IN THE
SUPREME COURT OF FLORIDA

BARRY KRISCHER, *Appellant.*	
v.	**CAUSE NO. 89,837**
CECIL McIVER, M.D., et al., *Appellees,*	District Court of Appeal, Fourth District No. 97-379
	Circuit Ct. No. CL-96-1504-AP

BRIEF AMICI CURIAE OF THE NATIONAL RIGHT TO LIFE COMMITTEE, INC. AND FLORIDA RIGHT TO LIFE, *INC.* IN SUPPORT OF APPELLANT

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2. Whether the recognition of a right to assisted suicide will be limited to persons who are terminally ill and mentally competent.

3. Whether criminal prosecution is an adequate deterrent to abuse.

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STATEMENT OF THE INTERESTS OF AMICI[1]

The National Right to Life Committee, Inc. ("NRLC") is a nonprofit organization whose purpose is to promote respect for the worth and dignity'of all human life, including the lives of persons until the time of natural death. NRLC is comprised of a Board of Directors representing ***51*** state affiliate organizations and about 3,000 **local** chapters made up of individuals from every race, denomination, ethnic background, and political view. It engages in various political, legislative, legal, and educational activities to protect and promote the concept of the sanctity of innocent human life. The members of NRLC have been strong proponents of laws protecting innocent human life from the time of conception until the time of natural death. The members of NRLC have actively opposed the various initiatives to overturn

'Consents from the parties to filing this brief have been filed with the Clerk pursuant to the Rules of Appellate Procedure Rule 9.370.

state statutes barring assisted suicide. NRLC seeks to advance its interests by addressing the public policy issues herein.

Florida Right to Life (FRTL) is a nonprofit service organization. FRTL's primary purpose is to educate through the presentation of detailed and factual information about fetal development, abortion, alternatives to abortion, infanticide, assisted suicide, euthanasia, and related issues, so that individuals and the general public may make fully informed decisions.

The legal protection of the right to life of innocent human beings is the basic issue upon which all other issues of human rights and justice depend. It is the pivotal human rights issue, today, because once we abandon the basic democratic principle of equality--that all human beings deserve the protection of the law no matter what their size, their age or their degree of dependency--then the rights of all of us are less secure.

FRTL recognizes that there are complex problems in caring for people with disabilities and persons who are older and infirm, but they believe that problems must be solved with respect for the lives, individual rights and dignity of all human beings, especially those too young, too old, or too physically ill or disabled to defend themselves.

Members of FRTL are active in the pro-life movement both within Florida and throughout the United States. They come from diverse social, economic, racial, age and political backgrounds, and they are bound together by a common dedication to protecting

all human life. Their **goal** is to foster and protect society's traditional respect for life by supporting the civil and human rights of the unborn, people who are defenseless, older, and/or disabled, and all human life.

SUMMARY OF ARGUMENT

Although the Circuit Court decision below is purportedly an "as applied" decision, it constitutes a rule of **law** that provides a precedent and legal standard for acceptable behavior in the State of Florida. The dangerous effect of this ruling, if affirmed, will be that people will immediately begin to exercise their new found constitutional right to assisted suicide without the benefit of judicial review, and assisted suicide will not be controlled or limited except by prosecution.

There are three basic public policy arguments which will be presented. First, the court's order yields no adequate system of procedural safeguards and is not in the best interest of the public. The decision declares certain prerequisites which are so minimal and inexact that they cannot be considered to be procedural safeguards at all, It leaves the regulation of the right to the legislature. The safeguards in Oregon Measure 16 are a good example of the kind of safeguards likely to be proposed. Upon examination, they are found to be ineffective to protect vulnerable persons from abuse.

Second, the recognition of a right to assisted suicide will not be limited to persons who are terminally ill and mentally

Competent. The right to refuse life-sustaining treatment has become so broad so as to include never competent persons and minors due to equal protection arguments and the doctrine of substituted judgment. The precedents provided by the refusal of treatment line of cases will no doubt be used to expand the right of assisted suicide to include non-terminally ill persons, incompetent persons, and persons unable to self-administer the lethal dose.

Third, criminal prosecution is the only real procedural safeguard and it is an extremely inadequate one. Like **abortion,** assisted suicide will take place behind closed doors without **witnesses.** Because of the physician-patient privilege, and the death of the key witness, prosecutions for abuse will be rare. The unsuccessful attempts to prosecute Dr. Kevorkian in Michigan illustrates the inadequacy of prosecution to control abuses.

For the above public policy reasons, the decision of the Circuit Court should be reversed and no right to assisted suicide should be recognized.

ARGUMENT

Although the Circuit Court decision below is purportedly an "as applied" decision, it constitutes a rule of law that provides a precedent and legal standard for acceptable behavior in the State of Florida. The dangerous effect of this ruling, if affirmed, will be that people will immediately begin to exercise their new found constitutional right to assisted suicide without

the benefit of judicial review, and assisted suicide will not be controlled or limited except by prosecution. Prosecutors will not prosecute for abuse of that constitutional right unless the evidence for that abuse is "beyond a reasonable doubt." Since the participating physician and family will not likely object to assisted suicide or euthanasia of a person deemed terminally ill, few cases of abuse will ever be filed. The legislature may or may not be able to pass further safeguards in an attempt to protect the lives of the vulnerable.

Once a right is recognized, few challenges are brought. For example, once withdrawal of life-sustaining treatment was recognized as lawful by the courts, cases of abuse rarely arise because the participants are all in agreement. Older people, people with disabilities, and people who are terminally ill are not deemed worthy of protection in a society that glorifies beauty, good health, and youthfulness. Once killing is seen as a right, it is impossible to regulate it effectively.

There are three basic public policy arguments which will be presented here: (1) The court's order yields no adequate system of procedural safeguards and is not in the best interest of the public; (2) The recognition of a right to assisted suicide will not be limited to persons who are terminally ill and mentally competent; and (3) Criminal prosecution is the only deterrent to abuse and it is an extremely inadequate one.

I. THE CIRCUIT COURT'S ORDER YIELDS NO ADEQUATE SYSTEM OF PROCEDURAL SAFEGUARDS AND IS NOT IN THE BEST INTEREST OF THE PUBLIC.

The Circuit Court's order yields six assisted suicide requirements: (1) the patient must be competent; (2) the patient must be imminently dying; (3) the patient must be prepared to die; (4) satisfaction of requirements 1-3 must be determined by a physician; (5) the patient must self-administer the lethal medication;[2] and (6) the patient may take the lethal dose at any time without supervision. Although these prerequisites may appear reasonable to some, the evidence on closer examination shows how inadequate they are when put into practice.

Although the above prerequisites may be viewed as safeguards against abuse, they are too minimal to be considered **real** procedural safeguards. The Circuit Court admits as much when it states that "the courts must decide the constitutional rights of individuals on a case-by-case basis until the Legislature adopts a regulatory framework." Final Declaratory Judgment and Injunctive Decree, pp. 18-19. The Court elaborates its position in footnote six on page 19:

> The State, however, has the authority and responsibility to adopt regulations which safeguard against potential abuses. These safeguards are necessary, but should not unreasonably infringe upon the individual's rights of privacy and equal protection of the law. Regulation is a legislative, not a judicial function. . . . Further, the Legislature is

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[2] The phrase "lethal **medication" is an oxymoron.** A more accurate name would be "lethal prescription" or "lethal dose."

> invited to prospectively enact laws balancing the individual's constitutional right to determine his or her course of medical treatment, including the option to hasten his or her death, against the State's interest in preserving life, preventing suicide, protecting innocent third parties, and maintaining the ethical integrity of the medical profession.

What will these Florida regulations look like? Although no one knows for sure, they will undoubtedly be similar to those in Oregon Measure 16.[3] Will these regulations be adequate to control abuses? An examination of the evidence relied upon by the U.S. District Court in Oregon, and upon which it granted a permanent injunction, indicates a negative answer.

The State of Oregon is the firststate to legalize physician-assisted suicide. However, before the law went into effect, it was successfully challenged in the case of *Lee v. Oregon, 891* F. Supp. 1421 (D. Or. 1995).[4] The U.S. District Court issued preliminary and permanent injunctions. *Id.* at 1439 (permanent injunction); 869 F. Supp. 1491 (D. Or. 1994) (preliminary injunction). A right to assisted suicide, whether created by referendum, by statute, or by recognition of a new constitutional right, constitutes an exception to the plethora of

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'Oregon Measure 16 (1994), *reprinted in* Verbatim, *The Oregon Death with Dignity Act,* 11 Issues in Law & Med. 333 (1995).

*Although the District Court granted a permanent injunction based on the evidence which follows, the Ninth Circuit Court of Appeals vacated the judgment of the District Court and remanded with instructions to dismiss Plaintiff's complaint for lack of jurisdiction. Lee v. Oregon, Nos. 95-35804, 95-35805, 95-35854, 95-35948, and 95-35949 (9th Cir. Feb. 27, 1997).

state **laws** protecting vulnerable persons. For example, the following Oregon statutes protect its vulnerable citizens.[5]

Oregon Revised Statutes § 163.117 provides that:

> It is a defense to a charge of murder that the defendant's conduct consisted of causing or aiding, without the use of duress or deception, another person to commit suicide. Nothing contained in this section shall constitute a defense to a prosecution for, or preclude **a** conviction of, manslaughter or any other crime.

Oregon Revised Statutes § 163.125 provides that:

> (1) Criminal homicide constitutes manslaughter in the second degree when:
> (a) It is committed recklessly; or
> (b) A person intentionally causes or aids another person to commit suicide.
> (2) Manslaughter in the second degree is **a** Class B felony.

Oregon Revised Statutes § 161.205 provides that:

> The use of physical force upon another person that would otherwise constitute an offense is justifiable and not criminal under any of the following circumstances: . . . .
> (4) A person acting under **a** reasonable belief that another person is about to commit suicide or to inflict serious physical self-injury may use physical force upon that person

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'Florida has similar statutues protecting its citizens from suicide: § 212.08(7)(o)2b(III), Fla. Stat. (1996), extending the state sales tax exemption to charitable institutions that seek to prevent suicide; § 231.17(2)(a)4, identifying the minimum competencies for teaching certificates to include skills in suicide prevention; §§ 382.011(1) and 406.11(1)(a)3, setting forth special procedures for death certificates, autopsies and examination in cases of death by suicide; § 440.09(3), denying workers" compensation coverage where the injury is primarily the result of a willful intent to commmit suicide; § 365.171(4)(b), including in the state plan for emergency telephone number "911" suicide prevention; § 401.015, incluidng suicide agencies in statewide emergency medical telecommunications system; § 934.15(1) authorizing law endorcement to cut, reroute or divert telephone lines when person is armed and threatening suicide; and § **394.463** identifying among the criteria for involuntary psychiatric examination threat of serious bodily harm to self; etc.

> to the extent that the person reasonably believes it necessary to thwart the result.

Oregon Revised Statutes § 426.005 defines a "mentally ill person" as, inter alia, "a person who, because of a mental disorder is . . . Cdlangerous to self . . . ." Oregon Revised Statutes § 426.070 et seq. provide commitment proceedings for one who is a "mentally ill person," including emergency commitment proceedings.

While the foregoing statutes protect most Oregon residents from self-harm and assisted suicide, Oregon has by Ballot Measure 16 determined that the lives of persons who have the disability of a terminal disease, who are suffering from depression or undue influence, are not entitled to the same protections from self-harm and assisted suicide as those not deemed terminally ill.

The following are the relevant provisions of Ballot Measure 16: (1) a written request by an adult who has been determined by two physicians to be suffering from a terminal disease; (2) two witnesses who attest that the patient is capable, acting voluntarily, and not under coercion; (3) the attending physician shall inform the patient of his diagnosis, prognosis, potential risks in taking a lethal medication, the probable result, and the feasible alternatives; (4) the consulting physician shall examine the patient and his records, confirm in writing the diagnosis, verify that the patient is capable and acting voluntarily; (5) if either physician thinks the patient may be suffering from a psychiatric or psychological disorder, or depression, he will

refer the patient for counseling; (6) the attending physician shall ask the patient to notify the next of kin of his request for medication; (7) a fifteen day waiting period; (8) civil and criminal immunities for the physicians and health care providers. At first blush, these safeguards seem reasonable enough and they are probably typical of the type of safeguards that will be proposed whenever assisted suicide is legalized.[6]

However, these safeguards are inadequate because they clearly fail to protect vulnerable persons. The record of the Oregon **case,** upon which the preliminary and permanent injunctions were issued, establishes certain key facts, which are summarized as follows: (1) physicians are unable to accurately diagnose a person **as** having a "terminal disease"; (2) people with terminal illness commonly suffer from the psychiatric illness of depression or other form of impaired judgment; (3) primary care physicians have difficulty in diagnosing depression; (4) depression is a major factor leading to suicide; (5) depression is treatable; (6) major life decisions should not be made while one is depressed; (7) recovery from depression takes more than 15 days; (8) patients with terminal illness are vulnerable to

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[6]These are the type of "appropriate, reasonable, and properly drawn safeguards" suggested by the 9th Circuit. *Compassion in Dying v. State of Washington,* 79 F.3d 790, 833 (listing example safeguards that could be adopted).

external pressures and abuse; and (9) drug overdoses are notoriously unreliable in actually causing death.[7]

First, physicians are unable to accurately diagnose a person as having a "terminal disease." The U.S. District Court in Oregon found that "physicians often misdiagnose terminal illness" and that "a physician's prognosis of six months to live is often fallible." Lee v. State *of Oregon, 869* F. Supp. 1491, 1497. The *Affidavit of Richard Fenigsen, M.D., Ph.D.*[8] gives evidence of a 20-40% error rate even in the clinical diagnosis of a particular disease. *Fenigsen Affidavit* at ¶ 6. The Oregon defendants did not contest this fact. In one study, lung cancer was misdiagnosed in over 49% of the cases. *Id.* A report in the *British Medical* Journal of four patients referred to a hospice for terminal care with "untreatable cancer" revealed that they had neither terminal illness nor cancer. *Id.* at ¶ 7. "One of these patients had the [erroneous] diagnosis of cancer established (from pleural biopsy)

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[7]Most if not all of the facts presented here by expert witnesses in the Oregon case were also testified to in the Florida case. However, the transcript of the trial testimony in the Florida case was not available at the time this amici brief was prepared in order to be filed by the due date. Thus, no citations to the Florida record were possible.

[8]Appellees' Supplemental Excerpts of Record 111 (hereinafter Oregon Supp. E.R.), Clerk's Record 33 (hereinafter C.R.), Lee v. *Harcleroad, Nos. 95-35804, 95-35805, 95-35854, 95-35948, 95-35949* (9th Cir. Jan. 24, 1996). Richard Fenigsen, M.D., Ph.D., has forty years of experience with severely ill and dying patients in the Netherlands. He has twenty years experience with euthanasia and physician-assisted suicide as practiced in hospitals and by family physicians in the Netherlands. His affidavit was cited by the Oregon District Court at 869 F. Supp. at 1497.

by two pathologists and confirmed by a third." Id. Defendants did not contest these facts. As to the ability of a physician to predict that a patient will die of a disease within a certain amount of time, even if correctly diagnosed, that ability is "notoriously fallible." *Id.* at ¶ 17. Oregon defendants' *Affidavit of Timothy M. Quill, M.D.* (C.R. 84) appends an article by Dr. Quill in which he writes, "we acknowledge the inexactness of such prognostications [about whether a patient is 'near death'] ." *Id.* at Appendix D-2. According to the Michigan Supreme Court, "[n]o clear definition of 'terminal illness' is medically or legally possible, since only in hindsight is it known with certainty when someone is going to die." People v. *Kevorkian,* 447 Mich. 436, 467 n.34, 527 N.E.2d 714, 726 n. 33 (1994). Thus, the purported safeguard of a "medically confirmed diagnosis carries a risk of error ranging from 20 to 40 percent ." *Fenigsen Affidavit* at ¶ 8. Clearly, many "qualified patients" under Measure 16 will not actually be within six months of dying as Measure 16 envisions.

Second, people with terminal illness commonly suffer from the psychiatric illness of depression or another form of impaired judgment. The *Affidavit of Carol J. Gill, Ph.D.*[9] establishes that

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[9] "Oregon Supp. E.R. 21, C.R. 29. Carol J. Gill, Ph.D., is a clinical psychologist specializing in issues affecting persons with disabilities, pain, and/or chronic illnesses. She has worked clinically with this population in both hospital settings and private practice. Her former positions include: Director of Rehabilitation Psychology at Glendale Adventist Medical Center, Commissioner in Psychology on the Los Angeles County Commission on Disability; and Acting Director of the Program in Disability and Society at the University of Southern California. For the past five

> [m]ost crisis intervention models allow a minimum of five weeks for resolution of the acute emotional disorder attending **major personal** loss. Crisis counselors recognize that the judgment of a person who is ***legally*** competent and grossly oriented to reality and logic may nonetheless be emotionally distorted when reacting to overwhelming loss.

Id. at ¶ 18 (emphasis in original). Receiving a diagnosis of **a** terminal disease is clearly a major life stress and personal loss. A pamphlet entitled ***Depression: What*** **You** ***Need to Know,*** published by the National Institute of Mental Health (no date), at 4, and placed in the Lee v. ***Oregon*** record as an attachment to the affidavit of Intervenor Levin (Exhibit 28 to Exhibits to Intervenor Levin's "Motions Against Plaintiffs' Claims"; Oregon C.R. 149), confirms Dr. Gill's assertion, stating that: 'A serious loss, chronic illness, difficult relationship, financial problem, or any unwelcome change in life patterns can also trigger a depressive episode." Thus, many people with the major life stress of a diagnosis of terminal illness will suffer from depression, whether or not it rises to the level of clinical or major depression, and will have impaired judgment for making life and death decisions, even though legally competent. The New York State Task Force on Life and Law, in an exhaustive study entitled ***When Death Is Sought: Assisted Suicide and Euthanasia in the*** Medical ***Context*** (1994),[10] noted that "[i]ndividuals with serious

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years, she has devoted her professional life to research and education projects concerning persons with disabilities and chronic illness. She is currently the President of the Chicago Institute of Disability Research. Her affidavit was cited by the Oregon District Court at 869 F. Supp. at 1498 n.2.

chronic and terminal illness face an increased risk of suicide—some studies suggest that the risk for cancer patients is about twice that of the general population." New York Task Force at 13. The New York Task Force summed up the link between terminal illness and depression as follows·

> Depression may coincide with other medical conditions for several reasons. First, the medical condition may biologically cause depression. Second, the condition may trigger depression in patients who are genetically predisposed to depression. Third, the presence of illness of disease can psychologically cause depression, as is often observed in patients with cancer, Finally, especially for cancer patients, some treatments or medications have side effects that cause depressive moods or symptoms.

New York Task Force at 15. However, the task force found that

> [i]t is a myth . . . that severe clinical depression is a normal and expected component of terminal illness. Healthy individuals, including health care professionals, often believe that it is normal for terminally ill patients to experience major depression. They understand feelings of hopelessness as expected and rational given the patient's condition and prognosis.

New York Task Force at **16.** Further, some will clearly be at risk for depression at the time when they take the lethal overdose, when Measure 16 provides no safeguards to screen out those who are acting incompetently.

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[10]The task force **was** convened in 1985 by Governor Mario Cuomo, who charged the twenty-five-member body with developing recommendations for state public policy on a variety of issues. The report, hereinafter referred to as "New York Task Force," has been recognized **as** authoritative and relied upon by the Ninth Circuit Court of Appeals in the case of ***Compassion in Dying*** *v.* ***State of Washington,*** 49 F.3d 586 (9th Cir. 1995) .

Third, primary care physicians have difficulty in diagnosing depression. In the *Affidavit of Patricia Wesley, M.D.*,[11] Dr. Wesley, a psychiatrist and neurologist teaching in the Department of Psychiatry at Yale, cites a study by 'David Clark, a major researcher in suicides, and others," of men 65 years and older who committed suicide. *Id.* at ¶ *26 (citing* David C. Clark, *"Rational" Suicide and People with Terminal Conditions or Disabilities,* 8 Issues in Law & Med. 147, 152 (1992)). The study showed that

> 25% had been to a physician within 24 hours of death, 41% within one week of death, and 70% within one month of death. These contacts were for vague physical complaints. The general physician did not, and probably could not have, picked up either the psychiatric condition or the suicidal intention, at least as they were diagnosed retrospectively, by the psychological autopsy technique used in thisstudy.

Id. Dr. Wesley concluded:

> The above data indicate that it is not an easy task to diagnose either psychiatric illness or suicidality, and that such tasks are probably beyond the expertise of most non-psychiatric physicians. Nonetheless, [Measure 16] asks just such busy, front-line, untrained physicians to perform this vital screening function. It will inevitably be done poorly,

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"Oregon Supp. E.R. 11, C.R. 28. Patricia Wesley, M.D., is an assistant clinical professor of psychiatry in the Department of Psychiatry, School of Medicine, Yale University, New Haven, CT, where she supervises psychiatric residents in their outpatient psychotherapy work. Her other professional responsibilities include the evaluation and treatment of seriously and persistently mentally ill individuals in two outpatient facilities in New York City. One of these facilities exclusively serves individuals 55 and over, many of whom have significant medical problems. While she does not personally manage their medical conditions, she has gained considerable exposure to the impact of significant medical illness on psychological functioning. Her affidavit was quoted and cited by the Oregon District Court at 869 F. Supp. at 1498 n.2.

> and many whose wish to die is based on psychiatric disturbance will be aided in killing themselves.

Id. at ¶ 27. Dr. David C. Clark concurs that psychiatric evaluation and treatment is necessary for terminally ill persons seeking suicide:

> The definitions of "attending physician" and "consulting physician" in the Act permit any licensed physician, regardless of experience or specialty training, to function in these roles. There is no requirement that either party have any knowledge or expertise in evaluating mental status, cognitive state and functioning, or psychiatric disorder beyond the fundamentals most physicians are exposed to in medical school. The medical/surgical literature is very clear and consistent in showing that medical/surgical general practitioners and specialists (other than psychiatrists) fail to recognize at least half of all cases of clear-cut major depressive illness in their own practices-i.e., among their own patients-and then they are not successful at recognizing the more severe half of cases. It is my professional opinion that the Act should include' a requirement that trained and experienced mental health professionals examine each patient who makes a request for assisted suicide. This would protect people who, in the state of clinical depression, request assisted suicide without the opportunity for treatment.

Affidavit of David C. Clark, Ph.D.[12] at ¶ 27. The latest literature on suicidology confirms the above facts. In the September-October *1995* issue of *Psychomatics,* Harvard Medical School psychiatrists Block and Billings confirm that:

> [d]epression and organic mental disorders are commonly seen among patients who request assistance in dying. These disorders can both impair patient autonomy and coexist with

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[12]Oregon Supp. E.R. 89, C.R. 32. David C. Clark, Ph.D., is Professor of Psychiatry, Psychology, and Preventive Medicine, and Director of the Center for Suicide Research and Prevention, at the Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois. His supplemental affidavit was cited by the Oregon District Court at 869 F. Supp. at 1501 n.4.

> autonomous wishes for hastened death. Because of the irrevocability of hastening death, decisions about competency must be especially rigorous. Determination of competence in this setting is often extraordinarily challenging, requiring subtle evaluations of thought processes and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of alternative choices. Very rarely are nonpsychiatric clinicians adequately prepared to address this broad concept of competence, so psychiatric input is essential.

Susan M. Block, M.D. & J. Andrew Billings, M.D., ***Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist,*** 5 Psychosomatics 445, 452 (1995) . In the August ***1995*** issue of the ***American Journal of Psychiatry,*** a team of seven psychiatrists and other researchers reported the results of a Canadian study on the desire for death in the terminally ill-that terminally ill persons who desire death do so because of depression-and urged psychiatric involvement in such cases. Harvey M. Chochinov, M.D. et al., ***Desire for Death in the Terminally*** *Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995).

The Oregon record clearly shows on empirical evidence that there ***is*** "reason to believe" that primary care physicians, who are concededly not specially trained to diagnose and treat depression, are not capable at discovering, diagnosing, and treating depression. Finally, this fact is confirmed by the New York Task Force:[13]

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[13]The New York Task Force may be viewed as an impartial voice because it included both persons who favored and opposed assisted suicide personally, but all agreed that, even with attempted safeguards, there is too great a "risk of harm" in implementing a regime of state-endorsed assisted suicide, a risk which "is

> Even psychologists and psychiatrist who routinely treat and diagnose depression may have limited experience doing so for patients who are terminally or chronically ill. For those patients, clinicians must be able to distinguish realistic sadness and sense of loss that accompanies such illness from severe clinical depression or the psychiatric disorders that impair decision-making capacity. These disorders are prevalent in those patients who ultimately choose to commit or attempt suicide.

New York Task Force at 127-28.[14]

Fourth, depression[15] is a major factor leading to suicide. "Suicide is the eighth leading cause of death in the United States" and "is a major health problem." *Affidavit of David C. Clark, M.D.* (Oregon Supp. E.R. 89; C.R. 32; at ¶ 3). "Those aged sixty-five and over make up 12% of the population but account for

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greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized group." New York Task Force at 119.

[14]Even where depression is diagnosed, it is often undertreated, New York Task Force at 127, leaving terminally ill persons at risk for suicide both because depression is undiagnosed and because it is undertreated.

[15]The term "depression" is used here and elsewhere herein as a shorthand expression for a range of judgment impairing psychapathologies. Because space and readability do not permit continued reference to a string of psychiatric diagnoses that may lead to suicide, necessity dictates that a shorthand substitute be used. The *Affidavit of David C. Clark, Ph.D.* (Oregon Supp. E.R. 89; C.R. 32) sets forth the wide range of psychopathologies which lead to suicide, including depression. Other treatable causes of suicidal ideation and attempt include unrelieved pain and suffering, substance abuse, organic problems, and side effects of certain treatments. While these latter are not psychiatric problems, they represent treatable conditions which can lead to suicidal impulses and should be recalled when the shorthand term "depression" is used herein.

21% of all suicides." *Id.* Major suicide researcher Dr. David Clark reports:

> There is considerable agreement among the findings from the large community-based psychological autopsy studies on the relationship between major mental disorder and death by suicide. Never less than 88% of the subjects qualified for a psychiatric diagnosis at the time of the suicide (never less than 94% in all but one study). . . . Thus suicides rarely occur in the absence of major psycho-pathology.

Id. at ¶ 4. Further, "15% of persons with major depression die by suicide." *Id.* at ¶ 6. A Canadian study on the desire for death in the terminally ill, reported in the August 1985 issue of the *American Journal of Psychiatry,* confirms the connection: "in the logistic regression analysis, depression emerged as the only predictor for the desire for death." Harvey M. Chochinov, et al. **supra,** 152 Am. J. Psychiatry at 1190. The authors of the article cautioned that: "our findings indicate that a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression." *Id.* A 1986 study, reported in the *American Journal of Psychiatry* questioned, on the basis of empirical evidence, "[t]he role of terminal illness, physical decline, or chronic pain as a reason for suicide." *Affidavit of David C. Clark, M.D.* (Oregon Supp. E.R. 89; C.R. 32) at ¶ 19. Dr. Clark reports of the study that

> Brown and colleagues, in a study of hospice patients diagnosed with terminal illness, severe pain, disfigurement, or disability, found that the great majority of these patients did not desire to die by suicide. Of the small percentage who expressed any wish to die, all met diagnostic criteria for major depressive illness.

Id. at ¶ 20.[16] From this and other evidence, Dr. Clark concluded:

> While it is compelling to assume that many persons with chronic, painful, or terminal illnesses will choose to end their suffering prematurely by opting for suicide, in fact this type of choice, usually referred to as 'rational" suicide, is rarely seen in hospital and hospice work. Except in those cases where physical illness is accompanied by a major depressive illness, the great majority of patients spontaneously reject the suicide option and choose to die naturally. The majority of terminally ill patients cling to life throughout their illnesses. Among older persons, for whom chronic painful illnesses are not uncommon, only 0.5% of male deaths and 0.2% of female deaths are attributable to suicide.

Id. at ¶ 19. Clark concludes that

> [t]o wish to end life by killing oneself is almost **always a** serious symptom arising from **a** temporary psychiatric illness, even when the person is terminally ill. While the subtlety and complexity of depressive illnesses often make it difficult for loved ones to recognize the gravity of the problem, it is generally **a** mistake to assume that a wish to die or end one's own life is **a** rational, carefully thought-through decision justified by a person's life situation or health status. One should always suspect that an unrecognized psychiatric illness has silently, invisibly influenced the judgment of a patient opting for suicide. When a patient asks to die, the burden of proof should lie with those who wish to defend **as** "rational" **a** decision to die by suicide.

Id. at ¶ 31. The Oregon defendants' *Affidavit of Jerome A. Motto, M.D.* (Oregon C.R. 87) provides corroborating evidence of the link between depression and suicide, conceding that, by this criteria, half of all persons committing suicide "suffer from a psychiatric disorder" and that "one-third of all suicides suffer

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[16]Such empirical evidence belies the notion that it is normal and rational for persons with a terminal illness to be depressed and want to kill themselves. *See* also *Affidavit of David C. Clark, M.D.* (Oregon Supp. E.R. 89; C.R. 32) at ¶¶ 9-12, 19-21, 23-25.

from clinical depression." *Id.* at ¶ 5.[17] Finally, the New York Task Force documented that "As explained by one sociologist who studied suicide: 'It is undeniable that all persons-100 percent-who commit suicide are perturbed and experiencing unbearable psychological pain."' New York Task Force at 95 n.65 (quoting Edwin S. Schneidman, *Rational Suicide and Psychiatric Disorders,* 326 New Eng. J. Med. 889 (1992)).

Fifth, depression is treatable. "[D]epressed patients generally respond well to standard treatments for depressive illness-psychotherapy and some antidepressant medication." Affidavit of *David C. Clark, M.D.* (Oregon Supp. E.R. 89; C.R. 32) at ¶ 21. "In response to treatment, patients with terminal illnesses and intractable pain are usually grateful that no one facilitated their suicide while they were temporarily depressed or having acute difficulties with pain." *Id.* Oregon defendants' *Affidavit of* Jerome *A.* Motto, *M.D.* (C.R. 87) declares that Major Depressive Disorder, the "type of mood disorder that is often associated with suicidal states," "can usually be treated effectively with antidepressant medication." *Id.* at ¶ 4.

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[17]Other treatable reasons people seek suicide include unrelieved pain and suffering, New York Task Force at 128; substance abuse, *Affidavit of David C.* Clark, *M.D.* (Oregon Supp. E.R. 89, 91 ¶ 4; C.R. 32); psychological suffering, New Task Force at 94-95; and psychological pressure, *Affidavit of* **Gary E. Lee,** *M.D.* (Oregon Supp. E.R. 159, 162 ¶ 9; C.R. 36).

Sixth, major life decisions should not be made while one is depressed. As already noted, the ***Affidavit of Carol J. Gill, Ph. D.*** (Oregon Supp. E.R. 21; C.R. 29) establishes that

> [m]ost crisis intervention models allow a ***minimum*** of five weeks for resolution of the acute emotional disorder attending major personal loss. Crisis counselors recognize that the judgment of a person who is legally competent and grossly oriented to reality and logic may nonetheless be emotionally distorted when reacting to overwhelming loss.

Id. at ¶ 18 (emphasis in original). Dr. Gill continues: "[c]lients in crisis therapy are, therefore, cautioned not to make any major life decisions within five weeks of a critical life stress. The Act needlessly narrows this window to fifteen days." ***Id.*** The assertion that important decisions should not be made while one is depressed is uncontested.

Seventh, treatment for depression takes more than 15 days. As noted in the material quoted in the previous paragraph, resolution of acute emotional disorders takes a minimum of five weeks for resolution. This fact was uncontested. If treated depression will not resolve itself in less than five weeks, then 15 days is clearly too short a time for depression to resolve itself if undetected and untreated.

Eighth, patients with terminal illness are vulnerable to external pressures and abuse.[18] "[D]emoralizations and a lack of

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[18]Even race may play a role here. Annette Dula, a University of Colorado research associate and one of a few black academics studying bioethical issues, says "There is a lot of suspicion. People know they don't get the health care they need while they're living. So what makes them think anything's going to be more

assertiveness may render the depressed terminally ill patient more vulnerable to the suggestions of others, thereby increasing the potential for abuse." Harvey M. Chochinov, M.D. et al., *supra,* 152 Am. J. Psychiatry at 1190. See *also Affidavit of William Petty, M.D.*[19]

Ninth, drug overdoses are notoriously unreliable in actually causing death. Dr. Jerome R. Wernow, a pharmacist, has submitted evidence that 25% of assisted suicides will fail, based on the writings of Derek Humphrey, a Measure 16 proponent and a co-founder of the Hemlock Society (which advocates legalization of physician-assisted suicide and euthanasia). Affidavit *of Jerome R. Wernow, Ph.D.*[20] Dr. Wernow also cites evidence that barbiturate poisoning is the 'most uncertain way of taking one's life," *id.* at ¶ 8, raising the specter of patient coma, renal damage, toxic psychosis, serious central nervous system damage,

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sensitive when they're dying." Lori Montgomery, *Blacks' Suspicion Level Rises With Doctor-Aided Suicides,* Indianapolis Star, Mar. 2, 1997, at 14. Mary Harris Evans, who holds degrees in law and medicine, is one of two black members on the board of the Death with Dignity Education Center, and worries about the consequences of legalization for blacks. "There's a big fear of genocide in our community, whether it is right or wrong," Evans said. "People in the black community see death with dignity as just another way for them to be offed." *Id.*

[19]Oregon Supp. E.R. 1, C.R. 23, at ¶ 10. William Petty, M.D., is one of the Plaintiffs in Lee v. Harcleroad (Oregon) , and is a physician with offices in Portland, Oregon. Eighty percent of his patients are cancer patients.

"Oregon Supp. E.R. 169, C.R. 169, at ¶ 7. Jerome R. Wernow, Ph.D., is a pharmacist and biomedical ethicist in Oregon. His affidavit was cited by the Oregon District Court at 869 F. Supp. at 1502 n.5.

and protracted suffering for the patient and her family. *Id.* at ¶¶ 9-10.

From *all* these medical facts, Dr. Patricia Wesley, a psychiatrist teaching at the Department of Psychiatry at Yale, has concluded that

> [a]s David Clark puts it, "when a patient asks to die, the burden of proof should be with those who wish to defend a wish to die by suicide as a rational decision." Oregon's Death with Dignity Act has it precisely the other way round, and regards a terminally ill person's suicidal wishes as deserving of speedy implementation, unless proven otherwise. This law flies in the face of what we know about suicide and the terminally ill.

Affidavit of Patricia Wesley, M.D. (Oregon Supp.E.R.11;C.R. **28) at ¶ 30**. As discussed *infra* this reversal of presumptions from those established by the facts of modern suicidology is irrational and based on erroneous, unscientific stereotypes about why people commit suicide.

The safeguards in Oregon Measure 16 are typical of the type of safeguards being proposed to protect against abuse. However, as can be seen from the above evidence and argument, those safeguards will be inadequate to protect the lives of vulnerable persons from undue influence, duress, and clinical depression.

The prerequisites of the court for assisted suicide are inadequate safeguards and put tens of thousands of vulnerable people at risk for early termination of their lives with or without their consent by persons who will rarely be prosecuted for abuses or violations of law.

II. THE RECOGNITION OF A CONSTITUTIONAL RIGHT TO ASSISTED SUICIDE WILL NOT BE LIMITED TO PERSONS WHO ARE TERMINALLY ILL AND MENTALLY COMPETENT.

If a right to assisted suicide is recognized, the right will not be limited to persons who are terminally ill and mentally competent. The case law establishing a right to refuse life-sustaining medical treatment is binding precedent which will permit assisted suicide for persons who are not terminally ill, and surrogate decisionmaking for persons who are incompetent, comatose, or in a persistent vegetative state.

The Circuit Court in its decision below found a right to assisted suicide under the Florida Constitution and the equal protection clause of the U.S. Constitution based on the Second Circuit's decision in Quill v. ***Vacco, 80*** F.3d 716, 724-25 (2nd Cir. 1996), cert. granted, 117 S. Ct. 36 (1996). Based on *Cruzan*[21] and other refusal/termination of medical treatment cases, the Second Circuit held that those persons not receiving life-sustaining treatment also have a right to hasten death, by physician-assisted suicide. Id. at 729. Thus, equal protection clause jurisprudence will no doubt require the recognition of a right to euthanasia (e.g. lethal injection) for those who cannot take a lethal dose by mouth, and a right to mercy killing for those who are incompetent, comatose, or in a persistent

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[21] *Cruzan* ***v. Director, Missouri Dept. of Health, 497*** U.S. 261, 110 S. Ct. **2841, 111** L.Ed.2d 224 (1990).

vegetative state or otherwise unable to exercise their constitutional rights to consent. Physician-assisted suicide will necessarily result in the legalization of euthanasia and mercy killing.

The jurisprudence of cases asserting a right to refuse medical treatment will provide the precedent. The right to refuse medical treatment has roots in both the common law right to be free from invasion of one's bodily integrity, and the notion of battery, which is a rejection of unwanted touching. ***Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105*** N.E. 92 (1914) . However, beginning in 1976 with ***In re Quinlan,*** 70 N.J. 10, ***335*** A.2d ***647, cert. denied sub nom.*** *Garzer* ***v. New Jersey,*** 429 U.S. 922 (1976) (when the New Jersey Supreme Court authorized the removal of a ventilator from Karen Ann Quinlan, who was in a coma), many courts have expanded this right by holding that the U.S. Constitution, through the right of privacy, guarantees to individuals a fundamental right to reject medical treatment, including medical treatment without which they will die. Some courts have explicitly characterized this as a "right to die." The following are several cases illustrating the breadth of the right to die since ***Quinlan.*** These are the precedents which will control any recognized right to determine the time and manner of death.

First, there are cases where competent persons who were terminally ill requested the right to refuse life support: ***Tune***

v. Walter *Reed Army Medical Hospital, No. 85-0697,* slip op. (D.D.C. Mar. 4, 1985) (held that competent adult patients with terminal illnesses have a right to determine for themselves whether or not they wish their lives to be prolonged by artificial life support systems).

Second, there are cases where competent persons who were disabled but not terminally ill and requested the right to refuse life-sustaining treatment or tube feeding: *Bouvia v. Superior Court,* 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (held that no compelling state interest in the preservation of human life exists that would outweigh a competent but disabled person's right to terminate treatment because "the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration." 225 Cal. Rptr. at 304);[22] *McKay v. Bergstedt,* 801 P.2d 617 (Nev. 1990) (ratified the right to die for competent persons with disabilities who were dependent on life-sustaining treatment in order to live, e.g. those it described as having "an artificially extended life," "artificial survival," and an unchanging interest in hastening "natural death" for lives 'irreparably devastated by injury or illness.");[23] and *State v. McAfee, 259* Ga. 579, 385 S.E.2d 651

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[22]Ms. Bouvia has quadriplegia due to cerebral palsy. She has not chosen to exercise her hard won right to die.

[23]Kenneth Bergstedt was a thirty-one year old man with quadriplegia who died before the court's decision when his father, his primary caretaker, loosened the ventilator from his trachea after first administering Seconal and Valium. One week later, his

(Ga. 1989) (upheld a lower court decision permitting Larry McAfee to shut off the ventilator that he had used since his accident. The trial judge had ruled that McAfee's right to refuse life-sustaining treatment outweighed the state's interest in preserving life and stated: "The ventilator to which he is attached is not prolonging his life; it is prolonging his death,") .[24]

Third, there are cases where the persons are incompetent, but have previously expressed their wishes regarding the use of life-sustaining treatment: *Brophy* ***v. New England Sinai Hospital, Inc.,*** 398 Mass. 417, 497 N.E.2d 626 (1986) (held that casual remarks made by a patient prior to the onset of any illness could be sufficient evidence to find that the now incompetent patient would, if competent, decline to receive tube feeding);[25] ***Cruzan v. Director, Missouri Dept. of Health, 497*** U.S. 261 (1990) (upheld the state of Missouri's requirement that there be clear

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father died from lung cancer. ***Ailing Father Dies; Quadriplegic Had Ended Own Life for Fear Dad Would Go First,*** San Diego Union, Oct. 12,1990, at A27.

[24]*In* ***re McAfee, No.*** D-70960, slip op. (Super. Ct. Fulton County, Ga. Sept, 7, 1989). At the time, Larry McAfee was a thirty-four year old man with quadriplegia, after a sudden accident that left him disabled and on a ventilator. After joining the United Cerebral Palsy of Greater Birmingham, Georgia, he was trained in voice-activated computers and was employed in computerized design and drafting. He has not exercised his right to die. Appleborne, ***An Angry Man Fights to Die,*** *Then* ***Tests Life, N.Y.*** Times, Feb. 7, 1990, **at** 1.

[25]Paul Brophy was forty-eight years old, unconscious or noncommunicative due to an aneurysm, but not terminally ill.

and convincing evidence that Nancy Cruzan previously decided to terminate her tube feeding in such circumstances as then existed, but did not require the clear and convincing standard be applicable in all states where removal of life-sustaining treatment and nutrition/hydration for incompetent patient was requested);[26] and In re Browning, 568 So.2d 4 (Fla. 1990) (authorized surrogates to withdraw life-sustaining treatment and tube feeding, without judicial approval, for incompetent patients who had previously expressed their wishes orally or in writing).[27]

Fourth, there are cases where termination of life-sustaining treatment was approved for persons who were incompetent and never previously expressed their wishes regarding the use of life-sustaining treatment: ***Barber*** *v.* ***Superior Court,*** 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (held that provision of tube feeding constitutes medical treatment that can be withheld from persons who are comatose upon the request of the family);" ***In re*** *Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) (held that a feeding tube could be removed at the request of a guardian based upon the

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[26]Nancy Cruzan **was** thirty-four years old, unconscious or noncommunicative due to an auto accident, but not terminally ill.

[27]Estelle Browning was ninety years old, incompetent due to a stroke, but conscious and communicative. She suffered from an incurable but not necessarily terminal illness. Her living will stated that tube feeding could be withheld or withdrawn if she was terminally ill and death was imminent.

[28]Clarence Herbert, the subject of this lawsuit, was fifty-five years old, comatose, but not terminally ill,

Patient's constitutional right of privacy and common law right to informed refusal of medical treatment);[29] ***In re Jobes*, *108*** N.J. 394, 529 A.2d 434 (1987) (held that a surrogate decisionmaker may withhold feeding by tube even when the incompetent patient has not left clear and convincing evidence of her intent);[30] and In ***re Smerdon,*** No. A-6031-89T1, slip op. (N.J. Super. Ct. App. Div. 1991) (held that a substitute judgment test should be applied when there is no clear and convincing evidence that the incompetent patient, while competent, wished to decline any medical treatment, including tube feeding).[31]

Fifth, there are cases where termination of life-sustaining treatment was approved for persons who had never been competent: ***In re Sue Ann*** *Lawrance*, 579 N.E.2d 32 (Ind. 1991) (held that the Indiana Health Care Act permits families to decide, in consultation with a physician, to withdraw life-sustaining treatment, including tube feeding, from never-competent patients in persistent vegetative state, without court approval, where

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[29]Claire Conroywas eighty-three years old, incompetent but not comatose or in an unconscious state, and not terminally ill.

[30]Nancy Jobes was thirty-one years old, unconscious or noncommunicative due to an accident in surgery, but not terminally ill.

[31]Theodore Smerdon was thirty-nine years old, unconscious and noncommunicative due to a stroke, but responded to pain, touch and smell, and was not terminally ill.

there is unanimity among those with tangible personal or professional interest in the patient) .[32]

And finally, there are cases where termination of life-sustaining treatment was approved for persons who were minors: In ***re Swan,*** 569 A.2d 1202 (Me. 1990) (held that pre-accident declarations made by a minor later left in a persistent vegetative state due to an accident may be found sufficient to satisfy a determination that clear and convincing evidence exists of the minor's decision to discontinue life-sustaining treatment and feeding tubes).[33]

Thus, based on the above decisions, the withdrawal of life-sustaining treatment includes withdrawal of life-sustaining treatment and tube feeding not only for those who are competent, terminally ill, and voluntarily electing to end their lives, but also persons who are comatose, in a persistent vegetative state, or otherwise incompetent, even those who were never competent including minors, whether they expressed their wishes prior to incompetency or not. Terminal illness is not required, only significant disabilities, or pain and suffering. For those who are deemed competent, no psychological examination is required to determine if they are suffering from depression or other

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[32]Sue Ann Lawrance was forty-two years old, had never been competent due to mental retardation, was unconscious or noncommunicative due to a fall in 1987, but not terminally ill.

[33]Chad Swan was seventeen years old, unconscious or noncommunicative due to an automobile accident, but not terminally ill.

psychological disturbance. For those who are deemed incompetent, no clear and convincing evidence of their prior expressed wishes is required, only a surrogate's decision based on substituted judgment. In some states, no prior investigation, hearing, or approval by a court or other state official is required, only the unanimous agreement of family and physicians.

What was universally prohibited under traditional laws only a couple of decades ago, has now become commonplace, without significant safeguards for the patient, whether competent or not. Having achieved this level of casual disregard for human life, especially for those most vulnerable, we are now poised to leap from withdrawal of treatment and tube feeding in order to cause death, to the prescription of lethal doses, and under the equal protection doctrine as established in various precedents, the administration of lethal injections by syringe or intravenous line for those unable to take lethal doses by mouth.

If Florida opens the door of intentional killing by lethal dosing, there will be no effective safeguards for persons who are incompetent, especially persons who are mentally disabled with significant physical disabilities. The precedents cited above make it clear that any new constitutional right of assisted suicide will extend to persons who are not terminally ill, persons who are merely disabled and/or suffering physically, and persons who are comatose, in a persistent vegetative state, or

otherwise incompetent.[34] Recognition of a right to assisted suicide is not so much the recognition of personal autonomy **as** it is the abandonment of persons whose lives are deemed to be without value. It is the institutionalization of discrimination based on the quality and remaining quantity of life for **a** person who is terminally ill and/or disabled.

The question before this Court, although rather narrow in its present construction, is likely to impact the vast majority of the people in Florida. Indeed, it will affect decisionmaking for everyone except those who are lucky enough to die quickly while in relatively good health and still living independently.

For these reasons it is clear that the recognition of a right to assisted suicide will not be limited to persons who are competent, terminally ill, and otherwise making a voluntary decision.

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[34] "If personal autonomy and the termination of suffering are supposed to be the touchstones for physician-assisted suicide, why exclude those with nonterminal illnesses or disabilities who might have to endure greater pain and suffering *for much longer periods of time* than those who are expected to die in the next few weeks or months? If terminally ill persons do have a right to assisted suicide, doesn't someone who must continue to live what *she considers* an intolerable or unacceptable existence for many years have an equal, or even greater, right to assisted suicide?" Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide-And Why These Are Not Convincing, 12* Issues in Law & Med. 113, 129 (1996).

111. CRIMINAL PROSECUTION IS THE ONLY DETERRENT AND IT IS AN EXTREMELY INADEQUATE ONE.

Since the Circuit Court prerequisites to assisted suicide involve only the physician and patient, and perhaps family members, it is unlikely that anyone involved will bring any charges for abuses or violations of law because all involved were in agreement. If criminal prosecution, with the concomitant "beyond a reasonable doubt" standard, is the only safeguard involving someone outside of the physician-patient relationship, then criminal prosecution is an extremely inadequate one. The primary reason this is so, is that a criminal prosecution will probably only take place after the death of the victim. The resulting injury is permanent and irreparable. Indeed, the key witness to the prosecution will always be unavailable due to his or her untimely death.

One need only look to the unsuccessful prosecutions of Dr. Jack Kevorkian in Michigan to see the difficulty of using criminal prosecutions to control assisted suicide abuses.[35] The vast majority of the 44 individuals Kevorkian has assisted to commit suicide were not terminally ill as that phrase is commonly understood--that is, persons having less than six months to live.

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[35]The material in this section is derived almost exclusively from the Brief of Amicus Curiae Richard Thompson, Oakland County Prosecuting Attorney in Support of Petitioners in the Supreme Court of the United States, *Washington* v. *Glucksberg*, and *Vacco v. Quill, Nos.* 96-110 and 95-1858, respectively. Richard Thompson is the Prosecuting Attorney for Oakland County, Michigan, and has prosecuted Dr. Kevorkian three times without obtaining a conviction.

Many of the people he assists to die are individuals who appear to have simply decided they don't want to live anymore. Two individuals have died after suffering from non-terminal emphysema. One woman had arthritis and osteoporosis. A recent patient/victim was depressed, overweight, and allegedly suffering from "chronic fatigue syndrome" and fibromyalgia. Prior to death she had made allegations of spousal abuse against her husband, allegations which she subsequently sought to disavow. If those allegations were true, they cast serious question on her reasons for seeking to end her life. If they were false, they cast serious questions on her mental competence in seeking death.

Supporters of assisted suicide maintain that with sufficiently stringent criteria and proper monitoring, the state could ensure that only competent, terminally-ill adults would receive the "benefit" of physician assistance to end their lives. However, practical experience demonstrates that it is naive to believe that the practice of assisted suicide, once legitimated even in a limited form, could be successfully restricted or regulated.

Estimates vary, but a clear majority of states currently outlaw assisted suicide. Yet the fact that it is criminally actionable in most states has not dissuaded numerous doctors and nurses from quietly practicing either assisted suicide or outright euthanasia, as the writing and practice of Dr. Quill show. See *generally,* T. Quill, *Death and Dignity: Making Choices and Taking Charge* (1993). Some people therefore argue that, since

it's being done anyway, why not simply legalize it under strict regulations and thereby control it? However, given that assisted suicide and euthanasia are being conducted in secret despite criminal bans, why should anyone but the most starry-eyed optimist believe that legalizing the practice under detailed regulations would serve to control the practice?

In their article *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village, 30* U. Richmond L. Rev. 1 (1996), authors Daniel Callahan and Margot White respond to the assertion that establishing specific rules and codes of practice will serve to bring the practice into the open and to control it:

> If it is truly the case that the present statutes forbidding euthanasia and PAS [physician-assisted suicide] are widely ignored by physicians, why should we expect new statutes to be taken with greater moral and legal seriousness? There is no available survey or other evidence to indicate that new laws will bring increased commitment to following the law.

Id. at 5.

An example which perhaps best illustrates the naivete of believing that strict regulations can prevent abuse is the case of Rebecca Lou Bedger. Kevorkian allegedly assisted Badger to commit suicide on July 9, 1996. Badger had been diagnosed with multiple sclerosis (MS). However, an autopsy revealed no evidence of the disease. Detroit Free Press, Oct. 31, 1996, at 1A, col. 1; see also, Detroit Free Press, Nov. 4, 1996, at 1B, col. 2. In interviews that Badger had with the Merced County [California] Sheriff's Department, she claimed that her mother

was pressuring her to commit suicide and "had twice provided her with narcotics" for that purpose. ***Id.*** The October 31, 1996, Detroit Free Press article goes on to report at page 12A:

> Friends and relatives interviewed in recent weeks described Rebecca Badger as an unreliable woman who often lied. But whether or not her accusations against her mother are true, the events she described--some of which are confirmed by hospital records and police reports--reveal a disturbed and confused woman who vacillated between a desire to die and a fervent wish to live.

In response to such criticism, Kevorkian's attorney is reported to have responded to the Free Press reporter: "What's the point? I do not care if she thought Martians were coming after her." ***Id.*** Similarly, in an article titled "*Post Mortem*" in the September 16, 1996 issue of People Magazine at page 53, Kevorkian's attorney is reported to have asserted that Kevorkian **merely** relied on Badger's medical records when deciding that she was a suitable candidate for this service. Badger's personal physician now says that she merely assumed Badger had MS because that was the diagnosis made by her neurologist. The neurologist says that "his diagnosis was never conclusive" and that Badger could have suffered from Munchausen's syndrome.[36] Detroit Free Press, Nov. 4, 1996, ***supra,*** at 8B. It also appears that Badger was likely making continuing claims of pain in an effort to

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[36]Munchausen's syndrome is "characterized by habitual pleas for treatment and hospitalization for a symptomatic but imaginary acute illness. The affected person **may** logically and convincingly present the symptoms and history of a real disease. Symptoms resolve with treatment, but the person may seek further treatment for another imaginary disease." *Mosby's* ***Medical*** *&* ***Nursing*** Dictionary 737 (2nd ed. 1986).

obtain more pain relievers such as Vicodin, Demerol, and liquid morphine. ***Id.***

Thus the case of Rebecca Badger tellingly reveals the way things will be if this Court recognizes **a** right to assisted suicide. Kevorkian followed the general steps that most supporters of assisted suicide have argued would control the practice. He reviewed Badger's medical records. He interviewed Badger herself to determine if she was competent and if it was her considered choice to commit suicide. His associate, Dr. Reding, also interviewed Badger to assure that she **was** competent to make the decision to end her life. The key determination in their assessment was whether this was her considered choice. Since it was viewed from the perspective that the "patient's" right to personal autonomy was paramount, when Badger stated that she wanted to commit suicide, and she exhibited an objective basis grounded in her apparent medical condition for that decision, then Kevorkian and his associates merely acted to facilitate her assertion of her autonomous right:

Kevorkian is answerable only to himself. Not only does he ignore the law, he taunts and belittles those who would enforce it against him. The Michigan Court of Appeals and the Michigan Supreme Court have upheld both a temporary state statute forbidding assistance in suicide and the continued validity of the State's common law prohibition against assisting **a** suicide. ***People v. Kevorkian,*** 447 Mich. 436; 527 N.W.2d 714 (1994), cert. ***den.*** ____ ***U.S.*** ____; 115 S. ct. 1795; 131 L. Ed. 2d 723 (1995);

People v. ***Kevorkian*** No. 1, 205 Mich. App. 180; 534 N.W.2d 172 (1994). Nevertheless, Kevorkian has not only convinced three juries to ignore the law,[37] he has continued to violate the law and publicly boast of his transgressions of it.

Practical legal problems beyond the specter of jury nullification have already arisen in this area, **as** the experience of the Oakland County Prosecuting Attorney has shown. Kevorkian initially announced his participation in the assisted suicides of his "patients." He would personally alert the police to the deaths. He **was** present when the police arrived and made statements to them. Evidence associated with the administration of the poisons (i.e., intravenous solutions, tubing, needles, carbon monoxide canisters, regulators, tubing, masks) was still present at the scene. Subsequently, when criminal charges were filed, he changed his practice. First, he would still contact the police, but when they arrived at the location of the suicide

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[37]Professor Yale Kamisar of the University of Michigan has noted the increased incidence of jury nullification associated with cases involving "mercy killing" in the 1940's and 1950's. Y. Kamisar, ***Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation, 42*** Minn. L. Rev. 969, 971-973 (1958). His observations have been proven to apply equally to physician-assisted suicide. Kevorkian has been tried three times (once in Wayne County, Michigan, and twice in Oakland County, Michigan, involving a total of five patients/victims) and has been acquitted by the juries in each case. In each case there was clear and abundant evidence that Kevorkian actively assisted the decedents to commit suicide by providing the poison and the poison-dispensing apparatus and by hooking the decedents up to the apparatus. The defense did not dispute that he had done so. Nevertheless, in each instance the jury has seen fit to respond to Kevorkian's claim that he did not intend that the decedents should die, but rather that he only wished to relieve their pain and suffering.

(often his Royal Oak apartment), the evidence associated with the suicide would have been removed. While he would make no statements to the police, his attorneys would subsequently call press conferences to announce Kevorkian's "attendance" at a suicide and to give details (often incorrect) of the deceased's medical background. Lately, Kevorkian has taken to simply dropping the body off at the medical examiner's office or at a local hospital, providing a few sketchy personal details about the deceased, and then leaving.

Thus, Kevorkian continues to ignore the law while making it practically impossible to investigate or prosecute him.[38] Since no one outside the immediate circle of participants knows for certain where the deaths occur, venue is difficult to establish. Since the bodies are dropped off at the medical examiner's office or at hospitals, none of the paraphernalia associated with the "suicide" can be examined or seized. Those who are present at

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[38]Such maneuvering to avoid prosecution is not unusual in the practice of assisted suicide/euthanasia. For decades Dutch physicians have falsified death certificates to avoid investigation and prosecution. H.R.G. Feber, Advocate General at The Court of Justice in The Hague, the Netherlands, stated: "The medical professional is in all likelihood the only academically trained group of professionals, who by virtue of their profession are guilty of making false statements in writing with great regularity when after a euthanasia procedure they make inaccurate death declarations which conceal the unnatural death cause." Barry A. Bostrom, ***Euthanasia in the Netherlands': A Model for the United States? 4*** Issues in Law & Med. 482 (1989) (quoting Feber, ***De wederwaardigheden van artikel*** 293 ***van het Wetboek van Strafrecht vanaf*** *1981* ***tot*** *heden* (The Vicissitudes of Article 293 of the Penal Code from 1981 to the Present), in *EUTHANASIE KNELPUNTEN* ***IN EEN DISCUSSIE*** (Euthanasia: Bottlenecks in a Discussion) 467 (G. van der Wal ed. 1987) .

the death are either not identified, or, if their names are mentioned at a Kevorkian press conference, they refuse to cooperate with investigations by law enforcement. In fact, when the police have subsequently contacted these individuals, they have refused to cooperate and referred the police to Kevorkian's attorney. The police and prosecutors have no way of compelling those witnesses to give information if they do not want to cooperate. Kevorkian's attorneys have routinely claimed to represent all the witnesses and have asserted their Fifth Amendment right not to incriminate themselves. Thus the public is left only with the self-serving statements of Kevorkian's attorneys describing what has occurred and the medical condition of the patient before his or her death.

Another legal obstacle to any effective regulation of assisted suicide is the venerated legal principle that mere presence at the scene of the crime is not itself a crime. ***People*** v. *Burrel*, 253 Mich. 321, 323; 235 N.W. 170 (1931). That is why Kevorkian can stand in front of a television cameras and state with impunity, "I was present at another assisted suicide." In that way Kevorkian takes credit for thumbing his nose at the law with no real risk to himself. Moreover, any comments his attorney makes cannot be used as evidence against Kevorkian.

If a right to physician-assisted suicide is recognized, regardless of how limited the right or how carefully the guidelines to prevent abuse are crafted, experience shows us that

there is no effective way to insure compliance with those guidelines and guarantee that significant abuses will not occur.

Police investigations into suspicious cases will be hindered by invocation of the physician-patient privilege. The physician and patient's family control all of the information. Assisted suicide, by its nature, is a private matter between physician and patient. Decisions about suicide are made in private and the action itself is taken in private. Since we cannot place witnesses in every doctor's office,. there is no practical way of knowing what the doctor and patient are going to do or what they have done. After death there is no practical way to determine whether the decision to commit suicide was voluntarily made, without subtle, or not so subtle, pressure or manipulation. A "conspiracy of silence" will develop since the "patient" will be dead and the physician will be able to invoke the privilege as **a** means of avoiding any questioning. Callahan and White, *supra*, 30 U. Richmond L. Rev. at 8.

Furthermore, the physician-patient privilege would prevent law enforcement personnel from knowing the patient's plans for death or from obtaining medical records to determine the true medical condition of the patient. The physician-patient privilege continues after death and thus, even after the suicide has occurred, there is no **way** in which the truth of the suicide's condition can be determined. Practical experience in Michigan has shown that this concern i‘s very justified. As noted above, Kevorkian has counseled "patients" and their families and friends

to decline to cooperate with police investigations': He has also apparently participated in one or more assisted suicides which have been covered up.

And what of the mental competency of the individuals who have surrendered themselves to Kevorkian's'assistance in suicide? Case law recognizes that one of the main reasons suicide itself **was** de-criminalized is that people who desired to commit suicide were generally considered to be mentally disturbed. T. Marzen et al., *Suicide: A Constitutional* Right? 21 Duquesne L. Rev. 1, 63, 69 and n.467, 85-86, 88-89 (1985); *In re Joseph G, 34* Cal. 3d 429, 433; 667 P.2d 1176; 194 Cal. Rptr. 163 (1983). Kevorkian's second "patient," Marjorie Wantz, had previously been committed to a mental hospital. Judith Curren was despondent over her weight, her "chronic fatigue syndrome," and perhaps, her marital situation. Rebecca Badger had a history of alcoholism, an apparent addiction to pain medication, vacillated on the question of whether she wanted to die or whether she was being pressured to do so by her mother, and is now said by her neurologist to have possibly suffered from Munchausen's syndrome. Kevorkian's response is that the mental condition is irrelevant as long as the "patient" has some physical malady and knowingly requests his assistance to die. Tr. at 40, 44-45, *People v. Kevorkian, No.* go-390963 AZ (Oakland County Circuit Court, June 8, 1990).

More significantly with respect to most potential "patients," however, is the fact that studies have shown that most individuals who express interest in committing suicide are

suffering from depression--often arising out of their condition or the absence of **a** support system--and that when the depression is treated, the desire to commit suicide disappears. See, e.g., Report of the New York State Task Force on Life and the Law, Executive Summary, p. x.[39]

In an article titled Mock *Medicine, Mock* **Law** in the June/July 1996 issue of the journal First Things, Dr. Eric M. Chevlen, the Director of Palliative **Care** at St. Elizabeth Health Center in Youngstown, Ohio (and a prosecution witness in both of the Oakland County criminal trials) has written of watching a Kevorkian-produced videotape of an interview with a "patient":

> The videotape seemed to be filmed in a cheap hotel room. It showed a man with advanced myeloma (bone cancer) asking for assistance in suicide. He appeared to be **a** textbook example of depression in the face of medical illness and inadequately treated pain: the flat voice, the lack of eye contact, the moving description of how life no longer yielded any pleasure, and even the veiled contempt he expressed for his own disability. I have seen many such patients in my career. In every case, the request for suicide was a symptom of depression, a treatable complication of cancer. In every case, proper treatment of the patient's pain, accompanied by emotional support and occasionally antidepressants resulted in reversal of the wish to be killed. As I watched the interview, I felt like shouting at the eerily jovial "doctor" on the screen, "He's depressed, you idiot! Treat him, don't kill him!"
>
> But of course I knew that only a few hours after the videotape **was** made the myeloma patient had joined the

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[39]The Report summarizes: "Contrary to what many believe, the vast majority of individuals who are terminally ill or facing severe pain or disability are not suicidal. Moreover, terminally ill patients who do desire suicide or euthanasia often suffer from **a** treatable mental disorder, most commonly depression, they usually abandon the wish to commit suicide."

> long list of those who had died "in the presence of" Jack Kevorkian.
>
> The encounter between Kevorkian and his victim was a simulacrum of a genuine medical interview. When Kevorkian asked the victim whether or not he had been experiencing pain, it was not with the intent to find a better medicine to treat it. It was to justify the use of the carbon monoxide he had obtained even before meeting him. When Kevorkian asked about the victim's anguish and wish to die, it was not to assess or relieve the obvious depression. It was to document that his "assistance" was given only with the victim's consent.

Id. at 17.

Additionally, in light of the delays that have occurred while the issue of assisted suicide was appealed in the Michigan courts, of the successful public relations campaign Kevorkian has conducted, the-inability of law enforcement to either stop the practice, issue charges in pending open investigations, or to secure convictions following three separate trials, public opinion and blatant defense appeals to jury nullification have made it increasingly difficult or impossible to obtain a jury that will follow the law.

In fact, given that judges in Michigan are elected, it is not surprising that many judges facing re-election (and with an eye on the public opinion polls) find it difficult to divorce their personal opinions on the issue from their legal duty to follow the law. This reality will work to discourage active investigation by the police or serious efforts to prosecute by the local prosecutors. The 1996 candidates for Oakland County Prosecutor from both political parties have publicly indicated that they will not prosecute Kevorkian under the Michigan common-

law prohibition recognized by the Michigan Supreme Court, and have further indicated reluctance to institute any prosecutions even if the Michigan legislature enacts a specific statutory prohibition.

In ***Legalization of Physician-Assisted Suicide, supra,*** Callahan and White observe:

> Nor are there any surveys or other available evidence to suggest that prosecutors will show more zeal with new laws than with the old ones, or that juries will display less sympathy for violation of the new rules than they have for those who transgressed the old rules. It is, in short, very odd to claim that physicians who now do as they please, with complete de facto immunity from prosecution, will act differently with new laws, and that the new laws will be more stringently enforced.

30 U. Richmond L. Rev. at 5-6 (citation omitted).

A strong and clear judicial response that unequivocally states that there is no right to assisted suicide would go far toward influencing public attitudes and putting the lie to the claim voiced by Kevorkian and his supporters that he is only doing that which is protected by the Constitution. Such a decision would place this serious and troubling issue into the proper forum--the Florida legislature where the people's elected representatives can debate and grapple with a solution. It is only by refusing to recognize a new and uncontrollable constitutional right to have the assistance of another person to commit suicide that this Honorable Court can ultimately protect the rights of those who would inevitably become the victims of the seductive "right to die."

CONCLUSION

For the above reasons, your *amici* respectfully pray this Court (1) to hold that there is no right to assisted suicide in the Constitution of the United States or the Privacy Amendment of the Florida Constitution, and (2) to reverse and/or vacate the decision of the Fifteenth Judicial Circuit Court in and for the County of Palm Beach, Florida, herein.

Dated: March 7, 1997

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was served on March 7, 1997, by U.S. Mail, first class postage prepaid, on the following individual(s) at the following address(es):

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