, the state Brittany Maynard moved from in order to become an Oregon resident and make use of the Death With Dignity Act, had been advancing legislation to permit physician-assisted suicide until June. California Senate Bill 128, which contains provisions similar to Oregon's act, has passed two committees as of April 2015, but is currently being held by the assembly. A Colorado bill introduced in January has been indefinitely postponed in committee. Bills in New York and Massachusetts are currently in committee, and a Connecticut bill has received a public hearing. A New Jersey bill has been reported out of committee without recommendation but no action has been taken by the full senate. At least 17 more states may be considering right-to-die legislation at some point in their current legislative session, according to a national advocacy group.

SOURCES

Wisconsin Legislation

Assemb.B. 1207, 1975 Leg., 82nd Sess. (Wis. 1975).

Assemb.B. 755, 1993 Leg., 91th Sess. (Wis. 1993).

Assemb.B. 174, 1995 Leg., 92nd Sess. (Wis. 1995).
Assemb.B. 298, 2007 Leg., 98th Sess. (Wis. 2007).
Assemb.B. 67, 2015 Leg., 102nd Sess. (Wis. 2015).
S.B. 90, 1995 Leg., 92nd Sess. (Wis. 1995).
S.B. 28, 2015 Leg., 102nd Sess. (Wis. 2015).

Other States

California: S.B. 128, 2015 Leg. (Cal. 2015).
Colorado: H.B. 1135, 70th Gen. Assemb., Reg. Sess. (Colo. 2015).
Connecticut: H.B. 7015, 2015 Leg. (Conn. 2015).
Massachusetts: H.B. 1991, 189th Gen. Ct., Reg. Sess. (Mass. 2015).
Montana: *Robert Baxter v. State of Montana*, 2009 MT 449, December 31, 2009.
New York: S.B. S03685, 2015 Leg., 238th Sess. (N.Y. 2015).
New Jersey: S.B. S382, 2014 Leg., 216th Sess. (N.J. 2014).

Oregon: Oregon.gov. "Death with Dignity Act." *Oregon Health Authority*. <https://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx>.
Vermont: VT. STAT ANN. tit. 18 § 5289 (2013).
Washington: Washington State Department of Health. "Death with Dignity Act." <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct>.

Newspapers

Bever, Lindsey. "How Brittany Maynard May Change the Right-to-Die Debate." *Washington Post*, November 3, 2014.
Eckholm, Erik. "New Mexico Judge Affirms Right to 'Aid in Dying'." *New York Times*, January 13, 2014.
Wisconsin Legislative Reference Bureau. "Medical Practice, Right to Die." (Clippings), September 1993 – September 1994. 614.23/R44z/pt. 10.