Life Planning: Advance
Directives for Health Care,
Euthanasia, and Physician-
Assisted Suicide

OBJECTIVES

After completing this chapter, you will be able to:

Explain the need for advance health care decision making.

Describe the types of advance health care planning documents.

Explain the legal issues surrounding euthanasia and physician-assisted suicide.

Describe palliative care.

INTRODUCTION

Elderly clients often have to deal with more health concerns as they age. Elder law attorneys and their staff should be aware of this fact and foster in their clients a commitment to planning before a medical emergency or incapacity strikes. Literally speaking, the need to make life-and-death decisions occurs more than 1,000 times per day in American hospitals and nursing homes. Failure to plan ahead for such unfortunate occurrences generally leaves the client's family addressing incapacity issues while dealing with their loved one's immediate physical and mental health needs.
advance directives for health care
Documents that specify an individual’s health care decisions and identify who will make decisions for the individual in the event the individual is unable to communicate his wishes to doctors.

health care power of attorney (HCPOA)
A document that specifies an individual or individuals to carry out the wishes of the principal regarding medical treatments the principal would want if he was unable to share his wishes with health care providers.

durable power of attorney for health care
A document that specifies an individual or individuals to carry out the wishes of the principal regarding medical treatments the principal would want if he was unable to share his wishes with healthcare providers. The document endures even if the principal becomes mentally incapacitated.

PLANNING BEFORE A HEALTH EMERGENCY

All 50 states allow for documents collectively known as advance directives for health care and have statutes that provide the procedural and substantive drafting requirements. Approximately 40 states have forms for drafting advance directives for health care. About 20 states require that these forms be substantially adhered to, but those 20 states still allow additional language to be inserted. It may appear confusing at first since advance directives for health care are known by a variety of names, including advance medical care directive. Some states use a document specifically named an advance health care directive. Some states use the term health care power of attorney (HCPOA). Some states recognize an advance directive written only in a certain format. Yet another option is called the durable power of attorney for health care.

Whatever name an advance directive for health care goes by, the primary objective should be the same—to specify an individual’s health care decisions and to identify who will make decisions for the individual in the event he is unable to communicate his wishes to doctors. Generally, one or two types of advance directives for health care documents are used. The first type is a living will. The living will is self-directed and should describe an individual’s wishes regarding medical treatments the person would want if he was unable to share his wishes with health care providers. For example, would the individual want artificial means of support? Very often living wills concentrate on prolonging the dying process when a person is fighting a terminal illness. A living will alone may not be as helpful as the creator of the will might have hoped because many living wills are standardized boilerplates that may be open to interpretation. For example, the National Conference of State Legislatures cited the terms heroic measures and terminally ill used in some state forms as examples of vague wording.

The second type of advance directive for health care document is a medical power of attorney. The medical power of attorney document allows an individual to appoint a trusted person to make health care choices when the individual is not able to share his health care choices with health care providers. The living will and the medical power of attorney frequently are merged into one document, which is a good idea if state statutes permit it. A trusted person appointed to deal with such issues can interpret a patient’s wishes based on their trusted relationship and mutual knowledge of their beliefs. Very often advance directives for health care specify a DNR (Do Not Resuscitate) order. Nearly all states have enacted legislation that allows their citizens to choose to refuse artificial means of support. Inclusion of DNR decisions makes sense when the historical background of advance directives for health care is considered. Such directives were originally advocated by right-to-die groups such as Choice in Dying. However, a national standard dealing with such refusal would be helpful because state standards vary widely.
The purpose of a medical power of attorney is clearly different from a general power of attorney. First, a medical power of attorney is very specific in its purpose (i.e., the making of medical treatment decisions by one person [usually called an agent, a health care proxy, or a health care representative] for another person. The creator of a power of attorney is called the principal.

A general power of attorney is usually very broad in its purpose (i.e., the handling of general business matters). For example, filing taxes, buying and selling real estate, entering safe-deposit boxes, and dealing with banking matters are permitted by a general power of attorney. An additional power that may be granted to an agent is running a business or employing professionals (such as attorneys and accountants) to assist the agent.

Another type of power of attorney is called the special power of attorney. As its name implies, a special power of attorney is usually created to give an agent one special power. For example, the agent may be authorized to represent the grantor at the closing of his home if the owner is out of town. The authority behind a special power of attorney usually ends with the completion of the responsibility.

All three types of powers of attorney (health care, special, and general) can be made a permanent part of a client’s life planning file by being designated as durable. A durable power of attorney remains in effect even if the creator becomes incompetent. This is not normally the case with the general or special power of attorney. Incompetence of the creator invalidates those two powers of attorney unless certain language is included to make a power of attorney’s effect durable. For example, the statement This power shall not be affected by my subsequent disability or incapacity would make a power of attorney durable. When a durable power of attorney is written so that the authority of the attorney-in-fact begins at a later time upon the occurrence of a certain event (usually incapacity), the document is called a springing durable power of attorney.

Making sure an advance directive for health care is in place can be especially important for an isolated person. An elderly patient who lacks capacity and has no concerned relatives places health care personnel in the perilous position of making uninformed decisions regarding the patient’s care. Only 13 states currently have enacted statutes dealing with this issue.³

Should Everyone Have an Advanced Directive for Health Care?

Elder law attorneys should ask their clients this question: What measures do you want taken if you are ever in a permanently unconscious state? If an advance directive for health care has not been written and a client is terminally ill or is in a permanently unconscious state, the question an elder law attorney should ask a client’s family members is this: What would the patient have wanted under the particular circumstances the patient is in now?

³ living will
A document describing an individual’s wishes regarding medical treatments the person would want if he was unable to share his wishes with health care providers.

³ medical power of attorney
A document very specific in its purpose that allows an individual to appoint a trusted person to make health care choices when the individual is not able to share his health care choices with health care providers.

³ general power of attorney
A document very broad in its purpose that allows an individual to appoint a trusted person to handle general business matters.

³ agent
The individual appointed to make medical treatment decisions for another person; also known as a health care proxy.
A wide client base is in need of advance directives for health care. Fewer than 10 percent of all Americans have written a living will. Creating such a directive forces the creator to think about intensely personal questions. For example, when should certain therapies be withheld or stopped to allow nature to run its course?

There is no "right way" to create an advance directive for health care. Issues of mental capacity, physical abilities, and quality of life should be pondered. For example, would a client want every possible medical intervention done to resuscitate him at 60, 70, 80, 90, or 100 years old? Clients should consider whether they want to be resuscitated if such medical intervention would mean a return to a conscious life of dementia due to AD or a life suffering the effects of a stroke.

Almost every hospital asks an incoming admission whether the person has an advance directive for health care and if not, whether he would like to sign one. Hospitals cannot refuse admission and insurance companies cannot deny coverage because an individual refuses to sign an advance directive for health care. It is a good idea for an individual to review and possibly rewrite an advance directive every few years.

Clients who have decided to draft a living will also should be asked if they want to sign an advance directive for health care. Some living will forms currently in use apply only when an individual is expected to die within a short period of time and do not allow for the withdrawal or withholding of artificial nutrition and hydration. They do not cover a condition such as a persistent vegetative state, which occurred in both of the well-known cases of Nancy Cruzan and Theresa Schiavo.

The American Medical Society, AARP, and the American Geriatrics Society highly recommend that everyone, regardless of age, take time to prepare a written plan of his preferences pertaining to health care. In its guidelines, the American Medical Society clearly includes its official position regarding the withholding or withdrawing of life-sustaining treatment and clearly supports patient preference in making treatment decisions. Refer to Exhibit 3-1 to read a portion of the American Medical Society's official position. The Uniform Health Care Decisions Act also provides guidance to states drafting statutory guidelines for dealing with health care decisions.

Drafting an advance directive for health care and designating a health care proxy are not the only factors impacting an individual's end-of-life decisions. The best way to comply personally with each state's requirements should be considered. What state a person lives in can make a huge difference in what kind of death the person experiences. For example, differences in state budgets are why some residents are more likely to die in a hospital than at home or in a hospice environment. For example, in a recent year, Mississippi spent 4.2 percent of its long-term health care budget to aid patients who wanted to be treated at home. Compare that number to Oregon spending 50.4 percent of its long-term budget that same year for long-term treatment of patients at home or in a
Evidence of the need for end-of-life decisions is everywhere. For example, allow nature to run its course, and the person may die of natural causes. Oregon is not alone in making such budgetary decisions. California spends, on average, 30 percent of its long-term health care budget on treatment for home and community care. Just as budgets vary greatly, so does the language of the advance directives for health care legislation across the country.

Medical Terminology Used in Advance Directives

Clients may ask their elder law attorneys to review unfamiliar medical terminology particular to advance directives for health care. These medical terms include the following:

- Artificially provided fluids and nutrition
- Cardiopulmonary resuscitation (CPR)
- Life-sustaining measures
- Decision-making capacity
- Terminal condition
- Permanent unconsciousness
- Persistent vegetative state
- Incurable and irreversible chronic diseases
- Whole brain death

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<th>EXHIBIT 3-1</th>
<th>E-20 WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING MEDICAL TREATMENT</th>
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The local commitment of the physician is to sustain life and relieve suffering. Where the performance of one’s duty conflicts with the wishes of the patient, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to refuse life-sustaining treatment of a competent patient, who possesses decision-making capacity. Life-sustaining treatment is any condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics and anticoagulants, hydration, and nutrition.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment. A competent, adult patient may, in advance, formulate and provide a valid consent the withholding or withdrawal of life-support systems in the event of injury or illness renders that patient incompetent to make such a decision. A patient may also appoint a surrogate decision maker in accordance with state law.

If the patient receiving life-sustaining treatment is incompetent, a surrogate decision maker should be identified. Without advance directive that designates a proxy, the patient’s family would become the surrogate decision maker. Family includes persons with whom the patient is closely associated. In the case where there is no person closely associated with the patient, there are persons who care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates.

A decision should provide all relevant medical information and explain to surrogate decision makers that decisions regarding withholding or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) even if there is evidence of the patient’s preference and values. In making a substituted judgment, decision makers may consider the...
Today the decisions that a health care proxy makes for an incompetent patient should be accepted by the patient's physician. However, four situations may require institutional (e.g., a hospital) or judicial review and intervention in the decision-making process:

1. No available family member is willing to be the patient's surrogate decision maker.

2. There is a dispute among family members, and no decision maker has been designated in an advance directive for health care.

3. A health care provider believes that the family's decision is not what the patient would have decided if he were competent.

4. A health care provider believes that the decision is not one that reasonably could be judged to be in the patient's best interests.

Refer to Exhibit 3-2 to review a list of the responsibilities of an individual who agrees to be a health care proxy.

Choosing a Health Care Proxy

An advance directive for health care may not be effective alone because family members do not always agree with what the incapacitated person has written in his directive. The choice of a health care proxy (also known as a health care agent or health care representative) who has similar end-of-life beliefs is one more preventive action that helps ensure that a creator's health care decisions are respected. The most important thing to remember in the choice of a personal health care proxy is to be confident that the person will follow any instructions to the letter, even if the patient's instructions differ with the proxy's personal beliefs. The choice of health care proxy can greatly impact the end-of-life experience for the principal.

ASKING OTHERS TO MAKE A HEALTH CARE DECISION

Today the decisions that a health care proxy makes for an incompetent patient should be accepted by the patient's physician. However, four situations may require institutional (e.g., a hospital) or judicial review and intervention in the decision-making process:

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4. A health care provider believes that the decision is not one that reasonably could be judged to be in the patient's best interests.

Refer to Exhibit 3-2 to review a list of the responsibilities of an individual who agrees to be a health care proxy.
When Does an Advance Directive for Health Care Become Operable?

No advance directive for health care takes effect unless the creator's mental state has deteriorated to a point that he is unable to make decisions for himself. The determination of incapacity is typically decided by the creator's personal attending physician and usually needs to be seconded by another physician.

Most states have laws that do permit the removal of life-sustaining treatment under very limited circumstances. Permanent unconsciousness, terminal illness, or treatment that will only prolong the dying process may trigger the removal of life-sustaining treatment. All states look to what the treatment is and whether the burden of the treatment is outweighed by the benefits and vice versa. If an advance directive for health care is ambiguous or unclear in explaining the patient's treatment wishes, the decision making will be left to a health care proxy (if one was appointed by the patient) or to family or perhaps to the patient's physician. A health care institution may be fined or penalized for not complying with a patient's advance directive for health care. An exception is usually made regarding a patient's wish to remove life-sustaining treatment if the hospital or other health care facility is one with a religious affiliation.

When Does a Durable Power of Attorney End?

The creator of an advance directive for health care can change or revoke his directive if he still has capacity. Depending on the state, the revocation can generally be done by any action, written or oral. It is better if the old written advance directive is destroyed and a new advance directive is written and signed.

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<th>EXHIBIT 3-2. THE RESPONSIBILITIES OF A HEALTH-CARE PROXY</th>
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<tr>
<td>A health care proxy/agent is normally permitted to do the following:</td>
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<tr>
<td>1. Consent or forbid any medical treatment</td>
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<td>2. Hire and fire all medical personnel</td>
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<td>3. Determine the contracted medical facilities</td>
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<td>4. Visit the medical facility treating the patient</td>
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<td>5. Review any medical records</td>
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<td>6. Appear in court proceedings on the patient's behalf to fight for compliance of the wishes of the proxy/agent and the patient's advance directives for health care.</td>
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Copies of the creator's advance directive for health care should be given to the designated proxy, to close family members, and to the creator's doctors to include with the medical records.

Any type of durable power of attorney ends upon the death of the principal. If a client wants his attorney-in-fact to handle his personal affairs posthumously, the attorney-in-fact must be named as an executor in the client's will. A durable power of attorney also can end if the document is invalidated by a court, the named attorney-in-fact dies or declines the authority, or the principal divorces and has previously named his now ex-spouse as the attorney-in-fact. This last point occurs only in a minority of states.

**Practical Advice**

A law firm can provide clients with a card stating that the bearer has an advance directive for health care. This is a thoughtful service similar to organ donor cards used across the country. Clients also should be given practical advice to help ensure that their advance directive for health care choices are recognized. For example, clients should be told to keep the number and name of their health care agent/proxy on their person, especially if they travel often. Elder law attorneys should suggest that clients talk with their spouse and adult children about their wishes when they are healthy and more willing to discuss such matters. Clients should be reminded to designate someone as their agent who will accept the position and will understand his role. In particular, clients should be advised to speak with their primary care physician to make sure the physician knows their choices and is supportive of those choices.8

**Where Should an Advance Health Care Directive Be Kept?**

It has been estimated that 35 percent of advance directives for health care cannot be found when needed.9 The U.S. Living Will Registry has been electronically storing advance directives for health care since 1996. The Registry is designed to provide health care providers with 24-hour document access. According to the Registry, once a person is registered, that person is registered for life. Other states are following the Registry's example. For example, the Secretary of State's office in North Carolina has set up a registry that allows citizens to file up to four different advance directives. The link for North Carolina's registry site can be found in the end-of-chapter section "Helpful Web Sites."
PRACTITIONERS SHOULD BE AWARE OF STATUTORY CHANGES

Changes in the law regarding advance directives for health care have evolved over the last two decades. One change is that all hospitals and nursing homes are now required by federal law to offer living wills as a no-cost service. Changes in laws pertaining to health care directives frequently occur. Practitioners need to be aware that these changes can make an advance directive for health care invalid. For example, Connecticut’s first living will statutes permitted a living will to take effect only if a patient was diagnosed with a terminal illness. Originally, a patient in a coma or persistent vegetative state would not have fallen under that living will statute. Connecticut’s living will statute evolved to include a permanently comatose patient under the definition of having a terminal illness and allowed the termination of artificial feeding under that fact situation. Another example of evolving legislation occurred when the California legislature changed its advance directive for health care statute and enacted the single document *Advance Health Care Directive* in July 2000. California’s *Advance Health Care Directive* actually consists of four sections, including the *Power of Attorney for Health Care, Instructions for Health Care, Donations of Organs at Death*, and *Primary Physician* designation. The power of attorney portion allows the creator to designate another person to make decisions about the signer’s health care. The *Instructions for Health Care* is very specific as to the types of health care the creator would want in the event he were not able to make such decisions. The type of health care wanted or refused can include both physical and mental health treatment. The *Donations of Organs at Death* section is optional and self-explanatory. The *Primary Physician* section is also optional and allows the creator to appoint a specific physician to make decisions regarding his health care instead of a non-medical professional agent. California’s one *Advance Health Care Directive* replaced the need for two documents, a durable power of attorney for health care, and a living will (also formerly known in California as the *Declaration Made Pursuant to the Natural Death Act*). California citizens are required by statute to replace any living wills and durable power of attorneys for health care created prior to 1992 with the four-sectioned *Advance Health Care Directive*.

Unfortunately, state laws often lack enforcement powers if a physician refuses or fails to honor a living will. In this day and age, patients need a backup advocacy plan. Patients need someone to call, someone to be at their bedside to help frame the issues, help clarify their desires, and go to court if necessary. This is where a client’s health care proxy is an invaluable asset.

Numerous advance directive ready-made forms are available, but time meaningfully spent thinking about one’s wishes, discussing one’s decisions with loved ones, and incorporating those thoughts into an advance directive for healthcare is a wiser choice than checking off boxes on a generic form. Elder law clients need to know that each state has its own legal requirements and often its own suggested form. An individual must check with his state statutes (or hire an...
The Health Insurance Portability and Accountability Act (HIPPA)
The first federal privacy standards designed to limit the information that health care professionals can share, use, and release to others concerning their patients.

Elder law professionals also should be aware of the changes wrought by the 1996 passage of the Health Insurance Portability and Accountability Act (HIPPA) the first federal privacy standards designed to limit the information that health care professionals can share, use, and release to others concerning their patients. The goal of this federal legislation is medical records privacy, but the result can prove problematic for an attorney asked to represent an unconscious patient and wade through privacy rules.

Refer to Exhibit 3-3 to read the health care power of attorney that Luke prepared, under Tara’s supervision, for their client Juliana Jameson.
Well, some of our clients do need to come to terms with their belief in superstitions, and I have to do my best to help them help themselves," Tara offered. "Juliana is a strong woman who knows what she wants. I think she finally understands that advance directives for health care are great tools for making sure she gets her way even if she is incapacitated and can't voice her feelings known."

"I guess," Luke continued. "Everyone should spare family members the angst of not knowing what he or she wants when the worst happens."

"Luke interjected, "The Terry Schiavo case should act as a reminder that without the proper paperwork in place, your personal and private life issues could fall into the hands of politicians and the courts."

"It seems to me that an advance directive is just one more way to make sure you don't have to suffer from indecision on the part of loved ones or from medical treatment you'd never permit if you were capable of saying so," Luke added.

"Exactly," Tara answered. "Luke, we've never gone over the process of creating an advance directive for health care, have we?"

"Not quite. We started to discuss it quite a few times, but then the phone rang, a client popped in, or something else interrupted us," Luke answered.

"Okay. I started out learning some vocabulary specific to living wills. Years ago I typed up a list of vocabulary words to remember to review with my clients. Renae, where is that list?" Tara asked. Renae shuffled the piles on her desk and passed a copy of the terms to Luke.

"Thank you, Renae," Tara began. "It helps to remember them by reading them aloud. We can do that right now. Go ahead and read the list aloud."

Luke looked doubtful about taking up Tara's valuable time.

"But it's okay, I want to train you to really know your stuff. The best way for you to help this firm is to learn, learn, and learn some more. Okay?"

Luke responded with a definitive "okay." He began, "(1) Artificially provided fluids and nutrition, (2) cardiopulmonary resuscitation (CPR), (3) life-sustaining measures, (4) decision making capacity, (5) health care representative or health care proxy, (6) terminal condition, (7) permanent unconsciousness, (8) persistent vegetative state, (9) incurable and irreversible disease, (10) whole brain death, and (11) the name of the attending physician."

"Do you have a clue as to what most of that means?" Tara asked smiling.

Luke answered, "Well, I did take an estates and trusts course in college, and the terms are familiar from my nursing school training. Right now, I'm thinking that I must have been figuratively, if not literally, absent the day we learned most of those terms.

Tara answered, "Well, many college courses don't have time to review in detail the vocabulary related to advance directives for health care. So it's settled. You'll learn it right now. Let's see. Numbers 2, 4, 5, and 10 are fairly self-explanatory. Number 1 concerns the giving of fluids and nutrition through tubes in a patient's arm or directly into the stomach. I usually think of Number 3 as including any action that will extend life. A terminal condition is one where the patient has no hope of recovery. Only one or more of the patient's physicians can determine Numbers 7, 8, and 9. Pretty straightforward. Numbers 1 and 10 are legally binding. In other words, the patient's directives are law. Numbers 2, 4, 5, and 10 will be adhered to in an emergency. And only the patient's physicians can determine Numbers 7, 8, and 9. Pretty straightforward..."
"Yeah, right," Luke mumbled. "If you've been doing this for years."
"Oh, it's not that bad," Tara remarked good-naturedly. "Anything worth doing and understanding is going to take some effort."

EXHIBIT 3-3  HEALTH CARE POWER OF ATTORNEY

This Health Care Power of Attorney is made this 10th day of May, 2007.

1. DESIGNATION AND AUTHORITY OF REPRESENTATIVE

JULIANA JAMESON, being of sound mind, do hereby willfully and voluntarily nominate, constitute and appoint my AGENT, REINA STEM, as my lawful health care representative. If, for any reason, my said AGENT is unable or unwilling to serve as my health care representative at the time that a health care decision must be made, I nominate, constitute and appoint MARY STEVENS, SUBSTITUTE AGENT, as my health care representative, whose affidavit shall be accepted by third parties as conclusive and binding.

Health Care Power of Attorney

1. To consent, refuse to consent, withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

2. To inspect and disclose any information relating to my physical and mental health or condition.

3. To sign documents, waivers, and releases, including documents signed or purporting to be a "Refusal to Permit Treatment" and "Leaving the Hospital or Refusing Treatment Against Medical Advice" and to execute any waiver or release from liability required by a hospital, medical institution or physician.

4. I DECLARE that this Power of Attorney, in its entirety, and its validity or operation thereof, shall not be affected by my subsequent disability, incompetence or incapacity as recognized under the applicable state laws and that the authority granted herein shall continue and remain in full force and effect in the event that I become, and during any period while I am disabled, incompetent or incapacitated, unless sooner revoked or terminated by me in writing.

5. The foregoing power and authority granted herein are herewith granted without, in any way, limiting the said appointed Agent, generally to do, execute and perform any other act, deed, matter or thing whatsoever that ought to be done, executed and performed in and about my premises, financial affairs, medical treatment, or health care of every nature and kind whatsoever consistent with my directives as fully effectual as I could do it personally present.
Karen Ann Quinlan is a well-known name in the personal right-to-die national debate. Quinlan was only 21 years old when she suffered irreversible brain damage and her parents' fight to have her removed from a respirator sparked a national debate. Quinlan’s case has been described as “the icon of the right to die movement.” It certainly changed the way many people look at life and death. In large part, the living will concept can be traced back to the 1975 Quinlan case.

The Quinlan family lost their privacy in what became a media farce when one reporter dressed as a nun to gain access to the comatose Quinlan’s room. The family met with hospital officials and Karen Quinlan’s doctors. An open discussion was conducted, the Quinlans expressed their wishes to have their daughter disconnected from her respirator and returned to her natural state. Hospital officials asked the Quinlans to sign an authorization for the hospital to disconnect, and they did. The next day the hospital reneged, according to Julia Quinlan, Karen Ann’s mother. The Quinlans eventually took their case to the New Jersey Supreme Court. New Jersey’s highest court sided with the Quinlans.
and Karen Ann Quinlan's respirator was removed. Surprising the experts, Karen Ann continued to breathe on her own while in what was described as a vegetative state. Karen Ann Quinlan died in 1985.

The Quinlan decision also is considered to have led to the current requirement that all hospitals, nursing homes, and hospices must have ethics committees available to discuss medical care issues. Virtually every court in the country dealing with a right-to-die issue has looked to the Quinlan case for guidance. The Quinlan family was influential in the opening of the Karen Ann Quinlan Hospice in Newton, New Jersey. It is designed to help terminally ill patients and their families.

National attention was focused for years on the more recent case of Floridian Terry Schiavo, also severely brain-damaged. The Schiavo case very publicly asked questions answered privately every day in hospitals and nursing homes across the country. The Schiavo case has been called an aberration because of the bitter conflict between Terry's parents and her husband. The argument centered on whether the decision should be made to withdraw nutrition and water from Terry Schiavo following her 15 years in a vegetative state. The husband's position was that Terry would not have wanted to continue to be kept alive in such a vegetative state. He claimed that Terry had made such a statement prior to lapsing into her vegetative state. Terry's parents believed she had a hope at recovery and should be kept alive at all costs.

It is doubtful the Schiavo case would have reached the national news if Terry Schiavo's wishes had been clearly known prior to her lapse. Nor would the Schiavo family have suffered the public anguish that resulted from the conflict. The media followed efforts by Florida lawmakers and Governor Jeb Bush to pass legislation that allowed the state court to reverse an earlier order, keeping Terry Schiavo fed and hydrated until the U.S. Supreme Court could hear her case. Congress followed by allowing her parents to take the unusual step of taking the case to federal court, but the Supreme Court finally declined to hear their appeal. The result was that her nutrition and hydration tubes were removed and Terry died in 2005.

Private Questions Answered Publicly in Court

The U.S. Supreme Court ruled in 1990 on the well-publicized case of Nancy Cruzan, a Missouri woman in her twenties who was severely injured in a 1983 car accident. Cruzan was in a comatose state, like Karen Quinlan and Terry Schiavo, after being deprived of oxygen for over 20 minutes at the time of her accident. (Brain damage can occur after only six minutes of oxygen deprivation.) It was the first case where the Supreme Court was presented with the issue of whether the U.S. Constitution provided a right-to-die.
In the Cruzan case, state officials (who got involved because Nancy was in a state-supported rehabilitation hospital) refused attempts made by Nancy's parents to have their daughter's life support treatment shut down. Joyce and Lester Cruzan, Nancy's parents, asked the hospital caring for Nancy for the cessation of all nutrition and hydration tubes. The hospital refused to do so without a court order. The Cruzans subsequently requested a Missouri trial court to issue a declaratory judgment. The Missouri court appointed a guardian ad litem for Nancy. A guardian ad litem is a person (often a lawyer) who is appointed by a court to take care of the interests of a person who cannot legally take care of himself in a lawsuit involving him. Subsequently, the court ordered the hospital to remove Nancy's nutrition and hydration tubes. The hospital appealed, and the Supreme Court ultimately ruled that Nancy's life support could be withheld. She died a short time later. The following case brief of the Supreme Court's opinion explains its decision.

Petitioner Nancy Beth Cruzan was rendered incompetent as a result of severe injuries sustained during an automobile accident. Co-petitioners Lester and Joyce Cruzan, Nancy's parents and co-guardians, sought a court order directing the withdrawal of their daughter's artificial feeding and hydration equipment after it became apparent that she had virtually no chance of recovering her cognitive faculties. The Supreme Court of Missouri held that because there was no clear and convincing evidence of Nancy's desire to have life-sustaining treatment withdrawn under any circumstances, her parents lacked authority to effectuate such a request. The U.S. Supreme Court granted certiorari. (i.e., the Court agreed to review the case and to hear an appeal).

Missouri's Supreme Court, adopting much of the trial court's findings, described Nancy Cruzan's medical condition as follows: (1) her respiration and circulation are not artificially maintained and are within the normal limits of a 30-year-old female; (2) she is oblivious to her environment except for reflective responses to sounds and perhaps painful stimuli; (3) she suffered anoxia of the brain resulting in a massive enlargement of the ventricles, filling with cerebrospinal fluid in the area where the brain has degenerated and her cerebral cortical atrophy is irreversible, permanent, progressive, and ongoing; (4) her highest cognitive brain function is exhibited by her grimacing perhaps in recognition of ordinarily painful stimuli, indicating the experience of pain and apparent response to sound; (5) she is a spastic quadriplegic; (6) her four extremities are contracted with irreversible muscular and tendon damage to all extremities; and (7) she has no cognitive or reflective ability to swallow food or water to maintain her daily essential needs and she will never recover her ability to swallow sufficient food to satisfy her needs.

In summary, Nancy is diagnosed as in a persistent vegetative state. She is not dead, she is not terminally ill.

Medical experts testified that she could live another thirty years. After it had become apparent that Nancy Cruzan had virtually no chance of regaining her mental faculties, her parents asked hospital employees to terminate the artificial nutrition and hydration procedures. All agreed that such a removal would cause her death. The employees refused to honor the request without court approval. The parents then sought...
and received authorization from the state trial court for termination. The court also found that Nancy's expressed thoughts at age twenty-five in a somewhat serious conversation with a housemate suggested that given her present condition she would not wish to continue on with her nutrition and hydration.

The Supreme Court of Missouri reversed by a divided vote. The Missouri Supreme Court found that Cruzan's statements to her roommate regarding her desire to live or die under certain conditions were unreliable for the purpose of determining her intent.

**Issue**
Whether the Due Process Clause will permit the state of Missouri to require that absent a patient's prior, expressed choice, a clear and convincing standard of proof is necessary to determine if a patient in an irreversible persistent vegetative state should remain on life support.

**Court Reasoning:**
In the _Quinlan_ case, young Karen Quinlan suffered severe brain damage as the result of anoxia and entered a persistent vegetative state. Karen's father sought judicial approval to disconnect her daughter's respirator. The New Jersey Supreme Court granted the relief, holding that Karen had a right of privacy grounded in the Federal Constitution to terminate treatment. However, after _Quinlan_, most courts have based a right to refuse treatment either solely on the common-law right to informed consent or on both the common-law right and a constitutional privacy right. Despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error.

The common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, many states demonstrate both similarity and diversity in their approaches to deciding what all agree is a perplexing question with unusually strong moral and ethical overtones. State courts have available to them for decision a number of sources-state constitutions, statutes, and common law which are not available to us. In this Court, the question is simply and starkly whether the United States Constitution precludes Missouri from choosing the rule of decision which it did. 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. We follow the judicious counsel of our decision in _Twin City Bank v. Nebeker_, 167 U.S. 196, 202, 17 S. Ct. 785, 769, 42 L. Ed. 134 (1912), where we said that in deciding "a question of such magnitude and importance it is the better part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject."

The Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. But determining that a person has a "liberty interest" under the Due Process Clause does not end the inquiry: Whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.

In the context presented here, a State has more particular interests at stake. The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements.

(continued)
Since Cruzan was a patient at a state hospital when this litigation commenced, the State has been involved as an adversary from the beginning. However, it can be expected that many disputes of this type will arise in private institutions, where a guardian ad litem or similar party will have been appointed as the sole representative of the incompetent individual in the litigation. In such cases, a guardian may act in good faith, and yet not maintain a position truly adversarial to that of the family. Indeed, as noted by the court below, this guardian ad litem in this case finds himself in the predicament of believing that it is in Nancy's best interest to have the tube feeding discontinued, but feeling that an appeal should be made because our responsibility to her as attorneys and guardians ad litem was to pursue this matter to the highest court in the state in view of the fact that this is a case of first impression in the State of Missouri.

Cruzan's guardian ad litem has also filed a brief in this Court urging reversal of the Missouri Supreme Court's decision. In review, Missouri has permitted attorneys to advance these interests through the adoption of a clear and convincing standard of proof to govern such proceedings. This level of proof, or an even higher one, has traditionally been imposed in cases involving allegations of civil fraud, and in a variety of other kinds of civil cases involving such issues as lost wills, oral contracts to make bequests, and the like. It is self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and societal level, than those involved in a run-of-the-mill civil dispute. An erroneous decision not to terminate results in maintenance of the status quo and an erroneous decision to withdraw life-sustaining treatment, however, is not susceptible to correction.

At common law and by statute in most states, the parol evidence rule prevents the variations of the terms of a written contract by oral testimony. The Statute of Frauds makes unenforceable oral contracts to leave property by will, and statutes regulating the making of wills universally require that those instruments be in writing.

In summary, we conclude that a state may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state. We note that many courts which have adopted some form of substituted judgment procedure in situations like this, whether they limit consideration of evidence to the prior expressed wishes of the individual's decision would have been, require a clear and convincing standard of proof for such evidence.

The Supreme Court of Missouri held that in this case the testimony presented at trial did not amount to clear and convincing proof of the patient's desire to have hydration and nutrition withdrawn. The testimony presented at trial consisted primarily of Nancy Cruzan's statements made to a housemate about a year before her accident that she would not want to live should she face life as a "vegetable" and other observations to the same effect.

**Holding:**

The judgment of the Supreme Court of Missouri is affirmed.

Justice Brennan, with whom Justice Marshall and Justice Blackmun join, dissented.

**Dissent:**

A gown woman at the time of the accident, Nancy had previously expressed her wish to forgo continuing medical care under circumstances such as these. Her family and her friends are convinced that this is what she would want. A guardian ad litem appointed by the trial court is also convinced that this is what Nancy would want. Yet the Missouri Supreme Court, alone among state courts deciding such a question, has determined that an irreversibly vegetative patient will remain a passive prisoner of medical technology—for Nancy, perhaps for the next 30 years.

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The Legacy of Public Tragedies

Each of the very public tragedies of the Quinlan, Schiavo, and Cruzan cases have spurred new court battles, new laws, and new attitudes in society regarding the way the right-to-die issue is viewed. Every state in the country now recognizes a person’s legal right to define how far that person wants medical treatment to go and where treating limits should be set. As noted previously, the Cruzan case inspired a 1991 federal law called the Patient Self-Determination Act. The Act requires hospitals and other care providers to inform patients of their state’s laws about end-of-life care and advance directives. Specifically, the Act addresses the right to autonomous patient decision-making. The Act also made each state responsible for developing written guidelines of its laws concerning advance directives for health care.

IS PHYSICIAN-ASSISTED SUICIDE A Viable END-OF-LIFE OPTION?

End-of-life issues for patients concentrate on three questions according to a recent national study spearheaded by the nation’s attorney generals:

1. Will my pain be managed?
2. Will my wishes be known and honored?

3. Will I receive competent care?17

Lack of satisfaction with the established end-of-life practices proffered by medical and insurance fields led to a renewed interest by many groups in the late twentieth century to redefine how a patient’s life is ended. One example of this interest was the attempts to legalize physician-assisted suicide. Physician-assisted suicide occurs when a physician knowingly assists in fulfilling a patient’s desire to die. The term assisted suicide can be used when a non-physician assists in fulfilling an individual’s desire to die.

A majority of Americans want to die at home, free of pain and surrounded by friends and family according to a Robert Woods Foundation report entitled, Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment. Interestingly, New Jersey’s legislature has required that the state’s version of the Patient Bill of Rights include the monitoring of a patient’s pain level as a fifth vital sign that medical personnel are to check as part of their regular monitoring routine.

The Study noted that while patients might sign an advance directive for health care before a life-threatening illness strikes, those directives might not be included in their medical records or may be unknown to family and medical personnel. Another problem is that some health care providers knowingly disregard a dying patient’s advance directives for health care.

Wrestling with Right-to-Die Issues

Many nations have wrestled with the right-to-die issue. The subject of physician-assisted suicide has been debated for years in Europe and Australia. Australia became the first country in the world to legalize euthanasia, but it overturned that ruling less than a year later in 1997. Euthanasia is the act of painlessly putting to death a person suffering from an incurable or painful disease without the final decision being made by the suffering person (often because the person is not conscious, capable, and communicative), but rather by the person’s physician. Euthanasia sometimes is described as a mercy killing. During the Schiavo case, the Vatican weighed in with its official condemnation of the removal of Terry Schiavo’s life support in particular and physician-assisted suicide and euthanasia in principal. The Netherlands was the first country in Europe to legalize physician-assisted suicide. Belgium followed in 2002 and became the second European nation to decriminalize euthanasia. Euthanasia is the term used in the Netherlands and Belgium for physician-assisted suicide.18

In the United States, Oregon’s legislature enacted Oregon’s Death with Dignity Act over a decade ago amidst opponent’s cries that the slippery slope would end with a veritable onslaught of physician-assisted suicides. Quite a few states, including Vermont and California, have had active discussions regarding the enactment of legislation that would permit physician-assisted suicide.
However, the closest vote occurred in Hawaii in 2002 when that state’s senate defeated such a bill. Voters in California failed to approve assisted suicide legislation in 1992 by a vote of 54 percent to 46 percent. Oregon’s Death with Dignity Act provides the right to die only to competent adults who have been diagnosed with a terminal illness; in addition, two doctors must confirm that the person is competent and has only six months to live. The patient must then write a written request for a lethal dose, but the patient must administer the dose himself.

According to Oregon state records, hundreds of people have gone through the preliminary requirements but only 171 have ingested a prescribed lethal dose since the 1994 law was enacted. This number is compared to the total 53,544 Oregon residents who died during the same period with the same diseases as the 171. Surveys by the Oregon Department of Health Services suggest that patients mainly want an option to end their life as they see fit.\(^{19}\)

Former U.S. Attorney General John Ashcroft disagreed with Oregon’s Death with Dignity Act and attempted to sink the legislation by urging that any physician prescribing a lethal dosage should have their medical licenses removed. Lawsuits resulted, culminating in the U.S. Court of Appeals for the Ninth Circuit upholding Oregon’s law and ruling that then-Attorney General Ashcroft had overstepped his authority and doctors in Oregon should not be punished. The following case was one such lawsuit involving physicians practicing in the state of Washington. It was decided by the U.S. Supreme Court.

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**CASE LAW**

**Washington, v. Glucksberg**

*111 S. Ct. 2258, 113 L.Ed.2d 772 (1991)*

**Facts:**

Petitioners in this case were the State of Washington and its Attorney General. Respondents were Harold Glucksberg, M.D., Abigail Halpern, M.D., Thomas A. Preston, M.D., and Peter Shell, M.D., who were physicians practicing in Washington. These doctors occasionally treated terminally ill, suffering patients, and declared that they would assist these patients in ending their lives if not for Washington’s assisted-suicide ban. The Respondents in January 1994, along with three gravely ill, pseudonymous plaintiffs who have since died and Compassion in Dying, a nonprofit organization that counsels people considering physician-assisted suicide, sued in the United States District Court, seeking a declaration that Wash. Rev. Code Ann. § 9A.36.060 (1) (1994) was unconstitutional.

The plaintiffs asserted "the existence of a liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a mentally competent, terminally ill adult to commit physician assisted suicide. The District Court agreed, because it "places an undue burden on the exercise of that constitutionally protected liberty interest." The District Court also decided that the Washington statute violated the Equal Protection Clause's requirement that "all persons similarly situated be treated alike."

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LIFE PLANNING: ADVANCE DIRECTIVES FOR HEALTH CARE, EUTHANASIA, AND PHYSICIAN-ASSISTED SUICIDE

CASE LAW: Washington, v. Glucksberg (continued)

It has always been a crime to assist a suicide in the State of Washington. In 1954, Washington's first Territorial Legislature outlawed "assisting another in the commission of self-murder." Today, Washington law provides: "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."

A panel of the Court of Appeals for the Ninth Circuit reversed the District Court emphasizing that "in the two hundred and five years of our existence no constitutional right to aid in killing oneself had ever been asserted and upheld by a court of final jurisdiction." The Ninth Circuit reheard the case en banc, reversed the panel's decision, and affirmed the District Court. The court also discussed what it described as "historical", and current societal attitudes toward suicide and assisted suicide and concluded that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death but that there is in short, a constitutionally recognized right to die." After "weighing and balancing" this interest against Washington's various interests, the court held that the State's assisted suicide ban was unconstitutional "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians."

Issue: Whether Washington's prohibition against causing or aiding a suicide offends the Fourteenth Amendment to the U.S. Constitution.

Court's Reasoning: In all due process cases, the court begins by examining our Nation's history, legal traditions, and practices. The majority of states in this country have laws imposing criminal penalties on one who assists another to commit suicide. More specifically, for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide. In the 13th century, Henry de Bracton, one of the first legal treatise writers, observed that "just as a man may commit felony by slaying another so may he do so by slaying himself."

The earliest American statute to explicitly outlaw assisting suicide was enacted in New York in 1828, and many of the new states and territories followed New York's example. Though deeply rooted, the States' assisted suicide bans have in recent years been reexamined and generally reaffirmed. Because of advances in medicine and technology, Americans today are increasingly likely to die in institutions, from chronic illnesses. Public concern and democratic action are therefore sharply focused on how best to protect dignity and independence at the end of life, with the result that there have been many significant changes in state laws and in the attitudes these laws reflect. States now permit "living wills" and surrogate health care decision-making. However, voters and legislators continue for the most part to reaffirm their states' prohibitions on assisting suicides. The Washington statute at issue in this case, Wash. Rev. Code § 9A.46.060 (1994), was enacted in 1975 as part of a revision of that State's criminal code. Four years later, Washington passed its Natural Death Act, which specifically stated that the "withholding or withdrawal of life-sustaining treatment shall not, for any purpose, constitute a suicide" and that "nothing in this chapter shall be construed to condone, authorize, or approve mercy killing." In 1991, Washington voters rejected a ballot initiative which, had it passed, would have permitted a form of physician-assisted suicide. Washington then added a provision to the Natural Death Act expressly excluding physician-assisted suicide.

Holding: The U.S. Supreme Court reversed.

Case Discussion: This case made great strides by reaching the U.S. Supreme Court. The case is important because the court held that patients should have more to say in how their end-of-life issues are determined. However, the court stopped short of providing a constitutional right to physician-assisted suicide when it reversed the lower court.
Court Says No to Euthanasia

The court in the following case stated that it was very much aware of the intense emotions and competing moral philosophies that characterized the debate surrounding suicide in general and assisted suicide in particular. The infamous defendant in the case “pushed the envelope” with his admitted actions so that the issue would ultimately be heard by the U.S. Supreme Court.

**CASE LAW:** People of the State of Michigan v. Jack Kevorkian

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**FACTS:**

A jury convicted defendant, Dr. Jack Kevorkian, of second degree murder and delivering a controlled substance. The trial court sentenced him to concurrent prison terms of ten to twenty-five years for the murder conviction and seven years for the controlled substance conviction. The defendant appealed.

On September 15, 1998, at 9:35 p.m., defendant went to Youk’s home to discuss Youk’s condition. As the videotape of this discussion revealed, defendant stated that he was recording their interaction in “connection with a request from Thomas Youk for help in ending his suffering.” Youk stated that, at the time, he could not do anything for himself, that he had discussed “his wishes” with his mother, brother, and wife, and “They understand why, it’s my decision.” Defendant then told Youk that he needed to sign a form indicating that he was consenting to a “direct injection instead of using the device, the machine.” Defendant then read the consent form, which stated in part:

“I, Thomas Youk, the undersigned, entirely voluntarily, without any reservation, external persuasion, pressure, or duress, and after prolonged and thorough deliberation, hereby consent to the following active euthanasia, to be administered by a competent medical professional, in order to end with certainty my inurable and hopelessly incurable suffering.” The meeting ended at 10:15 p.m.

On September 16, 1998, at 2:49 p.m., defendant again videotaped himself and Youk at Youk’s home. Youk stated that he “wanted to go through with this” and signed the consent form. Defendant remarked that he would inject Youk in the vein because “it’s quicker,” and stated, “Now I’m going to put on a cardiogram so we know when your heart is stopped, okay.” Defendant established a connection between Youk and the electrocardiogram. Defendant injected Youk with pentobarbital and potassium chloride. During the time, defendant provided a commentary on what was occurring: “Sleepy Tom? Tom are you asleep? And now we’ll inject the Anectine. You asleep? Tom? Tom? You asleep? He’s asleep. Now the Potassium Chloride. The machine is recording for some reason so I’m putting it by hand until the heart stops. It’s been, it’s been about two minutes since I injected the, ah, seconds, and one minute since I injected the—Now we’re getting apical complexes and that’s about the, the Potassium Chloride will stop the heart, so. Now there’s a straight line. A straight line and the cardiogram will be turned off, his heart is stopped.”

The police were dispatched to Youk’s house on September 17, 1998, at 1:30 a.m. They found Youk lying on his bed dead. The police also found a Federal Express receipt with defendant’s name at the scene. The medical examiner listed the manner of death as homicide and the cause of death as intravenous injection of substances. During the autopsy, the medical examiner found two “fresh” needle marks on Youk’s left and right wrists that had been covered with makeup.

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People of the State of Michigan v. Jack Kevorkian (continued)

News correspondent Mike Wallace interviewed defendant for 60 Minutes. In the first clip from the interview shown to the jury, Wallace stated at the outset, "You killed him." Defendant responded, "I did, but it could be manslaughter not murder." It's not necessarily murder. But it doesn't bother me what you call it. I know what it is. This could never be a crime in any society which deems itself enlightened." Defendant then told Wallace, "Either they go or I go." Apparently meaning that he would be acquitted for killing Youk if he convicted, he would starve to death in prison. As defendant put it, "I've got to force them to kill me. They must charge me. Because if they don't do that, that means they don't think it's a crime. Because they don't need any more evidence do they? Do you have to dust for fingerprints on this?" Defendant then returned to one of his main themes, saying, "If you don't have liberty and self-determination, you got nothing. That's what the country's built on and this is the ultimate self-determination to determine when and how you're going to die when you're suffering."

Defendant gave his own closing argument to the jury on March 25, 1999.

Whether the right of privacy should be expanded to include a right to euthanasia.

In this appeal, defendant has given almost no attention to his claim that this homicide had a legal justification or excuse. Indeed, exactly seven of the fifty pages in his brief to this Court address euthanasia. Even during oral arguments, defendant's appellate counsel made not a single reference to this issue. Nevertheless, euthanasia is at the core of this case. But for defendant's self-described reality, Thomas Youk's death would have been the subject of national attention, much less a murder trial. Defendant, in his own words, is now apparently something of an afterthought, and asks us to conclude that euthanasia is legal, and, therefore, to reverse his convictions on constitutional grounds. We refuse. Such a holding would be the first step down a very steep and very slippery slope. To paraphrase the United States Supreme Court in Washington v. Glucksberg, it would expand the right to privacy to include a right to commit euthanasia and thus place the issue outside the arena of public debate and legislative action.

On appeal, defendant makes two related, but separate, constitutional arguments. First, he argues that the unenumerated rights protected by the Ninth Amendment and its Michigan constitutional counterpart include a patient's right to be free from unbearable pain and suffering. Second, he maintains that the Fourteenth Amendment and its Michigan constitutional counterpart also include this right by proscribing state deprivation of liberty without due process of law either under constitutional privacy concepts or as a "necessary and direct corollary of this position and that a person should not be forced to suffer unbearably."

The Ninth Amendment of the United States Constitution states that "the enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." The counterpart provision in the Michigan Constitution states that "the enumeration in this constitution of certain rights shall not be construed to deny or disparage others retained by the people."

The Fourteenth Amendment of the United States Constitution states, in relevant part, that no state shall "deprive any person of life, liberty, or property, without due process of law." The counterpart provision in the Michigan Constitution states, in relevant part, that "no person shall be deprived of life, liberty or property, without due process of law."

At the outset, within the nature of the defendant's arguments, it is important to understand the nature of defendant's constitutional claims. The best way to do this is to state clearly the constitutional arguments that defendant does not raise. First, defendant does not ask us to hold that he acted properly in furtherance of the right to refuse life-sustaining medical treatment. In Cruzan v. Director, Missouri Department of Health.
the United States Supreme Court "assumed that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition," under the Fourteenth Amendment due process liberty interest analysis.

More recently, in Glucksberg, the court strengthened the constitutional basis for the Cruzan decision, interpreting Cruzan as holding that "the right to refuse unwanted medical treatment was so rooted in our history, tradition, and practice as to require special protection under the Fourteenth Amendment." Here, the defendant does not, and could not, rely on Cruzan; factually, this case does not involve removing life support. Further, though not resting their decisions precisely on the Fourteenth Amendment, Michigan courts have arrived at the same conclusion regarding a patient's right to refuse life-sustaining medical care. The limited scope of these cases does not establish a right to be free from unbearable pain and suffering that would make euthanasia legal. There is, of course, a substantial factual distinction between refusing care, even if done so hastens death, and purposefully ending a life.

The defendant makes no attempt to assert that he was engaged in assisted suicide when he injected Youk with potassium chloride causing his death. Rather, he asserts that if the Ninth Amendment "is to have any substantive meaning," the right to be free from inescapable pain and suffering must be among the unenumerated rights protected by that amendment and its Michigan counterpart. Defendant then contends that he cannot be prosecuted for "aiding in Thomas Youk's assertion of his constitutional right to be free from intolerable pain and suffering." Although defendant's appellate counsel has carefully avoided using the words, as we have already noted, the record indicates that defendant was quite specific when describing his actions; he said he was engaged in "active euthanasia" and the consent form that Youk signed directly refers to such active euthanasia. In summary, defendant does not, nor could he, ask us to hold that his actions were legally justifiable because he simply helped Youk exercise his right to refuse medical care. Defendant does not, nor could he ask us to hold that his actions constituted a legal form of assisted suicide. In a nutshell, and using his own terminology, defendant asks us to legalize euthanasia.

Third, we observe that by expanding the right of privacy to include a right to commit euthanasia in order to end intolerable and irredeemable suffering we would inevitably involve the judiciary in deciding questions that are simply beyond its capacity. Rather, the role of the courts is to apply the rule of law. As Chief Justice Burger once eloquently explained:

"It is often observed that hard cases make bad law. I suspect there is some truth to that adage, for the "hard" cases always tempt judges to exceed the limits of their authority . . . to reach a "desirable" result. Cardozo no doubt had this type of case in mind when he wrote:

"The judge, even when he is free, is still not wholly free. He is not to innovate at pleasure. He is not a knight-errant, roaming at will in pursuit of his own ideal of beauty or of goodness. He is to draw his inspiration from consecrated principles. He is not to yield to spasmodic sentiment, to vague and unregulated benevolence. He is to exercise a discretion informed by tradition, methodized by analogy, disciplined by system, and subordinated to 'the primordial necessity of order in the social life.' Wide enough in all conscience is the field of discretion that remains." What Cardozo tells us is beware the "good result," achieved by judicially unauthorized or intellectually dishonest means on the appealing notion that the desirable ends justified the improper judicial means. For there is always the danger that the seeds of precedent sown by good men for the best of motives will yield a rich harvest of unprincipled acts of others also aiming at "good ends."

(continued)
Status of Physician-Assisted Suicide

There are criminal prohibitions against physician-assisted suicide and heavy state criminal penalties levied upon those who participate in it. The U.S. Supreme Court has failed to find such penalties a violation of the Fourteenth Amendment's Due Process Clause in any of the state laws against physician-assisted suicide. In fact, in 1997, the Supreme Court unanimously upheld New York and Washington state court decisions that criminalized physician-assisted suicide. The Supreme Court clearly found that there was no constitutional right to die, but left it to the individual states to determine whether physician-assisted suicide would be permitted in their state. The majority of states have outright prohibited physician-assisted suicide through state statutes, and several states without statutes prohibit such assistance through common law. The American Medical Association (AMA) is very clear in its position on physician-assisted suicide. The AMA does not support it.

Oregon is currently the only state that has legalized physician-assisted suicide. The only federal law that has dealt with the concept of assisted suicide has been the Assisted Suicide Funding Restriction Act. It prohibits any federal funding to be used to support physician-assisted suicide.
PALLIATIVE CARE

Studies have shown that American patients near the end of their lives often spend more time in intensive care wards of hospitals than they do being treated for their incurable illnesses with palliative care and community-based hospice care. Palliative care is the comprehensive management of the physical, psychological, social, spiritual, and existential needs of patients. Refer to Exhibit 3-4 to read the World Health Organization's definition of palliative care. This care is especially suited to individuals who have incurable progressive illnesses. Palliative care is a broad term used to define the many types of non-medically intrusive care offered to patients with incurable diseases. It concentrates mainly on keeping a patient comfortable by dealing with his pain and is most often provided in a hospice setting. Admission to a hospice is sometimes hindered by Medicare and other insurance companies requiring that a patient's physician certify that the patient is in his last six months of life. These same studies stated that a patient's end-of-life treatment may not be designed around the patient needs, but is based on Medicare and insurance coverage. The reality is that the majority of Americans die in hospitals or nursing homes without their health care wishes known and often in intense pain.

In addition, physicians historically have not been trained to deal with the palliative care of patients, but to concentrate on curing patient illnesses. All of these factors combine with the economic need to fill hospital beds.

Florida's statutes provide a thorough description of what its palliative care must consist of. According to Florida's statutory authority, palliative care must include the following:

1. An opportunity to discuss and plan for end-of-life care
2. Assurance that physical and mental suffering will be carefully attended to
3. Assurance that preferences for withholding and withdrawing life-sustaining interventions will be honored
4. Assurance that the personal goals of the dying person will be addressed
5. Assurance that the dignity of the dying person will be a priority
6. Assurance that health care providers will not abandon the dying person
7. Assurance that the burden to family and others will be addressed
8. Assurance that any advance directive for care will be respected regardless of the location of care
9. Assurance that an organizational mechanism is in place to evaluate the availability and quality of end-of-life, palliative, and hospice care service, including the evaluation of administrative regulatory barriers
10. Assurance that necessary health care services will be provided and that relevant reimbursement policies are available.
11. Assurance that the goals expressed in subparagraphs one through 10 will be accomplished in a culturally appropriate manner.

**EXHIBIT 3-1: WORLD HEALTH ORGANIZATION DEFINITION OF PALLIATIVE CARE**

- Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological, and spiritual. Palliative care:
  - provides relief from pain and other distressing symptoms;
  - affirms life and regards dying as a normal process;
  - intends neither to hasten or postpone death;
  - integrates the psychological and spiritual aspects of patient care;
  - offers a support system to help families cope during the patient's illness and in their own bereavement;
  - uses a team approach to address the needs of patients and their families, including palliative care specialists, if indicated;
  - will enhance quality of life, and may also positively influence the course of illness;
  - is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Source: <http://www.who.int/cancer/palliative/definition/en>
The determination of incapacity is typically decided by an individual's primary physician and usually needs to be seconded by another physician. The U.S. Supreme Court has failed to find a violation of the Fourteenth Amendment's Due Process Clause in any of the state laws against physician-assisted suicide. The Supreme Court has found that there is no constitutional right to die, but leaves it to the individual states to determine whether physician-assisted suicide will be permitted in their state. The majority of states have outright prohibited physician-assisted suicide through state statutes, and several states without statutes prohibit such assistance through common law. Oregon is the only state that permits physician-assisted suicide under specific conditions.

**REVIEW QUESTIONS**

1. Advance directives for health care are known by a variety of names. What are those names?
2. What are the differences between a living will and a medical power of attorney?
3. What needs to be done for a client to make a power of attorney a permanent part of his planning file?
4. What is the name of the document that is created only upon the occurrence of a certain event?
5. What responsibilities does a health care proxy's job usually entail?
6. When and with whom should a living will's creator discuss the directives of the living will?
7. Where should an advance directive for health care be stored?
8. What was the state of Washington's position on physician-assisted suicide in the Washington v. Glucksberg case?
9. What is the American Medical Association's position on physician-assisted suicide?
10. What is the philosophy behind palliative care?