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No. 89,837

In the

Supreme Court of Florida

BARRY KRISCHER,

APPELLANT,

vs.

CECIL McIVER, M.D., et al.

APPELLEES.

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BRIEF OF *AMICI* CURIAE CHRISTIAN LEGAL SOCIETY, CHRISTIAN MEDIC& & DENTAL SOCIETY, CHRISTIAN PHARMACISTS FELLOWSHIP INTERNATIONAL, FELLOWSHIP OF CHRISTIAN PHYSICIAN ASSISTANTS, AND NURSES CHRISTIAN FELLOWSHIP IN SUPPORT OF APPELLANT

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INTERESTS OF THE AMICI CURIAE

The interest of each amicus curiae is set forth in the Appendix to this brief. The letters from the parties consenting to the filing of this brief have been filed with the Clerk of the Court pursuant to Rule 9.370.

STATEMENT OF THE CASE AND FACTS

Amici adopt the statement of the case and of the facts of appellant.

SUMMARY OF ARGUMENT

In the process of discovering a new constitutional right to physician-assisted suicide, the circuit court below failed to give adequate consideration to the consciences of the many health professionals who will be forced to participate in physician-assisted suicide. The decision below, and the numerous similar decisions that will inevitably follow it, will radically change the health care system in Florida into one in which health professionals routinely will be called upon to implement physician-assisted suicide. Many health professionals will find themselves coerced into some degree of involvement in the intentional killing of patients.

Inevitably, this taking of life will be extended to patients who are not competent to make the decision for themselves, are not terminally ill, or are not able to self-administer the lethal dosage. The privacy and equal protection arguments relied upon by the circuit court below cannot be cabined to "protect" only patients who are terminally ill, competent, and capable of self-

administering the lethal overdose. For example, in its decision finding a federal substantive due process right to physician-assisted suicide, the United States Ninth Circuit Court of Appeals essentially conceded that such a right would necessarily be extended to persons who were not competent, were not terminally ill, or were not capable of self-administration of the lethal overdose. Compassion in Dying v. State of Washington, 79 F.3d 790, 831-832 (9th Cir.), cert. granted sub nom. State of Washington v. Glucksberg, 117 S. Ct. 37-38 (1996) (No. 96-110) (argued January 8, 1997).[1]

The course of events in the Netherlands following its courts' de facto legitimization of physician-assisted suicide also demonstrates that physician-assisted suicide inevitably blurs into active euthanasia. In just two decades, the Dutch legal and medical systems have gone from "toleration of the practice of physician-assisted suicide for physically-suffering, terminally-ill, competent patients to the judicial and medical sanctioning of the non-consensual termination of patients' lives." Physician-Assisted Suicide and Euthanasia in the Netherlands, Report of Chairman Charles T. Canady to Subcomm. on the Const. of the House Comm. on the Judiciary, 104th Cong., 2d Sess. 2 (Comm. Print 1996). As a psychiatrist who has studied

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[1]The case was argued before the United States Supreme Court this Term, with a decision expected by July, 1997. Joan Biskuspic, Justices Skeptical of Assisted Suicide, Washington Post, January 9, 1997, at Al ("In the end, it appeared a majority [of the Supreme Court Justices] would not vote to establish a right to physician-assisted suicide.")

the Dutch experiment with physician-assisted suicide has concluded:

> The experience of the Dutch people makes it clear that legalization of assisted suicide and euthanasia is not the answer to the problems of people who are terminally ill. The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for people who are terminally ill to euthanasia for those who are chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to involuntary euthanasia (called "termination of the patient without explicit request"). The Dutch government's own commissioned research has documented that in more than one thousand cases a year, doctors actively cause or hasten death without the patient's request.

Herbert Hendin, M.D., Seduced by Death: Doctors, Patients, and the Dutch Cure 23 (1997) (citations omitted).

Amici include health care professionals who have substantial reason to believe that they will be subject to significant pressure from their supervisors, insurance companies, and their employers (including managed care associations, nursing homes, and hospitals) to participate in the administration of fatal drug dosages to patients. Amici have religious convictions against enabling others to kill themselves, as well as against killing patients, whether or not the patient has consented to the killing.

Contrary to popular belief, individual physicians on staff at a hospital, health clinic, nursing home, or managed care organization often do not have sufficient autonomy to make medical decisions that carry significant economic costs for their employers. Employers who are concerned about a profitable bottom-line are unlikely to allow employee health professionals

the requisite scope to obey their religious convictions, when the employers will be bearing the economic cost of the employees' inconvenient religious convictions.

Part I of this brief describes several practical scenarios in which objecting physicians, medical students, nurses, pharmacists, and other health care professionals will find it virtually impossible to avoid participation in physician-assisted suicide. For example, physicians likely will be required to justify, to their employers or insurance companies, a decision not to provide fatal drug dosages to terminally ill patients. Physicians will be asked to provide suicide assistance to patients unable to make such a decision for themselves, but whose legal guardian or surrogate decision maker desires a fatal dosage to be administered.

Nor will physician-assisted suicide affect only the patient and doctor. A nurse or physician assistant is most likely to be the agent required to administer the fatal dosages, just as he or she is the person who administers most medications to patients in hospitals, clinics, and nursing homes. The ordering physician is unlikely to be sensitive to a nurse's failure to "carry out orders," particularly when the physician is likely to perceive the nurse's refusal as an implicit condemnation of the physician's own morality.

In medical school or residency, medical students may be required to learn, using real patients, how to administer fatal dosages in the proper strength and manner. Medical facilities

that refuse to provide such training may be threatened with a loss of accreditation.

The circuit court below failed to give adequate consideration to the legitimate concerns of the numerous health professionals who are prohibited by religious convictions from intentionally killing another human being or assisting another person in committing suicide. The court below also wrongly assumed that appropriate legislation could be enacted to protect against the overwhelming potential for abuse created by its judicial finding of a right of physician-assisted suicide. See generally, Daniel Callahan & Margot White, The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village, 30 U. Richmond L. Rev. 1 (1996).

Part II describes the fundamental legal errors in the decision below. The circuit court wrongly equated termination of life-sustaining medical treatment with the affirmative prescription of lethal medication. Yet the common law, numerous state laws, several judicial opinions, and leading medical authorities all recognize that there is a critical distinction between a decision to stop treatment and a decision to administer deadly drug dosages.

ARGUMENT

I. PHYSICIAN-ASSISTED SUICIDE WILL PROFOUNDLY AFFECT THE ABILITY TO OBTAIN AND RETAIN EMPLOYMENT FOR HEALTH CARE PROFESSIONALS WHO HAVE RELIGIOUS CONVICTIONS AGAINST THE INTENTIONAL KILLING OF ONESELF OR OTHER HUMAN BEINGS.

A. CONTRARY TO THE DECISION BELOW, HEALTH CARE PROFESSIONALS WITH RELIGIOUS CONVICTIONS AGAINST KILLING OTHER PERSONS WILL NOT BE ABLE TO AVOID THE WIDESPREAD EFFECTS ON THE HEALTH CARE SYSTEM OF PHYSICIAN-ASSISTED SUICIDE.

At its core, the practice of medicine is based on a relationship--the relationship between the patient and the physician. Both have a moral stance in the relationship, with external and internal pressures acting upon each. The discussion regarding physician-assisted suicide typically focuses on the patient's desires, needs, or rights. However, even if a legitimate case could be made for the need of the patient to be assisted by a physician in committing suicide, the interests and needs of the other party to the relationship--the physician--must be protected.

Nor can the examination of the physician's role in physician-assisted suicide myopically focus solely on the physician who is willing to assist a patient in committing suicide. The legalization of physician-assisted suicide will affect all physicians and other health care professionals caught in the complex web of insurance companies, public and private hospitals, nonprofit and for-profit medical clinics, and government bureaucracies that constitute the modern health care system.

Legalizing physician-assisted suicide is certain to affect

physicians who object for religious reasons to the intentional termination of another human being's life. For legal as well as economic reasons, physicians will find it increasingly difficult to refuse to assist patients in committing suicide. Once legalized, the practice of physician-assisted suicide will become the norm, the standard of care expected from a physician. It is likely that a positive duty to perform this "service," to assist patients to commit suicide, will be recognized and become a potential source of malpractice claims against physicians who refuse to perform physician-assisted suicides.[2]

Physicians with religious objections to killing oneself or other human beings will be forced either to aid directly in suicide or, at a minimum, to be an accomplice to the suicide by arranging referrals to physicians who are willing to participate.[3] Under some forms of managed care organizations, physicians who refuse to assist a patient in killing himself are likely to be required to pay another physician's charges for

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[2]Government officials in the Netherlands, the Minister of Health and the Chief Inspector of Public Health, have stated that "if a doctor did not agree to perform euthanasia on a patient who requested it and did not refer the patient to another doctor who would, he was guilty of malpractice and should be brought up on disciplinary charges." Herbert Hendin, M.D., Seduced by Death: Doctors, Patients, adn the Dutch Cure 110 (1997).

[3]See Hendin, supra at 105 (Dutch doctor who "ceased his open opposition" to euthanasia after "[h]is practice, which depended on referrals from general practitioners, was hurt by his attitude toward euthanasia"); id. at 106 ("documentation of actual cases of involuntary euthanasia is difficult since Dutch doctors who witness involuntary euthanasia avoid saying so publicly... [g]iven the impact on their careers of opposing the medical establishment").

killing the patient. The overriding economic fact about physician-assisted suicide is that it will always be more cost effective to kill, than to heal.

Scenario 1: Dr. Smith is a primary care physician working in a managed care organization. The organization uses a strict capitation model for care, in which patients initially see their primary physician for all complaints and are referred to a specialist only if the primary physician feels it is necessary. The physician must certify the need and authorize the funding for this care, The organization adopts this model of care in order to decrease expenditures for specialty care and realizes a profit only if actual expenditures are less than or equal to those planned for during the term of the contract with the physician. Physicians who repeatedly exceed their "caps" are unlikely to have their contracts renewed.

Dr. Smith evaluates a patient with AIDS, who is still likely to live a considerable length of time but who requests Dr. Smith's assistance in committing suicide now. Dr. Smith considers the likely expenses involved in providing care for this patient if the patient chooses maximal therapy over the next months and years, as opposed to the expenses incurred if the patient commits suicide within the month.

Recognizing that maximal therapy will greatly exceed the cap for this patient, Dr. Smith is nonetheless unable for religious reasons to participate in the suicide herself or to refer the patient to another physician. As a result of this decision, Dr.

Smith faces several crises involving coercion of conscience:

1) May her employer, the managed care organization, require her to refer the patient to a physician willing to help him commit suicide?[4]

2) If Dr. Smith is bypassed and someone else in the managed care organization refers the patient to a physician who will assist him in committing suicide, may the employer, the managed care organization, require Dr. Smith to pay for the expenditure for the suicide procedure from her own account?

3) Given that the option for physician-assisted suicide is better financially for the managed care organization, may the organization require its employee Dr. Smith to inform all her HIV-positive, or other terminally ill, patients about the option of physician-assisted suicide?'

"The Uniform Health-Care Decisions Act, approved by the National Conference of Commissioners on Uniform State Laws in 1993, requires a health-care provider to comply with an individual's health-care decision unless the provider declines for reasons of conscience. If the provider or institution declines for reasons of conscience, the patient must be promptly informed and the provider or institution must "immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision." Unif. Health-Care Decisions Act §7(e)-(g), 9 U.L.A. 220, 239 (1993).

'Merely raising the option may suggest to a patient that "'his or her life was not worth living, a message that would have a powerful effect on the patient's outlook and decision."' Chairman Charles T. Canady, Subcomm. on the Const. of the House Comm. on the Judiciary, 104th Cong., 2d Sess., Physician-Assisted Suicide and Euthanasia in the Netherlands 9 (Comm. Print 1996) (hereinafter "Physician-Assisted Suicide Report") (quoting testimony by hearing witness psychiatrist Dr. Herbert Hendin on the prevalence of doctors in the Netherlands who initiate the idea of euthanasia as a treatment option with their patients).

4) Will Dr. Smith's "mix" of patients change, making her more likely to exceed her overall "cap," with the attending economic consequences for her practice and the likelihood that her contract with her employer will not be renewed?

5) May the managed care organization require Dr. Smith to inform all her patients, even those without lethal illnesses, of the option of physician-assisted suicide, in order for them to include the option in their advance written directives?

6) May Dr. Smith be required to record in a patient's records an advance written directive requesting physician-assisted suicide?"

Physician-assisted suicide also threatens nurses, medical students, pharmacists, and other health care providers with religious objections to the intentional killing of other human beings, As the following scenarios illustrate, " [n]urses and many other health care workers are particularly vulnerable to pressure because they occupy subordinate positions in the hospital/medical hierarchy." Lynn D. Wardle, Protecting the Rights of Conscience of Health Care Providers, 14 J. Leg. Med. 177, 220 (1993).

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[6]Cf., The Federal Patient Self-Determination Act, 42 U.S.C.A. § 1395cc(f) (West 1992 & Supp. 1995) (requiring all health care providers receiving Medicaid or Medicare to inform patients about state laws regarding advance directives to refuse life-sustaining treatment and to record any advance directive of the patient). If the decision below is affirmed, it is foreseeable that the state government might require all physicians to record patients' advance directives regarding physician-assisted suicide.

scenario 2: Nurse Doe is the registered nurse responsible for the medical/surgical floor in a small community hospital. A patient on the floor, who is unable to move or feed himself, requests his physician's assistance in committing suicide. The physician agrees to the patient's request and writes in the patient's chart the order for the patient to be given a lethal dosage of medicine.

Due to her religious convictions, Nurse Doe is opposed to the intentional killing of another human being. Therefore, she informs the physician that she will not administer the lethal dosage of medicine to the patient that the physician has ordered. The physician angrily states that he will administer the drug himself. He orders Nurse Doe to open the controlled substance cabinet to which she has the key.

Nurse Doe is unwilling to assist in the suicide at all. She faces job-threatening repercussions for her refusal to participate in the suicide, including:

1) May the physician file a complaint against her for refusing to carry out his orders?

2) May her supervisor take her refusal into consideration in her annual evaluation and in decisions regarding pay raises?

3) Must she abandon hospital nursing in order to avoid similar situations in the future as physician-assisted suicide becomes increasingly widespread?

This scenario is based on the Ninth Circuit's acknowledgment in <u>Compassion in Dying</u> that "in some instances, the patient may

be unable to self-administer the drugs and that administration by the physician, <u>or a person acting under his direction or control,</u> may be the only way the patient may be able to receive them." 79 F.3d at 831.

The nurse's role in assisting patients to commit suicide is the subject of the highly instructive, albeit chilling, <u>Guidelines for Euthanasia</u>, promulgated by medical groups in the Netherlands, "in regard to cooperation and job demarcation of doctors/nurses and aides in procedures relating to euthanasia." Royal Netherlands Society for the Promotion of Medicine and Recovery, Interest Association of Nurses and Nursing Aides, <u>Guidelines for Euthanasia,</u> <u>reprinted in</u> 3 Issues in Law and Medicine 429 (1988)(Walter Lagerwey trans.). The Guidelines concede that euthanasia has engendered problems between nurses and physicians:

> Lack of clarity in respect to tasks, competences, and responsibilities of doctors on the one hand and nursing personnel and aides on the other, with regard to euthanasia, gives rise to conflicts and dissension in daily practice.

<u>Id.</u> at 429-430.

While claiming that "euthanasia, if it occurs, is performed by a doctor," <u>id.</u>, the Guidelines "realize that there is a discrepancy between the content of these guidelines, in which it is posited that only a doctor shall be entrusted with the carrying out of euthanasia and <u>actual every day practice in which nursing attendants and aides are often directly involved in euthanasia activities</u>." <u>Id.</u> at 435 (emphasis added).

The Guidelines recognize that nurses will often receive the initial request for euthanasia. Id. at 433. In cases where the doctor has decided to carry out euthanasia, "[i]f the nursing and caring attendant has [sic] doubts about the manner in which the standards of appropriate medical care are carried out," the Guidelines direct the nurse to talk to the doctor. If the nurse still "continues to have serious doubts after receiving information from the doctor," she may consult a second physician or seek the "mediation of the nursing head of the division or directors of the institution," but she must inform both the patient and the attending doctor before she does any of the above. Id. at 434-435.[7]

As the primary direct caregivers to patients, nurses necessarily will be the persons most affected by the implementation of assisted suicide in hospitals and nursing homes. They are also the persons least likely to have sufficient influence or authority to be able to avoid complicity in assisting patients to commit suicide. The decisions below will force many nurses into an untenable position, forcing them either

[7]The Guidelines provide that doctors and nurses who have conscientious objections to euthanasia may refuse to participate in the process, But they must also not participate in the initial decisionmaking process "because then there can be no question of an objective participation in the decision for euthanasia." Id. at 436. That is, an anti-euthanasia physician's participation in the euthanasia decisionmaking process biases the process, but participation by a D-euthanasia physician does not. If a conscientious objector is the first person to hear the patient's request, "he is (morally) obligated to inform the patient of his view of euthanasia" and "give the patient the opportunity to contact another provider of assistance." Id.

to violate their religious convictions against taking the life of another human being or to forfeit their jobs.

Scenario 3: Dr. Jones is the physician attending the patients at a small nursing home owned and operated by a religious corporation. The religious tenets of the religious corporation prohibit the intentional taking of human life by oneself or by another. A patient in the nursing home, who has a terminal illness, requests that Dr. Jones assist her in committing suicide. Dr. Jones' religious convictions prohibit both the intentional taking of another human being's life and referral of the patient to a colleague whom he knows will assist her in committing suicide.

1) May the patient or her family sue Dr. Jones for refusing to accede to her request for assistance in committing suicide?

2) Must the religious corporation allow physician-assisted suicide for its patients who request it, even though its religious tenets prohibit such conduct?[8]

3) Must the physician or the religious corporation transfer

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[8]Some long-term care facilities have been required by judicial decrees to withdraw feeding and hydration tubes from patients despite the religious or moral objections of the institutions and their employees to withdrawal of life support. See, e.g., Gary v. Romeo, 697 F. Supp. 580 (D.R.I. 1988) (hospital ordered to remove feeding/hydration tube of patient in persistent vegetative condition unless patient could be promptly transferred to another facility); Matter of Jobes, 529 A.2d 434, 450-451 (N.J. 1987), stay denied, 483 U.S. 1036 (1987)(private nursing home prohibited from transferring patient to another institution and ordered to withdraw feeding/hydration tube from incompetent patient despite moral opposition of the institution and its employees); Brophy v. New England Sinai Hospital, 497 N.E.2d 626, 639 (Mass. 1986). See also, Wardle, supra, at 211-215.

the patient to a facility that will perform physician-assisted suicide?

Scenario 4: Pharmacist Johnson is on duty in the only pharmacy in town. He is filling a prescription for a large amount of barbiturates for a patient he knows to have a terminal illness. Because of the quantity and strength of the prescription, Mr. Johnson is reasonably certain that the drug will be used to terminate the patient's life. His religious convictions will not allow him to participate in a suicide. Mr. Johnson faces several issues as he ponders the situation, including:

1) Is it permissible for him to question the patient about the intended use of the prescription?

2) Is it permissible for him to discuss his concerns with the prescribing physician?

3) May the pharmacy owner require the pharmacist to fill the prescription, or would such an order be a violation of Title VII of the 1964 Civil Rights Act, or applicable state laws, prohibiting discrimination against religious employees?[9]

4) If so, what would constitute a "reasonable accommodation" of the religious employee's refusal to participate in a suicide?

5) If the pharmacy adopts a policy of not filling

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[9] See Wardle, supra, at 218 ("[I]n practice, Title VII has provided limited and uneven protection for the rights of conscience of health care workers. Some courts have been grudging in their application of Title VII to health care employees disciplined because of their opposition to abortion.")

prescriptions that the pharmacist reasonably believes might be used to commit suicide, will this lack of "service" make it less likely that the pharmacy will be chosen to participate in major health care plans that accept, even promote, physician-assisted suicide as a form of "treatment"?

Scenario 5: St. Mary Hospital is a health care and teaching hospital offering medical residency training programs, including programs in geriatrics, oncology, and AIDS treatment. St. Mary adheres to the directives of its sponsoring church, which prohibit the intentional taking of human life, including physician-assisted suicide.

The Accreditation Council for Graduate Medical Education (hereinafter "ACGME") is a nonprofit, private association that evaluates residency programs, based on its own standards. However, the state in which St. Mary Hospital is located bases its accreditation of a hospital entirely upon the recommendation of the ACGME. The ACGME withdraws St. Mary Hospital's accreditation as a teaching hospital, concluding that its programs for training medical residents in geriatrics, oncology, and AIDS treatment are deficient because they do not include actual clinical instruction in physician-assisted suicide.

1) If St. Mary Hospital sues for return of its accreditation, will its claim under the Free Exercise Clause of the First Amendment be outweighed by the ACGME's argument that the government has an overriding interest in providing

satisfactory physician education to residents?[10]

2) If St. Mary Hospital loses its accreditation, and thereby loses government funding and reimbursement (since a nonaccredited hospital generally cannot bill for government-funded health care), will it be able to remain open?

3) If medical training programs that refuse to provide actual clinical instruction in the administration of lethal drug dosages to patients are denied accreditation, will medical residents who desire a program in which they are not required to participate in clinical instruction in the administration of lethal dosages to patients be able to find such a program?[11]

If physician-assisted suicide is legalized, it is highly foreseeable that an attempt will be made to condition

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[10]The above scenario draws upon an actual case in which a religiously-affiliated hospital lost accreditation for its medical residency training programs in obstetrics-gynecology for a variety of reasons, including its refusal for religious reasons either to provide clinical instruction in abortion or to allow its students to receive such training elsewhere. A federal district court denied the hospital's claim under the free exercise clause to an exemption from the requirements of the ACGME, which the court assumed was a state actor for purposes of licensing medical facilities. The court ruled that the state's interest in "satisfactory physician education" overrode the hospital's religious convictions against providing training in abortion. St. Agnes Hospital of the Citv of Baltimore, Inc. v. Riddick, 748 F. Supp. 319 (D. Md. 1990).

[11]In the Netherlands, young doctors are reported to be "afraid to express publicly any opposition to euthanasia because they would not be given good academic appointments." Hendin, Seduced by Death, supra, at 107. See also, Wardle, supra, at 193, 221-222 (medical and nursing students are particularly vulnerable to pressure to participate in procedures to which they have moral or religious objections; students with such objections may be discriminated against in the admissions process or penalized during training, if they will not participate in morally controversial procedures.)

accreditation for all medical training programs upon the inclusion of clinical instruction in physician-assisted suicide. A similar requirement for abortion training was attempted in 1995, when the ACGME sought to impose on all medical training institutions a new accreditation standard requiring abortion training in all obstetrics/gynecological residencies. Diane M. Gianelli, Legislators Seek to Bypass ACGME Abortion Training Rule, American Medical News, July 17, 1995, at 1. Initially, the ACGME proposed standard required institutions that opposed abortion to make arrangements for residents who did not object to abortion to learn the procedure at another institution. Id. at 22. In response, in 1996, Congress prohibited the federal, state, and local governments from discriminating against a health care professional, a hospital, or a residency program because of the person's or entity's refusal to perform, train in the performance of, or make referrals for training in or performance of abortions. 42 U.S.C. §238n(a)(1) (1996). The law specifically provides that residency programs must be accredited if they meet all criteria for accreditation except for a requirement that it train in the performance of induced abortions. 42 U.S.C. §238n(b)(1) (1996).

As these scenarios illustrate, the ramifications of a decision to allow physician-assisted suicide will affect every health care professional, regardless of his or her religious or moral convictions about physician-assisted suicide. The decision below was naive in its assumption that the legalization of

physician-assisted suicide would affect only consenting patients and consenting physicians.

B. THE COURT BELOW FAILED TO CONSIDER ADEQUATELY THE RIGHTS OF CONSCIENCE OF MEDICAL CARE PROFESSIONALS.

As the scenarios in Part I illustrate, the right of physician-assisted suicide will contaminate every aspect of the health care system, Inevitably, this taking of life will be extended to patients who are not competent to make the decision for themselves, are not terminally ill, and are not able to administer the lethal dosage to themselves. The arguments relied upon by the circuit court below cannot be cabined to "protect" only patients who are terminally ill, competent, and capable of self-administering the lethal overdose. See, e.q., Yale Kamisar, Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia, in Euthanasia Examined 225, 230-240 (John Keown ed., 1995) ; Yale Kamisar, Aqainst Assisted Suicide--Even a Very Limited Form, 72 U. Det. Mercy L. Rev. 735, 745-749 (1995) (noting statements by leading advocates of physician-assisted suicide that active voluntary euthanasia should be extended to individuals physically unable to self-administer a lethal overdose) .

It is particularly instructive that the United States Ninth Circuit Court of Appeals in its decision finding a substantive due process right to physician-assisted suicide admitted that such a right would necessarily be extended to persons who were not competent, were not terminally ill, or were not capable of self-administration of the lethal overdose. Compassion in Dying

v. State of Washington, 79 F.3d 790 (9th Cir.), cert. granted sub nom. State of Washington v. Glucksberg, 117 S. Ct. 37-38 (1996) (No. 96-110)(argued January 8, 1997); id. at 831 ((definition of terminal illness "includes persons who are permanently unconscious, that is in an irreversible coma or a persistent vegetative state"); ibid. ("recogniz[ing] that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them" but denying that issue was being decided); id. at 832 n.120 ("Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.")

The course of events in the Netherlands following its courts' de facto legitimization of physician-assisted suicide is empirical evidence that physician-assisted suicide quickly becomes active euthanasia. In just two decades, the Dutch legal and medical systems have gone from "toleration of the practice of physician-assisted suicide for physically-suffering, terminally-ill, competent patients to the judicial and medical sanctioning of the non-consensual termination of patients' lives." Physician-Assisted Suicide and Euthanasia in the Netherlands, Report of Chairman Charles T. Canady to Subcomm. on the Const. of the House Comm. on the Judiciary, 104th Cong., 2d Sess. 2 (Comm. Print 1996). As a psychiatrist who has studied the Dutch experience with physician-assisted suicide has concluded:

> The experience of the Dutch people makes it clear that legalization of assisted suicide and euthanasia is not the answer to the problems of people who are terminally ill. The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for people who are terminally ill to euthanasia for those who are chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to involuntary euthanasia (called "termination of the patient without explicit request"). The Dutch government's own commissioned research has documented that in more than one thousand cases a year, doctors actively cause or hasten death without the patient's request.

Herbert Hendin, M.D., Seduced by Death: Doctors, Patients, and the Dutch Cure 23 (1997) (citations omitted). See also, John Keown, Euthanasia in the Netherlands: Sliding Down the Slippery Slope?, in Euthanasia Examined, supra, at 261. Furthermore, health professionals in the Netherlands who have religious or moral objections to the taking of other human beings' lives may be subject to disciplinary charges if they will not refer the person to a doctor who will assist in his or her suicide Hendin, suara, at 110-111, 123.

The court below casually addressed the deadly dilemma its decision would force upon many physicians when it wrote:

> Although Dr. McIver, under this Court's order, has the right, without fear of prosecution, to assist Mr. Hall, he cannot be compelled to do so. As an individual and a physician, he can determine his own ethical, religious, and moral beliefs in declining or agreeing to assist. Like Mr. Hall, he has that freedom of choice.

McIver v. Krischer, No. CL 96-1504-AF, slip op. at 23 (Palm Beach County Cir. Ct., Fla., Jan. 31, 1997).

The court's assertion that physicians will be able to act in accordance with their own "ethical, religious, and moral beliefs"

is completely unsupported in reality. The legalization of physician-assisted suicide leaves not only physicians, but also less-empowered health professionals, at the mercy of supervisors who have the authority to issue orders that they assist in patients' suicides. Physicians will face increased malpractice litigation as physician-assisted suicide becomes the accepted standard of care for all physicians, even those with religious objections. Nor does the decision protect religiously-affiliated health care facilities from state regulations or private lawsuits requiring such treatment.

Instead, the court below created a new right to physician-assisted suicide and then, in a footnote, passed the responsibility for implementing the right to the state legislature. Slip op. at 19 n.6. If the decision below is upheld, the Florida legislature now has no choice as to whether to recognize such a right but instead is left the messy task of making an unworkable "right" work. Public debate on an issue of vital importance to every Florida citizen has been thwarted by the decision below.

The court below wrongly assumed that appropriate legislation could be enacted to protect against the overwhelming potential for abuse created by its judicial finding of a right of physician-assisted suicide. To the contrary, sufficiently protective legislation is not only unlikely, but realistically impossible. As two legal commentators have concluded:

> Some PAS [physician-assisted suicide] proponents... appear to assume for PAS transactions an

> idealized picture of the physician-patient relationship as one characterized by relative equality, intimacy, shared power, and open communication. This ideal is rarely realized in practice....
>
> [I]t is not within the capacity of any law to pierce the veil of doctor-patient confidentiality, or to overcome the complex uncertainties of medical decisionmaking, the inherent instability of the concept of terminality, the vagaries of prognosis and mental status, the subtle emotional interactions of the dying and the doctor, or the infinity of human suffering.. ..**The belief that a better law could enact truly protective guidelines which would enable this practice to live up to the idealized vision of its proponents is to presume vastly more from medicine and law than either is capable of delivering....**
>
> [T]he proponents of legalization often claim that statutes will be able to limit the practice to PAS and maintain the prohibition against euthanasia where the state's legislators choose to do so, or that either or both practices can be limited to the conscious and alert patient and will not be administered to the unconscious or the unwilling. There is no basis, either in law or in history, for these assumptions.

Daniel Callahan & Margot White, The Lesalization of Physician-Assisted Suicide: Creatinq a Requlatorv Potemkin Villaqe, 30 U. Richmond L. Rev, 1, 62-63 (1996) (citation omitted) (emphasis added) .

At the very minimum, the court below should have required fundamental protection for the freedom and conscience of all health-care personnel and institutions when it created a right to assisted suicide. Ironically, the court below relied in part upon a decision by the Third District Court of Appeals stating that:

> Surely nothing, in the last analysis, is more private or more sacred than one's religion or view of life, and here the courts, quite properly, have given great deference to the individual's right to make decisions vitally affecting his private life according to his own conscience. It is difficult to overstate this right because it is, without exaggeration, the very bedrock

on which this country was founded.

Public Health Trust of Dade County v. Wons, 500 So.2d 679, 687 (Fla. 3d DCA 1987), aff'd, 541 So.2d 96 (Fla. 1987).

Yet, if this standard covers ending one's life by assisted suicide, then it certainly must cover not having to participate in another's suicide. Assisted suicide, by definition, is not a lone act: It requires one or more assistants. No one should be forced to aid in killing, even if that assistance is necessary for persons desiring to kill themselves -- as it most certainly will be for many hospital and nursing-home patients.

However, drafting, then enacting, and then enforcing comprehensive legislation that will realistically protect health workers' conscience rights from economic and legal coercion in every situation will be difficult, if not impossible. As one legal commentator concluded after surveying the current state and federal "conscience clauses" for health care workers:

> The current patchwork of state and federal conscience clause laws are well-intentioned but obviously and profoundly inadequate....Virtually all are too narrow, cover too few health care providers, in too few situations, are too easily circumvented, and provide inadequate remedies and procedures to be effective. The deficiencies of these statutes have been compounded by the grudging interpretation given such provisions by many courts.

Wardle, supra, at 226.[12]

Physician-assisted suicide threatens not only the right of health-care institutions and individual practitioners to refuse

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[12]Professor Wardle does offer a model "Health Care Providers' Rights of Conscience Protection Act." Id. at 227.

to assist patients in committing suicide but also jeopardizes the freedom and conscience of patients. Opponents of physician-assisted suicide reasonably fear that, if the practice is legalized, then it will lead to cases where patients are put to death without their full and free consent. See, e.g., Kamisar, Against Assisted Suicide--Even a Very Limited Form, supra, at 230-240. Indeed, in the Netherlands, the only country where physician-assisted suicide is openly practiced, many cases have been documented in which involuntary euthanasia has occurred despite rules against it and procedures theoretically designed to prevent its occurrence. See Carlos F. Gomez, Regulating Death: Euthanasia and the Case of the Netherlands, 104-13 (1991).[13]

If physician-assisted suicide were legalized in the United States, persons needing hospital or nursing-home care would need to be assured the realistic option to choose an institution where that practice could never happen to them, even when they were weakest and most vulnerable. These important concerns for health care professionals and patients whose rights are endangered by any legalization of physician-assisted suicide underscore its dangers and why it is reasonable (indeed compelling) for states

[13]The 1996 report, Physician Assisted Suicide and Euthanasia in the Netherlands, to the Subcommittee on the Constitution of the House Committee on the Judiciary, describes one account of a doctor allegedly "terminat[ing] the life of a nun a few days before she otherwise would have died because she was in excruciating pain, but her religious convictions did not permit her to ask for death." Physician Assisted Suicide Report, supra, at 19. The report concluded that "the doctor had as little respect for the right to self-determination as he had for religious freedom." Id.

to outlaw the practice.

II. THE COURT BELOW WRONGLY EQUATED TERMINATING LIFE-SUSTAINING MEDICAL TREATMENT WITH PRESCRIBING LETHAL MEDICATION IN ESTABLISHING AN EQUAL PROTECTION RIGHT TO ASSISTED SUICIDE.

In addition to its finding of a state constitutional right, the court below held there is a federal constitutional right to physician-assisted suicide under the Equal Protection Clause of the Fourteenth Amendment, relying exclusively on the decision of the United States Second Circuit Court of Appeals in Quill v. Vacco, 80 F.3d 716 (2d Cir.), cert. granted, 117 S. Ct. 36-37 (1996) (No. 95-1858) (argued January 8, 1997).[14] In Quill, the Second Circuit correctly identified "rational basis scrutiny" as the appropriate standard of judicial review under the Equal Protection Clause for statutes outlawing assisting another to commit suicide. However, on the crucial issue of equating types of terminally ill persons, the panel wrote that "those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." 80 F.3d at 729. Yet neither the panel opinion in Quill nor the

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[14]Like its companion case from the Ninth Circuit, the Quill case was argued before the United States Supreme Court on January 8, 1997. The argument has led some court observers to predict that the Court will not affirm a constitutional right to physician-assisted suicide. See Joan Biskuspic, Justices Skeptical of Assisted Suicide, Washington Post, January 9, 1997, at Al ("In the end, it appeared a majority [of the Supreme Court Justices] would not vote to establish a right to physician-assisted suicide,")

decision below offer any medical, ethical, or historical authority--indeed, any authority of any type other than their own reasoning from prior decisions--for equating the two groups,

The absence of authority here is telling because it involves a central issue in medical ethics. The great weight of authority maintains that there is a fundamental difference between allowing patients to die by withdrawing or withholding medical treatment and hastening death through medical intervention. This distinction dates at least as far back in Western medical tradition as the ancient Hippocratic Oath. Referring to this oath, the United States Supreme Court once observed: "It represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day." Roe v. Wade, 410 U.S. 113, 131, 93 S. Ct. 705, 716, 35 L.Ed.2d 147, 165 (1973). Under the Hippocratic Oath, which is attributed to the 4th century B.C. Greek physician Hippocrates, a physician may refrain from treating patients but may never prescribe any "deadly medicine," even if asked.[15]

A. PHYSICIANS AND MEDICAL ETHICISTS TODAY DISTINGUISH BETWEEN HASTENING DEATH AND ALLOWING TO DIE.

The major Anglo-American professional associations of physicians vigorously maintain this distinction today. Thus, for example, the American Medical Association condemns physician-assisted suicide as "contrary to that for which the medical

[15]The text of the Hippocratic Oath is widely reprinted, with this quote taken from the Oath as reprinted in Donald D. Millikin, Oath of Hippocrates, in 12 Collier's Encyclopedia 137, 137 (1994). For commentary on this distinction, see Willard Gaylin, et al., Doctors Must Not Kill, 259 JAMA 2139 (1988).

profession stands" while it condones the withdrawal of life-sustaining treatment if it is in accordance with "the decision of the patient and/or his immediate family."[16] The British Medical Association assumed a similar stance in its 1988 Euthanasia Report, which concluded, "There is a distinction between an active intervention by a doctor to terminate life and a decision not to prolong life (a nontreatment decision)."[17]

Leading medical ethicists also accept this distinction. For example, the Hastings Center, a prominent national institute for the study of medical ethics, concluded in a 1987 report that helped shape the right to refuse life-sustaining treatment:

> Some persons who accept this right of patients to decide to forego treatment are concerned nevertheless that the values supporting it, and in particular self-determination, necessarily imply that voluntary euthanasia and assisted suicide are also justified. We disagree. Medical tradition and customary practice distinguish in a broadly accepted fashion between the refusal of medical intervention and intentionally causing death of assisting suicide.

Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying 129 (1987). Four of America's premier physician-ethicists, Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino, and Mark Siegler, jointly declared on

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[16]Quoted from a 1973 resolution of the American Medical Association House of Delegates, reprinted in Thomas D. Sullivan, Active and Passive Euthanasia: An Impertinent Distinction?, in Euthanasia: The Moral Issue 53, 54 (Robert M. Baird & Stuart E. Rosenbaum, eds. 1989). For reference to a similar position taken by the Judicial Council of the American Medical Association in 1986, see Gaylin et al., supra n.15, at 2139.

[17]Conclusions of a British Medical Association Review of Guidelines on Euthanasia, in Euthanasia, supra, at 155.

this point, "Generations of physicians and commentators on medical ethics have underscored and held fast to the distinction between ceasing useless treatments (or allowing to die) and active, willful, taking of life." Gaylin et al., supra, at 2139. These ethicists added, "Neither legal tolerance nor the best bedside manner can ever make medical killings medically ethical." Id.

An exhaustive study of the issue by the official New York State Task Force on Life and the Law reached a similar conclusion in 1994. New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (1994).[18]

This Court has also distinguished the withdrawal of medical treatment from suicide. In In re Guardianship of Browning, 568 So.2d 4 (Fla. 1990), this Court stated: "[S]uicide is not an issue when, as here, the discontinuation of life support 'in fact will merely result in [her] death, if at all, from natural causes."' Id. at 14, quoting Satz v. Perlmutter, 362 So.2d 160, 162 (Fla. 4th DCA 1978), adopted, 379 So.2d 359 (Fla. 1980). This Court also stated that "[e]uthanasia is a crime in this state." Browning, 568 So.2d at 13, citing Sec. 782.08, Fla.Stat. (1987).

Given the overwhelming weight of medical and ethical

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[18]For a fuller discussion of this distinction, see Edward J Larson, Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide, 18 Seattle U. L. Rev. 509, 516-19 (1995).

authority against its position, it is understandable that the decision below does not cite any medical or ethical authority for equating physician-assisted suicide with terminating life-sustaining medical treatment. Physicians and medical ethicists typically view the two situations as fundamentally different.

B. THE COURT BELOW GAVE AN INADEQUATE BASIS FOR EQUATING PHYSICIAN-ASSISTED SUICIDE WITH THE RIGHT TO REFUSE TREATMENT.

The court below relied exclusively on the Quill case for its equal protection holding. The only evidence that the Quill court offered to support its equal protection holding was the citation of New York State statutory and common law regarding the right of terminally ill persons to refuse life-sustaining treatment. It then quoted Justice Scalia's concurring opinion in Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 296-297, 110 S. ct. 2841, 2861, 111 L. Ed.2d 224 (1990) (Scalia, J., concurring), as authority for dismissing "the action-inaction distinction" as irrelevant, leading to its conclusion that there is no legally meaningful distinction between "ordering the discontinuance of . . . artificial life-sustaining processes" and "writing a prescription to hasten death." Quill, 80 F.3d at 729. In both cases, the panel wrote, "The ending of life by these means is nothing more nor less than assisted suicide." Id. Justice Scalia's comment, of course, did not address the latter act and, as noted above, mainstream medical and ethical opinion simply does not equate the two actions. As the 1987 Hastings Center report concluded, "a reasonable, if not unambiguous, line can be

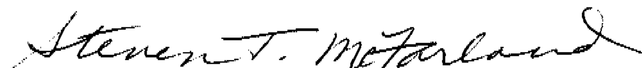
drawn between foregoing life-sustaining treatment on the one hand, and active euthanasia or assisted suicide on the other." Hastings Center, supra, at 6.

The Second Circuit panel and the court below ignored this line and wrongly ordered the state to do likewise. Either the distinction between withdrawing life-sustaining treatment and prescribing lethal medication is sufficient to satisfy rational basis scrutiny, or many of America's most respected medical ethicists and physicians are irrational regarding an issue of central concern to their profession.

CONCLUSION

For the above reasons, the decision below should be reversed.

Respectfully submitted,



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March 7, 1997

Appendix

INTERESTS OF THE *AMICI CURIAE*

The **Christian Legal Society** ("CLS"), founded in 1961, is a nonprofit ecumenical professional association of 4,000 Christian attorneys, judges, law professors and law students with chapters in every state and at 85 **law** schools. CLS' legal advocacy and information arm, the Center for Law and Religious Freedom, defends religious exercise and the sanctity of human life in state and federal courts at all levels.

The Society is committed to religious liberty because the founding instrument of this nation acknowledges as a "self-evident truth" that all persons are divinely endowed with rights that no government may abridge nor any citizen waive. Declaration Of Independence (1976). Among such inalienable rights are those enumerated in (but not conferred by) the First Amendment, the first and foremost of which being religious liberty. The right sought to be upheld here inheres in all persons by virtue of its endowment by the Creator, Who is acknowledged in the Declaration. It is also a "constitutional right," but only in the sense that it is recognized in and protected by the U.S. Constitution. Because the source of religious liberty, according to our nation's charter, is the Creator, not a constitutional amendment, statute or executive order, it is not merely one of many policy interests to be

weighed against others by any of the several branches of state or federal government. Rather, it is foundational to the framers' notion of human freedom. The State has no higher duty than to protect inviolate its full and free exercise. Hence, the unequivocal and non-negotiable prohibition attached to this, our First Freedom is "Congress shall make **no** law. . . ."

The **Christian Medical and Dental Society** ("CMDS") **was** founded in 1931 and today represents over 10,500 members--primarily practicing physicians representing the entire range of medical specialties. These members share a common commitment to the principles of biblical faith and the integration of those principles with professional practice. Among other functions, the CMDS Medical Ethics Commission gathers together member experts in the field of medical ethics who formulate positions on vital issues. These positions are subsequently voted upon for adoption, amendment, or rejection by over 100 elected representatives to the national convention of the Society.

CMDS has through this democratic process arrived at a life-honoring consensus among the membership on the issue of physician-assisted suicide. CMDS views this life-honoring principle as essential to protecting the lives and best interests of our patients, practicing medicine conscientiously according to long-standing Hippocratic and religious principles, and preserving the public respect accorded to physicians as guardians of health and life.

The **Christian Pharmacists Fellowship International** (CPFI) was incorporated **as** a non-profit group of Christian pharmacists in 1984 with the express purpose of promoting the integration of Biblical principles into the practice of pharmacy. CPFI's membership is composed of professionals practicing **all** branches and specialties within the field of pharmacy. CPFI members adhere to a Statement of Faith which is Biblical and consistent with centuries old, accepted medical practice. This code of ethics expresses the responsibility "to do no harm".

As pharmacists, our members are concerned with the possibility of being required to administer and dispense prescriptions in connection with physician-assisted suicide. This is in direct conflict with our faith, consciences, and code of ethics. An official position paper has been published by CPFI which addresses this situation and is consistent with the aim and purpose within this brief, Therefore, the Board of Directors of Christian Pharmacists Fellowship International, its staff, and the membership at large lend our name, credentials and reputation in support of this paper.

The **Fellowship of Christian Physician Assistants** represents more than 7000 Physician Assistants working in virtually every type of medical and surgical practice setting throughout this country. As dependent medical practitioners, each PA serves as an agent of **a** physician carrying out physician-delegated orders and procedures. There is no doubt that physicians will choose to

delegate the "assisted suicide" of their patients. As Christians, we believe in the sanctity of each human life, created by God for His purposes, and that it is morally wrong for man to intentionally end that life. We firmly believe that each individual can and should be afforded the right for adequate pain relief, the best quality of life possible, and death with dignity. Physician-assisted suicide would provide for state-sanctioned euthanasia, which is tantamount to murder.

The **Nurses Christian Fellowship** was founded in 1948 and is a department of Intervarsity Christian Fellowship. It represents approximately 2000 nurses and publishes The Journal of Christian Nursing, which has over 9000 subscribers. The Nurses Christian Fellowship represents nurses who are students and faculty in schools of nursing, and nurses who work in hospitals, long-term care facilities, and health agencies in the community.

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