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IN THE SUPREME COURT OF FLORIDA
Tallahassee, Florida

Case No. 89,837

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BARRY KRISCHER, in his official capacity as the State Attorney of the 15th Judicial Circuit,

Petitioner,

vs.

CECIL McIVER, M.D., C.B. ("CHUCK") CASTONGUAY, ROBERT G. CRON and CHARLES E. HALL,

Respondents.

BRIEF OF THE FLORIDA MEDICAL ASSOCIATION, THE AMERICAN MEDICAL ASSOCIATION, FLORIDA SOCIETY OF INTERNAL MEDICINE, FLORIDA SOCIETY OF THORACIC AND CARDIOVASCULAR SURGEONS, THE FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION, FLORIDA HOSPICES, INC. AND THE FLORIDA NURSES ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI*

Amicus Florida Medical Association ("FMA") is a statewide organization comprised of approximately 17,000 physicians who practice in Florida. Members of the FMA care each day for patients at all stages of life, including the final stages. The question presented by this case is "whether a competent adult, who is terminally ill, imminently dying, and acting under no undue influence, has a constitutional right to choose to hasten his own death by seeking and obtaining from his physician a fatal dose of prescription drugs and then subsequently administering such drugs to himself." Circuit Court Opinion ("Op.") at 2. This question is of obvious and immediate importance to FMA members.

Amicus American Medical Association (AMA") is a private, voluntary, non-profit organization of physicians. The AMA was founded in 1847 to promote the science and art of medicine and to improve the public health. The 290,000 members of the AMA practice in all states, including Florida, and in all fields of medical specialization.

Members of the AMA are fundamentally concerned about providing compassionate end-of-life care and about the role of physicians in providing such care. The AMA is committed to improving the quality of care provided to patients who are in pain or who are at the end of their lives. Among other efforts, the AMA is working with the Robert Wood Johnson Foundation in developing an education program to promote the use of palliative medicine for individuals at the end of life.[1]

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[1] Petitioner and respondents have consented to the filing of this brief. Petitioner's letter of consent has been filed with (continued...)

The Florida Society of Internal Medicine ("FSIM") is a Florida not-for-profit corporation whose 2,007 members are physicians specializing in Internal Medicine and who are licensed under Chapters 458 and 459 of the Florida Statutes. FSIM was created and exists for the purpose of securing and maintaining the highest standards of practice in Internal Medicine. FSIM regularly participates in legislative efforts, rulemaking proceedings, and litigation with regard to issues of interest to its members. FSIM's members routinely are confronted with terminally ill patients, and are therefore likely to be impacted greatly by the decision of the Court in this case.

The Florida Society of Thoracic and Cardiovascular Surgeons ("FSTCS") is a Florida not-for-profit corporation whose members are physicians specializing in thoracic and cardiovascular surgery and who are licensed under Chapters 458 and 459 of the Florida Statutes. FSTCS was created and exists for the purpose of elevating the character and protecting the rights and interests of those engaged in the practice of medicine as thoracic and cardiovascular surgeons. As such, FSTCS and its members have an interest in litigation such as this which will impact the ways in which its members may treat their patients.

The Florida Osteopathic Medical Association ("FOMA") is a statewide organization comprised of approximately 1,700 osteopathic physicians who practice in Florida. The FOMA's sole purpose is to advance the science and art of osteopathic medicine and surgery,

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[1] (...continued)
the Court. Respondents consented by means of Appellees' Response to Motions of All Proposed Amicus Curiae, which was filed with this Court on February 18, 1997.

and to extend improved health care and benefits of scientific advancement in the treatment, prevention, and alleviation of human ailments to the public in the State of Florida. The FOMA opposes physician assisted suicide.

Florida Hospices, Inc. ("FHI") is a cooperative association of 39 hospice providers in Florida. FHI is a not-for-profit organization founded in 1982 to foster and support quality hospice programs in the state. The organization seeks to promote compassionate, appropriate care for terminally ill patients and their families through advancement of the hospice philosophy. The hospice philosophy of care affirms life in all its changing phases. It is the mission of FHI members to offer professional palliative care that creates a pain-free, comfortable environment for patients thereby assisting patients with life limiting illnesses to live each day to the fullest.

The Florida Nurses Association ("FNA") is an association of registered nurses that is dedicated to the advancement of the goals and interests of registered nurses and of the nursing profession generally. The FNA was founded in 1909 to promote the professional and educational advancement of nurses in Florida. It has 7,000 members and represented registered nurses in Florida's 67 counties. The members of FNA care for terminally ill people in every type of health care setting in Florida. Through the efforts of the organization and the daily work of its members, FNA strives to assure that every person is receiving high quality care which attends to their physical and emotional needs in a dignified and supportive manner.

INTRODUCTION

The right to control one's medical treatment is among the most important rights that the law affords a person. Amici strongly support the recognition and enforcement of that right. Physicians and other health care professionals are committed to their ethical and legal obligations to honor patient requests to withhold or withdraw unwanted life-prolonging treatment and to provide patients with all medication necessary to alleviate physical pain -- even in circumstances where such medication might hasten death. Through these means, patients can avoid entrapment in a prolonged, painful, or overly medicalized dying process.

The decision below, however, takes the unprecedented step of announcing a right to control the timing and manner of one's death through reliance on physician-assisted suicide. The circuit court would confer upon health care professionals the awesome responsibility of deciding who, among the many patients who would request physician-assisted suicide, is eligible to obtain the assistance of a physician in killing themselves. The power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides the practice of medicine and nursing. It is a power that most physicians and nurses do not want and could not control.

Once established, the right to physician-assisted suicide would create profound danger for many persons with undiagnosed and inadequately treated depression and with severe pain or the apprehension of such pain in the future. For these persons, physician-assisted suicide, rather than good palliative care, could

become the norm. At greatest risk would be those with the least access to palliative care -- the poor, the elderly, and members of minority groups.

Amici and their members have deep compassion for those who are suffering the pain and torment of chronic or terminal illness. The health care professions have learned much in recent years about how to provide caring and effective palliative care at the end of life. At the same time, amici acknowledge that many patients today do not receive such care.

Nevertheless, declaring a fundamental constitutional right to physician-assisted suicide is not the answer to the problem of inadequate palliative care. Although for some patients it might appear compassionate intentionally to cause death, judicial legitimization of physician-assisted suicide as a medical treatment would put many more patients at serious risk for unwanted and unnecessary death. Rather than create a constitutional right to physician-assisted suicide, our society should instead recognize the urgent necessity of extending to all patients the palliative care they need and should redouble its efforts to provide such care.

To explain more fully the basis for amici's position, this brief begins by offering background information on the medical, social, and practical considerations involved in caring for seriously ill patients who request physician-assisted suicide. Based on this background, the brief then sets forth amici's analysis of the relevant legal issues under the Constitutions of this State and the United States.

BACKGROUND

A. Patient Autonomy

The core of the circuit court's opinion is its view that each individual has a fundamental right under the Florida Constitution "to control the time and manner of [one's] death." Op. at 14, 23. While this phrase is superficially appealing, it belies the sad reality that none of us has the power completely to control the circumstances of our death. Illness, itself only one potential cause of death, comes unbidden and with unpredictable effect. The circuit court's argument thus rests, at bottom, on an unrealistic assumption about our ability to control death.

At the same time, the circuit court overlooked the degree to which -- without resorting to physician-assisted suicide -- patients can already control the dying process. By recognizing patients' rights to refuse unwanted medical treatment or to have such treatment withdrawn and by providing adequate palliative care, the medical profession has the capacity to prevent a prolonged and painful dying process. While much more remains to be done to ensure that all patients have effective advance care planning and access to good palliative care, experience to date shows that properly trained health care professionals can effectively meet their patients' needs for compassionate end-of-life care without acceding to requests for assistance in suicide.

The ethical commitment of the health care professions to the principle of patient autonomy plays a vital role in providing patients the ability to control their course of treatment. This commitment is expressed, for example, in Opinion 2.20 of the AMA

Code of Medical Ethics. Opinion 2.20 provides, in part, that "[t]he principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision making capacity." AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics: Current Opinions § 2.20.

Opinion 2.20 has great significance for patients near the end of life. To those who fear unwanted medical intervention in the dying process, the message of Opinion 2.20 is that a patient need not accept, and physicians must not impose, a medical treatment that the patient does not want. As a practical matter, this means that a patient can refuse not only such mechanical interventions as respirators, feeding tubes, or dialysis, but also chemotherapy, antibiotics, or any other treatment that would have the effect of prolonging the patient's life. Through such means, persons suffering from chronic diseases (such as AIDS) as well as terminal diseases can plan in advance which life-sustaining treatment to accept.

Opinion 2.20 also makes clear that "[p]hysicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care" and, significantly, that this obligation "includes providing [effective] palliative treatment even though it may foreseeably hasten death." Although criticized by some as illogical, the recognition that physicians should provide patients pain medication sufficient to ease their pain, even where that may serve to hasten their deaths, is essential to ensuring that no dying patient need suffer from physical pain.

The principle of patient autonomy, however, has never been understood to give patients the right to every procedure or treatment they might demand. For example, physicians need not provide futile treatment -- that is, treatment that has no realistic chance of helping the patient. Code of Medical Ethics § 2.035. Similarly, physicians should not provide patients with treatments that are known to be ineffective or harmful. Such limitations on patient autonomy are critical. If patients may demand and receive anything that they want, health care professionals would cease being professionals.

B. **Physician-Assisted Suicide**

Long viewed as outside the realm of legitimate medical care, physician-assisted suicide occurs "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." Code of Medical Ethics § 2.211; AMA Council on Ethical and Judicial Affairs, Physician-Assisted Suicide, 10 Issues in L. & Med. 91, 92 (1994). The practice involves physicians intentionally providing patients with the means for suicide, such as prescribing barbiturates in an amount certain to cause death and for the purpose of causing death. See, e.g., Quill, Death and Disnity: A Case of Individualized Decision Making, 324 New Eng. J. Med. 691 (1991).

The ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics. Its roots are as ancient as the Hippocratic Oath, under which a physician "will neither give a deadly drug to anybody if asked for it, nor . . .

make a suggestion to this effect." The merits of the ban have been debated repeatedly in this nation since the late nineteenth century. Most recently, the AMA has reexamined and reaffirmed the ethical prohibition against physician-assisted suicide in 1977, 1988, 1991, 1993, and 1996.[2] Physician-assisted suicide remains "fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." Code of Medical Ethics § 2.211. Physicians have the ability to respond sensitively to the concerns of seriously ill and dying patients and can meet their patients' needs without acceding to requests for suicide.

C. Requests for Physician-Assisted Suicide

Strikingly, the circuit court made no finding that respondent Hall was in intractable pain or that, absent physician-assisted suicide, he would be condemned to face unmitigated pain before he died. Nonetheless, implicit in the court's holding are the views that those who request suicide do so to avoid excruciating pain, and that physician assistance in suicide is necessary if such pain is to be avoided. In fact, available information demonstrates that these views are misguided.

1. There is no evidence that increasing numbers of patients are dying in severe pain. To the contrary, "[t]he

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[2] AMA Council on Scientific Affairs, Good Care of the Dying Patient 275 JAMA 474, 477 (1996). Most recently, in the aftermath of the decision of the Ninth Circuit in Compassion in Dying v. Washington, 79 F.3d 790 (1996), cert. granted sub nom. Washington v. Glucksburg, No. 96-110, (U.S. argued Jan. 8, 1997), the AMA's House of Delegates in June 1996 overwhelmingly endorsed a recommendation to affirm the ethical ban on physician-assisted suicide.

potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts." AMA Council on Scientific Affairs, Good Care of the Dying Patient, 275 JAMA 474, 475 (1996). The pain of most terminally ill patients can be controlled throughout the dying process, without heavy sedation or anesthesia. Id.; see, e.g., Byock, **Consciously** Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia, 9 J. Pall. Care 25, 26 (1993); Foley, The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide, 6 J. Pain & Sympt. Mgmt. 289 (1991); Levy, Pharmacologic Treatment of Cancer Pain, 335 New Eng. J. Med. 1124 (1996). For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or weeks of life to prevent the patient from experiencing severe pain. N.Y. State Task Force, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context 40 & n.21 (1994). Notably, when pain medication is properly administered, for most patients the risk of respiratory depression that hastens death is minimal. N.Y. State Task Force at 162.

Given the increasing ability to control pain, it is not surprising that the demand for physician-assisted suicide does not in fact come principally from those seeking relief from physical pain. A recent study of such requests in Washington State found that "neither severe pain nor dyspnea was a common patient concern, suggesting that intolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia." Back et al., Physician-Assisted Suicide and Euthanasia in

Washington State, 275 JAMA 919, 924 (1996). This finding is consistent with the reports from Compassion-in-Dying. See Preston & Mero, Observations Concerning Terminally Ill Patients Who Choose ' ide, 4 J. Pharm. Care & Pain Sympt. Control 183, 187 (1996) ("[i]n no patient was pain the primary reason for suicide"). It also is consistent with other studies of United States physicians. See Emanuel et al., Suicide;ia and Physician-Assisted ' ' Attitudes and Experiences of Oncology Patients, Oncologists, and the Public, 347 Lancet 1805, 1809 & nn. 6, 12 (1996) ("[p]atients experiencing pain were not inclined to euthanasia or physician-assisted suicide"). And it is consistent with studies of Holland's experience. See Van der Maas et al., Euthanasia and Other Medical isions Concerning the End of Life, 338 Lancet 669, 672 (1991) (relief from pain was mentioned as a factor in fewer than half of cases, and was the sole factor in only five percent of cases).

This is not to say that all patients have access to and actually receive adequate pain relief and good palliative care. They do not. The delivery of such care is "grossly inadequate" today, and efforts to make such care universally available have not yet succeeded. N.Y. State Task Force at 43-47; Connors et al., A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients, 274 JAMA 1591 (1995).

There are many obstacles to the delivery of adequate pain management. These include a lack of professional training and knowledge, misconceptions about the risks of addiction and respiratory depression associated with pain medication, inadequate communication (reflecting both inadequate attention from health care professionals and undue patient reluctance to use pain relief

medication], and concern over criminal or licensure actions against the prescribing physicians. N.Y. State Task Force at 44-47; AMA Council, 275 JAMA at 476. Of further concern, individuals treated at centers that serve predominantly minority patients are more likely than others to receive inadequate pain treatment; the same is true for elderly and female patients. N.Y. State Task Force at 44 & n.37. Yet for "many patients, pain and suffering could be alleviated using medications and techniques that have been widely publicized and require only modest resources." Id. at 35. There is, in short, compelling evidence of the need to ensure that all patients have access to quality palliative care. There is no evidence of any need for a constitutional right to physician-assisted suicide.

2. Most patients who request suicide do so out of concerns that, in the future, their pain may become intolerable, they may suffer a loss of dignity and become dependent upon others, or they will excessively burden their families. Back et al., 275 JAMA at 921; Emanuel et al., 347 Lancet at 1807. The suffering that such concerns may cause is real. But if the anticipatory and existential nature of that suffering is recognized and addressed, it can often effectively be treated. Foley, 6 J. Pain & Sympt. Mgmt. at 289-90; N.Y. State Task Force at x, 181.

Concerns about future loss of control, loss of dignity, or pain frequently can be met by reassuring the patient of a continuing commitment to palliative care and by assisting the patient to confront an underlying and unspoken fear of death. "Many patients and physicians displace anxieties about death onto the circumstances of dying: pain, dependence, loss of dignity, and

the unpleasant side effects of medical treatments. Focusing on or becoming enraged at the process distracts from the fear of death itself." Hendin, Suicide, Assisted Suicide, and Euthanasia: Lessons from the Dutch Experience, Summary of Testimony Presented to House Subcommittee on the Constitution, at 1 (1996). A full approach to palliative care addresses spiritual and existential feelings as well as personal and social burdens. Clinicians with experience assisting dying patients to confront such concerns report that the desire for death passes, and that patients say they have found unexpected meaning in their lives that makes their final days worth living. E.g., Cundiff, Euthanasia is Not the Answer 29-39 (1992).

The anxieties that can accompany serious illness are often complicated, however, by the onset of depression. Depression is the single factor found to be a significant predictor of the desire for death. Emanuel et al., 347 Lancet at 1809; Chochinov et al., Desire for Death in the Terminally Ill, 152 Am. J. Psych. 1185, 1190 (1995). In one study of 44 terminally patients, all but one of the eleven patients with "clinical depressive illness" expressed some wish for death, while none of the remaining 33 expressed such a wish. Brown et al., Is it Normal for Terminally Ill Patients to Desire Death?, 143 Am. J. Psych. 208, 210 (1986); See also Conwell & Caine, Rational Suicide and the Right to Die: Reality and Myth, 325 New Eng. J. Med. 1100, 1101 (1991) ("Of 44 patients in the later stages of cancer, only 3 had considered suicide, and each of them had a severe clinical depression"); AMA Council, 275 JAMA at 475; Chochinov et al., 152 Am. J. Psych. 1185. In this regard, those with terminal or chronic illness are no

different than others who express suicidal wishes. Most who commit suicide suffer from depression or some other diagnosable psychiatric illness, which is treatable. Hendin, Suicide and the Request for Suicide: Meting and Motivation, 35 Duq. L. Rev. 285, 285 (1996); N.Y. State Task Force at 13, 180.

It is clear that "a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression." Chochinov et al., 152 Am. J. Psych. at 1190. For example, "[t]he elderly appear to be more prone than younger victims to take their lives during the type of acute depressive episode that responds most effectively to available, modern treatments." Conwell & Caine, 325 New Eng. J. Med. at 1101. Nevertheless, many physicians fail to recognize depression, thereby precluding the opportunity for effective treatment. Id. at 1101-02. See also Hirschfeld et al., The National Depressive and Manic-Depressive Association Consensus Statement on the Undertreatment of Depression, 277 JAMA 333 (1997).

3. The demand for physician-assisted suicide among the terminally ill is thus best understood not as a necessary response to severe pain uniquely felt by the dying, but in the broader context of requests for suicide generally. "Among all suicides, only two percent to four percent are terminally ill." N.Y. State Task Force at 12. Moreover, while severe chronic or terminal illness is a risk factor for suicide, "only a small percentage of terminally ill or severely ill patients attempt or commit suicide." Id. at 9, 13. And those patients are similar to physically healthy individuals who contemplate suicide -- they "are usually suffering from a treatable mental illness, most commonly depression." Id.

Thus, terminal illness does not present a special case for physician-assisted suicide. Patients with chronic or terminal illness who seek physician-assisted suicide are typically depressed or anticipating extreme suffering. Their needs and concerns are ones that health care professionals can meet with compassionate care. There may be, even in a system that provides optimal palliative care to all patients, individuals whose pain may not be treatable absent sedation and whose wish for suicide to avoid sedation is sincere. But the number of such individuals is likely to be small, and the social cost of accommodating their preference for physician-assisted suicide is likely to be high. For the reasons that follow, even if physician-assisted suicide were thought appropriate for such patients, no one can predict with any confidence that the practice, if authorized by the state, could reliably be limited to them.

D. The Inherent Difficulty In Regulating Physician-Assisted Suicide

Even proponents of physician-assisted suicide agree that lines must be drawn between categories of individuals for whom physician-assisted suicide is to be deemed acceptable or unacceptable. The circuit court, for example, issued its order because respondent Hall was "terminally ill, imminently dying" and under no "undue influence." Op. at 2. Likewise, the Second Circuit, in Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), cert. granted, No. 95-1858 (U.S. argued Jan. 8, 1997), purported to restrict physician-assisted suicide to those who were "in the final stages of terminal illness." 80 F.3d at 727. And the Ninth

Circuit in Compassion in Dying v. Washington, 79 F.3d 790, 835-36, cert. granted sub nom. Washington v. Glucksburg, No. 96-110 (U.S. argued Jan. 8, 1997), similarly permitted physician-assisted suicide only for those who are "terminally ill."

All three courts expressly limited their holdings to the provision of physician-assisted suicide to the terminally ill. However, the Ninth Circuit candidly expressed its doubt that any reasonable distinction could be maintained between physician-assisted suicide and voluntary euthanasia. Id. at 831-32. The "critical line," the Ninth Circuit stated, was between the "voluntary and involuntary termination of an individual's life." Id. at 832.

1. One difficulty in restricting physician-assisted suicide to those in the last stages of a terminal illness -- or, in the words of the circuit court, those who are "imminently dying" -- is identifying the eligible class. Available evidence suggests "that physicians' predictions of expected remaining life are generally inaccurate." Callahan & White, The Legalization of Physician-Assisted Suicide: Creatins a Regulatory Potemkin Village, 30 U. Rich. L. Rev. 1, 46 & n.202 (1996). For example, while Medicare coverage for hospice care is contingent on a diagnosis of six or fewer months to live, a recent study showed that fifteen percent of hospice patients survived longer than six months and eight percent survived longer than one year. Christakis & Escarce, Survival of Medicare Patients After Enrollment in Hospice Programs, 335 New Eng. J. Med. 172 (1996); see Lynn et al., Defining the "Terminally Ill": Insights from SUPPORT, 35 Duq. L. Rev. 311 (1996). Life expectancy is thus inherently problematic as a

criterion for establishing eligibility to exercise a constitutional right.

The experience in the Netherlands illustrates the difficulty of limiting physician-assisted suicide to a particular class of individuals. Physician-assisted suicide and euthanasia remain unlawful in the Netherlands but are not prosecuted if performed by a physician in accordance with established procedures. Keown, "Some Reflections on Euthanasia in the Netherlands," in Euthanasia, Clinical Practice and the Law 193, 197 (Gormally ed., 1994). In one recent, much discussed case, a physician, who assisted in the suicide of a physically healthy, 50 year-old woman who sought death in the aftermath of the death of her two sons, was acquitted by a three-judge court in Assen of charges that he had violated the Dutch procedures. The Assen case is significant in that it "marked Dutch acceptance of depressed suicidal patients as eligible for assisted suicide or euthanasia." Hendin, Seduced by Death: Doctors, Patients, and the Dutch Cure, 10 Issues in L. & Med. 123, 129 (1994). The Assen case also demonstrates the difficulty of restricting the availability of physician-assisted suicide even to those with a physical illness.

Moreover, evidence from the United States suggests that if physician-assisted suicide is judicially legitimized, it will be impossible to confine the procedure to the "terminally ill, imminently dying" patient. Thus, a study of 118 San Francisco physicians who treat AIDS patients conducted early in 1995 indicates that approximately half of them would grant a request to prescribe a lethal dose of medication to an AIDS patient who was neither in excruciating pain nor imminently dying. Slome et al.,

Physician-Assisted Suicide and Patients with Human Immunodeficiency Virus Disease, 336 New Eng. J. Med. 417, 419 (1997). Significantly, these responses were given even though physician-assisted suicide is unlawful. Were physician-assisted suicide held to involve a fundamental constitutional right, confining the practice to the "terminally ill, imminently dying" would become practically impossible.

2. There also are formidable obstacles to restricting physician-assisted suicide only to those patients who voluntarily request it, in the words of the circuit court, "under no undue influence." Op. at 2. The fact that many patients do not receive adequate pain relief or suffer from undiagnosed and untreated depression may unduly influence them to seek physician-assisted suicide. A substantial percentage of elderly patients suffer mental confusion that also routinely goes undiagnosed. Francis et al., A Prospective Study of Delirium in Hospitalized Elderly, 263 JAMA 1097 (1990). Moreover, poor and minority individuals are at the greatest risk for receiving inadequate care and thus may feel the greatest pressure to request physician-assisted suicide.

Pressure to contain health care costs exacerbates the problem. Even if, as one would expect, health care insurers would consciously seek to avoid suggesting to patients or physicians that they consider financial costs in making a decision to hasten death, the continuing pressure to reduce costs can only constrain the availability and quality of palliative care and support services that patients and families need. Wolf, Physician-Assisted Suicide in the Context of Managed Care, 35 Duq. L. Rev. 455 (1996). These limitations on the availability of proper care clearly can place

pressure on patients to express a wish for suicide that they might not otherwise feel. As the Chief of the Pain Service at Memorial Sloan-Kettering Cancer Center reports, "[w]e commonly see [requests for physician-assisted suicide] dissolve with adequate control of pain and other symptoms." Foley, 6 J. Pain & Sympt. Mgmt. at 290.

A recent study shows that support for physician-assisted suicide was highest among those health care professionals least knowledgeable about pain symptom management and least capable (due to emotional exhaustion) of empathizing with the patient. Portenoy et al., Determinants of the Willingness to Endorse Assisted uicide: A Survey of Physicians, Nurses, and Social Workers, __ Psychosomatics __ (forthcoming April 1997); see also Bachman et al., Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia, 334 New Eng. J. Med. 303, 308 (1996) ("doctors who had the least contact with terminally ill patients were the most likely to support the legalization of assisted suicide"). There is thus added reason to doubt that patients seeking physician-assisted suicide would receive adequate palliative care before such a request is granted.

Further, separating the wishes of the patient from those of the family is extremely problematic. One of the most common reasons why patients request suicide is to spare their families and loved ones the burdens and expense of caring for them. See, e.g., Blendon et al., Should Physicians Aid their Patients in Dvins?, 267 JAMA 2658, 2660-61 (1992); Emanuel, Cost Savings at the End of Life: What Do the Data Show?, 275 JAMA 1907 (1996). But to what extent are these feelings the result of the family's expectation?

In one recent study, families of elderly, terminally ill patients were significantly more likely than the patients themselves to express support for physician-assisted suicide. Koenig et al., Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide, 156 Arch. Int. Med. 2240, 2244 (1996). Families, especially when confronted with the expense and burden of caring for a terminally ill family member, may be beset with conflicting feelings about hastening a family member's death, as recent cases vividly illustrate. See, e.g., "Countdown to a Suicide," The New York Times, Dec. 20, 1995, at A-20. Even those family members consciously committed to preserving their loved one's sense of dignity and autonomy may needlessly acquiesce in or encourage a suicide that could be avoided by assuring the patient that, in their eyes, illness has not compromised the patient's dignity. Byock, "Physician-Assisted Suicide Is Not An Acceptable Practice for Physicians," in Physician-Assisted Suicide: Ethical Positions, Medical Practices and Public Policy Options __ (Weir ed., forthcoming May 1997).

Experience to date provides little basis for confidence that health care professionals can reliably determine whether patients have provided voluntary, authentic consent for assisted suicide that is free from undue influence. Frank, sensitive, and extended conversations between physicians and patients are presumptively antecedents to such a determination. Such conversations would be infinitely more complex than any that regularly occur today. For example, ineffective communication remains a major obstacle to achieving pain management, even though pain relief is plainly a goal shared by both physicians and

patients- American Pain Society Quality of Care Committee, Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain, 274 JAMA 1874, 1874 (1995). And, despite their importance, discussions about advance care planning are rare and poorly handled, which hampers effective and responsive end-of-life care. Emanuel, "Advance Directives," in Principles and Practice of Supportive Oncology __ (Berger et al. eds., forthcoming 1997).

The well-established phenomenon of transference and countertransference further complicate the problem of relying upon physicians to identify voluntary requests. Miles, Physicians and Their Patients' Suicides, 271 JAMA 1786 (1994). Particularly when caring for chronically ill, dying, or suicidal patients, caregivers often have "difficulty tolerating such patients' dependency." Id. at 1786 (footnote omitted). Their "feelings of frustration and inadequacy occasioned by irreversible medical problems" sometimes lead them "to withdraw from such patients or see them as hopelessly or rationally suicidal" when in fact they are not, which "in turn may precipitate suicides." Id. As one physician with extensive experience caring for dying patients has observed, "[o]nly because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying." Miles, quoted in Kass & Lund, 35 Duq. L. Rev. at 418.

Health care professionals also experience great frustration at not being able to offer patients a cure. For some, the ability to offer a patient the "treatment" of assisted suicide may provide a sense of "mastery over the disease and the accompanying feelings of helplessness." Hendin, Seduced by Death, 10 Issues in L. & Med. at 129. This may cause physicians or a

Patient's family to endorse and reinforce requests for suicide more readily than the patient's own ambivalent feelings would warrant. Miles, 271 JAMA at 1786. Published accounts of physician-assisted suicide reveal that even those physicians who consciously seek only to implement a patient's voluntary request overlook ways in which their recommendation and support of physician-assisted suicide reinforced the patient's decision for death and left unexamined indications that the patient really did not want to die. Hendin, Selling Death and Dignity, 25 Hast. Ctr. Rep. 19 (1995); Hendin, Seduced by Death, 10 Issues in L. & Med. at 125-29.

SUMMARY OF ARGUMENT

I.A. Article I, section 23 of the Florida Constitution protects the "right to be let alone." This section encompasses those rights that are deeply rooted in the State's history and tradition -- including the right to refuse unwanted medical treatments. Article I, section 23 does not, however, create a right to physician-assisted suicide. Physician-assisted suicide is not in any sense a "medical treatment," because it has no therapeutic benefit and is provided with the intent to kill. Moreover, the asserted right to physician-assisted suicide has no roots in the history or tradition of this State.

The purported right to physician-assisted suicide does not involve a right to be "let alone." To the contrary, it involves enlisting a physician to participate in intentionally causing death. Thus, the right found by the circuit court cannot be reconciled with the language of Article I, section 23.

B. A right to physician-assisted suicide, if created by this Court, could not be limited in the manner proposed by the circuit court. Any legislative effort to regulate that right would survive only if narrowly tailored to advance a compelling state interest. Under that standard, few, if any, restrictions would survive.

First, the right could not be limited to those who are "terminally ill, imminently dying." Op. at 2. Article I, section 23 makes no distinction between the terminally ill and any other group -- for example, the chronically ill -- who are suffering to an equal extent. And from a legal perspective, there is no compelling rationale for distinguishing between these groups. As a practical matter, moreover, the "terminally ill, imminently dying" cannot be identified with any certainty.

Second, any legislative efforts to ensure that persons seeking to exercise their "right" are acting without "undue influence" -- such as waiting periods, physician certifications, etc. -- almost certainly would be struck down as insufficiently tailored to advance a compelling state interest. Third, there is no compelling rationale for limiting the asserted right to persons who obtain lethal prescription drugs "from his physician" as opposed to from some other source. Likewise, the requirement that patient's "self-administer" the lethal medication cannot stand if the right to physician-assisted suicide truly is fundamental.

Few question the need to restrict substantially any "right" to physician-assisted suicide, But the very fact that it is generally acknowledged that the asserted constitutional right should be quite narrow counsels strongly against establishing the

right in the first place. Indeed, it is antithetical to the nature of a fundamental right that its exercise be so troubling that extensive regulation is necessary.

In determining whether to establish a right to physician-assisted suicide in the first place, this Court should consider at least three important reasons why the State may want to regulate -- or even ban -- the practice. First, the State has an interest in avoiding preventable suicides, which likely would increase in frequency if the practice of physician-assisted suicide is judicially legitimized. Second, the State has a strong interest in avoiding the damage to patients and the medical profession that would flow from allowing physicians intentionally to assist in causing death. Finally, the State has a strong interest in expanding the provision of effective palliative care, which undoubtedly would be undermined if the option to assist in suicide is legitimized.

II. The Equal Protection Clause of the United States Constitution provides no more protection for the practice of physician-assisted suicide than does Article I, section 23. In holding to the contrary, the circuit court relied exclusively on the Second Circuit's decision in Quill **v.** Vacco, 80 F.3d 716 (2d Cir. 1996). That decision, however, is unpersuasive. There are in fact numerous rational bases on which the State could justify permitting persons to refuse unwanted medical care while prohibiting physician-assisted suicide.

Among other rational distinctions is the fact that refusing unwanted therapy has long been recognized at common law while physician-assisted suicide has not. Likewise, it would be

rational for the State to conclude that there are important moral and practical differences between the two practices. And it also would be rational for the State to conclude that honoring the right to refuse unwanted care serves a vital, life-promoting purpose -- it allows patients to try a course of therapy without fear that they cannot stop it. That consideration has no analogue in physician-assisted suicide.

ARGUMENT

I. ARTICLE I, SECTION 23 OF THE FLORIDA CONSTITUTION DOES NOT ENCOMPASS A RIGHT TO PHYSICIAN-ASSISTED SUICIDE.

Relying on Article 1, section 23 of the Florida Constitution as interpreted in a series of cases decided by this Court, the circuit court announced a fundamental right to "control the time and manner of [one's] death." Op. at 14, 23. In so doing, that court misconstrued the proper scope of Article 1, section 23. That provision protects the right to refuse unwanted medical treatment. It does not establish any right to obtain assistance in committing suicide.

A. Article I, Section 23 Encompasses Rights That Have Deep Historical Roots, Including The Right To Refuse Life-Sustaining Therapy But Not The Right To Physician-Assisted Suicide.

1. Article I, Section 23 Encompasses Rights That Have Deep Historical Roots, Including The Right To Refuse Life-Sustaining Therapy.

Article I, section 23 provides that "[e]very natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided

herein." Fla. Const. art I, § 23. This provision does not specify which "rights" are incorporated in the general right "to be let alone." This Court has held, however, that this provision "was not intended to be a guarantee against all intrusion into the life of an individual." City of North Miami v. Kurtz, 653 So. 2d 1025, 1027 (Fla. 1995) (citing Florida Rd. of Bar Examiners Re. Applicant, 443 So. 2d 71 (Fla. 1983)), cert. denied, 116 S. Ct. 701 (1996).[3] It also has held that the "components of privacy are the same as those encompassed in the concept of freedom, and . . . are [those that are] deeply rooted in our nation's philosophical and political heritage." In re Guardianship of Browning, 568 So. 2d 4, 10 (Fla. 1990) (internal citation omitted).[4] It is for this Court to determine which rights are sufficiently "rooted in our [nation's] heritage" to warrant incorporation. Winfield v. Division of Pari-Mutuel Wasering, 477 So. 2d 544, 546 (Fla. 1985).

One right that the Court has recognized as included in the general constitutional right to be let alone is the more specific right to be let alone by health care providers -- i.e., the right of individuals to refuse unwanted medical treatment. Thus, in Satz v. Perlmutter, 379 So. 2d 359, 360 (Fla. 1980), this Court held that a competent adult, with no minor dependents and

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[3] See also Winfield v. Division of Pari-Mutuel Wagering 477 So. 2d 544, 547 (Fla. 1985) ("'this constitutional provision was not intended to provide an absolute guarantee against all governmental intrusion into the private life of an individual'") (quoting Florida Bd. of Bar Examiners Re. Applicant, 443 So. 2d 71, 74 (Fla. 1983)).

[4] See also Rasmussen v. South Fla. Blood Serv., Inc., 500 So. 2d 533, 536 (Fla. 1987) (Article I, section 23 provides "an explicit textual foundation for those privacy interests inherent in the concept of liberty").

suffering from a terminal illness, had the constitutional right to discontinue extraordinary medical treatment where all affected family members consented.

This Court has reaffirmed that constitutional right on at least three other occasions. In John F. Kennedy Mem'l Hosp. v. Bludworth, 452 So. 2d 921, 923 (Fla. 1984), it held that "terminally ill incompetent persons being sustained only through use of extraordinary artificial means have the same right to refuse to be held on the threshold of death as terminally ill competent persons." In Browning, 568 So. 2d at 12-13, this Court for the first time confirmed that the right to refuse medical treatment was protected by Article I, section 23, and held that where a person is unable to exercise her constitutional right of privacy by reason of her medical condition, proxies and surrogates, including family members and friends, are authorized to exercise it for her. Id. at 13.[5] And in In re Dubreuil, 629 So. 2d 819 (Fla. 1993), the Court held that a Jehovah's witness had the right to refuse a blood transfusion which was not, in that case, overridden by the state's interest in preventing the "abandonment" of minor children. In so holding, the Court relied on the principle that "[t]he state has a

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[5] In exploring the nature of the health care-related rights under Article I, section 23, this Court has used broad language, concluding that the right at issue "encompasses all medical choices." Browning, 568 So. 2d at 10. It ultimately made clear, however, that the protected right does not extend to all health care choices, but rather involves the choice to be free of unwanted medical therapy. Specifically, it held that "[w]e can conceive of few more personal or private decisions concerning one's body that one can make in the course of a lifetime , . . [than] the decision of the terminally ill in their choice of whether to discontinue necessary medical treatment " Id. (internal citation omitted) (emphasis added).

duty to assure that a person's wishes regarding medical treatment are respected." Id. at 822 (emphasis added).[6]

The privacy interest in refusing medical treatment that this Court recognized in these cases is grounded in the common law protection afforded to every person to be free of unwanted medical intervention. That right is deeply rooted in Anglo-American law. "Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment." Natanson v. Kline, 350 P.2d 1093, 1104, clarified, 354 P.2d 670 (1960).

Historically, the common law has protected the right to refuse medical treatment by considering such treatment performed without consent to constitute a battery, excusable only in emergency circumstances. Id. at 270; Keeton, Prosser & Keeton on the Law of Torts 39-42, 190 (5th ed. 1984); Winters v. tiller, 446 F.2d 65, 68 (2d Cir.), cert. denied, 404 U.S. 985 (1971). In this century, the common law has developed further protection for patients through the doctrine of informed consent to medical treatment, which requires a physician to disclose to the patient all appropriate information about the medical procedures being proposed in advance of obtaining consent. As with the requirement of consent, the root premise of informed consent is the concept that "'[e]very human being of adult years and sound mind has a

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[6] See also Public Health Trust v. Wons, 541 So. 2d 96, 99 (Fla. 1989) (state's interest in having children raised by two parents not sufficient to overcome patient's right to refuse blood transfusion, particularly where "abandonment" not proven).

right to determine what shall be done with his own body. . . .'" Browning, 568 So. 2d at 10 (quoting Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (1914) (Cardozo, J.)).

2. Article I, Section 23 Does Not Encompass A Right To Physician-Assisted Suicide, Which Is Neither A Medical Therapy Nor Deeply Rooted In Our Nation's History.

Assisting in suicide involves intentionally providing patients with the means for killing themselves. It is the antithesis of "medical" treatment, and it has never been recognized as a legitimate part of medical practice either by the medical profession or by state law. Accordingly, the right to physician-assisted suicide is not encompassed by Article I, section 23.

Medical treatments are those that are provided to patients with the intent to heal, comfort, or provide other therapeutic benefits. Assisting in suicide, by contrast, has no therapeutic benefit and is provided with the intent to kill. To be sure, it may involve the tools of medicine. But the fact that a procedure may use the tools of medicine does not make the procedure a medical treatment. For example, a physician who administers a lethal injection in carrying out a legally authorized execution may be using medical modalities, but that physician is not providing medical care. See AMA Council on Ethical and Judicial Affairs, Code of Medical Ethi rrent Opinions § 2.06

The fact that physician-assisted suicide is provided with the intent to kill distinguishes it from "double-effect" therapies -- i.e., therapies, such as narcotics, which relieve pain but which, in sufficient doses, may suppress breathing and cause death.

Where such therapies are provided with the intent to ease the patient's pain and not to cause death, they fit squarely within the traditional therapeutic model. Indeed, the provision of such medication is in principle no different than the provision of chemotherapy that is intended to heal but could have the unintended effect of hastening death.

Because physician-assisted suicide is not a legitimate medical treatment, the asserted "right" to physician-assisted suicide, unlike the right to refuse unwanted medical treatment, has no deep roots in the history or traditions of this State or the nation as a whole. To the contrary, Florida has barred assistance in "self-murder" since at least the 1860s. See § 782.08, Fla. Stat. (West 1992). In addition to Florida, thirty-four states proscribe assisting in another's suicide, and eight other states prohibit it as a common law crime. 2 Meisel, The Right to Die § 18.17, Table 18-1 at 478 (2d ed. 1995).

Thus, the purported right to physician-assisted suicide, like a number of other purported rights, including the "right" to patronize retail establishments to purchase obscene material and the "right" of a government employee not to disclose whether he used tobacco, is not encompassed within Article I, section 23. See Stall v. State, 570 So. 2d 257, 260 (Fla. 1990); Kurtz, 653 So. 2d at 1027-28. This Court has found that individuals had no "reasonable expectation" of privacy with respect to those "rights" because there was no objective -- i.e., historical -- basis on which the individual could base such an expectation.[7] Likewise, in

[7] See also Winfield v. Division of Pari-Mutuel Wagering, 477 So. (continued...)

light Of the State's longstanding and clear prohibition on assisted suicide, no citizen of Florida could "reasonably expect" to obtain assistance of a physician in suicide without interference from the State.

The conclusion that a purported right to the assistance of a physician in committing suicide is not a basic part of this State's history or tradition is underscored by the way in which the Legislature accommodated this Court's holding that patients have a fundamental right to refuse unwanted medical care. In the early 1990s, the Legislature adopted a series of procedures designed to make it easier for individuals to appoint surrogates for health care decisions and to complete living wills. Rather than repealing the general prohibition on assisting in "self-murder," however, the Legislature carved out an exception to that prohibition and adopted legislation which stipulated that "[t]he withholding or withdrawal of life-prolonging procedures from a patient in accordance with any provision of this chapter does not, for any purpose, constitute a suicide." § 765.309(2), Fla. Stat. (West Supp. 1997). At the same time, the Legislature made clear that "[n]othing in this chapter shall be construed to condone, authorize or approve mercy killing or euthanasia, or to permit any affirmative act or deliberate act or omission to end life other than to permit the natural process of dying." § 765.309(1), Fla. Stat. (West Supp. 1997) (emphasis added).

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[7] (...continued)
2d 544, 547 (Fla. 1985) ("before the right of privacy is attached . . . a reasonable expectation of privacy must exist." Accordingly, there is a "threshold question" whether an individual has a "legitimate expectation of privacy" in the matter at issue.)

3. The Language Of Article I, Section 23 Protects The Right "To Be Let Alone" -- Not The Right To Enlist The Assistance Of Physicians In Committing Suicide.

Finally, the language of Article I, section 23 itself does not support a right to physician-assisted suicide. Physician-assisted suicide has nothing to do with being "let alone" -- which is all that Article I, section 23 protects. Nor does it have anything to do with the avoidance of "battery," which underlies the right to be let alone in this context. Obtaining the assistance of a physician in committing suicide involves receiving, rather than refusing, treatment. It is the opposite of being "let alone."

The distinction between the right to refuse treatment and a right to receive treatment is an important one. Courts in other contexts have been extremely reluctant to find a constitutional right to receive any particular treatment. See, e.g., United States v. Rutherford, 442 U.S. 544 (1979) (terminally ill cancer patients may not be given a drug that has not been approved by the Food and Drug Administration); New York State Ophthalmological Soc'y v. Bowen, 854 F.2d 1379, 1389-92 (D.C. Cir. 1988), cert denied, 490 U.S. 1098 (1989). Amici believe that there should be constitutional protection for the "freedom to determine the course of [one's] own treatment," Cruzan, 497 U.S. at 289 (O'Connor, J., concurring), and the right to receive legitimate medical treatment. It would be particularly ironic, however, if the first "treatment" to which patients were held to have a constitutional right was treatment by death.

In sum, this Court has never recognized any constitutional right relating to health care other than the right

to refuse unwanted medical treatment. That right has its origins in the common law prohibition on battery. There is no comparable historical tradition of physician-assisted suicide in this State. Indeed, the State's longstanding and recently reiterated prohibition on assisting in suicide makes any expectation of "privacy" with respect to obtaining the assistance of a physician in committing suicide entirely unreasonable. Finally, the language of Article 1, section 23 does not support the creation of a separate right to physician-assisted suicide.

B. A Right To Physician-Assisted Suicide, If Established By This Court, Could Not Be Limited In The Manner Proposed By The Circuit Court.

The circuit court purported to limit the right to physician-assisted suicide to competent adults who are "terminally ill, imminently dying"; who are acting under no undue influence; and who wish to hasten their death with "prescription drugs" obtained from a physician. Op. at 2. However, if a constitutional right to physician-assisted suicide exists, any limitation on that right would be unconstitutional unless it directly advanced a compelling state interest. Winfield, 477 So. 2d at 548. Few restrictions would survive scrutiny under this exacting standard. As a practical matter, any fundamental constitutional right to assisted suicide therefore could not be limited to a small, well-defined class of individuals.

First, it is unlikely that any right to physician-assisted suicide could be limited to those who are "terminally ill, imminently dying." For one thing, that group of people is likely impossible to identify. See supra pp. 15-18. But equally

important, there is no compelling rationale for distinguishing between that group and other individuals who are in extreme distress -- for example, those who are chronically ill, but not near death.[8] See Slome, 336 New Eng. J. Med. 417.

In this regard, it is noteworthy that Article I, section 23 refers to all "natural persons" -- not just the terminally ill. No one can confidently say that the degree of pain or suffering experienced by a person whose death is imminent is greater than that experienced by someone at an earlier stage of terminal illness, or by someone who is chronically ill. Moreover, if the pain or suffering is thought to be irremediable, then the longer the patient's life expectancy, logically the more pain and suffering awaits the patient. Kamisar, -Assisted Suicide -- Even A Very-ted Form, 72 U. Det. Mercy L. Rev. 735, 737, 740-41 (1995).

Second, it is unlikely that the right to physician-assisted suicide could ever be restricted to those who make truly "voluntary" choices. To try to ensure such voluntariness, the Legislature, could, for example, establish waiting periods, a requirement that the patient's decision be certified as "voluntary" by physicians or other witnesses, or even a requirement for a court hearing. But each of these, while unquestionably rational, is unlikely to be found to be sufficiently narrowly tailored and to advance a sufficiently compelling state interest to survive strict

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[8] It is well established that profound suffering that can prompt a request for suicide arises not simply in the terminally ill but in the chronically ill and physically healthy as well. E.g., Kamisar, Against Assisted Suicide -- Even a Very Limited m, 72 U. Det. Mercy L. Rev. 735, 739 (1995).

scrutiny. In any event, a waiting period makes little sense in the context of someone who is terminally ill; a certification requirement is easily abused by those who for whatever reason wish to hasten death; and judicial intervention would inject the courts into issues which they are ill-equipped to decide.

Finally, there is no compelling rationale for limiting the asserted right to "control the timing and manner of one's death" to situations in which a person obtains a "fatal dose of prescription drugs" from a physician and self-administers that dose. As an initial matter, there appears to be no basis to limit the asserted right based on the source of the lethal drugs. If the right to control the timing and manner of one's death is truly fundamental, then whether a person obtains lethal drugs from a physician or from some other source should not matter. For the same reason, whether or not the lethal agent is legal -- i.e., "prescribed" -- should not be of any significance.

The "self-administration" limitation also is indefensible under a strict scrutiny standard. This Court has already made clear that mental incompetence should be no bar to the exercise of the constitutional right to refuse medical care. John F. Kennedy Mem'l Hosp. v. Bludworth, 452 So. 2d 921, 923 (Fla. 1984). If that is the case, then surely physical incapacity should be no bar to the right to commit suicide. And if it were, then individuals in failing health would likely push forward the date on which they decided to commit suicide to ensure that they did not lose the ability to self-administer lethal drugs.

C. In Determining Whether There Is A Fundamental Constitutional Right To Physician-Assisted Suicide, The Court Should Consider The Important State Interests That Could Not Re Vindicated If Such A Right Were Created.

Even proponents of a constitutional right to physician-assisted suicide recognize that the right should be quite narrow. The circuit court, as well as the Second and Ninth Circuits, each restricted the purported right to those who are near death, in great suffering, and acting without undue influence. Implicit in all of these holdings is a recognition that states have a strong interest in limiting the exercise of the purported right.

The very fact that states have important interests in limiting the exercise of the right counsels strongly against establishing such a right in the first place. Indeed, it is inconsistent with the nature of a fundamental right that its exercise be so susceptible to abuse that extensive state regulation is necessary. Thus, before determining whether to remove questions concerning the issue of physician-assisted suicide from the legislative purview, this Court should consider all of the potential state interests that could not be addressed legislatively if physician-assisted suicide were found to be a fundamental constitutional right. Specifically, there are three such interests: the State's interest in preventing suicide; the State's interest in regulating the profession of medicine; and the State's interest in promoting palliative care.

First, the State has an overwhelming interest in avoiding preventable suicides. Transforming physician-assisted suicide into a legitimate medical procedure, however, would create momentum in favor of its use that even regulation could not reverse. If

physician-assisted suicide becomes a legitimate medical option, then a decision not to select that option will make patients responsible for their own suffering and for the burden that the patient imposes on all other parties. Once a patient can choose physician-assisted suicide, it is but a short step to ask why the patient has not done so. Indeed, it seems likely the patient would feel pressure to revisit the question repeatedly, perhaps every day. Many patients thus will "experience -- and be helped [by their families or physicians] to experience -- their right to choose physician-assisted death as a duty to do so." Kass & Lund, Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession, 35 Duq. L. Rev. 395, 407 (1996).[9]

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[9] Concerns that making physician-assisted suicide available to some would cause a substantial increase in the number of such suicides justifies a total ban for several reasons. To begin with, the Legislature justifiably could conclude that relatively few, if any, patients, would ever legitimately meet the kind of strict criteria that it might seek to impose in lieu of banning physician-assisted suicide outright. Most terminally ill patients do not raise the issue of physician-assisted suicide and, given advances in palliative care, it is unlikely that the needs of those who do raise the issue cannot be met through other means. Moreover, the Legislature also reasonably could conclude that restrictions intended to limit physician-assisted suicide to a narrow class of patients would not work. The demand for physician-assisted suicide principally comes not from the patients in actual and untreatable pain at the very end of life, but from patients, whether healthy, chronically ill, or terminally ill, who are depressed, or who fear future pain, loss of dignity, or unduly burdening their families. If physician-assisted suicide becomes a fundamental constitutional right, many patients whose needs could have been met through appropriate palliative care will instead be directed toward physician-assisted suicide. Finally, the Legislature could further conclude that the many pressures on patients that may lead to consideration of suicide could, if suicide were judicially legitimized as a medical treatment, exert powerful pressure on patients to accept suicide more as a duty than as a right.

Second, contrary to the suggestion of the circuit court, the State has a strong interest in avoiding the damage to the medical profession and its ability to serve patients that would flow from an abandonment of the prohibition against physician-assisted suicide. E.g., Semler v. Oregon Bd. of Dental Examiners, 294 U.S. 608, 612-13 (1935) (state's strong interest in "maintenance of professional standards" permits it to enforce "a general rule even though in particular instances there might be no actual" harm); Ohralik v. Ohio State Bar Ass'n, 436 U.S. 447, 460 (1978) (state interest in "maintaining standards among members of the licensed professions" is "particularly strong"); Shapero v. Kentucky Bar Ass'n, 486 U.S. 466, 485 (1988) (O'Connor, J., dissenting) (state "should have considerable latitude to ban" conduct that "undermines the substantial government interest in promoting the high ethical standards" of a profession). Health care professionals have long understood that with the right to practice comes enormous responsibility. Patients come to physicians and nurses at times of greatest need and vulnerability, depending on them to respond to their needs capably and faithfully.

The rule against physician-assisted suicide is an extraordinarily valuable protection against temptation to seek an immediate solution to a burdensome problem that health care professionals, no less than any other human being, can feel. Many patients may understandably wonder, finding themselves in great pain but in the care of a physician they do not know, whether that physician will act only to preserve their lives. Will they be confident, as they watch the physician draw a dose of morphine, that the physician is committed only to ease their pain and not to

take their lives? See Kass & Lund, 35 Duq. L. Rev. at 408. The ban on physician-assisted suicide helps ensure the State that patients will never lose the trust that must exist for the physician-patient relationship to flourish.

Finally, the Legislature has a strong interest in expanding the provision of palliative care to all patients. Although efforts to expand palliative care would not end if physician-assisted suicide were permitted, a prohibition on physician-assisted suicide provides health care professionals with a tremendous incentive to improve and expand the availability of palliative care. Permitting physician-assisted suicide also would jeopardize both (a) the right to have unwanted medical treatment withheld or withdrawn, and (b) the right to receive medication sufficient to ease pain even if that medication might hasten the patient's death. The widespread acceptance of these rights by health care professionals, courts, legislatures, and the public depends upon the recognition and acceptance of the distinction between these rights and the purported right to physician-assisted suicide. See generally 2 Meisel, The Right to Die § 18.18, at 479-85. If that important boundary is lost, much support for withholding and withdrawing treatment or to providing ample pain medication may be lost as well.

II. THE EQUAL PROTECTION CLAUSE DOES NOT PROHIBIT A STATE FROM DISTINGUISHING BETWEEN WITHHOLDING OR WITHDRAWING TREATMENT AND ASSISTING SUICIDE.

The circuit court's alternative holding that Florida's ban on physician-assisted suicide violates the federal Equal Protection Clause also is without merit. The Equal Protection

Clause provides no more protection for the practice of physician-assisted suicide than does Article I, section 23.

In finding that the State's prohibition on physician-assisted suicide violated the Equal Protection Clause, the circuit court relied exclusively on the Second Circuit's decision in Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996). In that case, the Second Circuit found that it was irrational for New York to prohibit physician-assisted suicide for patients in the last stages of terminal illness while at the same time permitting patients to request that physicians withdraw or withhold life-sustaining treatment. Because the latter involves a physician taking action that hastens a patient's death, the court reasoned that it amounted to physician-assisted suicide. Such precedent made it irrational, in the court's view, for the state to maintain a ban against physician-assisted suicide for patients in the last stages of terminal illness.

In deciding whether to follow Quill, therefore, the principal question before this Court is whether it is rational for the State to distinguish between physician-assisted suicide on the one hand and honoring patient requests to withhold or withdraw life-prolonging treatment on the other. There are, in fact, many distinctions between the two practices.

First, it would be rational for the Legislature to adhere to a distinction that has long been recognized at common law and that has withstood the test of time. Specifically, the common law distinguishes between the right to refuse unwanted medical treatment and physician-assisted suicide. See Cruzan v. Director,

Mo. Dep't of Health, 497 U.S. 261, 269-70 (1990); see also supra pp. 28-31.

Second, there is an important moral and practical difference between refusing unwanted medical treatment and obtaining physician-assisted suicide. The circuit court and the Second Circuit were able to equate withdrawal of medical treatment with physician-assisted suicide only by ignoring the fundamental difference in the physician's intent in participating in those two acts. In respecting a patient's decision to have treatment withheld or withdrawn, physicians are respecting their roles as individuals who respond to the patient's needs by providing medical treatment to the extent the patient consents. Although the act of withholding or withdrawing medical treatment may allow a patient's underlying disease to take its course more rapidly, the intent of a physician in so acting is not to cause death, but to respect the patient's fundamental right to decide if and when to let the disease process take its course.

Conversely, when the physician responds affirmatively to a request for help in committing suicide, the physician's intent is only to help the patient in taking his or her life. The physician thus acts with intent to kill. To distinguish between two acts with a similar result based upon the intent of the actor is elemental in the law. Morissette v. United States, 342 U.S. 246, 250 (1952) (legal distinctions based on intent are "universal and persistent in mature systems of law"). There can be little doubt that a state would act rationally in choosing to respect the distinction in this context.

Third, the Legislature rationally could conclude that preserving the ethical boundary as drawn by the medical profession is important to prevent serious damage to the ability of the profession to serve patients. E.g., Semler v. Oregon Bd. of Dental Examiners, 294 U.S. 608, 612-13 (1935); Ohralik v. Ohio State Bar Ass'n, 436 U.S. 447, 460 (1978); Shapero v. Kentucky Bar Ass'n, 486 U.S. 466, 485 (1988) (O'Connor, J., dissenting). The ban on physician-assisted suicide helps ensure that patients will never lose the trust that must exist for the patient-physician relationship to flourish. See supra pp. 38-39.

Fourth, the Legislature reasonably could conclude that abandoning the prohibition on physician-assisted suicide will undermine the provision of palliative care to those who need it. Such a step may discourage some patients from seeking adequate pain medication for fear that their physician will determine that their demands are grounds for hastening their deaths. The Legislature also could conclude that abandoning the prohibition would undermine the profession's efforts to expand the provision of palliative care to all patients. Although such efforts would not end if physician-assisted suicide were permitted, the prohibition on physician-assisted suicide provides health care professionals with a tremendous incentive to improve and expand the availability of palliative care.

Similarly, the Legislature could reasonably conclude that preserving the prohibition against physician-assisted suicide is essential to avoid jeopardizing the recent advances to establish the right to have unwanted medical treatment withheld or withdrawn and the right to receive pain medication sufficient to ease pain,

even if it would hasten the patient's death. As discussed above, the distinction between these rights and any right to physician-assisted suicide has been crucial to the widespread acceptance of these rights. See supra pp. 6-9, 28-32. If that important boundary is lost, support for withholding and withdrawing treatment or providing ample pain medication may be lost as well.

Fifth, the Legislature reasonably could conclude that the potential for abuse is significantly greater in the context of physician-assisted suicide than in the case of the withholding or withdrawal of treatment. It is true that the difficulty of identifying truly voluntary requests for physician-assisted suicide has some analogue in the context of requests to withhold or withdraw medical treatment. But the analogy is only partial at best. The right to refuse treatment is a right that applies to all competent, informed individuals at any time. The right articulated by the court below to assisted suicide is one that purports to be limited to a very discrete category of patients. Such a right requires physicians to make multiple subjective judgments that simply are not required in the typical treatment withdrawal situation. Furthermore, the historic protection for patients' rights to limit what others may do to their bodies supports a degree of deference to patient decisions to withdraw and withhold treatment that is absent in the case of physician-assisted suicide.

Sixth, honoring the right of patients to refuse unwanted care serves a vital, life-promoting purpose that has no analogue in permitting physician-assisted suicide. There would be a strong disincentive to accepting life-sustaining treatment if patients and their surrogates knew that, once the treatment were started, it

could never be stopped. For example, it may not be until some months after treatment begins before it can be known whether a patient in a vegetative state as a result of an accident will recover consciousness. And even apart from emergency situations, "the decision to initiate treatment is often acceptable to the patient and to the health care professionals because treatment can be withdrawn or withheld if the patient's condition worsens or the treatment proves intolerable for the patient." N.Y. State Task Force at 147.

Finally, the Legislature reasonably could conclude that, given the difficulty of persuasively defending and enforcing rules that allow some categories of patients but not others to obtain physician-assisted suicide, and given the State's unquestioned interest in preventing avoidable suicides, an outright prohibition is best. The artificiality of the lines drawn by the court below is instructive. There is no principled basis on which to limit the right found by the court below to those who are "imminently dying," to those under no "undue" influence, and to those who are able to "self-administer" physician-prescribed lethal medications.

In this connection, the State could rationally conclude that the imposition of a panoply of safeguards, such as those casually itemized in a footnote in the Quill opinion (see Quill v. Vacco, 80 F.3d 716, 730 n.4 (2d Cir. 1996)), would not be effective in regulating physician-assisted suicide. Surely the experience in the Netherlands and the attitudes of many San Francisco physicians who treat AIDS patients would provide a state with a rational basis for skepticism that its rules could be enforced. See supra pp. 17-18. The essential confidentiality of the relationship between

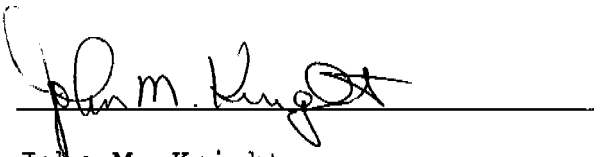
patients and their physicians precludes any effective monitoring of physician-assisted suicide, at least absent a kind of intrusive oversight that states could very rationally wish to avoid. See, Callahan & White, 30 U. Rich. L. Rev. at 67.

For these reasons, the line drawn by the Second Circuit and adopted by the circuit court is more subject to challenge on rationality grounds than the line between permitting withdrawal of life supports while prohibiting physician-assisted suicide. Where the problems are as complex and sensitive as the ones at issue here and where core interests in protecting the health and welfare of citizens are at stake, courts should be particularly reluctant to remove policy decisions from the Legislature by declaring a fundamental constitutional right.

CONCLUSION

The judgment of the court below should be reversed.

Respectfully submitted,



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March 10, 1997

CERTIFICATE OF SERVICE

I hereby certify that on this 10th day of March, 1997, I served copies of the foregoing BRIEF OF THE FLORIDA MEDICAL ASSOCIATION, THE AMERICAN MEDICAL ASSOCIATION, FLORIDA SOCIETY OF INTERNAL MEDICINE, FLORIDA SOCIETY OF THORACIC AND CARDIOVASCULAR SURGEONS, THE FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION, FLORIDA HOSPICES, INC. AND THE FLORIDA NURSES ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONER by United States first class mail, postage prepaid, on the following parties:

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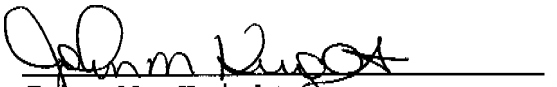

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