

Interview

Legislation on "death with dignity" in U.S.

Interviewee; Dr. Carol Suzuki

Interviewer; Dr. Masako Minooka (Executive Director of JACE)

A Interview with Dr. Suzuki who is a tenured professor of law at the University of New Mexico School of Law in Albuquerque, New Mexico .

On 18th April 2013, we had a meaningful talk for hours about End-of-Life Care and legislation on "Death with Dignity".

Some of the main Questions & Answers are below.

Q1;

Please tell us about the present situation of legislation on "death with dignity" in U.S. I hear in some states they discuss not only withholding & withdrawing life sustaining treatment by the patient's wish (1) or surrogate's wish (2), but also physician assisted death or aid in dying (3).

A1;

As a general matter, withholding or withdrawing life-sustaining treatment are measures that may allow a patient to die a natural death with dignity. As specific terminology, "death with dignity" has legal significance in the United States, with a different focus than how the term is utilized in Japan, because the term is used in some state laws that allow physician aid in dying. Oregon, Washington, and Vermont¹ have "death with dignity" laws that allow a competent state resident, with an incurable and irreversible disease that will lead to death within six months, to self-administer a legally-prescribed lethal dose of medication. Physician aid in dying is also allowed in Montana based on a 2009 state court decision.²

1. Or. Rev. Stat. §§ 127.800 to 128.995 (effective 1997), available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/statute.pdf>
; Wash. Rev. Code §§ 70.245.010 to 70.245.904 (effective 2009), available at

<http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245>; S.B. 77, 2013-14 Leg. (Vt. 2013) (enacted May 20, 2013) (to be codified at Vt. Stat. Ann. tit. 18, §§ 5281-5292), available at <http://www.leg.state.vt.us/docs/2014/Acts/ACT039.pdf>.

2. *Baxter v. State*, 224 P.3d 1211, 354 Mont. 234 (2009).

Q2;

In Japan the legislation on "death with dignity" is being discussed enthusiastically. It is that "If a patient shows his wish to refuse life sustaining treatment in writing, medical providers are not impeached for his death". It is the case of (1) withholding & withdrawing life sustaining treatment by the patient's wish. Some patient groups oppose the legislation. What do you think of this legislation?

A2;

Legalization of advance directives, such as a living will, supports patient autonomy and dignity. Advance directives provide direction to medical care providers, or an agent, guardian, surrogate or other person with legal decision-making power, to help guide decisions where a patient is not competent to state his or her wishes. The "death with dignity" legislation proposed in Japan would allow a doctor to withhold life-sustaining medical treatment to a terminally ill patient if the patient has a written document setting forth those wishes. A second proposal additionally allows a doctor to withdraw life-sustaining measures that have already been initiated. In the United States, we would need to look at the laws of each state to see how a state addresses the withholding and withdrawal of life-sustaining medical treatment based on a patient's living will or other advance directive. A patient should consider creating a directive prior to a medical emergency so that the patient has an opportunity to make thoughtful choices in regard to medical care and any agent or proxy permitted by law. A Japanese law that legalized an advance directive would help to ensure that a patient's preferences could be documented and would be followed. It would protect medical care providers who act in accordance with the written wishes.

Q3;

In the case that patient is incompetent and no Advance Directive, is it possible to withhold or withdraw life sustaining treatment by the opinion of the family (surrogate) in the U.S.?

A3;

We would need to look at state law in the situation where there is an incompetent patient without a written advance directive addressing the withholding or withdrawal of life-sustaining treatment. It would be important to try to determine what the patient's wishes are in order to respect patient self-determination and autonomy. A pivotal case is *Cruzan v. Director, Missouri Department of Health*³, where the U.S. Supreme Court found that a person has a right under the U.S. Constitution to refuse medical treatment, but that a state could require "clear and convincing evidence" that the patient would want life-sustaining treatment withdrawn. Although there was no written advance directive in that matter, the state trial court allowed the guardians to terminate treatment after it heard witness testimony that the patient had made prior oral statements that demonstrated she would not want the life-sustaining treatment.

As always, we would look to state law for guidance. Under the doctrine of substituted judgment, we could try to determine what the patient would want if the patient had decisional capacity. Are there relevant prior statements of the patient that reflect the patient's values? Let's consider a hypothetical situation where a patient is incompetent, and the patient's wishes are unknown because they have never been expressed through an advance directive or other instructions, and the patient had not appointed a health-care agent (decision-maker). If the patient had not appointed an agent and if there is no guardian to make health-related decisions, state law may require we look to the surrogate established by law, and the law may require the surrogate to make decisions in the patient's best interest. Generally, a provider will provide life-sustaining treatment if there is no one to speak on behalf of the patient's interests. Bioethicists might consider turning to beneficence, a principle of bioethical decision-making, to determine the best interest of the patient.

3. 497 U.S. 261 (1990).

Q4;

What do you think of the case of Kameda General Hospital in Japan? [A competent patient with ALS wished to remove respirator when he couldn't communicate (it means status of 'locked-in'). He wrote his wishes on 9 pages papers. His family understood his wish. And hospital interdisciplinary ethics committee discussed for 1 year and decided to accept his wish. But the director of hospital refused to accept his offer being afraid of lawsuit.]

Do you have the same case like Kameda General Hospital in U.S.? And what happens after patient's wish is rejected?

(Please refer to what you said [It can happen in U.S. But after the rejection the family sues the hospital. Or change the hospital.]

A4;

In the United States, where there is conflict between the medical care provider and its ethics review board, and the patient or the patient's health-care agent, guardian or surrogate, or concern about liability, a party might choose to go to court to get an order regarding the continuation of or the termination of life-sustaining treatment.

We would need to look at the laws and case law of each state to see how a patient's right to refuse treatment is balanced against state interests and criminal laws prohibiting physician aid in dying. There is precedent to allow a competent adult to refuse life-sustaining medical treatment, including nutrition and hydration. For example, the patient in *Bouvia v. Superior Court*⁴ was a competent 28-year-old woman with severe cerebral palsy who was quadriplegic. She could not eat on her own and a feeding tube was inserted after she expressed an intent to starve herself in order to die. With sufficient feeding, the patient would probably live another 15 to 20 years. She sued to be allowed to refuse medical treatment. The California Court of Appeal stated, "Being competent she has the right to live out the remainder of her natural life in dignity and peace. . . . Personal dignity is a part of one's right of privacy." It granted the patient the relief she sought and ordered the feeding tube to be removed. After the court case ended, the patient decided to continue to receive medical treatment.

4. 225 Cal. Rptr. 297, 179 Cal. App. 3d 1127 (Cal. Ct. App. 1986).

Q5;

Some Japanese people worry about the pressure on "Death with Dignity" by the legislation. Is there such unreasonable pressure by the family in the U.S.?

A5;

Certainly, unreasonable pressure is at least in theory a possibility when a patient considers end-of-life plans. A patient should be able to consult with family and friends prior to entering into an advance directive, and as a society we hope that family members and friends assist the patient to make informed decisions that reflect the patient's preferences. With respect to an advance directive, a patient should not sign one where consent would be given by mistake, or obtained through duress, menace, fraud, or undue influence; additionally, an advance directive should not be executed through coercion by a person who is not acting to support the patient's wishes.

In the case of physician aid in dying or "death with dignity" laws in the United States, the laws require that the physician determine that the patient requesting a prescription for a lethal dose of medication is competent, is acting voluntarily, is making an informed decision, and is not being coerced.⁵In Washington state, it is a felony to coerce or exert undue influence on a patient to request medication to end the patient's life.⁶

5. See Or. Rev. Stat. §§ 127.810 to 127.830; Wash. Rev. Code §§ 70.245.030 to 70.245.070; Vt. Stat. Ann. tit. 18, § 5283.

6. Wash. Rev. Code § 70.245.200(2).

Q6;

How do you reflect the change of patient's wish/intention after making Advance Directive in the U.S? How the legal specialists (lawyers) in U.S. advise or counsel the patients to better ensure that their choices (A.D.) are

followed?

A6;

Just as state law would direct the creation of an advance directive, we would need to look at the laws to determine how changes to an advance directive would be recorded. Depending on the state, a patient, while having capacity, may be able to revoke provisions of an advance directive either by a signed writing or by personally informing the health-care provider. In a situation where a patient is competent but cannot sign, a written revocation may be able to be signed on behalf of the patient. A competent patient may be able to orally state changes to a medical care provider, who can record those changes in the patient's medical records. In the event where an individual enters into a new advance directive, the provisions of the older one might be considered invalid where they conflict with the new directive.

As a lawyer, I would advise a client to consider executing any advance directive, including a living will or a power of attorney for health care, when the client is not involved in an emergency. The directive should be made voluntarily, with appropriate counseling so that the decisions regarding an advance directive are informed. The client should have time to reflect on her or his preferences for the withholding of or discontinuation of medical treatment and choice of agent for decision-making. There should be time to consult with family and friends. The advance directive should be created and executed following the relevant state laws, and copies should be given to the relevant people, including close family members and medical-treatment providers, so the information is accessible when needed.

Q7;

In Japan ethical discussion about DNAR order has just begun recently. But actually medical providers sometimes withhold some treatments other than CPR to the patient with DNAR order.

I think the concept of POLST (Physician Order for Life Sustaining Treatment) is important to improve the present situation in Japan. Please explain to us about POLST.

A7;

The POLST (Physician Order for Life Sustaining Treatment; sometimes called a MOLST, Medical Order for Life Sustaining Treatment) is a product of state law. Generally, a POLST is a document containing specific orders regarding end-of-life medical treatment based on the wishes of a patient with a serious, progressive or chronic illness. It can contain provisions beyond what is found in a Do Not Resuscitate Order. It is made after consultation with and on consent of the patient or the patient's health-care agent, guardian or surrogate, and signed by the physician. A POLST will be honored by medical-care providers, including emergency-care professionals, in a number of health-care settings and outside of a hospital setting. A patient-executed advance directive, even if otherwise legal, might not be effective to give emergency medical care providers instructions to withhold emergency medical treatment.

Q8;

If you have any other opinions or advices about legislation on "death with dignity" in Japan, please write freely.

A8;

A law that allows a competent person to give informed consent with regard to commencement of or termination of medical treatment, and protects a medical professional who provides treatment based on those written wishes, supports patient autonomy, beneficence, and social justice. "Death with Dignity," whether we mean withholding or withdrawing treatment pursuant to an advance directive, as in the proposed legislation in Japan, or if we mean physician aid in dying,⁷ legal in some states in the United States, raises social, legal, medical, ethical, moral, philosophical, political and constitutional issues. Some differences in medical decision-making in the United States and in Japan are cultural in nature and should be explored further. I think patient autonomy and family decision-making can be in conflict and are significant to our understanding of cultural differences. The United States Constitution and state laws support liberty interests and self-determination; decisions in Japan may be considered more family and society directed. However, it

seems as if the discussions in both countries reflect a desire to honor and respect the patient and the patient's values and wishes.

7. With regard to physician aid in dying, there are a number of states that are now considering such measures, either through proposed legislation, or through the court.



Dr. Masako Minooka Dr. Carol Suzuki

Profile

CAROL MARI SUZUKI (Professor of Law, University of New Mexico)

As a law professor, she teaches in the clinical law program; Torts; a Bioethics seminar; and an AIDS and the Law seminar. Her clinical teaching and practice areas include interviewing and counseling, trial practice, family law, juvenile delinquency, and immigration. She is also the Faculty Advisor for the New Mexico Law Review, a student-edited legal journal which publishes professional and student articles.