NEVADA LEGISLATIVE COUNSEL BUREAU
OFFICE OF RESEARCH BACKGROUND PAPER

1977 No. 8

RIGHT TO DIE

I

The name Karen Ann Quinlan brings to mind the plight of many apparently terminally ill patients who are kept alive by life-sustaining mechanical procedures. On March 31, 1976, the New Jersey Supreme Court spoke to the issue raised by Miss Quinlan's specific plight and said, based on Karen's right to privacy, that "The present life support systems may be withdrawn * * * without any civil or criminal liability therefore on the part of any participants." Ironically, Miss Quinlan lives on; so does the question of the role of machines and medication in sustaining vital functions and the propriety of stopping or withholding such treatment from patients.

The dilemma doctors, patients, relatives and the legal community face in cases like Karen's is largely due to medical progress in the development of ever more sophisticated means of life support. Several years ago, a patient died when his heart stopped and "extraordinary" treatment consisted of an injection of adrenaline. However, with respirators, heart-lung machines, organ transplants and similar measures, patients who would have died in the past can now be kept alive, at least technically, for weeks, months and even years.

The slogan "death with dignity" implies a rejection of the paraphernalia by which a terminal patient is kept alive, usually at great cost to his family and in isolation from it. Such "intensive care," so the argument goes, is often less for the patient's benefit than for the physician's. It allegedly reduces the patient to an object, prolongs dying for many people and needlessly makes death a psychologically, if not physically, anguishing experience.

The upsurge of interest in so-called death with dignity, however, has partially obscured an undercurrent of doubt and some outright opposition on the part of certain clergymen, doctors, legal experts and others who question whether dying is quite that simple, or that it is a "right" that can be isolated from society's duty to protect human life. Some believe that society has an investment in human life, and the concept of its sacredness, that overrides the individual, if not legally, at least morally.

II

Determination of the legal aspects of the "right to die" issue has rested primarily with the courts. During the last 4 years, however, increasing legislative interest has been given to this topic. According to the Society for the Right to Die, 25 states have recently considered right to die type legislation. Only one state, California, has enacted such a measure, "The Natural Death Act."

The current trend in legislative proposals stresses a specific personal decision on the part of an adult as to treatment or nontreatment in hopeless medical cases. The proposed bills permit an individual to avoid prolongation of his life beyond the point of meaningful (as defined) existence. One type of proposed measure found in some states sanctions painless inducement of death. Another type of measure being considered permits individuals to decide whether life support systems should be used, or continued to be used if they are already in use, if the individuals become terminally ill.

Bills introduced in several states legalize approaches such as the "living will," a document which permits a person to indicate, in advance of terminal illness, the course of treatment he wishes to receive should he become terminally ill. An example of a living will, developed by the Euthanasia Education Council, says, in part:

> If the situation should arise in which there is no reasonable expectation of any recovery from physical or mental disability, I request that I be allowed to die and not be kept

> alive by artificial means or heroic measures * * * I therefore ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.

Perhaps the most interest to date has been generated by California's Assembly Bill No. 3060 (chapter 1439, Statutes of 1976) which permits adults to prepare written instructions directing their physicians to withhold or withdraw life-sustaining procedures in specified circumstances of terminal illness on the grounds that adult patients have the right to control decisions affecting their own medical care. The so-called heart of the measure is a "directive to physicians" which must be signed in the presence of two unrelated witnesses. This directive was adopted from various living wills (noted above) and modified to meet the demands of diverse California interest groups.

The law, among other things:

1. Specifies procedures for executing and revoking directives and provides that they be effective for 5 years from the date of execution unless revoked sooner.

2. Requires that a patient's terminal condition be certified by two physicians who have examined him.

3. Requires that terminal patients confined to skilled nursing facilities who sign such directives must have as a witness a person designated by the California State Department of Aging as a patient advocate or ombudsman.

4. Provides that any person who, except where justified or excused by law, falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation with intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant of the directive, thereby causing life-sustaining procedures to be withheld or

withdrawn and death to be hastened, shall be subject to prosecution for unlawful homocide.

5. Relieves physicians and other specified health professionals from civil liability, criminal prosecution and charges of unprofessional conduct for withholding or withdrawing life-sustaining procedures when such individuals are acting in accordance with the law's provisions.

6. Requires that the withholding or withdrawal of life-sustaining procedures when done in accordance with the measure's provisions does not constitute a suicide.

7. Requires that the making of a directive not restrict, inhibit or impair the sale, procurement or issuance of any life insurance policy nor modify the terms of an existing life insurance policy.

8. Requires that no life insurance policy be legally impaired or invalidated by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient.

9. Specifies that the measure does not condone, authorize or approve mercy killing or permit any affirmative or deliberate act or omission to end life other than to permit the so-called natural process of dying.

10. Makes it a misdemeanor to willfully conceal, deface, obliterate or damage the directive of another without the declarant's consent.

11. Defines such terms as "physician and attending physician," "directive," "life-sustaining procedure," "qualified patient," and "terminal condition."

III

The issues involved in considering a so-called right to die measure are very complex and require thorough policy and legal analysis. Besides numerous technical considerations,

it may be appropriate to consider the following four questions when reviewing a right to die measure:

1. Does a terminally ill person have the right to control his own destiny (even if it means shortening his existence) by sharing in the responsibility or deciding about the course of medical treatment, or nontreatment, which he will receive?

2. Should right to die legislation sanction the painless inducement of death for terminally ill patients who request it (euthanasia), or should such legislation be restricted only to allow adults to decide when, and for how long, life support systems should be used on them if they become terminally ill?

3. Is the right to die concept consistent with contemporary medical ethics, theology and popularly expressed notions of human decency?

4. What effect might the passage of right to die legislation have on the manner in which medical treatment is provided to seriously ill patients, regardless of whether or not they sign "directives" or otherwise indicate that they do not want heroic medical procedures employed on them? In other words, how will the passage of right to die legislation affect the medical profession's view of its obligation to treat people who are dying?

An adjunct of the right to die issue is another current issue, namely the definition of death. No such definition is available in the Nevada Revised Statutes.

Traditionally, death has been evidenced by a lack of vital functions: respiration and pulse. With improvements in medical technology, more situations are occurring in which these traditional indicators have been rendered inapplicable. The definition of death has already been a central issue in some criminal cases when prosecutors believed that terminating the treatment of helplessly injured victims could vitiate

murder charges. It has also been an issue in organ transplant cases when surgeons have been reluctant to remove needed organs because they were concerned about civil or criminal liabilities. The most sensational aspect of the definition of death issue has centered around the treatment of comatose patients who are in so-called vegetative states.

Because of these and other problems, many believe that the definition of death should be broadened by expanding the meaning of "vital signs" to include brain function, either as an alternative measure to respiration and pulse or as a reserve measure to be used if respiration and pulse are being supported by external equipment. The propriety of brain function as a measure of death where machines are maintaining pulse and respiration is supported by the apparent consensus of physicians that the brain is the last of the three vital signs (breathing, pulse, brain function) to terminate under normal conditions.

Since 1970, at least 12 states have enacted legislation confirming the propriety of brain function in the determination of death. These states are Kansas, Maryland, New Mexico, Oregon, Virginia, California, Georgia, Illinois, Alaska, Michigan, West Virginia and Tennessee.

Many doctors are concerned that rigid statutory definitions of death may not provide the flexibility needed to reflect rapid advancements in medical technology. Therefore, most believe that any legislative attempt to define death should be drafted in such a fashion to allow for new advances in the medical field.

This paper has only attempted to highlight issues. It has made no attempt to assess the situation in Nevada concerning the need, or lack of it, for right to die legislation. Rather, it has tried to make the subject comprehensible. Finally, it has made no attempt to recommend action. Various proposals are represented with certain of the arguments their proponents use and do not reflect any position of the Office of Research.

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SUGGESTED READINGS

(Available in the Research Library)

"A Right to Die?" Newsweek, November 3, 1975, pp. 58-69.

"The Living Will and the Will to Live," The New York Times Magazine, June 23, 1975, pp. 12-26.

"Legislating Death," State Government, Summer 1976, pp. 130-134.

"Politics, Legislation, and Natural Death," The Hastings Center Report, October 1976, pp. 5-6.

"Death," State Government News, November 1976, p. 6.

"The Quinlan Decision," The Hastings Center Report, February 1976, pp. 8-19.

"Death and Dying," U.S. Catholic, April 1972, pp. 8-13.

"When There is No Hope . . . Why Prolong Life?" The National Observer, March 4, 1972, p. 1.

"Euthanasia Kills," Las Vegas Review Journal, February 25, 1973.

California's "Natural Death Act" (chapter 1439, Statutes of 1976) and various material from the California Assembly Committee on Health reviewing and analyzing this measure.

Statutory Definitions of Death (see "Right-to-Die File" for statutory definitions from: Kansas, Maryland, New Mexico, Oregon, Virginia, California, Georgia, Illinois, Alaska, Michigan, West Virginia and Tennessee).

"Right-to-Die" measures introduced in other states. (See files for The Legislative Manual prepared by the Society for the Right to Die which contains right-to-die measures introduced in 22 states.)