2015 Senate Bill 28, introduced February 11, 2015 LRB-1503/1 & 2015 Assembly Bill 67, introduced March 3, 2015 LRB-0888/1[1]

Legal Analysis of the Bill

A. As a criminal statute, this law would be broadly interpreted to shield physicians, witnesses and others from criminal liability for helping other people obtain lethal doses and helping them take the lethal doses.

1. Currently, anyone who assists another person to attempt or commit suicide is criminally liable for the felony of assisting suicide. § 940.12[2].
2. The bill excludes all activities under proposed chapter 156 from being treated as "attempted suicide" or "suicide". §156.23(1)(a).
3. Criminal statutes are interpreted to protect the accused from criminal liability, not victims from criminals. State v. Schaller, 70 Wis.2d 107, 233 N.W.2d 416 (1975).
4. So, this bill's language will be broadly interpreted to encompass assisted suicide in order to limit criminal liability.

B. Safeguards are non-existent after the lethal dose prescription is filled.

1. Nothing in the bill would prohibit someone from obtaining multiple lethal doses from different physicians and then giving them to others as part of a suicide pact or in a murder-suicide.
2. Nothing in the bill would prevent someone other than the requester from picking up the filled prescription.
3. Nothing in the bill would prevent someone from helping a person who received the lethal dose to swallow it. The bill would shield any one who put the lethal dose in the requester's mouth who would then take it by swallowing.
4. Someone else could mix the lethal dose into a drink[3] without the person's knowledge, which the person would then take by swallowing the drink.
5. Involuntary administration of the lethal dose without the requester's consent could easily be undetected.

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[1] These companion bills are patterned after Oregon's Death with Dignity Statute, Oregon Revised Statutes, Section 127.800 et al. (2013).

[2] § 940.12, says: "Whoever with intent that another take his or her own life assists such person to commit suicide is guilty of a Class H felony." This applies to anyone, not just physicians, who help another person to die.

[3] In Oregon, the typically prescribed lethal doses of secobarbital and pentobarbital are recommended to be dissolved or mixed with a sweet substance such as juice when taken. J. Fass and A. Fass, *Physician-assisted Suicide Ongoing Challenges for Pharmacists* American Journal of Health System Pharm. 2011;68(9):846-849 available at http://www.medscape.com/viewarticle/742070_3

a. No one is required to be present when the lethal dose is taken.

b. Access to the lethal dose is not restricted before the dose is taken.

c. The requestor is not required to be mentally capable when the lethal dose is taken.

For these reasons, criminal penalties for intentionally causing an involuntary ingestion of the lethal dose, §156.27, ring hollow.

6. Requiring disinterested witnesses at the death would not be much of a safeguard. Many wills are properly witnessed and nonetheless set aside for undue influence, fraud, coercion, etc.

7. A person, who changes his /her mind, can revoke a request for the lethal dose, but this does not rescind the prescription, nor does it recover a lethal dose after the prescription is filled. §156.17.

C. People with years to live could have their lives ended by lethal doses.

To receive a lethal dose, a person must have a terminal disease that "will produce death within six months." §§156.03, 156.01(15) [4]. This casts a much wider net than one would assume.

1. The bill's six month prognosis language assumes a person, otherwise unlikely to die, will die within six months by receiving no medical treatment and not going into remission.

a. For example, the bill's language would treat the following people as terminal.

1) A person prone to deadly allergic reactions would be assumed to not be taking or carrying allergy medicine.

2) A diabetic would be assumed to not be taking insulin.

3) A person with abnormal heart rhythms would be assumed to not have a pacemaker.

4) A person with cancer, multiple sclerosis, etc. would be assumed to not be in remission.

b. Oregon's similar definition[5] is interpreted to include chronic treatable conditions such as chronic lower respiratory disease and insulin dependent diabetes according to their 2014 annual report[6].

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[4] "Terminal disease" means an incurable and irreversible disease that has been diagnosed by the individual's attending physician and medically confirmed and that will, within reasonable medical judgment, cause death within 6 months. Proposed §156.01 (15).

[5] Oregon Rev. Stat. **127.800 §1.01 (12)** says "'Terminal disease' means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."

[6] Oregon's Death with Dignity Act Annual Report for 2014, at page 5 and note 6 on page 6 available at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf

c. An Oregon doctor reports:

> Our law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions such as lower respiratory disease and diabetes. Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live. They are unlikely to die in six months unless they don't receive their medications. Such persons, with treatment, could otherwise have years or decades to live.
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> Letter to the Editor, William Toffler M.D.[7]

d. Oregon is now considering expanding its definition to include diseases that will produce death within one year.[8] Assisted suicide supporters are worried this proposal will bolster "slippery-slope" arguments endangering the passage of similar legislation in other states.[9]

e. The proposed Wisconsin definition like its Oregon counterpart casts a wide net by ignoring life-extending medical treatment, regardless of how effective or non-invasive, and ignoring the possibility of periods of remission or advances in treatment.

2. Doctors are unable to accurately predict how long people will live.

a. The authors of the United States' most extensive study of prognosis and treatment of terminal illness had this to say:

> Deciding who should be counted 'terminally ill' will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide.[10]

b. "Estimating when someone will die is very difficult…."[11]

c. A large research study published by the Journal of the American Medical Association concluded clinicians could not predict which seriously chronically ill patients would survive for 6 months or less.[12] The study also found that 70% of those eligible for hospice care (predicted to survive 6 months or less) lived longer than 6 months. *Id.*

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[7] Letter published by the New Haven Register, February 24, 2014 available at http://www.nhregister.com/opinion/20140226/letters-to-the-editor-dying-deserve-right-to-choice.

[8] Oregon House Bill 3337, https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB3337/Introduced

[9] *Bill to expand Oregon's Death with Dignity Act runs into a buzz saw of opposition*, Oregon Live, March 2015 available at http://www.oregonlive.com/mapes/index.ssf/2015/03/bill_to_expand_oregons_death_w.html

[10] J. Lynn et al., *Defining the "Terminally Ill": Insights from SUPPORT*, 35.1 Duquesne Law Review 311-336 (Fall 1996) at 334.

[11] J. Lynn, et al., *Improving Care for the End of Life: A Sourcebook for Health Care Managers and Clinicians*, 2nd edition, at page 6, Oxford University Press 2008.

[12] E. Fox, et al., *Evaluation of Prognostic Criteria for Determining Hospice Eligibility in Patients With Advanced Lung, Heart, or Liver Disease,* Journal of the American Medical Association 1999; 282(17): 1638-1645. doi:10.1001/jama.282.17.1638 at http://jama.jamanetwork.com/article.aspx?articleid=192058

d. In late 2012 Valerie Harper was diagnosed with brain cancer and given three months to live. Two years later she says, "I feel wonderful. What luck! Here I am. The three months didn't prove to be correct. The cancer I have is quite rare and terminal and incurable. I'm the recipient of a great research project that has kept me alive."[13]

D. The bill deviates from public policy that protects the vulnerable and those easily coerced or tricked.

1. As a matter of public policy, the level of legally required mental ability and related safeguards increase as vulnerability to harm increases.[14]

2. This bill deals with a matter of life and death, which should require competence[15], the highest level of mental ability, and safeguards to adequately assure this level is met.

a. Yet, proposed §156.03 allows adults having lower mental ability than competence to request the lethal dose, raising questions about whether coerced (involuntary) requests will be caught.

AND

b. The bill's safeguards, the two oral requests to a physician and a witnessed written request to obtain the lethal dose (more fully described in the next section E.) are unlikely to prevent coerced requests.

3. The witnesses to the written request sign a statement saying they believe the request is voluntary and that the requester is "of sound mind". §156.15

a. Being of sound mind is a minimal or diminished level of mental ability. People who are incompetent and incapable of managing their finances and affairs may still be of sound mind. Sorenson v. Ziemke (In re Estate of Sorenson), 87 Wis.2d 339, 274 N.W.2d 694 (1979); In re Dobrecevich's Estate, 14 Wis.2d 82, 109 N.W.2d 477 (1961).

b. Those incompetent persons, whose affairs are managed outside of guardianship, by family members and unsupervised agents under powers of attorney for health care and finances, are often victims of elder abuse, [16] yet §156.03 authorizes them to obtain the lethal dose.

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[13] See http://www.etonline.com/news/153793_valerie_harper_on_cheating_death_after_cancer_diagnosis/

[14] Frolik L. and Radford, M., *"Sufficient" Capacity: The Contrasting Capacity Requirements for Different Documents* NAELA Journal Vol 2 303-323 (2006). Wisconsin law provides special legal protection for major transactions, but allows people with lesser mental abilities to complete simpler less dangerous transactions. Wisconsin State Bar, Advising Older Clients and Their Families, §§ 2.67-2.73.

[15] Competence requires the ability to make decisions so as to meet the essential requirements for one's physical health and safety and to manage one's property and financial affairs. §54.10(3) defining incompetence.

[16] Elder abuse is often perpetrated by agents under powers of attorney. Black, Jane A. (2012) *The Not-so-Golden Years: Power of Attorney, Elder Abuse, and Why Our Laws Are Failing a Vulnerable Population*, St. John's Law Review: Vol. 82: Iss. 1, Article 7, at: http://scholarship.law.stjohns.edu/lawreview/vol82/iss1/7. A national study found 64% of attorneys had encountered elder abuse by financial powers of attorney. Bates, C., *Legislature to Consider Durable Power of Attorney Update*, Wis. Elder Law News, Winter 2010 at 6.

c. Being of sound mind applies to making or revoking a will (§853.01), yet properly witnessed wills are set aside due to fraud and undue influence. Juries are more likely to find a person with diminished capacity was susceptible to being tricked by unscrupulous individuals; the elderly, those with failing memories, dementia and confusion are more easily duped.[17]

d. Wisconsin law also uses being "of sound mind" for choosing one's health care agent (§155.05(1)), but requires a higher level of mental ability called incapacity to trigger the shift in decision-making to that agent (§155.50(2)). Until 2010, Wisconsin law for financial powers of attorney was similar (§243.10 witness statement, 2007-2008 statutes).

e. In 2010, Wisconsin law for financial powers of attorney changed to equate incapacity to incompetency in order to protect vulnerable people. [18] The law for health care powers of attorney remains unchanged.

4. An attending physician, with confirmation by a consulting physician, is to determine that the requester does not have incapacity and is voluntarily requesting the lethal dose. §§156.09(1), 156.11

a. Incapacity is a mid-level of mental ability, usually determined by doctors for health care decisions. [19] The bill defines "incapacity" at §§156.01(7) by incorporating §155.01(8) the level used to transfer health care decisions to an agent. It says:

"Incapacity" means 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. …Mere old age, eccentricity or physical disabilities, singly or together, are insufficient to make a finding of incapacity. 155.05(2).

b. Doctors often fail to detect coercion and so believe the individual is acting voluntarily. A recent journal article[20] reported:

1) Only 1 of 14 cases of elder abuse or neglect (neglect includes lack of health care) is ever reported to authorities.

2) Of those that are reported, only 2% are reported by physicians.

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[17] Frolik L., "Sufficient" Capacity, see note 14 for full citation, at 321.

[18] In 2010 Wisconsin adopted the Uniform Power of Attorney Act. Ch. 244 of Wis. Stats. after a national study found most states' laws came up short in protecting vulnerable people from financial abuse by agents Bates, C., *Legislature to Consider Durable Power of Attorney Update*, Wis. Elder Law News, Winter 2010 at 6. "Incapacity" is defined consistently with the standard for appointment of a guardian (referred to as a incompetence in Wisconsin). National Conference of Commissioners on Uniform State Laws, Uniform Power of Attorney Act (2006) at page 3.

[19] "Incapacity" for health care decisions is not the same as incompetence for guardianship purposes. Eckhardt's Workbook for Wisconsin Estate Planners §§11.153, 11.181.Wisconsin law originally required a mid-level "capacity" for appointing an agent under a durable power of attorney. Advising Older Clients, June 1977 § 2.73.

[20] Wagenaar, D, et al., *Primary Care Physicians and Elder Abuse: Current Attitudes and Practices*, Journal of the American Osteopathic Association, December 1, 2010 vol. 110 no. 12 703-711.

3) Older adults without obvious physical evidence of abuse may be unwilling to talk about being abused because they fear retaliation or abandonment.

4) Inability to recognize subtle signs of elder abuse continues to be a barrier for primary care physicians.

c. Training by the Wisconsin Public Psychiatry Network, says:

"Often, coercion can be very subtle, related to the power differential between doctor and patient, by family members, or by being in an institution or being ill."[21]

d. Influencers dominate vulnerable people by creating isolation, a siege mentality, dependence, a sense of powerlessness, fears of abandonment, and unawareness of the real world. [22] Similarly, the most frequently mentioned concerns of those who ingested lethal doses in Oregon were loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (86.7%), and loss of dignity (71.4%).[23]

e. Over 90% of people who die by suicide are clinically depressed or have another diagnosable mental disorder.[24] The attending or consulting physician is to refer the requester for review and counseling before the writing the prescription if either thinks the person's judgment is impaired by a psychological disorder, including depression. §156.13. Oregon has a similar provision[25], yet only 3 of the 105 people who died by lethal dose in Oregon in 2014 were so referred.[26]

f. For those who live in nursing homes or community-based residential facilities (CBRF, often dementia care facilities), the bill creates a resident's advocate at §156.19 who is required to communicate with the attending physician about the person's desire for the lethal dose, needs and other wants. The bill does not address how to assure the requester is making a proper request through this advocate, who in any event is given immunity.

g. The resident advocate's role undercuts safeguards for the prevention of

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[21] Rolli, M., *Evaluating Decision Making Capacity*, Wisconsin Public Psychiatry Network Teleconference (WPPNT) 2012, Slide 14 available at https://www.dhs.wisconsin.gov/sites/default/files/legacy/MH_BCMH/docs/confandtraining/2012/11-8-12DecisionMaking6perPage.pdf

[22] Singer, M. *Undue Influence and Written Documents: Psychological Aspects*, 10 Cultic Studies Journal Vol. No. 1, 19-33(1993) available at https://docs.google.com/document/export?0=mp&1=ws&2=print&3=1&format=pdf&id=1UHcIM0z5AiJGHzcLNEK5Jnc8iqjJPxm-IU1CrBRV6HE&token=AC4w5Vi9i07tArisNZkxyFXfvF5z-pOmBA%3A1426016286921

[23] Oregon Annual Death with Dignity Report for 2014 cited at footnote 6, page 2.

[24] WebMD at http://www.webmd.com/depression/guide/depression-recognizing-signs-of-suicide Also American Association of Suicidology at http://www.suicidology.org/resources/infographics/diagnosable-mental-disorder

[25] Oregon Rev. Stat. 127.825 §3.03.

[26] Oregon Annual Death with Dignity Report for 2014 cited at footnote 6, page 2.

elder abuse and mistreatment of long term care residents as more fully described at E.12. This person receives immunity from liability for fulfilling his or her role as a witness at §§156.21(3). This immunity would extend to this person's communication duties if seen as oral witnessing.

E. The procedures by which the requester obtains and fills a prescription for the lethal dose are subject to loopholes and open to abuse.

Briefly, over a two-week period, the process requires two oral requests and a written request to the attending physician as well as an examination and report to the attending physician by a consulting physician. §§156.05(2). Either physician can further refer if depression is suspected. §156.13.

1. The two oral requests to the attending physician do not have to be made in person or be witnessed. Nothing prevents someone other than the "authorized requester" to request the lethal dose by phone.

2. The bill does not require the "attending physician" to examine the requester.

3. The informed consent disclosures §156.05(1) and §156.09 required of only the attending physician do not include all alternative viable treatments, such as those that could manage the person's illness or stop its progression, as required of all physicians by §448.30. Instead the bill limits the disclosures to feasible alternatives to taking the lethal dose, i.e., other ways of dying, such as comfort care and hospice care.

4. The "consulting physician" chosen by the attending physician (§156.09(3)) is required to examine the requester, §156.11, for the purpose of preparing a written report to the attending physician confirming that physician's determinations. The consulting physician is not required to communicate those determinations or informed consent disclosures to the requester.

5. The person who receives the lethal dose is called the "requester" (see §156.01(11)), not a "patient". In this way, the normal duties health care providers owe patients are overridden as is the oversight of the licensing authorities.

6. The requester's family does not have to be notified of the request for lethal drugs. §156.05(3), §156.09(5). Documentation about the request is confidential under s. 146.82 by requiring its inclusion in "patient health care records". See §156.01(9), §156.07(1)(f), §156.09(8), §156.11, §156.13 and §156.25.

7. The written request form will be widely available and therefore easily obtained. Section §156.15 requires the department to distribute it to health care providers, senior citizen centers, county clerks, local bar associations and individuals.

8. The written request form is to be signed, which includes being signed by another at the requester's direction, in the presence of three witnesses, §156.07, all of whom are given immunity from liability under §156.21 (3) for acting in good faith as witnesses, a low standard based on unverified belief.

9. The witnesses sign a statement saying they believe the requester is "of sound mind" without having to state the requester does not have incapacity. §156.15.

10. Witnesses must be unrelated to the requester, not be owed money by the requester or in line to inherit from the requester, or health care providers (except social workers and chaplains). §156.07(2). Nothing prohibits a witness from otherwise financially benefiting, say by receiving funds from an heir or relative, or by receiving incentive bonuses for holding down costs or resolving a difficult resident problem.

11. Disinterested witnesses are not much of a safeguard. Many wills are properly witnessed and nonetheless set aside for undue influence, fraud, etc. It is also possible that close relatives could forge witness signatures and escape criminal liability – see G.8.

12. If the requester resides in a nursing home or assisted living facility (community based residential facility), one of the witnesses must be a long-term care Ombudsman who is designated as a residents' advocate. §156.07(2)(b), §156.19 and 16.009(2) as amended in Section 1 of the bill. The resident's advocate has a conflicted role:

    a. The resident's advocate speaks for the requester in obtaining the lethal prescription from the attending physician. See §156.19.

    b. The Ombudsman is supposed to prevent elder abuse,[27] 42 U.S.C. §3027(a)(12) and investigate complaints by long-term care residents about facility conduct and decisions that adversely affect residents' health, safety, welfare or rights. 42 U.S.C. §3058g(3)(A).

    c. It is certainly more than conceivable that residents who are mistreated and abused may want to escape by receiving a lethal dose. Thus, the bill misappropriates the role of the Ombudsman to provide a free pass on poor care and abuse by mismanaged residential care facilities.

F. No Conscience Protection.

1. The bill does not provide conscience protection for providers who do not want to participate. Instead their failure to participate is branded unprofessional conduct. Those who do participate receive immunity from criminal, civil and professional liability. §156.21.

2. "Attending physicians" are allowed to transfer the requester which is a limited way of participating; other providers such as pharmacists are given no options.

[27] Seven percent of complaints to Ombudsmen about facilities were complaints of abuse, neglect, or exploitation (NORS Data 2010); in interviews of 2,000 nursing home residents, 44% said they had been abused and 95% said they had been neglected or seen another resident neglected. (Broyles, 2000); 50% of nursing home staff admitted they mistreated residents. (Ben Natan, 2010). NCEA Research Brief: Abuse of Residents of Long Term Care Facilities available at http://www.ncea.aoa.gov/Resources/Publication/docs/NCEA_LTCF_ResearchBrief_2013.pdf

Failing to fulfill a request for medication, except that failure of an attending physician to fulfill a request for medication constitutes unprofessional conduct if the attending physician refuses or fails to make a good faith attempt to transfer the requester's care and treatment to another physician who will act as attending physician under this chapter and fulfill the request for medication. §156.21(1)(a).

If the attending physician refuses to prescribe the lethal dose as required by this law, then the attending has a similar transfer requirement. §156.09(9).

G. The bill lacks transparency and accountability.

1. Bill sections 4 and 5 modify §979.01 so that the cause of death will not be investigated if it is believed the person died from the lethal dose. Otherwise, deaths which are unexplained, unusual or in suspicious circumstances, homicides, suicides, deaths due to poisoning, deaths following accidents and deaths when a physician refuses to sign the death certificate must be reported to law enforcement and the medical examiner/coroner.
2. Information reported to the department of health services, §156.09(8)(g) is to be kept confidential unless an alleged violation is investigated.
3. There is no reporting requirement prior to writing or filling the prescription for the lethal dose.
4. The department is required to sample reported records, §156.25, but is not required to do any reporting or investigation based on its review of sampled records.
5. No information is reported about the actual taking of the lethal dose.
6. No one is required to witness the actual taking of the lethal dose.
7. Criminal penalties for those who cause receipt and ingestion of the lethal dose against the wishes of the requester, §156.27(2) and (3) are meaningless when access to the lethal dose is not controlled and no one is required to witness the taking of the lethal dose.
8. There may be a possible drafting error in §156.27(2) and (3). Sub. (2) applies to any person and penalizes falsifying or forging a request for the lethal dose. Sub. (3) does not penalize this and applies only to responsible persons which includes immediate relatives (but not relatives by marriage) and health care providers. See definition of responsible person. The LRB analysis suggests the purpose of these two provisions is to exempt health care facilities from being imprisoned. However, it appears that they also have the effect of not penalizing any relative who is a "responsible person" (spouse, child, parent, grandparent or sibling of the requester) for forging or falsifying the written request form.