OA 5-8-97

IN THE SUPREME COURT OF FLORIDA

BARRY KRISCHER,

Petitioner,

v.

Case No. 89,837

CECIL McIVER, etc., *et al.*

Respondents,

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INITIAL BRIEF OF AMICUS CURIAE

ADVOCACY CENTER FOR PERSONS WITH DISABILITIES, INC.

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INTEREST OF THE AMICUS CURIAE, ADVOCACY CENTER FOR PERSONS WITH DISABILITIES, INC.

Amicus Advocacy Center for Persons With Disabilities, Inc. (Advocacy Center) is a Florida not-for-profit corporation, which is, pursuant to the Executive Order of the Governor of the State of Florida, No. 87-151, 91-60 and 94-333, the agency charged with carrying out the federally mandated and funded protection and advocacy system for persons with disabilities in the State of Florida, By Order dated February 19, 1997, this Court has extended leave to the Advocacy Center to file this brief *amicus* curiae. The Advocacy Center sought to file this brief to advocate for the rights of Floridians with disabilities because of the importance of issues in this case.

States which receive federal funds under three statutes must create a protection and advocacy system to protect the rights of persons with disabilities within such states. These federal laws pertain to persons with developmental disabilities (42 USC §§6041-6042), persons in residential facilities with mental illness (42 USC §§10801-10841), and persons with disabilities who receive vocational rehabilitation services (29 U.S.C. $732).

The Advocacy Center fulfills its responsibility to provide protection and advocacy in Florida by investigating instances of abuse and neglect, monitoring facilities which serve persons with disabilities, engaging in systemic reform on

behalf of persons with disabilities, bringing legal and **administrative actions on their behalf, informing, advising, and representing** them **in various ways.**

STATEMENT OF THE CASE

The Fifteenth Judicial Circuit Court in and for Palm Beach County, Judge S. Joseph Davis, Jr., issued a final declaratory judgment and injunctive decree on January 31, 1997, in favor of plaintiffs. They included a patient diagnosed with a terminal disease and a physician, Charles E. Hall and Cecil McIver, M.D., the respondents in the instant case. The judgment allowed the physician to provide Mr. Hall with a lethal dose of medication and to be present when he administers it. The court enjoined the State **Attorney** of the circuit, Barry Krischer, the petitioner in the instant case, from prosecuting Dr. McIver under Section 782.08, Florida Statutes (1995) for assisting Mi. Hall to kill himself. The court also found that the statute violates the Fourteenth Amendment to the United States Constitution by denying Mr. Hall the right to hasten his impending death with the assistance of a physician, while other terminally ill persons are permitted to reject life-sustaining treatment or assistance and refuse sustenance. The State of Florida appealed the order to the Fourth District **Court** of Appeal, and a stay of the judgment issued. Another judge in the Circuit Court in and for the Fifteenth Circuit lifted the stay on February 6. The appeals court certified the case to the Florida Supreme Court as an issue of great public importance. This Court accepted this case, reimposed the stay and set oral arguments for May 9 by its order of February 11, 1997.

STATEMENT OF THE FACTS

Respondent Charles E. Hall, age 35 at the time of his petition to the Circuit Court, is terminally ill. He suffers from Acquired Immune Deficiency Syndrome **(AIDS)** for which there is no known cure. He uses a wheelchair, is in obviously deteriorating health, and is suffering. (Circuit Court Judgment, finding of fact no. 3) He has had fourteen secondary infections including hepatitis B virus, herpes simplex, Epstein-Barr, pneumocystis camii, esophagitis, gastritis, and pneumonia. (Id, finding of fact no. 6)

Mr. Hall petitioned the lower court to allow him to kill himself when he believes his agony will no longer be followed by a period of acceptably renewed health, (Id., finding no. **4)** Mr. Hall fears that any attempt **to** kill himself will be unsuccessful and may worsen his condition. He seeks the assistance of a Dr. McIver to help kill at the time and place of his choosing by enabling him to administer to himself a quick-acting, lethal substance. (Id.)

Mr. Hall was found to have "a clear and vivid picture" of his condition. (Id., finding of fact 5) Only one psychiatrist, obtained by Dr. McIver, provided the basis for this finding of the **Court** that Mr. Hall was competent. (*Id.* finding of fact 9) The lower **court** also determined that Mr. Hall was not suicidal although he was asking to kill himself, nor acting under any undue influence. (*Id.*, finding 12)

SUMMARY OF ARGUMENT

All persons have the right to refuse any form of treatment. Persons who are terminally ill and who are in the last stages of life have the right to direct, either at that time or in advance, that no extraordinary, heroic or intrusive measures be used to extend their lives. People have the right to die naturally when their bodies can no longer sustain their lives.

Assisted suicide is distinctly different from dying naturally. It is the active killing of a person. Persons who are gravely ill or who are suffering from severe disabilities or mental illness may be influenced by others or by their own mental or physical conditions. A person in a depressed state is especially vulnerable to the argument that the world would be better off if he or she died immediately. If the state does not prohibit assisted suicide, there is great danger, even probability, that physicians or others in a position of influence or authority will abuse their position. There are no real safeguards to prevent this abuse, as the safeguards are only as good as the persons administering them

Predictions of the time of death are notoriously inaccurate. Love and support creates a “will to live” that outperforms modern medicine. New developments in the treatment of supposedly incurable illnesses have enabled persons to live far longer than expected and to recover a substantial degree of good health, vitality, and independence. This has been notably true in the combined uses of medication to combat Acquired Immune Deficiency Syndrome **(AIDS).**

To give someone, including a physician, the right to assist a person with a severe disability in killing himself or herself is discrimination based on a disability. It lessens the value of a person's life based on health status and subjects persons with severe physical and mental disabilities **to** undue pressure to which they may be especially vulnerable.

The Advocacy Center for Persons with Disability, Inc., opposes the legalization of assisted suicide, either by judicial decision negating its prohibition or by legislative enactment. If assisted suicide is permitted in Florida, Floridians will be put on the so-called slippery slope of determining the relative value of life. Floridians with severe physical and mental disabilities, who are particularly vulnerable to being devalued as burdens of society, would be at **grave** risk.

ARGUMENT

I.

The right to die is not the right to assist another to commit self-murder, There is a bright line difference between refusing life-sustaining treatment or support and actively participating in a killing oneself or another,

a. There is no constitutionally protected liberty interest to assisted suicide as there is to refusing unwanted medical treatment.

A mentally competent adult has a constitutionally protected liberty interest to refuse unwanted medical treatment subject to relevant state interests. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 110 S.Ct. 2841 (1990). Florida courts had established the same right in the previous decade.[1] Recognition of rights that are not readily identifiable in the text of the Constitution depends on whether they are "implicit in the concept of ordered liberty" so that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325, 326, 58 S.Ct. 149, 151-153 (1937). These rights must be "deeply rooted in the Nation's history and traditions." *Moore v. City of East Cleveland*, 431 U.S. 494,

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[1] The courts have already upheld the right to die naturally by letting a person reject treatment, or letting the guardian do it for the patient, such as removing a mechanical respirator in *Satz v. Perlmutter*, 379 So.2d 359, 360 (Fla. 1980), removing a nasogastric feeding tube in *Corbett v. D'Alessandro*, 487 So.2d 368, 370 (Fla. 2d DCA 1986), parents removing artificial life support from a terminally ill child *In re Guardianship of Barry*, 445 So.2d 365, 371 (Fla. 2d DCA 1984), wife removing mechanical ventilator in *John F. Kennedy Hospital v. Bludworth*, 452 So. 2d 921 (Fla. 1984), guardian of 88-year-old woman refusing nasogastric tube *In re Guardianship of Browning*, 568 So. 4, 11, 15 (Fla. 1990), *et al.*

503, 97 S.Ct. 1932, 1938 (1977). Suicide has traditionally been a criminal offense. 2 LaFave & Scott, *Substantive Criminal Law*, $7.8, pp. 246-251, cited by ***Kevorkian v. Thompson,*** 947 F.Supp. 1152, 1997 WL 3291 at pp. 11, 12 (E.D. Mich. 1997). Suicide was a crime at English common law, punishable by forfeiture of lands and chattels. ***People v. Kevorkian,*** 527 N.W.2d 714, 731, n. 49 (Mich. 1994). The criminalization of suicide carried over to America and remained a crime on the books of a majority of states through most of the 19th century. Thomas J. Marzen, "Suicide: A Constitutional Right," 24 Duq.L.Rev., 1, 64-65, citing A. Scott, *Criminal* Law *in Colonial Virginia* at 198, 199 & n. 16 (1930). In Florida, $782.08, Fla. Statutes Annotated (1995), which prohibits "assisting self murder," dates back to 1868.

The U.S. Court of Appeals, Second Circuit, declined to find a fundamental right to assisted suicide in ***Quill v. Vacco***, 80 F.3d 716, 724-735 (2d Cir., 1996) ***cert. granted,*** ___U.S. 117 S.Ct. 36 (1996). The ***Quill*** court recognized in April, 1996, ***that*** "[c]learly, no ***'right'*** to assisted suicide ever has been recognized in any state in the United States." *Id.*[2]

The U.S. Court of Appeals, Ninth Circuit, held ***en banc***, in contrast, in May,

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[2] However, *Quill* **found that the New York statute making assisting a suicide a criminal offense violated the Equal Protection Clause of the 14th Amendment to the United States Constitution.**

1996, that there is such a right. *Compassion in Dying v. State of Washington,* 79 F.3d 790, 813,838 (9th Cir. 1996), *reh. den.* 85 F.3d 1440 *cert. granted sub nom Washington v. Gluckstein,* ___ S.Ct.___ (Oct. 1, 1996).[3]

However, the Ninth Circuit failed to note that the abortion decisions uniformly recognize that at the point the fetus attains viability, the state's interest in protecting that life predominates over the mother's liberty interest to chose to end that life. *See Roe v. Wade,* 410 U.S. 113, 159-164, 93 S.Ct. 705,730-732, *Roe* strictly forbids the abortion of a viable fetus except when absolutely necessary to save the life of the mother. *Id,* 410 U.S. at 163, 165, 93 S.Ct. at 732.[4]

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[3] The Ninth Circuit *en banc* agreed with a lower court ruling that there is a constitutional due-process liberty interest in controlling the time and manner of one's death. The majority relied almost exclusively on *Planned Parenthood v. Casey*, *505* U.S. 833,851,112 S.Ct 2791, 2807 (1992) and on *Cruzan,* supra. However in *Casey* the plurality repeatedly stated that it was the combined force of stare *decisis* and liberty that protected a woman's right to abortion. *Id.* at 505 U.S. 845, **853** and 112 S.Ct. 2804, 2808. The implication is that liberty alone was insufficient to support the new fundamental right to abortion. The Ninth Circuit en *banc* declined to describe the liberty interest it upheld as *an* interest in commiting suicide. "We use the broader and more accurate terms, 'the right to die,' 'determining the time and manner of one's death; and 'hastening one's death' for an important reason. *Compassion in Dying, supra, at* 802. The en *banc* panel reversed the opinion of the three-judge panel. *Compassion in Dying v. State of Washington*, 49 F.3d *586* (9th Cir., 1995), vac. by 79 F.3d 790 (9th Cir., 1996) ***(en banc).*** The U.S. District Court in Michigan in January, 1997, characterized the Ninth Circuit's en banc decision of *Compassion* as "seriously **flawed"** in affirming the U.S. District Court's summary judgment for the plaintiff in *Compassion in Dying v. State of Washington,* 850 F. Supp. 1454 (W.D. Wash., 1994). *Kevorkian v. Thompson, supra,* 947 F.Supp. 1152 (E.D. Mich., 1997).

[4] The Ninth Circuit en *banc* court quoted and then dismissed language in *Cruzan* that would defeat its ruling: "[W]e think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." *Cruzan,* supra, at 497 U.S. at 282 and 110 S.Ct. 2853. The en banc panel stated simply that the state's interest is not always controlling or otherwise there

A U.S. District Court in Michigan in January, 1997, roundly criticized the analysis of the Ninth Circuit's en *banc* opinion in equating the constitutional right of abortion with the right to have someone assist in a suicide.

> This Court agrees that attempting to equate abortion rights and their constitutional status with a right to have someone assist in a suicide confuses constitutional analysis with individual or moral notions of 'human dignity.' In the case of abortion rights, the Supreme Court balanced society's interest in protecting an inchoate life against the liberty interests of a woman to determine how she will live her life...(T)he distinction between this fulcrum of constitutional analysis seems clearly different and separate from that presented in cases such as this in which there is claimed a constitutional right to have assistance in killing oneself...
>
> Thus, this Court believes that rather than supporting a liberty interest in assisted suicide for those who are able to sustain life without life-support systems, ***the abortion decisions--by affirming the states' paramount interest in protecting viable life--actually supports the view that the state has a strong interest in protecting vulnerable, but viable, life.***

Kevorkian v. Thompson, supra, 1997 WL 3291 (E.D. Mich.) at pp. 13, 14.

[Emphasis added]

The lower court in the instant case refused to recognize a federal fundamental right to physician-assisted suicide. ***McIver v. Krischer*** ___ Fla. Supp. ___ (15th Cir. Ct., Palm Beach Co., Jan. 31, 1997) pp. 19, 20. The United States

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would be no capital punishment and no defense *budget. Compassion, supra,* 79 F.3d at 817 and f.n. 72. The Ninth Circuit overlooked the other compelling state interests that justify the exceptions it cited.

Supreme Court indicated its "great resistance to expand the substantive reach of [the due process clauses of the Fifth and Fourteenth Amendments to the U.S. Constitution], particularly if it requires redefining the category of rights deemed fundamental." Bowers *v. Hardwick*, 478 U.S. 186, 190 (1986). Likewise, this Court should avoid any temptation to do so.

b. The Florida constitutional right to privacy does not encompass the right to hurt oneself or to have someone hurt oneself.

The right to assisted self-murder is not the same right as "the right to be let alone and free from government intrusion into [one's] private life..." FLORIDA CONSTITUTION, Article 1, §23 (the Privacy Amendment). Up to now the amendment has been used to protect the right to choose or refuse medical treatment. Mutter *of Dubreuil*, **629 So.2d 819,** 822 (Fla. 1993) and cases in f.n. 1of this brief. That right does not extend to committing crimes, particularly as a co-conspirator, without interference by law enforcement.

This court held in 1985, when the Privacy Amendment was five years old, that it "demands the compelling state interest standard. This test shifts the burden **of** proof on the state to justify an intrusion upon privacy. The burden can be met by demonstrating that the challenged regulation serves a compelling state interest and accomplishes its goal through the use of the least intrusive means...The drafters of the amendment rejected the use of the words 'unreasonable' or 'unwarranted' before the phrase "governmental intrusion" in order to make the privacy right as strong as possible." *Winfield v. Division of Pari-Mutuel* Wagering, 477 So. 2d 544,547,548 (Fla. 1985).

There is no compelling state interest to allow murder or assisted murder. Rather, there is a compelling state interest in protecting vulnerable persons from harm to themselves they cannot prevent because they are depressed or because they are being pressured. The Supreme Court of the United States has imposed protection on those who were too improvident to protect themselves.. Buck *v.* Bell, 274 U.S. 200 (1927) (sterilization); Jacobson *v.* Massachusetts, 197 U.S. 11, 26 (1905) and *Zucht v. King,* 260 U.S. 174 (1922) (vaccinations). In Florida, where the right of privacy may be stronger, this Court has never ruled that "the right to be let alone and free from government intrusion into [one's] private life..." means that the government should neglect its citizens by withdrawing protection of their lives.

c. The statute criminalizing assisted self-murder does not deny equal protection under the Fourteenth Amendment, although there is a right to refuse life-extending medical treatment and artificial life support.

The argument that Section 782.08, Florida Statutes (1995) violates the equal protection guarantee of the Fourteenth Amendment to the United States Constitution is a fallacy. The statute punishes assisting self-murder as a second-degree felony , while case law allows one to refuse life-extending medical treatment and life support. The Circuit Court in the instant case found no difference in the distinction between withholding or withdrawing essential medical treatment and hastening death, for example by introducing a lethal substance? The rationale of the Second Circuit in *Quill* strongly persuaded the trial court below in this case:

> Indeed there is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers
>
> Moreover, the writing of prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those emotionally competent, terminally ill persons who seek to hasten death but whose treatment does not include life support are

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[5] *McIver v. Krischer, supra,* pp. 21, 22.

> that those emotionally competent, terminally ill persons who seek to hasten death but whose treatment does not include life support are treated equally.

Quill, supra, **at 729**

This argument fails to distinguish between acts of omission and acts of commission (overt acts). The distinction between misfeasance **and** nonfeasance is well established in both tort and criminal law. Further, **the** majority of the U.S. Supreme Court rejected Justice Scalia's argument that there was no meaningful distinction between withdrawal of life support and the overt taking of life.[6]

The *Cruzan* majority, while recognizing a right to refuse medical treatment **under** common law and the **U.S.** Constitution, emphasized that no right to suicide exists: "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve **to** death." *Cruzan, supra,* 497 U.S. at 280, 110 S.Ct. at 2852. The court recognized the state's interest to regulate by law the circumstances surrounding the withdrawal of life support. Id. at 497 U.S. 279-284, 110 S.Ct. at 2852-2854.

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[6] Justice Scalia argued that the line should **be drawn** between "**those** forms of inaction that consist of abstaining from 'ordinary' care and those that consist of abstaining from **'excessive' or** 'heroic' **measures."** *Cruzan*, supra, at 2861. This reasoning **actually supports the** distinction between the withdrawal of artificial life support from a person in a vegetative state, which would **be** permissible, **and** affirmatively hastening the death of a competent, suffering adult, which would not be, thus defeating the equal-protection argument.

The Michigan Supreme Court had already recognized this difference in 1994:

> ...[T]he distinction between "misfeasance" and "nonfeasance" (the distinction of active misconduct and passive inaction) is deeply rooted in the law of negligence. The reason for the distinction is said to lie in the fact that a defendant creates a new risk of harm by misfeasance, but merely fails to benefit another by nonfeasance. As Dean Prosser explains, the duty to do no wrong is a legal duty, while the duty to protect against wrong, is for the most part, a moral obligation.

People v. Kevorkian, supra, 527 N.W. 2d at 728.

The Michigan Supreme Court also found a rational basis for the distinction:

> [W]hereas suicide involves an affirmative act to end a life, the refusal or cessation of life-sustaining medical treatment simply permits life to run its course, unencumbered by contrived intervention. Put another way, suicide frustrates the natural course by introducing an outside agent to accelerate death, whereas the refusal or withdrawal of life-sustaining medical treatment allows nature to proceed, i.e. death occurs because of [t]he underlying condition.

Id.

The Supreme Court of the United States has explained that "the Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." The Supreme Court left to the states the initial discretion to determine what is "different" and what is "the same" with "substantial latitude to establish classifications that roughly approximate the nature of the problem perceived, that accommodate competing concerns both public and private, and that account for limitations on the practical ability of the State to remedy every ill." *Plyler v.* Doe, **457** U.S. 202,216, 102 S.Ct. 2382,2394 (1972).

The Second Circuit in *Quill* overlooked significant state interests in prohibiting assisted suicide when it determined that none were furthered by the statutes prohibiting assisted suicide where another statute allowed the withdrawal of life support. The Second Circuit used **the** list in vacated order of a three-judge panel in *Compassion in Dying v. Washington,* **49** F.3d *586* (9th Cir., 1995) vac. by 79 F.3d 790 (9th Cir.,1996) ***(en banc):***

1. The interest in denying to physicians "the role of killers of their patients;"
2. The interest in not subjecting the elderly or infirm to psychological pressure to consent to death;
3. The interest of preventing the exploitation of the poor and minorities;
4. The interest in protecting handicapped persons against societal indifference;
5. The interest in preventing the **sort** of abuse that has occurred in the **Netherlands.**

Quill, supra, 80 F.3d at 730 [emphasis supplied]. While the Ninth-Circuit panel found that the Washington state statute furthered these interests, the Second Circuit did not. Id. With respect to **the** fourth interest, the Second Circuit glibly dismissed it as not furthered by the statute prohibiting assisted suicide:

> With respect to the protection of ...the non-mentally handicapped, it suffices to say that these classes of persons are entitled to treatment equal to that afforded to all those who now may hasten death by means of life-support withdrawal. In point of fact, these persons themselves are entitled to hasten death by requesting such withdrawal and should be free to do so by requesting appropriate medication to terminate life during the final stages of terminal illness.

Id. The Second Circuit in Quill did not consider the pressure to choose death that persons with disabilities, whose value as productive human beings is often devalued by society, may be subject. Assisted suicides could be repeatedly portrayed as the "heroic" thing to do to reallocate scarce medical resource to others. Persons with disabilities could be repeatedly told that they were a drain on society and their loved ones, and that they were being "selfish' for lingering. The Second Circuit also did not consider that persons who have brain injuries or cerebral palsy may have great difficulty expressing their wishes to live, either orally with a speech synthesizer or in writing with laborious effort.

There is a clear bright line between active and passive conduct that is well rooted in the history of law. No one should mistake hastening death by lethal injection with the refusal to accept artificial means to extend life, like providing nutrition through a nasogastric tube.

II.

The creation of a right to assisted suicide is a policy decision better left for the Legislature.

Respondents mistakenly argue that the Court should declare unconstitutional a law which prohibits assistance in taking a "vulnerable, but viable, life.'' Assisting "self-murder"--as suicide is called in Florida, has historically been subject to criminal sanctions. *Kevorkian v.* Thompson, supra. Such a radical departure from legal tradition requires action by the Legislature, if one is to occur. **As** the U.S. District **Court** in Michigan declared:

> ...(T)he Constitution is not a Rorschach test in which judges are free to find whatever shapes of morality **and 'human** dignity' we wish. In a democracy, judges are not free to simply look at the Constitution **and** declare new rights to correct every perceived wrong, for if the Constitution comes to mean everything to everybody--a veritable grab bag of rights--it will mean nothing when we really need it to protect those fundamental rights which are clearly delineated, because its legitimacy **and** grandeur will have been drained from it.

Kevorkian v. Thompson, supra, at p. **14.** The same court added:

> ...(T)he Court cannot help but observe that we live in an age of instant gratification--people want things when they want them and how they want **them.** Those who are unable to achieve the result the[y] wish from the policy branches of government (or through the referendum process) immediately come to the courts for relief; **and,** all too often, courts are seduced by the siren call to "do justice.'' Indeed, it sometimes seems that the Judiciary is in danger of becoming the "fast-food' institution of government. (If we are not careful, the sign

> "Welcome to McJustice" may replace "Equal Justice Under Law" above courthouse doors.

Kevorkian v. Thompson, supra, at f.n. 17.

The proposed legalization of assisted self-murder where it involves a second person would be a radical departure from Florida legal tradition. Only the Legislature, with its opportunity for public hearings and debate, is the more appropriate forum to examine the issue, balance interests, and draft appropriate legislation, if any, The Legislature's position at present is that all legal persons should be protected from assisted self-murder.

III.

Persons with disabilities are devalued as contributing members of society, and Section 782.08, Fla. Statutes protects them from undue pressure to kill themselves or be killed as an act of "mercy," to which they may be especially vulnerable.

a. Determining who should die on the basis of physical condition puts Floridians on a slippery slope to euthanasia.

The propensity of Americans to value life according to a certain style of superficial physical beauty, good health and strength is obvious from even the most cursory survey of Hollywood films, television programming and advertisements. Accordingly, persons with severe disabilities, who might be viewed by the majority as bizarre or worthy of ridicule, are also devalued as nonproductive human beings, regardless of their accomplishments. They are subjected to pervasive prejudice and discrimination, which the Americans for Disabilities Act has begun to address since its passage. Some 43 million Americans have one or more physical or mental disabilities. This number will increase as the population grows older.

Congress recognized discrimination against persons with disabilities in the "Findings and purpose" clause of the Americans with Disabilities Act of 1990:

> ...(2) [H]istorically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

> (3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health *services,* voting, and access to public services;
>
> (7) individuals with disabilities are a discrete and **insular minority** who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals **and** resulting **from** stereotypic **assumptions not truly** indicative **of the individual** ability of such individuals to participate in, **and** contribute to society...

42 U.S.C. §12101(a), Americans with Disabilities Act (ADA) [emphasis supplied]

Persons with disabilities, based on the way they have been historically treated, have a well-founded fear that any legalization of assisted suicide will. deny them adequate suicide prevention that persons with only subtle disabilities receive. The case law is replete with examples of persons with disabilities who were deprived of counseling, therapy, nursing home placements, or appropriate in-home support that would give them peace of mind and dignity.[7] Persons with disabilities,

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[7] Kenneth Bergstedt, 30, a quadriplegic on a ventilator, was encouraged by his father, who was dying of lung cancer, to commit suicide. The son believed that he would be forced to live in a nursing home after his father died and was unaware of in-home support services to allow him to live independently. The young man succeeded. *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990). David Rivlin was paralyzed from a surfing accident for 18 years before he committed suicide. He used a ventilator, but had no terminal illness. He was confined to a nursing home against his will because of the lack of in-home assistance. In addition his relationship with his fiance had ended. Stanley S. Herr, et *al.*, "No Place to Go: Refusal of Life-Sustaining Treatment by Competent Persons with Physical Disabilities," 8 Issues in Law & Medicine 3, 13-15 (1992).

often viewed by our society as not worth saving, also have a well-founded fear based on well-publicized cases that **removing** the prohibition against assisting self-**murder** in **Florida will create undue pressure on them** to consent to **suicide'** and **will result** in the **withholding and withdrawal of life sustaining medical** treatment.[9]

The U.S. Supreme Court acknowledges the "history of unfair and often grotesque mistreatment" by withholding lifesaving medical assistance **by** medical professionals **from children** with **lifelong, severe disabilities, which results from**

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[8] Larry McAfee, 34, sustained quadriplegia in an accident. The State of Georgia would not pay for community support, but would pay for his confinement to a nursing home and for eight months in an intensive care hospital unit, even though he was not critically or terminally ill. In the nursing home, he was told when to eat, sleep, and even what he could watch on his own video-tape player. He won his 'right to die" in court, but received help from disability advocates in getting out of the nursing home and using computer-aided drafting to do engineering work. He had been close to receiving his engineering degree when injured. Mr. McAfee felt that he was pressured to end his life. He received a voice-activated computer and a system to control his telephone and television. He finally moved into a home of his own with personal assistance and said that he was "living a good life." *State v. McAfee,* 385 S.E.2d 651, 652 (Ga. 1989) and Joseph Shapiro, "Larry McAfee, Invisible Man: The Agonizing Fight to Prevent Legalized 'Suicide'," U.S. News & World Rep., Feb. 19, 1990, at 59, 60. *See also* Joseph Shapiro, *No Pity* (Times Books, 1993). Without the bureaucratic impediments to assisted suicide, Mr. McAfee no doubt would have killed himself.

[9] Proponents of assisted suicide have urged, sometimes with apparently good intentions, that it be applied to persons with disabilities who are not suffering from terminal illness. In Final Exit, author Derek Humphry, founder of the Hemlock Society, which promotes assisted suicide, wrote, "What can those of us who sympathize with a justified suicide by a handicapped person do to help? When we have statues on the books permitting lawful physician aid-in-dying for the terminally ill, I believe that along with this reform there will come a more tolerant attitude to the other exceptional cases." In contrast, Mark O'Brien, a correspondent for the Pacific News Service, reacts to the pity from the point of view of the recipient: "It is tempting to pity a man in an iron lung. But pity has become a lethal weapon....[P]eople have said, 'That poor thing...how he must suffer! He's terminally ill, you know.' I'm not 'suffering,' 'terminal,' or even 'ill.' Don't waste your pity on me. *I want to live!*" 23 *TASH* Newsletter 6 (January, 1997)

"prejudice and ignorance." City *of Cleburne, Texas v. Cleburne Living Center,* 105 S.Ct. 3249,3262,3266 (1985).

The experience with assisted suicide in The Netherlands demonstrates that, despite the "safeguards" that are proposed in this case, there is a short slip down the slope to euthanasia. An independent study for the Dutch government found that more than 1,000 persons in one year were subjected to euthanasia without an explicit request of some 3,300 mercy killings per year, and that some doctors provided assisted suicide in cases where the only suffering was caused by psychiatric illness, including depression. ***When Death Is Sought, Assisted Suicide and Euthanasia in the Medical Context*** **(May, 1994) The** New **York** State Task Force on Life and the Law, Executive Summary, p. xv. ***See also Medical Decisions About the End of Life,*** an official report of the Dutch government, also known as the "**Rommelink Report**," (Sept., **1991**).

The danger of the slippery slope can be seen very clearly in the decision of the Ninth Circuit in Compassion *in Dying,* supra. The Court observed that Nancy Cruzan was not **terminally** ill and could have lived another 30 years. the Ninth Circuit asserted that, therefore, the Supreme Court in *Cruzan* did not limit the liberty interest in stopping life supports only to those persons who are terminally ill. Id. at 816, f.n. 69. By analogy, if assisted self-murder is permitted, persons who are not terminally ill (including persons who are disabled but not terminally ill) will be endangered by the menace of assisted self-murder.

The definition of "terminally ill" itself evades precision of any kind. The Ninth Circuit made conflicting statements when, on one hand, it stated that the danger of undue influence is limited in a situation where "...the person will die shortly in any event." Id. at 826. On the other hand, the **Ninth** Circuit said that "terminally ill" may include conditions in which there is **no** fixed time period **within** which death may occur, and referenced the Washington statute's inclusion of persons "...who are permanently unconscious, that is an irreversible coma or a persistent vegetative state." Id. at 831.

The Ninth Circuit made a chilling statement that should give **any** person of good conscience great pause. One of the greatest dangers of assisted suicide is that guardians and other surrogates will make decisions for persons who are no longer able to voice their **own** wants. The Ninth Circuit stated: "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." *Id.* at 832, f.n. 120. If the guardian's decision becomes that of the person who is disabled, then the guardian or surrogate can make decisions about assisted suicide, even if the person never made any preference known before becoming unable to voice a choice.” This places the decision to kill a disabled person in the hands of guardians who are acting under the authority of state law. Even more oppressive would be the role of the Public Guardian, who typically represents many persons with disabilities residing in institutions. The Public Guardian, an agent of the state, would make the decision on whether the person should be killed.” Since guardians have been allowed to terminate life support for persons who are “terminally ill,” there is grave danger of guardians or other surrogates also being allowed to direct the killing of persons with incapacitating disabilities.

The slippery slope upon which legalization of assisted suicide would put Floridians is a well-founded fear.

b. Adequate safeguards to protect persons with disabilities cannot be implemented, so an unequivocal prohibition of assisted suicide is necessary.

Safeguards, no matter how theoretically reliable, will be subject to the prejudices of the people who enforce them. Legalizing assisted suicide puts persons with disabilities in peril because of “the continuing existence of unfair and

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[10] Section 765.201 *et seq.*, Fla. Statutes, provide for a health care surrogate.

[11] Ch. 744, Fla. Statutes, provides for public guardians.

unnecessary discrimination and prejudice [that] denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous..." 42 U.S.C. §12101(a), ADA Findings.

when medical professionals and the media speak: of persons with disabilities who are "imprisoned in their bodies," "helpless," suffering needlessly," when they weigh "quality versus quantity of life" in a purportedly humane manner, and when they say, "I could never live like that," they are in fact expressing primitive, human fears of their own disability. Society translates these primitive emotions into a supposedly rational social policy of assisted suicide.

Dr. C. J. Gill, an Illinois psychologist, pointed to the danger that persons with disabilities face:

> Permanent disability is [defined] as the problem, death is the solution....[T]he wish to die is transformed into a desire for freedom, cot suicide. If it is suicide at all, it is "rational" and, thereby, different from suicides resulting from [the same] emotional disturbance or illogical despair [of persons who are not disabled].

C. J. Gill, "Suicide Intervention for People with Disabilities: a Less in Inequality," 8 Issues in Law & Medicine 37, 39 (1992), cited by Not Dead Yet and Americans Disabled for Attendant Programs Today in their brief to the U.S. Supreme Court in *Vacco v. Quill,* Stephen F. Gold, Esq. and Diane Coleman, Esq. (October, 1996, term).

In her affidavit included in a brief to the U.S. Supreme Court in *Quill,* supra, Dr. Gill pointed out that many persons who suffer traumatic injuries express the desire to die--and then months later thank doctors and family for saving their lives. These people, she notes, would be especially vulnerable to the temptation of assisted suicide:

> [W]hen the "critical life stress" involves a life-threatening illness or disability, the process of adjustment often takes considerably longer. Therapists experienced in working with terminally ill and irreversibly disabled individuals report a series of stages---including shock, grief despair, and resolution--that are navigated before such individuals regain basic emotional control...However, emotional disorder can well be hidden and remain undetected unless carefully assessed by properly trained professionals. Most physicians are not trained to identify hidden depression, treatable suicidal intent, and other non-flagrant psychiatric disorders. Studies have revealed that a significant portion of persons who attempt suicide seek medical attention shortly before the event and their physicians typically remain unaware of their emotional distress and need for psychological intervention...Attending physicians, therefore, have not proven to be qualified gatekeepers in determining a patient's need for psychological services.
>
> ...It is extremely dangerous to respond to the expression of a death wish by providing the means to die. That type of response, especially if it comes from a respected authority...(e.g., a physician), can unduly influence a vulnerable individual to embrace death as the 'right' solution...
>
> A society that weighs the value of a citizen's life according to health or physical attributes is entering risky territory. When physicians are instructed to adopt such a scale with impunity, the silent and far-

> reaching effects on health care and society will be as impossible to predict as to control. One of the most certain and tragic outcomes, however, is that it will lead to the wrongful premature deaths of persons who, if given basic support and reasonable options instead of a socially and medically sanctioned exit, would prefer to live.

8 *Disability Compliance Law Bulletin (National Disability Law Reporter)* 6 (Dec. 19, 1996)

Given the lack of adequate health care and appropriate support services for persons with disabilities in Florida, it is unlikely that the state would provide the same level of suicide prevention for this population, which would need more of it than those without disabilities.[12] Further, as public, and increasingly more private, insurance plans pay for treatment by the diagnosis rather than by the number of

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[12] One of numerous examples is that the Florida Legislature recently proposed a sudden, dramatic overnight reduction in services within community based Intermediate Care Facilities for persons with developmental disabilities (ICF/DD). This was to be done by a shifting in funding source to the Home and Community Based Waiver to avoid the active treatment requirements for ICF/DD. The proposal would cut $33 million to $54 million and a corresponding reduction in necessary medical and quality of life supports and therapies for persons with significant disabilities and retain institutions with 64 to 120 residents without adequate community supports. Many in these institutions have complex medical conditions are extremely vulnerable. They were abused and neglected in old, state operated institutions. The Advocacy Center worked for the adoption of Home and Community Based Waiver in 1992 as a means to remove persons with disabilities from institutional to home care where they could achieve more dignity and independence. However, the legislature seeks to use the waiver to change the funding stream and leave people in institutions with reduced support. More than 6,000 Floridians with developmental disabilities languish on the waiting list of the Fla. Department of Children and Families for services. Many of them are cared far by their parents who are aging and increasingly unable to provide continual care. Only after the Advocacy Center litigated, did the state restore funds for the orderly and proper transition to the Home and Community Based Waiver. *Cramer v. Chiles*, U.S. District Court (S.D., Fla. 1996) 96-6619 CIV-Ferguson.

days of stay or the number of procedures performed, there is no longer even a financial incentive for hospitals and nursing facilities to keep their patients.

Psychiatrist Herbert Hendin first traveled to The Netherlands in 1993 to study the **only** nation in the world permitting assisted suicide? He is the executive director of the American Suicide Foundation, which he helped found in 1987 to provide funds for research into prevention, **and** has treated numerous suicidal patients in his own practice. He is considered one of the world's foremost experts on suicide. 'What I quickly discovered in **the** Netherlands was that they hadn't discovered a new way at all," he said. "There were alleged controls and the need fox second opinions, but it soon became *pro forma.* Doctors who were for physician-assisted suicide referred their patients for second opinions to like-minded doctors. So the answer was yes--and *yes.* And, of course, the horrible, individual cases." "The Case Against Doctor-Assisted Suicide," Paul Wilkes, The New *York* ***Times*** *Magazine* **(July 21, 1996)**, p. *25*.

"Virtually every guideline established by the Dutch to regulate euthanasia has been modified or violated with impunity,'' Hendin warns in his book Seduced by Death (W.W. Norton), published last fall. Id. at 26.

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[13] The Third Reich through systemic **and** state-sanctioned euthanasia **succeeded** in killing approximately 375,000 persons with disabilities. Paul Steven Miller, Esq., 9 *Issues in Law & Medicine* **No.** 1 (1993), p. 55.

"When you have a dying or impaired person asking for assistance in their death, it is a cry for help, not for a drug overdose that will kill them. Suicidal ideation and the underlying depression don't last forever; they will lift. When health-care workers are sent in for someone who feels a burden or for a family that is stretched beyond their resources, the depression goes. We can bring them back from depression. We can't bring them back from the dead." Dr. Hendlin, *Id.*

Using "imminent death" as a criterion for determining who shall be eligible for assisted suicide as it was in Oregon's statute, approved in referendum in November, 1994, is unworkable. Dr. Hendlin warned, "It is not just that it is impossible to predict with certainty that a patient has only six months to live, making mistaken or falsified predictions inevitable. Any law that permits assisted suicide when patients are neither in pain nor imminently about to die will encourage people who fear death to take a quicker way out." Hendlin, Herbert, "Scared to Death of Dying." The New *York* Times Op-Ed December 16, 1994).

Appellee Mr. Hall and many like him who face terrible illnesses that kill slowly need not endure unbearable pain or suffer in spirit. Florida has a network of hospices that aggressively manage pain and symptoms of the disease and address the "psychosocial" and spiritual needs of the person as well.[14]

If this Court were to hold that the state's interest in protecting life diminishes as the potential for life or quality of life--as an outsider determines it-- diminishes, then assisted suicide will become the most lethal discrimination to date for persons with disabilities. It will be a form of genocide.

c. Denying persons with disabilities protection of the state from suicide or homicide violates the Americans with Disabilities Act (ADA) and the Equal Protection clause.

The ADA mandates that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. §12132. The same prohibition applies to hospitals and physicians and prohibits:

> a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden.

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[14] See Appendix, A. Affidavit of Tim Broeseker, M.D.; B. Affidavit of Lori Ladd, C.N.S.; C. Affidavit of Anne Thal, L.C.S.W., D.C.S.W.

42 U.S.C. §12182(b)(2)(A)(iii). See also 28 C.F.R. §35.130(b), et *al.* The statute, as interpreted by U.S. Department of Justice, prohibits states, hospitals and doctors from discriminating against persons with disabilities by denying or depriving them of services that are equal to or as effective as that afforded persons without the same disabilities.

Pressuring persons with severe disabilities to choose assisted suicide and withholding suicide prevention services from them are prima *facie* violations of the ADA.

The State of Florida is correct in protecting the lives of every person from both suicide and assistance in committing suicide. To protect some, but not all, persons would violate the Equal Protection clauses of the U.S. and Florida constitutions. There is no rational basis, and there is no compelling reason, for the state to allow doctors or others to lull persons with disabilities and not also allow doctors or others to help persons who do not have disabilities kill themselves. The act of suicide on the part of, or allowing a doctor to kill, a person with a disability is no more rational than an “able-bodied’ person committing suicide, Rather, it is a reflection of self-hatred that is reinforced by stigmas that society attaches to persons with disabilities.

Persons with disabilities have the **right** to receive supports that will help them to live independently and with dignity. Such is required by fundamental democratic concepts such as self-determination, freedom, and personal dignity. Proponents of assisted suicide turn these concepts inside-out, however, in asserting that they form the basis for a right of rational death for persons with disabilities.

Instead of seeking to give persons with disabilities a "death with dignity," it is the rightful role of the state to seek to assist persons with disabilities in achieving life with dignity, just as it is the role of the state to do so in general. Thomas Jefferson once stated that a government that fails to protect human life and human happiness is not a legitimate government. Any ruling by this Court that hampers the state in its role as a protector of the lives, liberty, and dignity of all persons will lessen the legitimacy of the State of Florida.

Until society is rid of the prejudice that devalues a life with a disability, assisted suicide will not be a "choice." Rather, it will be a rational decision that reflects the bigotry of persons who see a life with a disability as a tragic life that would be better off not existing. Would the Circuit Court have seriously considered allowing Dr. McIver to kill Mr. Hall if Mr. Hall did not have AIDS or some other serious disability? Certainly not. Remove the disability, and the support for a person's right to kill themselves, or for a doctor to kill the person, disappears. This is the prejudice that pervades our society, and which the law has only begun to eradicate.

The Circuit Court's judgment is a blatant violation of the Americans with Disabilities Act and denies equal protection of the laws, which require that the state give equal protection to the lives of all persons, regardless of disability. To do otherwise in this case will create a second class of citizens whose lives are worth less.

CONCLUSION

A bright line exists between the right to refuse life-sustaining medical treatment or support and the proposed right to assist another to commit self-murder--as it is described in the statute--even out of “mercy.” To confuse the two is to endanger the lives of persons who are devalued in our society; for example, persons with disabilities. There is a rational basis for the state to allow persons on artificial life support to choose to die naturally, but to prohibit persons to assist those who are robust enough to require some intervening cause, like a lethal injection, to effect their deaths.

The right to be let alone by government in Florida has not been construed by this Court to require the state to withdraw its protection of persons with civil rights, nor should such be construed.

Any creation of a right to help another kill themselves is a policy question that is best left to the Florida Legislature with its mechanism to receive public opinion and to balance interests.

The statute which prohibits self-murder, Section 782.08, Florida Statutes, is constitutional in that it protects the lives of persons with severe mental or physical disabilities who are often devalued and perceived as burdens to society. They may be susceptible to persuasion to die because of depression over their condition, the current lack of adequate health care **and** support services, **and** due to suffering pervasive prejudice.

For this court **to** determine that the state's **interest** in protecting **life** lessens **as** the potential for quality of life --as **an** outsider perceives it--diminishes, puts Floridians on a slippery ethical slope. .The line between assisted suicide **and** euthanasia blurs completely, especially when surrogates make the decision, as the Netherlands experience shows. Safeguards on the right to assist in suicide are **as** good **as** the persons implementing **them.** There is no adequate protection. People with disabilities will be the primary victims. It is a form **of genocide.**

Denying persons with disabilities the protection of the state discriminates against **them and** violates **the Americans** with Disabilities Act. In a Brave New World of assisted suicide, it is doubtful that the same level of suicide prevention will be provided for persons with disabilities **as** for able-bodied persons.

Respectfully submitted,

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WITH DISABILITIES

Certificate of Service

1 HEREBY CERTIFY that a true and complete copy of the foregoing was provided this 10th day of March, 1997, to

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APPENDIX

A. **Affidavit of Tim Broeseker, M.D.**

B. **Affidavit of Lori Ladd, C.N.S.**

C. **Affidavit of Anne Thal, L.C.S.W., D.C.S.W.**

D. **Hendlin, Herbert, M.D. "Scared to Death of Dying."** ***The*** **New** ***York Times*** **Op-Ed (December 16, 1994).**

E. **Wilkes, Paul. "The Case Against Doctor-Assisted Suicide,"** *The New York Times Magazine* **(July 21, 1996), p.** *22 et al.*

F. *When Death Is Sought, Assisted Suicide and Euthanasia in the Medical Context* **(May, 1994) The New York State Task Force on Life and the Law, Executive Summary.**

IN THE SUPREME COURT OF FLORIDA

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

Appellants,

v. Fla. Supreme Court No. 89,837

CECIL McIVER, M.D.,
CHARLES E. HALL.

Appellees.

AFFIDAVIT OF TIM BROESEKER, M.D.

STATE OF FLORIDA
COUNTY OF LEON

BEFORE ME, the undersigned authority, appeared TIM BROESEKER. M.D., , who deposes and says:

1. I, Tim Broeseker, M.D., am board certified in hematology, medical oncology, and internal medicine. I received my medical degree from the University of Florida in 1982 and completed my internship and residency at Rhode Island Hospital in 1985. I have managed the cases of thousands of cancer patients and more than a thousand who were terminally ill with cancer. I have practiced in Tallahassee since 1988 and am a partner in a private practice here.

2. My experience confirms the medical literature that cancer-related pain in 90 to 95 per cent of patients is controllable with pills in an aggressive, but careful approach. For the remainder of patients more invasive techniques of intravenous administration, epidurals or surgical techniques are necessary to control the pain. Research and development in pain management has blossomed in the past 10 years. Pain is subjective, so patients are asked to rate their own perceptions, usually on a 1 to 10 scale to make these determinations. Pain

[redacted]

Appendix A

medication runs the gamut from ibuprofen or acetominophen to codeine, and finally morphine. Morphine works with the least side effects of other strong pain medications and rarely causes addiction in patients who have pain

3 While we can manage pain effectively, I do not think that we can eliminate suffering entirely. It is a part of life and not realistically eliminated from our existence. Dying is not easy. However, we have to be honest as to whose pain and suffering we seek to eliminate by hastening death It is frequently that of the family rather than that of the patient The Holland experience which shows there are more than 1,000 cases of "involuntary euthanasia" per year, would likely occur hers. Any decision that would legalize physician-assisted suicide cannot be made in a vacuum. One must consider the cost-cutting efforts in the health care industry, Shorter lives lower costs.

4. Determining whether death is "imminent" as a criterion for determining when to employ assisted suicide is problematic. Prognoses are more accurate when made dx a patient with one to three days of life remaining, but become more difficult when measured in months. The cases where patients live years longer than their prognoses occurs. but is unusual.

5 I cannot see how legalized assisted suicide could be limited only to certain cases. The limitations would be arbitrary Qualitatively tnere is little difference between a 21 year-old with one week to live and a 19-1/2-year-old with two weeks to live. For these reasons and others I, like the majority ot' physicians, oppose legalized assisted suicide, especially by physicians

I SWEAR OR AFFIRM that the above information is true and correct to the best of my knowledge. Further affiant sayeth naught

Tim Broeseker

TIM BROESEKER, M.D.

SWORN TO AND SUBSCRIBED before me this 6 day of March, 1997, by **the affiant** who **is personally** known **to** me ☑ OR who **has** produced identification ☐ in the **Form** of

Annette M Herzfeldt

NOTARY PUBLIC

NOTARY PUBLIC STATE OF FLORIDA

ANNETTE MARIE HERZFELDT
My Comm Exp. 2/28/98
Bonded By Service Ins
No. CC351372
[ ] Personally Known [ ] Other I.D.

Print, **type** or **stamp commissioned name** of notary public:

My commission expires: 2/28/98

IN THE SUPREME COURT OF FLORIDA

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

Appellants,

v. Fla. Supreme Court No. 89,837

CECIL McIVER, M.D.,
CHARLES E. HALL,

Appellees.

AFFIDAVIT OF LORI A. LADD

STATE OF FLORIDA
COUNTY OF PINELLAS

BEFORE ME, the undersigned authority, appeared LORI A. LADD, who deposes and says:

1. I, LORI A. LADD, am the immediate past president and current member of the board of directors of the Florida Cancer Pain Initiative. It is a grassroots organization comprised of health care professionals in the state who are attempting to improve pain assessment and management through increased awareness and education. I am also an appointed commissioner on the Florida State Pain Commission of the Florida Agency for Health Care Administration. The Commission was funded by the Florida Legislature and appointed by the director of the Agency to make recommendations regarding pain management in Florida. I earned Master of Science in Nursing and Bachelor of Science in Nursing degrees from the University of Missouri at Columbia. Currently, I am a Clinical Nurse Specialist/Pain Resource Specialist and Professional Development Coordinator at The Hospice of the Florida Suncoast in Largo, FL. For the three years prior to this I worked as a Clinical Nurse Specialist in pain management with the Interdisciplinary Pain Program at the H. Lee Moffitt Cancer Center and Research Institute in Tampa, FL. A curriculum vitae is attached to this affidavit.

[redacted]

Appendix B

2. I am of the opinion, from my education, training and experience with hundreds of patients, newly diagnosed, chronically ill and actively dying, that assisted suicide is not necessary. Research has shown that patients who request assisted suicide often do so as a result of fear. Fear not only of uncontrolled pain but also of existential suffering, loneliness, becoming a burden and loss of control. These fears may surface at any point following diagnosis with a chronic or terminal illness and may not be associated with a presence of pain but rather fear of future pain and suffering . Fortunately, there are a multitude of interventions available to greatly reduce or even alleviate pain.

3. It has been estimated that approximately 90 percent of patients with cancer-related pain can now have that pain dramatically improved through the use of relatively simple means such as oral medications including opioids, non-opioid agents and adjuvant medications, and attention to the psychosocial and spiritual dimensions of pain and suffering. In the remaining cases, pain can be greatly reduced with medications administered in transdermal patches, intravenous or subcutaneous infusions. In very few cases, pain may require interventions which are more invasive such as infusions near the spinal canal or nerve blocks. In conjunction with pharmacologic management, pain relief is obtained through the use of non-pharmacologic interventions including, but not limited to, relaxation techniques, acupressure, acupuncture, herbal therapy, spiritual support and physical therapy. Aggressive attention to all dimensions of pain is essential in improving comfort and quality of life.

4. Perhaps nothing is more universally experienced as pain. Unfortunately, health care providers often have not received the necessary education and training to adequately address and manage issues of pain and suffering. Research has shown that this is in part the result of inadequate attention to pain physiology, assessment and multidimensional management in schools of medicine, nursing, pharmacy and social work. This is despite the acknowledgment that pain negatively influences physiological and psychological function. Perhaps of even greater

significance is a patient's reluctance to report pain, physical or psychological, to their health care providers. Until patients understand that it is their basic right to have pain and symptoms addressed and demand that health care providers utilize all resources available, people will continue to suffer. Given the knowledge that the fear of pain, existential suffering, and loss of control may be of greater significance than actual pain, health care providers must address the issues at all points of care from acute to chronic disease management, and of course at end-of-life.

5. An interdisciplinary, multidimensional approach to pain management is essential for maintenance or improvement in quality of life of patients who fear or experience pain. One such model of this approach is hospice care. In choosing hospice care, patients do not relinquish aggressive care, the emphasis simply shifts from aggressive disease management to aggressive symptom management. Hospice staff have knowledge and expertise in end-of-life care which is directed at management of complicated pain syndromes and other symptoms. In hospice all fears, concerns and symptoms are addressed by attending to patients' physical, psychosocial and spiritual needs. Support is also offered to family members and friends through counseling, support groups, respite care, and bereavement support prior to and after the death of a loved one.

6. While hospice care is available to all dying patients in Florida very few health care environments offer similar multidimensional services to patients who are suffering but have a life expectancy greater than 1 year. However, even access to hospice care may be limited by the well documented and widely acknowledged difficulty in predicting a patient's length of survival. Physicians may be reluctant to refer a patient to hospice if they are unsure of a one year prognosis, or in the case of Medicare patients, a six month prognosis. This uncertainty often results in referral to hospice when pain and suffering are profound and quality of life is diminished, often in the last hours, days, or weeks of life.

7. The proposed safeguard of limiting assisted suicide only to patients who face

"imminent" death is a tremendous problem because of the difficulty in judging when someone is going to die. With good physical, psychosocial and spiritual support, we have seen not only a dramatic improvement in quality of life and desire to live but also patients who live well and longer than had been predicted. The prolonged, quality filled life can be rewarding for the patient and his or her loved ones.

8. The answer to pain and suffering is not assisted suicide but rather aggressive management of symptoms and attention to the physical, psychosocial and spiritual needs of patients at all times, in all health care settings. In my opinion, health care professionals do not have the right to choose what is best for another person. They do, however, have the responsibility to always, not just at the end of life, attend to and try to alleviate all aspects of suffering. We as a society have the responsibility to recognize the implications of pain and suffering and to remove the barriers to adequate pain management. The public outcry for assisted suicide is one born out of fear, despair and **a lack** of awareness that pain and suffering can be controlled and meaningful quality of life maintained.

I SWEAR OR AFFIRM that the above information is true and correct to the best of my knowledge. Further affiant sayeth naught.

Lori A Ladd
LORI A. LADD

SWORN TO AND SUBSCRIBED before me **this** 7 day of March, 1997 by the affiant who **is** personally known to me ☐ OR has produced identification ☐ in the form of
____

Sarah A Brinnon
NOTARY PUBLIC

Print, type or stamp commissioned name of notary public:

My commission expires:

STATE OF FLORIDA
NOTARY PUBLIC
SARAH A. BRINNON
My Comm Exp. 3/14/99
Bonded By Service Ins
No. CC443222
[✓] Personally Known [ ] Other I. D.

Lori A. Ladd, MSN, RN
1604 Druid Road East
Clearwater, Florida 34616
(813)447-3095 (Home)
(813)586-4432 (Work)

Educational Preparation

01/87- 08/89 **Master of Science in Nursing**
University of Missouri Columbia-Columbia, Missouri
Major: Adult Medical/Surgical Nursing Clinical Specialization/Nursing Administration
Emphasis: Nursing management of oncology patient populations
Recognition: 1988 - **89** Who's Who Among Students in American Universities and Colleges
Internships
12/88 Ann's Haven Hospice - Denton, Texas
01/89 Memorial Sloan Kettering Cancer Center: Pain Service-New York, New York

1985 **Bachelor of Science in Nursing**
University of Missouri Columbia - Columbia, Missouri

Professional Experience

01/96- present **Professional Development Coordinator/Clinical Nurse Specialist**
The Hospice of the Florida Suncoast - Largo, Florida
Responsibility for overall professional development for all employees and educational activities that support Hospice's goals for professional community education and projects. Serve as resource to staff and patients in areas of pain and symptom management. Participate in educational activities of the Hospice Institute.

08/93 - 01/96 **Oncology Clinical Nurse Specialist - Interdisciplinary Pain Program**
H. Lee Moffitt Cancer Center & Research Institute - Tampa, Florida
Clinical Nurse Specialist in the Interdisciplinary Pain Program. Primary care of cancer and sickle cell anemia patients with acute and chronic pain in both an inpatient setting and outpatient pain clinic. Emphasis is placed on ongoing assessment and intervention through both formal and informal consultation. Available as a resource person to staff within the center and community. Of primary importance is the formal and informal education of medical, nursing and lay communities regarding cancer pain and its management. Ongoing participation in continuing quality improvement and research activities directed at the promotion and maintenance of optimal pain assessment and management in the cancer patient.

07/94 - present **Clinical Instructor, University of South Florida College of Medicine, Department of Neurology**

10/89- 07/93 **Oncology Clinical Nurse Specialist-Therapeutic Radiology**
Rush-Presbyterian-St.Luke's Medical Center-Chicago, Illinois
Clinical Nurse Specialist in an out-patient radiation therapy department in joint practice with three Radiation Oncologists. Comprehensive care of patients receiving radiation and chemotherapy. Primary focus of practice was education of patients and their significant others regarding disease, treatment and its side effects. Emphasis placed on assessment and intervention in pain and symptom management including acute and chronic wound care, psychosocial counseling, and nutritional intervention. Acted as consultant/resource person to in-house nurses and medical staff,

providing lectures and in-services. Research involvement included both nursing and medical research studies.

11/90- **Complemental Faculty, Rush University College of Nursing**
07/93 **Chicago, Illinois**

09/90 **In-House Registry-Oncology, Oak Park Hospital-Oak Park, Illinois**

12/88- **Research Director-B.A.P. Inc. - St. Louis, Missouri**
12/89 Researched the applicability of various business and management theories and concepts to health care and the expansion of B.A.P.'s concept of self-motivation.

10/86- **Staff Nurse III-Hematology/Oncology**
12/88 **University of Missouri Hospital and Clinics-Columbia, Missouri**

05/87- **Staff Nurse 111-Short Stay Center**
12/88 **University of Missouri Hospital and Clinics-Columbia, Missouri**

06/86- **Registered Nurse Consultant/Nurse Aide Certification Instructor**
09/87 **Columbia Manor Care Center-Columbia, Missouri**

12/85- **Staff Nurse-Orthopedics and Rehabilitation**
10/86 **Harry S. Truman Veterans Administration Hospital-Columbia, Missouri**

Professional Memberships/Certifications

1994-97	Florida Cancer Pain Initiative
1989-90 **1993-97**	The American Pain Society
1996-97	National Hospice Organization
1996-97	National Council of Hospice Professionals of the National Hospice Organization
1996-97	Hospice Nurses Association
1995-96	Southern Pain Society
1993-97	American Society of Pain Management Nurses
1988-95	Oncology Nursing Society
1993-95	Oncology Nursing Society - Pain Management Special Interest Group
1991-95	Oncology Nursing Society - Radiation Therapy Special Interest Group
1991-95	Oncology Nursing Society - Pediatric Special Interest Group
1992-95	American Society for Therapeutic Radiology and Oncology, Associate
1989-95	Sigma Theta Tau-Alpha Iota Chapter
1989-93	Chicago Chapter Oncology Nursing Society
1989-93	Research Committee-Chicago Chapter Oncology Nursing Society
1989-93	Midwest Nursing Research Society

1986-94 Missouri League of Nursing Home Administrators, Inc. Nurse Aide Training Course Examiner/Instructor-Certification

1987-89 University of Missouri Hospital and Clinics Chemotherapy Certification

1986-89 University of Missouri-Graduate Nurses Association

Professional Committee Participation

1994-96 Florida Cancer Pain Initiative - State President

1994-97 Florida Cancer Pain Initiative - Board of Directors

1995-97 Florida State Pain Commission - Commissioner

1995 American Pain Society - Analgesic Regulatory Affairs Council

1994-95 Continuing Quality Improvement: Pain Management - Facilitator, H. Lee Moffitt Cancer Center

1994-95 Pain Resource Nurse Committee - Facilitator, **H.** Lee Moffitt Cancer Center

1993-95 Pharmacy Editorial Board, H. Lee Moffitt Cancer Center

1994-95 Patient Controlled Analgesic Pumps - BMTU, H. Lee Moffitt Cancer Center

1994-95 Pharmacy Residency Advisory Board: Pain, H. Lee Moffitt Cancer Center

1994-95 Hospice Steering Committee, H. Lee Moffitt Cancer Center

1993 Bone Marrow Transplant Unit Integument Committee, H. Lee Moffitt Cancer Center

1989-93 Chicago Chapter Oncology Nursing Society - Research Committee

1990-93 Department of Therapeutic Radiology Research Committee, RPSLMC

1991-92 Illinois Cancer Pain Initiative

1990-92 Radiotherapy Committee of the Illinois Cancer Council, Clinical Trials Division
Subcommittee on Nursing
1991 Chairman - Subcommittee on Nursing

1987-88 Nursing Standards of Practice, UMHC

1987-88 Primary Nursing, UMHC

1988 Nurse Recognition **Week,** UMHC

1986 Theory Based Practice: Orem's Self Care Nursing Theory, HSTVAH

Appointments

1994-96 Florida Cancer Pain Initiative, State Chairman

1994-96 Florida State Pain Commission - State of Florida Agency for Health Care Administration

1995 American Pain Society - Analgesic Regulatory Affairs Council

1993 The Society of Nursing Professionals, "Who's Who in American Nursing, 1993-1994."

1991-93 LaRabida Children's Hospital and Research Center Business Council.

Professional Presentations/Contributions

02/97	"Relief of Suffering: Pain and Symptom Management at the End of Life." The Future of Death: A Community Response to End-of-Life Issues, A Conference on End-of-Life Care. Largo, FL.
01/97	"Care Issues in the Chemically Dependent Patient." The Hospice of the Florida Suncoast Professional Development. Largo, FL. Ongoing Training.
11/96	"Advanced Pain Management: The Intricacies of Managing Complex Pain Problems." National Hospice Organization's 18th Annual Symposium & Exposition. Chicago, IL.
11/96	"Children at Risk: Pain Management in Pediatrics." National Hospice Organization's 18th Annual Symposium & Exposition. Chicago, IL.
11/96	"Symptom Management in Palliative Care." Suncoast Hospital Residents Training. Largo, FL.
10/96	Surviving and Thriving Through the Frustrations of Pain Management: Vulnerabilities of the Professional Caring for Patients in Pain." Third Annual Florida Cancer Pain Initiative Meeting, Pain Issues in Vulnerable Populations. Largo, FL.
10/96	"Pain Management of HIV/AIDS: Unique Issues in Assessment & Management." **A** Community of **HEART:** Living with HIV. Largo, FL.
10/96	"Pain Management Issues in Palliative Care." Suncoast Hospital Residents Training. Largo, FL.
10/96	"Palliative Care: Issues in Pain Assessment & Management." Alhambra Nursing Home. St. Petersburg, FL.
09/96	"Children at Risk: Pain Management in Pediatrics." Florida Hospices, Inc. Twelfth Annual Symposium, Diversity: Embracing the Challenge. Orlando, FL.
09/96	"Case Studies in Cancer Pain Management." Florida Cancer Pain Initiative Northern Region Meeting. Jacksonville, FL.
08/96	"Legalities, Controversies and Ethics in Cancer Pain Management." Sixth Annual Hematology/Oncology Reviews. Ponte Vedra Beach, FL.
08/96	"Pain Management." Hospice Nurses Certification Review. Largo, FL.
07/96	"Palliative Care: Issues in Pain Assessment & Management." Tyrone Medical Inn. St. Petersburg, FL.
06/96	"Barriers to Effective Pain Management." Pain Management Concepts, A Workshop for Nurses. Jacksonville, FL.
06/96	"Pain Assessment." Pain Management Concepts, A Workshop for Nurses. Jacksonville, FL.
05/96	Contemporary Issues in Palliative Care Medicine: Pain and symptom Management in Advanced Cancer and Other Illness. Program Moderator. Orlando, FL
05/96	"Cancer Pain Management: A Health Care Imperative." Rocky Mountain Health Care Corporation Teleconference. Denver, CO.

03/96	“Managing Cancer Pain: Opportunities for Nursing Involvement.” Pain Management in the 90’s: A Nursing Perspective, Holmes Regional Medical Center, Inc and the American Academy of Pain Management conference, Cocoa Beach, FL.
03/96	“Interdisciplinary Pain Management: **A** Comprehensive Training for Nurses, Psychosocial Professionals, Chaplains, Home Health Aids, and Volunteers.” The Hospice of the Florida Suncoast Ongoing Professional Development Program. Largo, FL.
02/96	“Pediatric Pain: The Family Perspective.” Pediatric Pain Management Conference, All Children’s Hospital, St. Petersburg, FL.
01/96	“Current Concepts in Pain Management Part II: Cancer Pain.” Shands Teaching Hospital at the University of Florida, Gainesville, FL.
01/96	“Chronic Cancer Pain Management.” New Port Richey Hospital, New Port Richey, FL.
11/95	“Chronic Cancer Pain Management for Community Pharmacists.” Palm Beach County Pharmaceutical Association. West Palm Beach, FL.
11/95	“Pain and Suffering: Management of Multidimensional Phenomena Using a Multidisciplinary Approach.” Ethical Issues in Hospice. Augusta, GA.
10/95	“State Cancer Pain Initiative and the Florida Experience.” Delaware Cancer Pain Initiative Community Introduction, “Choices-You Can Make a Difference:, Newark, Delaware.
09/95	“Cancer Pain Management: A Nurse’s Challenge, A Health Care Imperative.” Oncology Nursing Society, Imperial Polk County Chapter, Lakeland, FL.
08/95	“Advanced Pain Management: Everything You Never Knew You Needed to Know.” H. Lee Moffitt Cancer Center, Tampa, FL.
07/95	”Pain Management in Older Adults.” Florida Association of Homes for the Aging State Conference, Naples, FL.
06/95	”Cancer Pain Management." Hospice of Citrus County, Lecanto, FL.
06/95	”Cancer Pain Management." Florida Community Cancer Center, Brooksville, FL.
06/95	“Utilizing Resources to Overcome Patient and Provider Barriers to Optimal Pain Management." Cancer Pain and Symptom Management: Contemporary Techniques and Resources, Jacksonville, FL.
06/95	”Cancer Pain Management, Overcoming the Obstacles and Improving Life’s Quality." Trends in Oncology, Rockledge, FL.
06/95	”Pain in the Patient with Sickle Cell Anemia." Sickle Cell Anemia in the Adult Patient, Tampa, FL.
05/95	”Advocate, Educate, Communicate: Overcoming Obstacles to Cancer Pain Management." Big Bend Hospice, Tallahassee, **FL.**

05/95	"Pain in the Patient with Sickle Cell Anemia." Sickle Cell Anemia in the Adult Patient, Tampa, FL.
05/95	"Pain Management: A Health Care Imperative." VA Hospital, Gainesville, FL.
02/95	"Pain Management '101': Everything You Ever Wanted To Know About Pain But Were Afraid to **Ask.**" **H.** Lee Moffitt Cancer Center.
02/95	"Interdisciplinary Management of Cancer Pain - Pain Teams: Who, What, When, Why." Multidisciplinary Psychosocial Oncology Conference, H. Lee Moffitt Cancer Center.
01/95	"The Intricacies of Cancer Pain Management: Managing Complex Pain Problems." Hospice of North Central Florida, Gainesville, FL.
01/95	"Pediatric Chronic Pain Management: Controversies and Interventions." Neonatal and Pediatric Pain Management. All Children's Hospital, St. Petersburg, FL.
11/94	"Understanding Pain and the New AHCPR Guidelines for Cancer Pain Management." Jewish Hospital, St. Louis, MO.
11/94	"Cancer Pain Management: Overcoming the Obstacles and Improving Life's Quality." Florida Hospital, Altamonte Springs, FL.
11/94	"Pain Management '101': Everything You Ever Wanted To Know About Pain But Were Afraid to Ask." **H.** Lee Moffitt Cancer Center.
11/94	"Cancer Pain Management: Overcoming the Obstacles and Improving Life's Quality." Visiting Nurses Association and Hospice, Vero Beach, FL.
11/94	"Understanding Pain and the New AHCPR Guidelines for Cancer Pain Management." Group Health Plan, St. Louis, MO.
10/94	Statewide Organizational Meeting: Florida Cancer Pain Initiative, Program Chair. Orlando, FL.
09/94	"Pain Management '101': Everything You Ever Wanted To Know About Pain But Were Afraid to Ask." H. Lee Moffitt Cancer Center.
9/94	"**A** Patients Response to Cancer" OCN Review Course, Tampa, FL
8/94	"Pain and its Management." Wuesthoff Health Systems, Inc., Rockledge, FL.
8/94	"Please Nurse, Help Relieve My Pain." Holmes Regional Medical Center, Melbourne, FL.
7/94	"Promoting Excellence in Patient Care: The Role of the Advanced Practice Nurse." Medical Grand Rounds, **H.** Lee Moffitt Cancer Center
07/94	"Pain Management '101': Everything You Ever Wanted To Know About Pain But Were Afraid to Ask." H. Lee Moffitt Cancer Center.
07/94	"Pediatric Pain Management, Part 11: Management Through Pharmacologic, Non-Pharmacologic and Crisis Intervention." H. Lee Moffitt Cancer Center.

06/94	"Pediatric Pain Management, Part I: Pathophysiology and Assessment of the Pediatric Cancer Patient in Pain." H. Lee Moffitt Cancer Center.
06/94	"Increasing Public Awareness." Florida Cancer Pain Initiative Meeting. Clearwater Beach, FL.
05/94	"Pain Management '101': Everything You Ever Wanted To Know About Pain But Were Afraid to Ask." H. Lee Moffitt Cancer Center.
05/94	"Patient Controlled Analgesia: Why We Do the Things We Do." H. Lee Moffitt Cancer Center Bone Marrow Transplant Unit Clinical Concerns.
03/94	"Qualitative vs. Quantitative Research." Nursing Research for Clinicians - You Can Do It." Chicago, IL.
01/94	"Cancer Pain: Special Considerations in the Transplant Patient." H. Lee Moffitt Cancer Center BMTU.
01/94	Cancer Series "Pain Management Today." H. Lee Moffitt Cancer Center.
11/93	"Non-Pharmacologic Interventions for Pain Control." H. Lee Moffitt Cancer Center.
10/93	"Management of Painful Tissue Fibrosis." Pain Program Rounds - H. Lee Moffitt Cancer Center.
04/93	"Wound Care Issues in Oncology." Chicago Chapter Oncology Nursing Society, Chicago, IL.
02/93	"The Role of Radiation Therapy in the Treatment of Breast Cancer." The Sixth Annual Oncology Nursing Conference: "Breast Cancer: Reflecting on the Past, Focusing on the Future", Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL.
11/92	"Skin and Wound Care Issues in Oncology." Oncology Course: Issues and Trends, RPSLMC.
10/92	"The Use of Non-Steroidal Anti-Inflammatory Agents in Oncology." The Purdue Frederick Company Sales Representative Training Program. Atlanta, GA.
09/92	"Radiation Therapy as a Treatment Modality." Oncology Nursing: A Comprehensive Review, Triton College, Chicago, IL.
06/92	"Physiology of Cancer Pain and Its Management." Oncology: Science of Disease, Treatment, and Survival, The Visiting Nurse Association of Chicago, IL.
05/92	"Nursing Involvement in Medical Research: Establishing Your Role and Ensuring Recognition", round table facilitator. Oncology Nursing Society 17th Annual Congress, San Diego, CA.
05/92	"Management of Post-Irradiation Tissue Fibrosis: Massage and Scar Tissue Integration Therapy." Round table Facilitator-Oncology Nursing Society 17th Annual Congress, San Diego, CA.
04/92	"Skin Care Needs of the Oncology Patient". Medical Oncology Grand Rounds, Chicago, IL.
11/91	"Wound Management: An Overview." Resident's Conference, Chicago, IL.

11/91 "Radiation Therapy as a Treatment Modality." RPSLMC.

10191 "General Principles of Radiation Therapy and Skin Care in the Oncology Population." Rehabilitative Medicine Rounds. RPSLMC.

10191 "Radiation Therapy as a Treatment Modality: An Overview." RPSLMC.

08/91 "Radiation Therapy as a Treatment Modality." Oncology Nursing: **A** Comprehensive Review, Triton College, Chicago, IL.

08191 "Care of the Pediatric Patient Receiving Radiation Therapy." Pediatric Nursing, RPSLMC.

08191 "Radiation Safety and Care of the Brachytherapy Patient." RPSLMC.

06/91 "The Multidimensional Need to Understand Breast Cancer." Chicago, IL, Sponsored by Norrell Health Care.

04191 Radiation Therapy 36-201: Patient Care, "Prevention and Control of Infection." National Louis University, Chicago, IL.

04/91 Radiation Therapy 36-201: Patient Care, "Pain the Cancer Patient-Avoidance, Recognition and Control." National Louis University, Chicago, IL.

11/90 "The Role of Radiation Therapy in Patients Receiving TBI in Preparation for Bone Marrow Transplantation." RPSLMC.

08/90 "The Role of Radiation in the Prophylactic Treatment of Heterotopic Bone Formation in Patients Receiving Total Hip Replacements." RPSLMC.

07/90 "Radiation Therapy and the Adolescent Oncology Patient." RPSLMC.

04/90 "The Effect of Administration Rate of Cyclophosphamide on the Immediate Side Effects of Taste, Nausea and Vomiting." Poster Presentation-Midwest Nursing Research Society **14th** Annual Conference, Indianapolis, IN.

02/90 "Combined Modality Therapy for Cancers of the Upper Abdomen." Round Table Facilitator-Rush Cancer Center and Rush University's Oncology Nursing Conference, Chicago, IL.

Academic Contributions

12/96 "Introduction to Pain Assessment and Management." University of South Florida School of Nursing.

06/96 "Pain Management for the Critically Ill Adult." Concepts in the Critically Ill Adult. University of South Florida School of Nursing.

12/95 "Nursing's Responsibility for Care: Pain Management Across Life's Continuum." University of South Florida School of Nursing.

11/95 "Pain Management: Introduction to Clinical Judgement." University of South Florida School of Nursing.

05/95- 07/95 Preceptor: Graduate Nursing Student, Psychiatric Mental Health Nursing, University of South Florida School of Nursing.

01/95 - 04/95 Preceptor: Graduate Nursing Student, University of South Florida School of Nursing.

10/94 "Pain Management in the Cancer Patient: **An** Overview." University of South Florida Undergraduate Program: RN Sequence.

09/94 - 10/94 Preceptor for Pain Management Clinical Rotation: Undergraduate Nursing Students. University of South Florida School of Nursing.

07/94 "Cancer Pain Management: An Overview Including Review of the AHCPR Guidelines." University of South Florida Undergraduate Nursing Program.

05/94 "The Role of the Clinical Nurse Specialist on an Interdisciplinary Pain Team: Role Definition, Methods and Obstacles." University of South Florida Graduate Nursing Program.

05/94- 07/94 Preceptor: Graduate Nursing Student, University **of** South Florida School of Nursing.

12/93 "Cancer Pain Management: Making a Difference in Life's Quality." University of South Florida Undergraduate Nursing Program.

04/93 "Superior Vena Cava Syndrome." Graduate Nursing Course 534D: Nursing Care of the Cancer Patient, Rush University College of Nursing.

04/93 "Spinal Cord Compression." Content Expert-Graduate Nursing Course **534D**: Nursing Care **of** the Cancer Patient, Rush University College of Nursing.

Win '92 Graduate Student Preceptor, Rush University College of Nursing

Sum '91 Graduate Student Preceptor, Rush University College of Nursing

Sum '91 Graduate Student Preceptor, Rush University College of Nursing Independent Study in Advanced Radiation Oncology

04/91 "Spinal Cord Compression." Content Expert-Graduate Nursing Course **534D:** Nursing Care **of** the Cancer Patient, Rush University College of Nursing.

08/89 "Chronic Pain: The Nurses Role in Management." University of Missouri, Columbia, MO, Graduate Nursing Course **340.**

04/91 "Hypercalcemia of Malignancy." Graduate Nursing Course 534D: Nursing Care of the Cancer Patient, Rush University College of Nursing.

04/90 "Hypercalcemia of Malignancy." Graduate Nursing Course **534D:** Nursing Care **of** the Cancer Patient, Rush University College of Nursing.

Research/Grants

Current	"Last Rights, Preserving the Rights of Dying Patients." Development of a Community Model of Care. The Hospice of the Florida Suncoast & St. Anthony's Hospital. Supported by a grant from the Jessie Ball DuPont Fund.
Current	"A Study to Evaluate Pain Assessment Tools in the Elderly." Principle Investigator. H. Lee Moffitt Cancer Center.
Current	"Double Blind Placebo Controlled Evaluation of Salmon Calcitonin in the Treatment of Malignant Metastatic Bone Pain." Co-Investigator. H. Lee Moffitt Cancer Center.
1992 - 1995	"The Effectiveness of a Non-Steroidal Anti-Inflammatory Agent (Trilisate) in Reducing Mucosal Reactions in Patients Receiving Radiation to the Pelvis." Co-investigator and prior nursing coordinator, Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL.
1993	"Phase III/IV Study Comparing Three Skin Care Products Used During Radiation Therapy for Breast Cancer." Co-Investigator and prior RPSLMC nursing coordinator. In cooperation with the Oncology Nursing Society.
1993-94	"Randomized Trial of Palliative Radiation Therapy for Osseous Metastases: A Study of Palliation of Symptoms, Quality of Life, and Health Care Costs." Co-Investigator, Rush-Presbyterian-St. Luke's Medical Center.
1991	"Biochemical Markers of the Response to Radiation." Nursing coordinator, Rush-Presbyterian-St. Luke's Medical Center.
1991-92	"Comparison of Vigilon to Biolex Gel in the Treatment of Moist Desquamation Secondary to Radiation." Principal Investigator-Illinois Cancer Council Radiotherapy Nursing Subcommittee. Incomplete due to folding of the Illinois Cancer Council.
1989	"Recognition and Reinforcement Needs of Staff Nurses: Use of a Self-Reporting System." Principal Investigator (unpublished).
1989	Thesis: "The Effect of Administration Rate of cyclophosphamide on the Immediate Side Effects of Taste, Nausea, and Vomiting." Poster presentation: Midwest Nursing Research Society 14th Annual Conference, Indianapolis, IN, April, 1990.

Publications

Cronin Y, **Ladd L.** Utilizing the Clinical Nurse Specialist to Promote Interdisciplinary Pain Management. J FL M **A** 1997: 84; 772-774.

Ladd L (contributor) Hospice and Palliative Care Clinical Practice Monograph on Dyspnea. Hospice Nurses Association, in press.

Ladd L, McGough K, Dahmer K, Rettig M: "Last Rights: Preserving the Rights of Dying Patients, Plan of Care Reference Manual."

Egan K, **Ladd L:** "**A** Comprehensive Model of Pain Management: Applications Beyond Hospice." Pain Intervention Network Newsletter, **1996:** 2; 9-11.

Ladd L, Chrisit J: Pain and Symptom Management. In ***The Hospice Institute of the Florida Suncoast Certification Program Manual.*** Largo, FL, 1996.

Ladd L: "The Florida Cancer Pain Initiative." ***Intravenous Nurses Society Newsletter,*** 1995.

Ladd L: "The State Cancer Pain Initiative Movement with Highlights from Florida." *SPS* News, **1995.**

Ladd L (contributor). In Groenwald **SL,** Frogge MH, Goodman **M,** Yarbro CH (eds): ***A Clinical Guide to Cancer Nursing.*** Boston: Jones and Bartlett, 1995.

LaPerriere J, **Ladd L:** "The Interdisciplinary Management of Pain: The True Team Approach." ***Pharmaceutical Synergies,*** Spring 1994.

Goodman M, **Ladd L,** Purl **S:** Integumentary and mucous membrane alterations. In Groenwald **SL,** Frogge MH, Goodman M, Yarbro CH, (eds): ***Cancer Nursing Principles and Practice.*** (3rd ed). Boston, Jones and Bartlett, 1993, 734-799.

Ladd L: Commentary in Continence, Skin and Wound Care: **A** Report From Clinicians. Volume 1, pg. 11, 1993. Bard Patient Care Division.

Ladd L: "Efficiency in Research: **An** interdisciplinary approach." ***CCONS Update.*** 15:2,8,1993

Ladd L: "The dry mouth dilemma." ***Oncology Nursing Forum,*** 18:4;785-786,1991.

Ladd L, Schroeder L: "What's the big deal?" ***CCONS Update,*** 18:3;7,1990.

IN THE SUPREME COURT OF FLORIDA

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

Appellants,

v. Fla. Supreme Court No. 89,837

CECIL McIVER, M.D.,
CHARLES E. HALL,

Appellees.

AFFIDAVIT OF ANNE THAL

STATE OF FLORIDA
COUNTY OF HILLSBOROUGH

BEFORE ME, the undersigned authority, appeared ANNE THAL, who deposes and says:

1. I, Anne Thal, Licensed Clinical Social Worker, Diplomate in Clinical Social Work, have been president and chief executive officer of Hospice of Hillsborough, Inc., since 1987. We have grown to the third largest not-for-profit hospice in the United States with more than 350 employees and a budget of nearly $23 million. I earned in 1968 a master of arts degree from the University of Chicago, School of Social Service Administration, and in 1966 a bachelor of arts degree from the University of Chicago. I have been, since 1995, the chair of the Ethics Committee of the National Hospice Organization.

2. I have been a lecturer, trainer, preceptor, consultant, and presenter for local and national organizations on more than 300 occasions over the past 20 years. I am a co-author of the pamphlet *Proactive* Responses to ***the Assisted*** Suicide */Euthanasia* Debate, published by the National Hospice Organization, Arlington, Virginia, 1996; the article “Should Assisted Suicide Be Legal?,” National Association ***of Social*** Workers News, May, 1992, and ”Reinforcing the

[redacted]

Appendix C

Front Lines: Guidance to Hospice Works on Assisted Suicide," Hospice Magazine, National Hospice Organization, Fall, 1996, among other publications. I am included in Who's Who in the World (1992 to present) and Who's Who in America (1992 to present). A more complete list appears in my curriculum vita, attached.

3. The Hospice movement in the United States cared for more than 400,000 terminally ill patients and their families in 1996. Mare than 40,000 were in Florida with 3,000 in our program. Out of this vast body of experience with the needs of the dying has evolved a strong position against the legalization of assisted suicide.

4. In my opinion the creation of the right to assisted suicide would be disastrous policy in a society where we have not yet made the commitment to care for people. As in the Netherlands, I believe we would quickly find the "right to die" becomes the obligation to die for those among us who are the most vulnerable and with the least other resources. Family members, health care providers and society frequently exert subtle or overt pressures upon terminally ill patients to consent to excessive disease-oriented therapy. Terminally ill patients may similarly be pressured to consent to assisted suicide if it becomes a legal option.

5. I agree with the assessment of the New York State Task Force, which reported: "No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society including health care." The practices will pose the greatest risks to those who are poor, elderly, members af a minority groups, persons with disabilities, and those without access to good medical care.

6. I also share the perceptions of Herbert Hendlin, a professor of psychiatry at New York Medical College, quoted in the New York Times on December 16, 1994, as follows: "The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally

ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to involuntary euthanasia. The Dutch Government's own commissioned research has documented that in more than 1,000 cases a year, doctors actively caused or hastened death without the patient's request." This is in spite of very rigid guidelines and regulations not dissimilar from those proposed to accompany legalization in the United States.

7. It is our experience that most terminally ill patients express an interest in suicide out of fear --the fear of suffering (physical, emotional and spiritual), the fear of loss of control, the fear of being a burden, and the fear of abandonment. When these fears are effectively dealt with--as they all can be by Hospice--that wish or interest goes away, and people are able to live the last part of their lives in comfort and peace.

8. Many people greatly fear being subjected to tortuous life-prolonging procedures and believe that the only alternative to this outcome is assisted suicide. Vast education about the use of advance directives and expansion of palliative and hospice care is greatly needed, not a change in the law that would make these alternatives even less available to those in need.

9. Failure to diagnose easily treatable depression in the terminally ill is widespread. Some studies have shown that non-psychiatric physicians miss this diagnosis almost 90 per cent of the time. Assisted suicide is not a reasonable treatment for depression. The New York State Task Force on Life and the Law in its report, When ***Death Is Sought,*** found that they were "particularly struck by the degree to which requests for suicide assistance by terminally ill patients are correlated with clinical depression or unmanaged pain, both of which can ordinarily be treated effectively with current medical techniques." As a society, we can do far more to benefit these patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or to obtain a lethal injection.

10. Assisted suicide can never be adequately controlled, so it must not be legalized. We cannot condition it on whether the prognosis is “imminent” death, as some have proposed. Medicine is an inexact science. There are numerous cases of patients, with the proper love and support, living years beyond the time given to them by their physicians. The federal government recognized this in 1990 with an amendment to the 1983 Medicare Regulation §418.22(b), Hospice Care, pertaining to the physician’s certification of terminal illness, which qualifies a patient far hospice care. The regulation had previously read, “The certification must specify that the individual’s prognosis is for a life expectancy of six months or less.” The language was amended to read, “...if the terminal illness runs its normal course.”

10. While there may always be a “compelling” case, it is my opinion that to enact a change in law that might help an extremely small number of persons, risks a sea change in our society and the loss of the true caring and compassion that should be extended to the terminally ill and their families. Tough cases make bad law.

11. Finally, dying is frequently a rich and meaningful process for individuals and their families. It is valued as a life cycle event. It may not always be easy, but what of value in life is? Dying is not “undignified.” It is simply part of being human. When we all come to terms with that and take death out of the taboo closet into which our society has shoved it, we will all see that the true indignity would be laws that promote the premature cut off of our allotted days.

I SWEAR OR AFFIRM that the above information is true and correct to the best of my knowledge. Further affiant sayeth naught.

Anne E Thal

ANNE E. THAL

SWORN TO AND SUBSCRIBED before me this 6TH day of March, 1997 by the affiant who is personally known to me ☒ OR who has produced identification ☐ in the form of________________________________

Sharon Stiner

NOTARY PUBLIC

Print, type or stamp commissioned name of notary **public:**

My commission expires: December 06, 1997

NOTARY PUBLIC STATE OF FLORIDA

SHARON D STINER
My Commission CC334414
Expires Dec. 06, 1997
Bonded by HAI
800-422-1555

ANNE E. THAL, LCSW, DCSW

Hospice of Hillsborough, Inc.
3010 West Azeele Street
Tampa, Fl. 33609-3139
(813) 877-2200

Professional Experience

HOSPICE OF HILLSBOROUGH, INC., Tampa, Florida 1987 - Present
President/CEO

Assumed full administrative responsibility for rapidly growing multi-disciplinary agency serving the terminally ill and their families. In 1987, the agency had 20+ employees, a <$1 million budget and an outmoded management and organizational structure. Today it is the third largest not-for-profit hospice in the United States, with over 350 employees and a budget approaching $23 million.

PRIVATE PRACTICE - Management Consulting; Psychotherapy, Tampa Florida **993 -** Present

UNIVERSITY OF SOUTH FLORIDA, Department of Social Work, Tampa Florida **975 -** 1983
Adjunct Lecturer/Field Instructor

TAMPA JEWISH SOCIAL SERVICE, Tampa, Florida **974 -** 1983
Executive Director

SUICIDE CRISIS CENTER, Tampa, Florida 973 - 1974
Executive Director

HILLSBOROUGH COUNTY PUBLIC SCHOOL SYSTEM, Tampa, Florida **972** - 1973
Research Social Worker

Other

THE PLAYMAKERS, INC., Tampa, Florida 1983 - 1985
Director of Management and Development

HILLSBOROUGH COUNTY COMMISSION, Tampa, Florida 1977 - 1978
Chairperson - Crisis Council

Education

Master of Arts Degree, School of Social Services Administration - University of Chicago, Chicago, Illinois 1968

Awards and Accomplishments:

- Casework Fellow. National Institute of Mental Health

Bachelor of Arts, College of Human Development - University of Chicago, Chicago, Illinois 1966

Awards and Accomplishments:

- Howell Murray Alumni Award
- Maroon Key, Nu Pi Sigma Honor Societies

Graduate School of Business - University of South Florida

Course Work: Finance, Accounting, Economics, Marketing, Statistics, Computers, Management Systems

Professional Affiliations and Appointments

- National Hospice Organization, Ethics Committee, 1991 - Present; Chair - 1995-Present.
- Florida Hospices, Inc., President, 1992-1995.
- University of Pennsylvania, Leonard Davis Institute of Health Economics National Study of Hospice Care and Aids Advisory Board, 1995 - Present.
- University of South Florida, School of Social Work, Professional Advisory Committee - 1994 - 1996.
- Corecare Registry, Editorial Advisory Board - 1994-1995.
- Leadership Tampa Alumni.
- Network of Executive Women.
- Actors Equity Guild.
- Diplomate in Clinical Social Work - 1987 - Present.
- National Association of Social Workers - 1968 - Present.
- Licensed Clinical Social Worker, State of Florida.

Honors

- "Executive Woman of the Year," Finalist - 1994.
- Who's Who in the World - 1992 - Present.
- Who's Who in America - 1992 - Present.
- Who's Who in the South & Southeast, 1991 - Present.
- who's Who of American Women - 1984 - Present.
- Who's Who of Human Service Professionals - 1990.
- Personalities of the South - 1986.
- "33 Women to Watch," Tampa Tribune - 1982.
- "Outstanding Young Woman of America" - 1978-1979.

Academic

Lecturer, trainer, preceptor, consultant, presenter for local and national organizations on more than three hundred occasions over the past twenty years. (Complete list available.)

Publications

Thal, Anne E., et.al.: "Proactive Resaonses to the Assisted Suicide/Euthanasia Debate," National Hospice Organization, Arlington, Virginia, 1996.
Thal, Anne E.: "Letter to the Editor." Tampa Tribune; 11/29/95.
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Thal, Anne E.: "Letter to the Editor." Journal of the American Geriatric Society, Volume 41, #8. August 1993.
That, Anne E.: "Health Care Reform Act Passed in Florida." National Hospice Organization Newsling; volume 3, # 12. July 15, 1993.
Thal, Anne E.: "Letter to the Editor." American Journal of Hospice & Palliative Care; May/June 1992.
Thal, Anne E.: "Should Assisted Suicide Be Legal?" National Association of Social Workers News; May 1992.
That, Anne E.: "Letter to the Editor." National Association of Social Workers Newsletter, Florida; July/August 1991.
Thal, Anne E: "Reinforcina the Front Lines: Guidance to Hosaice Workers on Assisted Suicide," Hospice Magazine, National Hospice Organization, Fall, 1996

11/27/96

Scared To Death Of Dying

By Herbert Hendin

Alan E. Cober

The conflict over legalizing assisted suicide and euthanasia might well tear our society apart. Yet neither legalization nor opposition to it constitutes a public policy that addresses the much larger problem of how to care for the terminally ill.

The call for legalization is a symptom of our failure to develop a better response to death and the fear of intolerable pain or artificial prolongation of life.

The absence of such a policy permits doctors like Jack Kevorkian to be seen as the only champions of the terminally ill and legalization to be perceived as the cure for fear.

A law that Oregon voters approved in November would permit doctors to prescribe lethal drugs to patients judged to be in the last six months of life. The law, under a restraining order pending a hearing Monday on its constitutionality, is the latest example of how public frustration can lead to action that only compounds the problem.

It is not just that it is impossible to predict with certainty that a patient has only six months to live, making mistaken or falsified predictions inevitable. Any law that permits assisted suicide when patients are neither in pain nor imminently about to die will encourage people who fear death to take a quicker way out.

A few years ago, a young professional in his early 30's who had acute myelocytic leukemia was referred to me for consultation. With medical treatment, he was given a 25 percent chance of survival; without it, he was told, he would die in a few months.

His immediate reaction was a desperate preoccupation with suicide and a request for support in carrying it out. He was worried about becoming dependent and feared both the symptoms of his disease and the side effects of treatment. His anxieties about the painful circumstances that would surround his death were not irrational, but all his fears about dying amplified them.

Many patients and physicians displace anxieties about death onto the circumstances of dying — pain, dependence, loss of dignity, the unpleasant side effects resulting from medical treatment. Once the young man and I could talk about the possibility or likelihood of his dying — what separation from his family and he destruction of his body meant to him — his desperation subsided. He accepted medical treatment and used the remaining months of his life to become closer to his wife and parents. Two days before he died, he alked about what he would have missed without the opportunity for a oving parting.

Under the Oregon law, he probably would have asked a doctor's help n taking his own life. Because he was mentally competent and did not meet the clinical criteria for a diagnosis of depression, he would have qualified for assisted suicide and would surely have found a doctor who would agree to his request.

Since the Oregon law, using guidelines like those in effect in the Netherlands, does not require an independently referred doctor for a second opinion, he would have been referred by a physician supportive of assisted suicide to a colleague who was equally supportive. The evaluation would very likely have been pro forma. He could have been put to death in an unrecognized state of terror, unable to give himself the chance of getting well or of dying in the dignified way he did.

Many of us have known situations in which a doctor would have acted humanely by helping a terminally ill person die in the final weeks of an illness. Partly because of such experiences, when people are asked, "Are you in favor of euthanasia?" most answer yes.

The terminally ill need better care, not euthanasia.

But if people were asked, "If terminally ill, would you rather be given treatment to make you comfortable or have your life ended by a physician?," their responses might be different. Or consider this question: "If terminally ill, should it be your decision or your doctor's when you should die?"

My observations in the Netherlands persuade me that legalization of assisted suicide and euthanasia is not the answer to the problems of the terminally ill. The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the 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 1,000 cases a year, doctors actively caused or hastened death without the patient's request.

Virtually every guideline established by the Dutch to regulate euthanasia has been modified or violated with impunity. A healthy but grief-stricken social worker mourning the death of her son two months earlier was assisted in suicide. A man in his 30's who is H.I.V.-positive but who has no symptoms and may not develop them for years was also helped to die, without any effort to address the terror behind his desire to end his life.

Euthanasia in the Netherlands — intended as an unfortunate necessity in exceptional cases — has become almost a routine way of dealing with serious or terminal illness, and even with grief. A statute passed last year codifying guidelines provides added protection for doctors — but not for patients.

Yet the dangers threatened by legalization of assisted suicide can be avoided. They are being avoided elsewhere in Western Europe, where there is no great demand for legalizing assisted suicide or euthanasia.

Care for the terminally ill is better in the Scandinavian countries than in the United States and in the Netherlands. Scandinavian doctors do not accept excessive measures for prolonging life in people who are virtually dead, but neither do they encourage people to choose death prematurely.

There is a great deal of evidence that in the United States, as in the Netherlands, doctors are not sufficiently trained in the relief of pain and discomfort in terminally ill patients. We have not yet educated the public about their choices at the end of life. And we have not devoted enough time in medical schools to educating future physicians about the painful truth that there will be patients they will not be able to save but whose needs they must address.

Dr. Kevorkian and others are using the courts to test LO law, and the Michigan Supreme Court ruled this week that the state may impose criminal penalties on those who assist in suicide.

But we need more than a case-by-case testing or even a ruling by the United States Supreme Court if we are to address national concerns over how we die. We need a national commission to study the care of the terminally ill — one similar to the Presidential commission that in 1983 produced guidelines on when to withhold life-sustaining treatment from dying patients. Both euthanasia advocates and opponents would participate, but the panel would be primarily concerned with the larger question of the care of the terminally ill. Whatever its conclusions, a commission would educate the medical profession and the public and help us arrive at a consensus. ☐

Herbert Hendin is executive director f the American Suicide Foundation and professor of psychiatry at New York Medical College

Appendix D

The New York Times Magazine

JULY 21, 1996 / SECTION 6

AMY FISHER
A So-Called life
B[illegible]d Bars

David Austin's
HOT 'ENGLISH
ROSES'

WHY MEN DON'T
APOLOGIZE
By Deborah Tannen

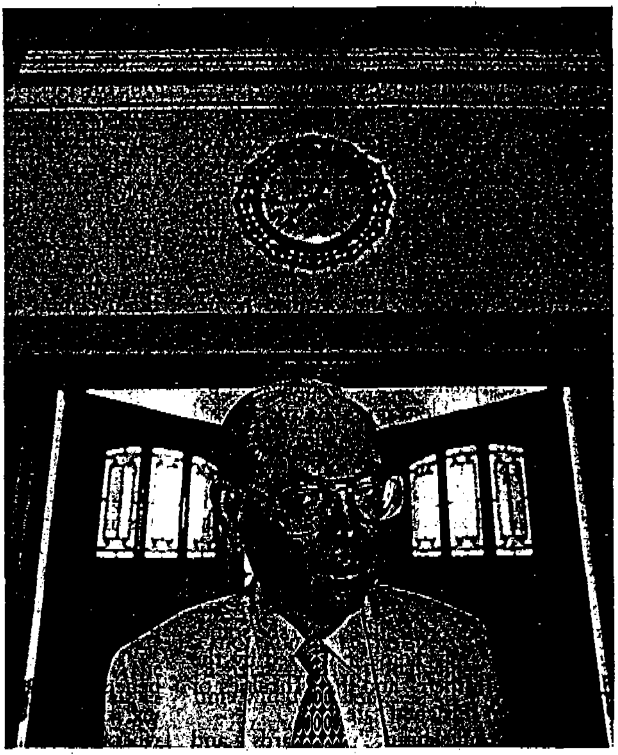
THE CASE AGAINST DOCTOR-ASSISTED SUICIDE

A New Pro-Life Movement in the **Making,** by Paul Wilkes
Why the Courts Are Dead Wrong, by Stephen L. Carter

Appendix E

The Ethicist 'In our society, we have never maintained that suicide is good — we have only looked on it as sad. . . . With physician-assisted suicide, we have a sea change.'

– DANIEL CALLAHAN



The Lawyer 'If assisted suicide went through, we'd be providing more safeguards for criminals picked up on the street than we would for the dying.'

–YALE KAMISAR

The Next

They are conservatives and liberals, believers and agnostics. What they share is

LISA JARRELL WAS SITTING ON HER CRISPLY MADE BED not long ago at the University of Virginia's hospital in Charlottesville, her tiny legs saucily crossed, daring Dr. Carlos Gomez once again to keep her dive. Jarrell was born 31 years ago with cerebral palsy, one of its cruel adjuncts being an esophagus that ended abruptly in a pouch, unconnected to her stomach. Five surgeries to fix this anomaly had riddled her frail chest with scar tissue, and over the past four years she had lost the ability to ingest and keep down food. Now for 12 hours each day, a ghastly Viscous liquid seeped down a feeding tube imbedded in her abdomen to sustain her 72-pound body. Her daily list of medications, a pharmacological cornucopia addressing everything from pain to nausea to depression, filled a double-spaced sheet of paper.

Late last year she tried to commit suicide, and words from her diary have continued to send up a cry to heaven for deliverance. In the thinly disguised patois of the very sick that most doctors have heard — "I am

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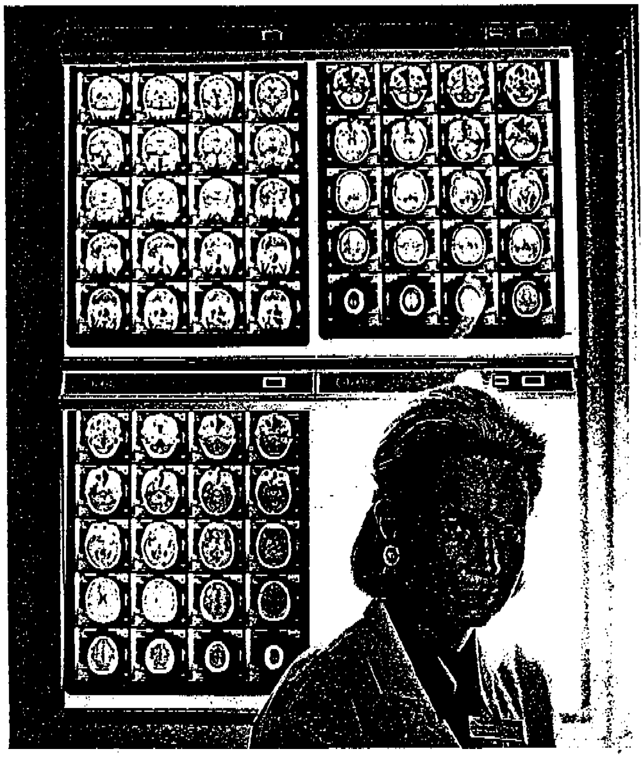
Paul Wilkes's most recent article for the Magazine was about choosing the next Pope. His latest book, "The Good Enough Catholic: A Guide for the Perplexed," will be published in the fall. ...

PHOTOGRAPHS BY JOSEPH PLUCHINO FOR THE NEW YORK TIMES

The Psychiatrist 'The Netherlands has moved from assisted suicide to euthanasia ... from euthanasia for physical illness to euthanasia for psychological **distress....'**
– **HERBERT HENDIN**



The **Neurologist** 'It's a well-documented fact that those asking **for assisted** suicide almost **always** change their mind once we **have** their pain under control.'
– **KATHLEEN FOLEY**

Pro-Lifers

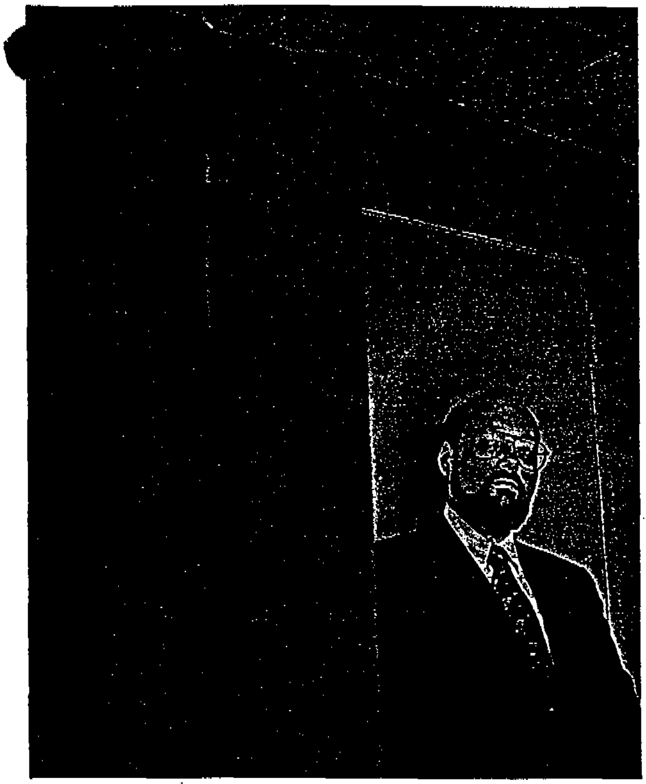
conviction that to legalize assisted suicide is to sanction murder. By Paul Wilkes

trapped inside this body; I want to be out" — she has cloaked her request that Gomez help her to die.

She has proved herself to be a most difficult patient; discarded doctors litter her thick volumes of medical history. Gomez is the latest. Her last? He is a handsome man, 38, with soft brown eyes and hands that instinctively reach out to reassuringly touch his patients. Bending toward Jarrell and speaking in a voice so low it registered midway between a whisper and an exhale, he said, 'We're going to take some of the colon from your large bowel and give you a new esophagus, Lisa." Her eyes rolled uncontrollably, and he tried to interpret: Doubt? Irritation? Fear? 'Yes, this is a radical surgery," he said, as if in reply to what her eyes were saying, "and we have the absolute best surgeon doing it. Let's try this, give it a chance."

Jarrell is most doctors' nightmare — intelligent, depressed, multi-handicapped, determined to die if the pain and constriction defining her life cannot somehow be overcome. For Gomez, she is more: a rejoinder to those who would say the day has come when a patient's wish for an assisted suicide should be — indeed, must be — executed.

Gomez is shaken by the thought that this country might soon permit doctors to prescribe and administer lethal doses of drugs to patients, or that patients might actually be able to demand this of their doctors. He has written thoughtfully and passionately against doctors' helping their patients to die, attacking the procedure on not only medical but also ethical and legal grounds. He has testified in court against Jack Kevorkian, who has been



The Catholic Although the Church *sees* both ortion and assisted suicide **as part** of **a** consistent ethic f life ... it would be unwise to **link** the **two** right now'

– RICHARD DOERFLINGER

involved in more than 30 suicides. Gomez has appeared before Congress, pleading that it make no law sanctioning others to do what Kevorkian has done. On a daily basis, he has tended the patients who occupy the six beds the university hospital has dotted him to care for the terminally ill, and he has supervised the specially trained nurses who serve the hundreds of hospice patients within a 100-mile radius of Charlottesville.

When Gomez speaks against legalizing doctor-assisted suicide, he does so pensively, carefully. 'There are always compelling cases, but we can't allow sweeping public policy to be made out of individual, compelling cases," he told me. "It cannot be legalized, because it can never be adequately controlled. Tough cases make bad law. Today's compelling m e is tomorrow's Lisa. That's why I maintain we leave the line where we drew it centuries ago."

But it is not people like Gomez who are controlling the debate on how and when and with the help of whom that death should come. Hardly. The right-to-die movement, long situated on the fringe of American public ethics, is suddenly mainstream. In recent months, two Federal courts have ruled, in effect, that laws dating back to the 19th century prohibiting assisted suicide need no longer inhibit late-20th-century Americans. Not that these court decisions were reached in a vacuum. Americans are disquieted by the cost and cold technological arrogance of modem-day medical care and fear being kept alive in ways that will destroy their sense of themselves and burden their loved ones. A Gallup poll in April showed that 75 percent of Americans believe doctors should be allowed to end the lives of terminally ill patients by painless means if the patients request it. And there are newspapers across the country (including this one) that have endorsed the court rulings in their editorial pages.

Doctor-assisted suicide has finally been thrust to the forefront of our national consciousness, and the stage is set for a Supreme Court judgment, which, when it comes — as early as next spring if the COUK, as expected, agrees to take one or both of the cases — will wield a moral force and have a societal imoact that rivals or surpasses that of Roe v. Wade, the 1973 decision legalizing abortion. But where is the ethical, legal and political debate? Americans have never been good at discussing death. Now, it would seem, the country doesn't want to talk seriously about a way to death that represents a fundamental break with thousands of years of moral and medical tradition.

Standing up against the COUK decisions, and a right-to-die movement that has articulately and doggedly pursued its goals, arc a growing number of doctors, clerics, ethicists, lawyers and others who in the crucial days ahead will try to change America's mind about assisted suicide. It is an odd coalition indeed: agnostics and believers; those who support legalized abortion and those who oppose it; those who bow to God and those who exalt reason; AIDS activists and Orthodox rabbis, the American Medical Association and Pope John Paul II. At its core is a group of thoughtful men and women who over the years have traded information; appeared in one another's footnotes, files and phone logs, and have been seated together on numerous professional panels. While they may disagree with one another on many other issues, on assisted suicide they stand together.

The week ahead is an important one for this loose coalition. There will be an anti-assisted-suicide legal conference in Washington to plan for the probable Supreme Court case, If those opposing the legalization of assisted suicide should become a movement, this may well bc the time that history judges it coalesced During the past few months, I have met with a number of the more outspoken and articulate opponents of legalized assisted suicide, seeking to hear their arguments before they are reduced to slogans and sound bites. What is certain is that these men and women are not angry zealots and will not be easily dismissed as such.

The Ethicist

ETHICS, THAT MODERN GROWTH INdustry tucked somewhat uncomfortably in the folds of our technology-driven, take-control-of-your-destiny way of life, has been summoned often and persuasively by those who advocate assisted suicide. Do we not have the right, they ask, to self-determination? Is this not what makes us human? And do we not have a moral and ethical obligation to relieve suffering? As for doctors, is it not their very duty to do whatever is' in their power to relieve that sufferiig? Then, what can the thinking, ethical person conclude but that assisted suicide provides the most moral, compassionate, reasonable answer to those who are terminally ill — or intolerably alive — and want to end their lives.

'That it only were so," Daniel Callahan said, his voice laced with the fatigue of those who must respond to the same arguments over and over again. Callahan is the co-founder and president of the Hastings Center, a research organization in Westchester County that specializes in bioethics. Callahan, who is 66 years old, started writing and speaking on medical ethics, and against assisted suicide, nearly 30 years ago, when both subjects were considered so arcane as to be perhaps worthy of a few pages in a learned journal. It was the dawn of a new era, when advanced medical technology and "miracle" drugs were beginning to hold death further and further at bay. Then came the issue of Karen AM Quinlan, a brain-dead woman kept alive by artificial means even though her parents sought the *termination* of that life support. The Quinlan case horrified people and it galvanized public opinion; in 1977, more than 50 percent of Americans favored some form of euthanasia. The modern right-to-die-movement had been born.

I had caught up with Callahan in early May at the javits .Convention Center in

PHOTOGRAPH BY JOSEPH PLUCHINO FOR THE NEW VORK TIMES

New York, where the American Psychiatric Association's annual meeting was under way. Callahan had participated in one of the gathering's four panel discussions devoted to assisted suicide, It was a hotly debated and troubling topic for psychiatrists at this year's meeting, where they heard an extraordinarily moving presentation by George Delury detailing his role in the suicide of his wife, Myrna Lebov, last year in a Manhattan apartment. (At the convention, Delury was about a week away from being sentenced to a six-month jail term for attempted manslaughter.) But when asked to raise their hands if they would sign off on a document approving doctor-assisted suicide, few psychiatrists were ready to accept this role. Ambivalence seemed palpable in the cavernous convention center as Callahan completed a particularly grueling question-and-answer session and then sat and talked briefly with me.

'This is not only about medicine and what it can or cannot do," he said. "It is about us. We are a highly and proudly individualistic people, but that individualism cuts both ways — today we no longer have confidence that we will be taken care of once we are weakened and no longer able to assert control by the pure force of our wills.

"What we are trying to do with assisted suicide is to take a step beyond which there are no other steps in gaining full individual self-determination. And as people have turned away from religion and elevated medicine as the supreme arbiter of our lives, we ask for medicine's sanction. It might be argued that if a person wants to commit suicide, they can most often do it themselves — why bring in the medical community to legitimate it? Why? Because we need somebody in authority to say it is O.K. for us to do something that we know is reprehensible."

Our conversation continued by phone over the next few weeks as we talked and distilled what he had written in his *1993* book, 'The Troubled Dream of Life: In Search of a Peaceful Death," one of the intellectual pillars of anti-assisted-suicide thinking. "In our society, we have never maintained that suicide is good — we have only looked on it as sad, but forgivable," he said. "With physician-assisted suicide, we have a sea change: we are saying it is good, humane and dignified and that it can be handled in some systematic way, free from abuse. But under this guise of a new-found empathy, it will be no more than an exercise in self-deception, a societal deceit, with a medical cover-up. Why bother to worry about health care reform or hospice care when you have this short cut? And if this is so humane, it will become a legitimate medical option. People with a terminal diagnosis will find themselves facing a doctor who may not only pose it as an option, but even the first option, the most sensible, the most humane. 'I can help you to die — or you can take these treatments, which are expensive and may be painful, and then apply for hospice care that may or may not be available. Which do you choose?' And just think of the power of suggestion that a physician has. If this trusted person is recommending this, what can be wrong with it? The very privacy of the doctor-patient relationship invalidates any attempt to control what goes on."

Responding to those who argue that as assisted suicide is already a quiet practice (as many as 25 percent of doctors admit they have helped people die), it should therefore be made legal, Callahan said: 'Yes, there are cases where the termination of life might be merciful. But those are the exception and cannot be made the rule. It is no different from the woman whose husband has abused her for years and she finally shoots him, Perhaps she's justified: But do we then have a law that says if you can check off 12 of 15 things your husband does, you can kill him?

"It comes to this: Asking for this ultimate control does great harm to the individual and to society. If autonomy is the greatest moral good, we will have an impoverished, self-involved society. Life presents us with all sorts of difficult choices, but we need a malleable self to deal with them. Who are the people we admire, who set the tone for what it is to be a human being? Those who take the moral short cuts, come up with the easy answers? Or someone like Elie Wiesel, who didn't commit suicide when others were using what appeared a reasonable means of escape? We are not fully formed people without going through these life crises."

And what of those who have helped people to die and maintain that their own conscience is clear, who feel they have made the correct decision in alleviating awful suffering?

"How people feel is not terribly important to the moral judgment," Callahan replied. 'The Nazi doctors felt they were doing something patriotic. We have to look at the reality. I wonder how anyone could say they feel good about it. They ought to have a problem; that they don't and cast themselves as heroic — that's the problem."

The **Psychiatrist**

HERBERT HENDIN FIRST TRAVELED to the Netherlands in **1993** *to* study the only nation in the world that has permitted assisted suicide. Maybe, just maybe, he thought, the Dutch had found a safe and circumscribed way to mercifully relieve people of end-of-life suffering — a way that had thus far eluded American psychiatrists like himself who were dedicated to preventing suicide.

Hendin, who is *69,* has treated numerous suicidal patients in his psychiatric practice and, as a clinical researcher, is considered one of the world's leading experts on suicide. He is also the executive director of the American Suicide Foundation, which he helped to found in 1987 and which provides funds for research aimed at suicide prevention. It was in the foundation's office on upper Park Avenue that we spoke, His amber and gray eyebrows stood in startled attention over uncommonly bright and welcoming eyes as he began in a tone hinting at a certain resigned bemusement about his findings.

"What I quickly discovered in the Netherlands was that they hadn't discovered a new way at all," he said. 'There were alleged controls and the need for second opinions, but it soon became pro forma. Doctors who were for physician-assisted suicide referred their patients for second opinions to like-minded doctors, So the answer was yes — and yes. And of course, the cases, the horrible individual cases." He shook his head slowly; the bemusement was gone.

He then talked of a couple of cases he had discovered. "A depressed 50-year-old woman, a former social worker, otherwise healthy, asked to be put to death two months after she lost a son to cancer. She also had been abused by her husband. She was seeing a psychiatrist regularly, and

The stage is set for a Supreme Court judgment. When it comes, it will wield a moral force and have a societal impact to rival that of the 1973 decision legalizing abortion.

The Clinical **Ethicist** 'This is a defining moment in medicine. If doctors **are allowed** to **kill** patients, the doctor-patient relationship will never be the **same** again.'

– **LINDA EMANUEL, left,** with **patient**

when, two months later, she again asked that psychiatrist to help her die — the request thus qualifying under Dutch law as a persistent request — her wish was granted. A man with a chronic disease whose wife, grown tired of caring for him, offered him the alternative of a nursing home or euthanasia. He chose the latter. And these are only the cases we know about, in essence, their 'best' cases."

What is the lesson for the United States in all this? I asked.

"People point to the Netherlands as a prototype for American practice on assisted suicide, for their laws to be a model for our laws," Hendin said. 'The Netherlands? With a homogenous, pretty much law-abiding citizenry, almost all of whom have medical coverage? And America, with many different cultures represented, many marginalized people, tens of millions without health care insurance? As bad as it was *there*, in other words, it could be much, much worse *here.*"

As Hendin sees it, those seeking a doctor's assistance to commit suicide are people suffering from depression and asking for relief from it. "I deal with depressed people all the time, people who are suicidal," he said, and added that most people who successfully commit suicide are clinically depressed.

"When you have a dying or impaired person asking for assistance in their death, it is a cry for help, not for a drug overdose that will kill them. Suicidal ideation and the underlying depression don't last forever; they will lift. When health care workers are sent in for someone who feels a burden or for a family that is stretched beyond their resources, the depression goes. We can treat the depression, we can bring people back from depression. We can't bring them back from the dead."

Hendin points to other aspects surrounding assisted suicide in the Netherlands that he finds illustrative of what is now *going* on in America. "It became a political issue, perhaps we could even say a politically correct issue," he maintained. "Even with these horrible, unnecessary deaths, no thinking person would be caught talking against it. And it became a red badge of courage for liberals" — a label he claims for himself as well — "to be so enlightened as to be for it. Supposedly it was the thinking person's decision and statement of their independence, so that they wouldn't be looked upon as some unthinking religious fundamentalist. The more and more I studied Dutch cases, I could see this was not an extension of personal rights — in many instances,,it became a doctor's decision, not a patient's. And as for hospice and palliative care for those who want to die naturally, they are relatively low priorities in the Netherlands. After all, with assisted suicide available, who needs them? It was almost as if you are a poor sport for not choosing it,"

In medicine and ethics, there is speculation about the "slippery slope" that might result from what at first might seem a very limited form of doctor-assisted suicide. "Virtually every guideline established by the Dutch to regulate euthanasia has been modified or violated with impunity," Hendin warns in a book, "Seduced by Death," which will be published this fall by W. W. Norton. "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." And some in the Netherlands are now taking defensive action: Hendin told me that a number of people have taken to carrying a "passport for life" in their pockets so they won't be euthanized in medical emergencies without their consent.

He also fears what will happen to medicine should suicide be sanctioned. "A quite troubling thing happens to the physicians who participate in this," he said. 'The first assisted suicide may give them a moment's pause. The second is easier. It eventually turns into a kind of compulsion, as if the more times they do it, the more they are assured it is right. One doctor claims he has assisted 1,000 patients to die. If this were ever legalized here, there would be a class of physicians, Kevorkian-like. They would be sought for their services, and they would render that service. Or if a state approved it, we could see people traveling there — to die."

The Catholic

ORTHODOX JEWRY — OUT OF DEEP religious belief and with a still-fresh memory of the euthanasia of the Holocaust — stands in adamant opposition to assisted suicide. So do most Protestants; the Southern Baptist Convention, evangelical Christians and the Lutheran Church-Missouri Synod have been among the most vocal. But it is the Roman Catholic Church — by virtue of its hierarchal structure, sheer numbers and an extensive theology of the sanctity of life — that commands a dominant role. It is basic to Catholic teaching that human life is formed in the image and likeness of God and must therefore be regarded as sacred, so the value of a human life is not a matter of human choice or convenience.

In the months ahead, the Catholic bishops of America will no doubt be seen and heard espousing the Church's categorical opposition to assisted suicide, but it is Richard Doerflinger, a policy expert for the National Conference of Catholic Bishops' Secretariat for Pro-Life Activities, who is their key source and strategist. The bishops will speak with a fairly uniform voice, pointing out that no doctor and no patient can be permitted to play God with a lethal dose. But as Doerflinger looks out to the body of the Church, more than 60 million Catholics — by far the largest religious group in the country — he will hardly

PHOTOGRAPH BY JOSEPH PLUCHINO FOR THE NEW YORK TIMES

glimpse a bastion protecting the sacredness of life. Yes, there are those Catholics who obediently adhere to official doctrine on all matters. but a much larger number are of more independent mind. The overwhelming majority do not follow Church teaching on birth control, and Catholics support abortion rights in roughly the same ratio as non-Catholics. On assisted suicide, Catholics are only slightly more likely to oppose than approve its legalization.

'We are trying to come at assisted suicide fresh," Doerflinger said when we spoke in Washington during a break in a conference at the **U.S.** Holocaust Memorial Museum entitled "Holocaust Precedents and the Obligations of Medicine to the State" — his attendance reinforcing the small-"c" catholic nature of his work, Doerflinger, 43, is scholarly looking and speaks in a stentorian tone more in keeping with a lecture hall than with the pleasant table at a sidewalk cafe where we sat and talked. "Although the Church sees both abortion and assisted suicide as part of a consistent ethic of life — and both morally wrong — it would be unwise to link the two right now," he said. "It's best to work on them separately as we are speaking to two quite different groups. Although we will continue to strenuously oppose abortion, people have their minds made up on that. We are not going to sway a lot of people. On assisted suicide, a great number of Catholics are undecided, or what I would term poorly decided, and we must show them it is both morally wrong and personally potentially tragic."

Doerflinger pointed to the 1992 California referendum on assisted suicide as an example, The first polls showed that the majority of Catholics as well as non-Catholics favored the initiative. Then the local Catholic conference sent an information packet to every parish, encouraging Masses to be said for the dying and urging churchgoers to volunteer at a hospice. Eighty-two percent of churchgoing Catholics and 60 percent of all Catholics eventually voted against the referendum and it was defeated. In *1994* in Oregon, which has a smaller percentage of Catholics than California, a similar referendum was approved, by just 51 percent, even though the Church worked hard to defeat it. "We feel Catholics — one in every four Americans — really are the national leaven on this issue," Doerflinger said.

In Pope John Paul II, the Church has a powerful contemporary voice — one invoked by even the nonreligious who are fighting doctor-assisted suicide, who certainly part company with the Pontiff on other moral issues. The Pope's assaults on a "culture of death" and the unfettered quest for personal autonomy find their way not only into official Church proclamations but also into the vocabulary, writings and testimony of a broad range of those fighting doctor-assisted suicide.

"So often, the Church's posture and teaching on end-of-life issues is so badly misunderstood," Doerflinger said, 'The Church has come out strongly that life need not be maintained at any cost, that heroic measures and aggressive medical treatment need not be employed and that life support can be withdrawn. This is not an acceptance of euthanasia but rather the acceptance of the human condition in the face of death. Painkillers can be used even if they may decrease consciousness and shorten life.

"And as for suffering, yes, suffering can be purifying, ennobling. For some. But it is not to be sought and it is not to be allowed to persist if it can be controlled. The example of the Good Samaritan is illustrative. A severely injured man in pain, in danger of dying, lay at the side of the road. The Good Samaritan didn't say, 'Suffer on, my son, it will make a you a better person.' He bound up his wounds, put him on his own donkey and brought him to an inn where he could be cared for."

Catholic teaching is, as Doerflinger knows, both a beacon and a lightning rod. Kevorkian has repeatedly said that opposition to assisted suicide is largely Church-based, as has the Hemlock Society. And so Doerflinger is careful not to mount the pulpit when it does not serve the cause. An example of this occurred in late April when a hearing on assisted suicide was held before the Constitution Subcommittee of the House Judiciary Committee. Some of the key opponents appeared — including Carlos Gomez, Daniel Callahan and Herbert Hendin. Doerflinger, as the Church's knowledgeable representative, stayed in the background as not to provide a straw man for the opposition to knock over.

"It is religion's role to remind society of both the value of life and of death," Doerflinger told me. "And of what lies beyond. But these reminders need to be skillfully presented, so people have a chance to hear them."

The Lawyer

YALE KAMISAR WEARS *HIS* CIVIL LIBertarian credentials proudly and will recite them loudly — as is his penchant, whether teaching, testifying, arguing the merits of a case or simply talking — to anyone within shouting distance. "I'm a member of the A.C.L.U., backed the Warren Court and was quoted in both the Miranda and Gideon decisions," he shouted at me when we talked by phone recently. 'With *every* ounce of strength, I've backed the right to free speech add personal rights time and time again. And for what it's worth, I'm also a fervent agnostic. I resent being labeled a conservative on this!"

Kamisar, 66, is a professor at the University of Michigan Law School and has been writing and arguing against doctor-assisted suicide for almost 40 years. Like the best of legal scholars who help sculpt the laws by which we are governed, he uses the tools of history and human psychology, ethics and philosophy as well as common law and constitutional mandates. And so, when the anti-assisted-suicide legal conference is convened in Washington this week, Kamisar's booming voice and impressive body of work will command substantial attention.

"It's damned interesting that the two Federal court decisions are based on very different legal theories, different rights," Kamisar had remarked when we had talked earlier at the American Psychiatric Association convention, where he was a panel member. He explained that the United States Court of Appeals for the Second Circuit, in ruling unconstitutional a New York law forbidding doctor-assisted suicide, concluded that there is no constitutional distinction between a patient's refusing treatment and obtaining a lethal prescription for the specific purpose of ending life. "I'm flabbergasted by this," Kamisar said. "The court lumped together the Supreme Court rulings on Quinlan and Cruzan and said

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The ample literature on people with degenerative diseases points to unrelievable pain as the thing most likely to lead them to **ask** that their lives be ended.

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assisted suicide was a logical extension. Quinlan allowed a respirator to be removed; Cruzan, a feeding tube — and both of them were in a persistent vegetative state. Anyone who can't see the difference between stopping treatment of the brain-dead and consciously causing death — in other words, turning off a machine or administering a lethal dose — n& to have their head examined." Kamisar then began arguing his case even more loudly, as if to underline his underlining. "It doesn't take a genius to see what will follow: from giving pills to be swallowed, on to administering a lethal injection to those who can't swallow, and then making those who are paralyzed or in the early stages of Alzheimer's eligible for this right.

"I identify with the dying patient, who is weak, vulnerable, subject to suggestion, coercion, seduction. If assisted suicide went through, we'd be providing more safeguards for criminals picked up on the street than we would for the terminally ill."

The U.S. Court of Appeals for the Ninth Circuit reached a far broader decision a month earlier, Kamisar said, for it declared that doctor-assisted suicide was a constitutional liberty protected by the 14th Amendment. This decision established a fundamental right that would not be limited to the terminally ill, Kamisar believes. States could no more legislate against this right than they could ban contraceptives or outlaw abortion in the first trimester. Suddenly, the "right to die" had become a constitutional issue.

Kamisar is one of a small coterie of lawyers whose writings provide the bedrock of legal arguments in assisted-suicide cases and whose words and ideas appeared in the dissents to both the Second and Ninth Circuit rulings. Alexander Capron of the University of Southern California, Seth Kreimer of the University of Pennsylvania and Robert Burt of Yale — all professed civil libertarians — are other lawyers ready to stand against the legalization of assisted suicide.

Key to that battle is the abortion issue and the precedent or (as they will maintain) lack of precedent Roe v. Wade set. Those opposing assisted suicide want to establish a legal distinction not just between pulling the plug and administering a lethal dose; they want to establish a distinction between a woman's right to choose and a patient's right to die. "Simply put, if we cannot convince the Court to separate this issue from abortion, we will not prevail," Kamisar told me. "Personally, I'm pro-choice. I agree with Roe v. Wade. Bur when the Court ruled in 1973, it termed abortion unique. It never said the right of privacy should be mended this far, The point is crucial"

If, as expected because of the legal confusion and building public sentiment on the assisted-suicide issue, the Supreme Court takes the cases, how will it decide?

"Six months ago, I would have said you couldn't find five Justices to sustain," Kamisar said. "Now, I don't know. Six months ago, we didn't have two major lower-court decisions. I still think the Supreme Court will overturn and send it back for the states to decide for themselves. But if the High Court did affirm, In sure they realize they'll be spending the next 25 years shaping the outer limits of assisted suicide as case after case comes up to them. Talk about a Pandora's box!"

The Doctors

CARLOS GOMEZ HAS raised the eyebrows of local pharmacists ,bemuse of his extensive use

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of large doses of narcotics to control his patients' pain. For Lisa Jarrell, as she struggled through four days in intensive care after the surgery on her esophagus and then was placed in a regular hospital room — as well as for his hundreds of terminally ill hospice patients — Gomez boldly prescribes doses that might make other doctors cringe. The ample literature on people with terminal illness — the majority of them with cancer — as well as that on people with degenerative diseases like multiple sclerosis and amyotrophic lateral sclerosis points to unrelievable pain as perhaps the greatest fear patients have and what is most likely to bring them to the point where they will ask that their life be ended.

One recent afternoon, I discussed the realm of pain with Kathleen Foley, a pain specialist at Memorial Sloan-Kettering Cancer Center in New York. As she sat at her desk, a smile resided easily on her face. But as Foley, 52, knows so well, outside her small office on the swath floor of Memorial Sloan-Kettering — a premiere institution for cancer treatment — and beyond the reach of her reassuring words, pain and sheer terror stalk the hallways.

Foley, a pioneer in what some 20 years ago was the uncharted field of palliative are and pain management, has addressed the nature of pain in a flurry of professional articles and addresses at professional meetings, maintaining that pain resulting from cancer can, in the majority of cases, be effectively controlled. "It is not managed well because we doctors don't have time for the pain," she said. "Even oncology residents and fellows are poorly trained. People are crying out in agony. We are not listening to them.

"It's a well-documented fact that those asking for assisted suicide almost always change their mind once we have their pain under control. We undermedicate terribly in American medicine, afraid of overprescribing narcotics because of the societal fear of addiction and unwilling to revise what we were taught in medical school — that only acute, postsurgical pain was to be treated this way. We now know that the chronic pain of a cancer patient is also treatable; without the drugs' causing the craving of an addict. But even when we do prescribe, only 10 to 20 percent of pharmacies in New York carry drugs like morphine, hydromorphine and methadone. The starting point I take with the doctors who work with me on Memorial's pain service is; if patients say they are hurting, believe them. And do something about it."

While she is an expert on pain, Foley considers it but the tip of an emotional and psychic iceberg for those facing death who might consider doctor-assisted suicide. "In the first place, it is not people *in* pain but those *anticipating* pain who most often request physician-assisted suicide," she said. 'We are not talking about pain as much we are talking about control — or the loss of control. We have institutionalized death, taken it out of the home and into the hospital, where up to 80 percent of people die. And the hospital is a horrible place to die. No family, no community, no loved ones are present. And so for those facing death, it is not only symptoms or pain but existential suffering, loneliness, fear of abandonment, isolation, being a burden. A patient with the support of family and friends, a sense of the transcendent — however defined — and

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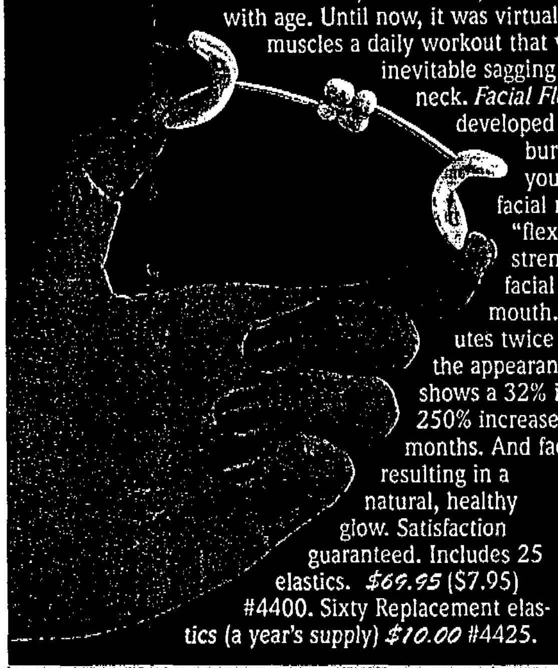

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PRO-LIFERS

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a doctor who makes it clear the patient will not be abandoned [illegible] not going to ask to have life [illegible]ded.

"Oh, yes, and a compassionate managed-care provider helps."

As we left the haven of her office and walked out into the hallway, Foley noted with a wry smile: "It's so ironic — many people fighting assisted suicide were horrified with the two court decisions. I welcomed them, even if they are little more than court babble. Now, at last, the issue is out in the open and we'll really begin to talk honestly about death." To further this "death talk," Foley was appointed director of the $15 million Project on Death in America, which is financed by the Open Society Institute, founded by the billionaire George Soros to promote the free exchange of ideas. One of its innovative program links doctors-in-training with dying patients so that tomorrow's doctors will be in a better position to help their patients die comfortably and decently.

LINDA EMANUEL, 42, HAS JUST left a prestigious post at Harvard Medical School *to* become the American Medical Association's vice president for ethics standards and director of its Institute for Ethics. One of her first tasks is to spearhead the A.M.A.'s declared battle against doctor-assisted suicide, A few weeks ago, the association's house of delegates, with a resounding voice vote followed by thunderous applause, affirmed that stand. (The house of delegates may not reflect the medical profession as a whole, however: various polls have found doctors evenly divided on whether assisted suicide should be legalized.)

A slender woman with short brown hair, who was raised in England and speaks with a British accent in crisp, complete sentences, Emanuel is an internist and a medical ethicist. Her opposition to assisted suicide is firm. "I simply have never seen a' case nor heard of a colleague's case where it was necessary," she told me not long ago when I visited her in her Harvard office. "If there is such a request, it is always dropped when quality care is rendered"

while practicing as an internist, she began to develop a strategy called advanced-care planning, presenting patients with a number of options for how "quality dying can be achieved without transgressing moral boundaries" so they can face death more easily. Invited a year ago to edit a Harvard University Press series on medical ethics, the first volume of which will be about euthanasia, Emanuel was forced to think harder about an issue that she was having more and more difficulty keeping at the back of her mind.

"I am continually impressed by people's practical wisdom," she told me. 'If you just sit down with them, propose various end-of-life scenarios that they might be faced with, you quickly find their thresholds, their goals in what kind of heroic medical measures they want — or usually *don't* want taken. Then a person feels in control and feels that rational wishes will be honored when they can no longer make those decisions. They are very good about getting their own big picture, given the opportunity."

Emanuel's work in end-of-life issues made her the perfect choice for the A.M.A. position, but she initially was torn about accepting it. "I had to decide if I felt strongly enough about this to uproot my family and move to Chicago," she said. 'This is a defining moment in medicine. If doctors are allowed to kill patients, the doctor-patienr relationship will never be the same again. If killing you is an option, how can I expect you to trust me to do all I can to heal you? My work at the A.M.A. will allow me to put values back in medicine, which it so desperately needs right now."

Emanuel said the association will begin an ambitious outreach pro*gram* to encourage doctors to undertake advanced care planning with patients. On behalf of the group, she is also assembling a huge nation-coalition of medical specialty groups, nurses and hospice and hospital organizations — who will be additionally informed by experts from foreign countries — to meet early next month in Chicago to discuss a variety of approaches to fighting doctor-assisted suicide.

LIKE CARLOS GOMEZ, IRA Byock of Missoula, Mont, routinely works with the terminally ill, and as he sees it, death is neither to be fought at all costs nor to be courted but, in a sense, richly orchestrated "For the moment, set aside the morality or immorality of assisted suicide," Byock, who is 45 and has been in hospice work for 17 years, told me recently. "WhatI see in those who advocate physician-assisted suicide is a real deficit of imagination. I am continually amazed and humbled that something good can come of this last portion, however grim or painful, of a person's life. There is always that letter to be written to a daughter whose graduation the dying person will not attend, a son to be told how wonderful he is, an estranged relationship to be repaired, old stories of growing up to be tape recorded. People want their death to mean something, for accounts to be settled. For the dying the last days *can* bring with them a heightened awareness, contentment, connectedness. The transition from life to death *can* be as beautiful and profound as the miracle of birth."

For Byock, it is not so much a case of seeking a "good death" — "that is too formulaic, like *there* is a checkoff list; death is often not pretty or easy" — but rather "dying well," which is also the title of a book of his experiences that will be published next spring by Putnam. 'There is a legacy that reverberates beyond a last breath, depending on how, one way or another, those last days were faced," he said "I treated a young man with AIDS who begged for me to help him die. His religiously fundamentalist family was appalled with him. So much was unspoken, unsettled. Gradually the hospice team was able to bring them together, and to see that father gently bathing his son's rectal herpes was nothing short of a miracle. Just think about that for a moment. It's all right there, the moment of truth. This man died in peace, and his family will always know they had loved him, something that wouldn't have happened if I or some other doctor had listened to his request to die."

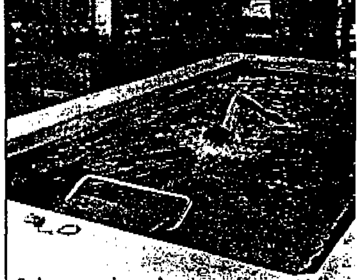
Lisa Jarrell and Us

THE ROAD FOR THOSE TERminally ill or painfully disabled who, though tempted, choose not to end rheir lives is certainly neither straight nor easily navigated In Jarrell's use, a 12-hour surgery, followed by days of pain, an infection and a test revealing a stubborn blockage that portended further radical surgery, brought her to the point of both rage and depression. But eventually, the blockage cleared, and on Day 11, post-operation, Gomez watched as she tentatively nibbled on a Klondike bar. She was taking some of the first solid food she had ingested and kept down in *years*, and it was following a normal path through her very abnormal esophagus.

Two weeks later. during a clinic visit, Jarrell reported she had taken 1,000 calories by mouth, enough to sustain life. But she spent little time on her diet and diminishing drug regimen. Instead, she smiled coquettishly at Gomez and talked about the wardrobe she would need when she began to gain weight. She might be going back to college. after all. In essence, a new person had been fashioned about a slender piece of colon and a doctor‘s adamant belief in her worth. Jarrell was ingesting not only food but also life itself.

Of course, there are only so many doctors like Carlos Gomez. Only so many medical plans that bear up under the long march of an extended illness. Only so many happy endings. Only so many Lisa Jarrells.

But what the opponents of legalized assisted suicide insist is that it is not, in the end, about doctors like Gomez or patients like Jarrell. It is about what will happen to all of us if we live amid such sanctioned death. Who will regulate assisted suicide, and how? Will we begin looking upon the old and enfeebled in a different way? What will happen to families whose members can't agree on who should die, and when? In dealing with all these decisions about death, how will we live? About these profound matters, **we haven't begun** to give the slightest thought. ■



When Death Is Sought

Assisted Suicide and Euthanasia in the Medical Context

May 1994

The **New York State** Task **Force on Life** and the Law

Appendix F

Contents

Part I — The Clinical, Legal, and Ethical Context

Part II – Deliberations and Recommendations of the Task Force

Appendices

Executive Summary

Over the past two decades, the right to decide about medical treatment, including the right to refuse life-sustaining measures, has become a fundamental tenet of American law. The Task Force has sought to make this right a reality for the citizens of New York State, recommending legislation on do-not-resuscitate orders, health care proxies, and, most recently, surrogate decision making for patients without capacity. The Task Force's legislative proposals reflect a deep respect for individual autonomy as well as concern for the welfare of individuals nearing the end of life.

Recent proposals to legalize assisted suicide and euthanasia in some states would transform the right to decide about medical treatment into a far broader right to control the timing and manner of death. After lengthy deliberations, the Task Force unanimously concluded that the dangers of such a dramatic change in public policy would far outweigh any possible benefits. In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care.

In the course of their research, many Task Force members were particularly struck by the degree to which requests for suicide assistance by terminally ill patients are correlated with clinical depression or unmanaged pain, both of which can ordinarily be treated effectively with current medical techniques. As a society, we can do far more to benefit these patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or to obtain a lethal injection.

In General

- This report, like much of the current debate, focuses solely on assisted suicide and euthanasia by physicians, nurses, or other health care professionals.
- In this report, "assisted suicide" refers to actions by one person to contribute to the death of another, by providing medication or **a** prescription or taking other steps. With assisted suicide, the person who dies directly takes **his** or her own life. In contrast, "euthanasia" **refers** to direct measures, **such as a** lethal injection, by one **person to** end another **person's** life for benevolent motives. Both **practices** are distinct from the withdrawal or withholding of life-sustaining treatment in accord with accepted ethical and medi**cal standards.**

The Clinical Background

- 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. When these patients receive appropriate treatment for depression, **they usually** abandon the wish to commit suicide.
- Depression **is** distinct from the normal **feelings** of sadness generally experienced by terminally **ill** patients. **It** is **a myth** that major clinical depression ordinarily accompanies ter**minal illness.**
- While thoughts about suicide ("suicidal ideation") are **a** significant risk factor for suicide, many individuals experience suicidal ideation but never commit or attempt suicide. **These** thoughts can be an important and normal component of coping with terminal **illness.**
- Uncontrolled **pain,** particularly when accompanied by feelings of hopelessness and untreated depression, is a significant contributing factor for suicide and suicidal ideation. Medications and **pain** relief techniques now make it possible to treat **pain** effectively for most patients.
- Despite the fact that effective treatments are available, severely and terminally ill patients generally do not receive adequate relief from pain. Studies report

patients suffer from unrelieved pain, even though patients with cancer are more likely than other patients to receive pain treatment.

- Numerous barriers contribute to the pervasive inadequacy of pain relief and palliative care in current clinical practice, including a lack of professional knowledge and training, unjustified fears about physical and psychological dependence, poor pain assessment, pharmacy practices, and the reluctance of patients and their families to seek pain relief.

Existing Law

- Under New York law, competent adults have a firmly established right to accept or reject medical treatment, including life-sustaining measures. Competent adults also have the right to create advance directives for treatment decisions, such as a living will or health care proxy, to be used in the event they lose the capacity to make medical decisions for themselves.
- New York is one of two states in the nation that does not currently permit the withdrawal or withholding of life-sustaining treatment from an incapacitated adult patient who has not signed a health care proxy or provided clear and convincing evidence of his or her treatment wishes. Legislation proposed by the Task Force, under consideration by the New York State Legislature, would permit family members and others close to the patient to decide about life-sustaining treatment in these circumstances.
- Neither suicide nor attempted suicide is a criminal offense in any state. Like most other states, New York prohibits assisting a suicide. Euthanasia is barred by law in every state, including New York.
- Suicide assistance generally constitutes a form of second-degree manslaughter under New York law. Euthanasia falls under the definition of second-degree murder, regardless of whether the person consents to being killed.
- The provision of pain medication is legally acceptable even if it may hasten the patient's death, if the medication is intended to alleviate pain or severe discomfort, not to cause death, and is provided in accord with accepted medical standards.

- Neither the United States nor the New York State Constitution grants individuals a "right" to suicide assistance or euthanasia, Although the right to refuse life-sustaining treatment is constitutionally protected, the courts have consistently distinguished the right to refuse treatment from a right to commit suicide. In affirming the right to forgo treatment, the courts have recognized the state's legitimate interest in preventing suicide.

Ethical Issues

- Three general positions about assisted suicide and euthanasia have emerged in the ethical and medical literature. First, some believe that both practices are morally wrong and should not be performed. Others hold that assisted suicide or euthanasia are legitimate in rare and exceptional cases, but that professional standards and the law should not be changed to authorize either practice. Finally, some argue that assisted suicide, or both assisted suicide and euthanasia, should be recognized as legally and morally acceptable options in the care of dying or severely ill patients.
- While many individuals do not distinguish between assisted suicide and euthanasia on ethical or policy grounds, some find assisted suicide more acceptable than euthanasia, either intrinsically or because of differences in the social impact and potential harm of the two practices.

The Task Force's Recommendations: Crafting Public Policy

The Ethics of Assisted Suicide and Euthanasia

- The members of the Task Force hold different views about the ethical acceptability of assisted suicide and euthanasia. Despite these differences, the Task Force members unanimously recommend that existing law should not be changed to permit these practices.
- Some of the Task Force members believe that assisted suicide and euthanasia are inherently wrong, because the practices violate society's long-standing prohibition against ending human life. These members believe that one person should not assist another's death or kill another person, even for benevolent motives.

- Other Task Force members are most troubled by the prospect of medicalizing the practices. They believe that physician-assisted suicide and euthanasia violate values that are fundamental to the practice of medicine and the patient-physician relationship.
- Some Task Force members do not believe that assisted suicide is inherently unethical or incompatible with medical practice. On the contrary, they believe that providing a quick, less prolonged death for some patients can respect the autonomy of patients and demonstrate care and commitment on the part of physicians or other health care professionals. Nonetheless, these members have concluded that legalizing assisted suicide would be unwise and dangerous public policy.

The Social Risks of Legalization

- The Task Force members unanimously concluded that legalizing assisted suicide and euthanasia would pose profound risks to many patients. For purposes of public debate, one can describe cases of assisted suicide in which all the recommended safeguards would be satisfied. But positing an "ideal" or "good" case is not sufficient for public policy, if it bears little relation to prevalent social and medical practices.
- No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.
- The growing concern about health care costs increases the risks presented by legalizing assisted suicide and euthanasia. This cost consciousness will not be diminished, and may well be exacerbated, by health care reform.
- The clinical safeguards that have been proposed to prevent abuse and errors would not be realized in many cases. For example, most doctors do not have a long-standing relationship with their patients or information about the complex personal factors relevant to evaluating a request for suicide assistance or a lethal injection. In addition, neither treatment for pain nor the diagnosis of and treatment for depression is widely available in clinical practice.

- In debating public policies, our society often **focuses** on dramatic individual cases. With assisted suicide and euthanasia, this approach obscures the impact of what it would mean for the state to sanction assisted suicide or direct killing under the auspices of the medical community.
- From the perspective of good health, many individuals may believe that they would opt for suicide or euthanasia rather than endure **a** vastly diminished quality of life. Yet, once patients are confronted with illness, continued **life** often **be**comes more precious; given access to appropriate relief from pain and other debilitating symptoms, many of those who consider suicide during the **course** of a terminal illness **aban**don their desire for **a** quicker death in favor of **a** longer life made more tolerable with effective treatment.
- The Task Force members feel deep compassion for patients in those rare cases when pain cannot be alleviated even with aggressive palliative care. They also recognize that the desire for control at life's end is widely shared and deeply felt. **As** a society, however, we have better ways to give people greater control and relief from suffering than by legalizing assisted suicide and euthanasia.
- Depression accompanied by feelings of hopelessness **is** the strongest predictor of suicide for both individuals who **are** terminally ill and those who **are** not. Most doctors, however, are not trained to **diagnose** depression, especially in complex **cases** such as patients **who** are terminally ill. **Even** if diagnosed, depression is often not treated. In' elderly patients **as** well **as** the terminally and chronically ill, **depression** is **grossly** underdiagnosed and undertreated.
- The presence of unrelieved pain also increases susceptibility to suicide. The undertreatment of pain **is a** widespread failure of current medical practice, with far-reaching implications for proposals to legalize assisted suicide and euthanasia.
- If assisted suicide and euthanasia **are** legalized, it will blunt our perception of what it means for one individual to assist another to commit suicide or to take another person's life. Over time, as the practices are incorporated into the standard arsenal of medical treatments, the sense of gravity about the practices would dissipate.

- The criteria and safeguards that have been proposed for assisted suicide and euthanasia **would** prove elastic in clinical practice and in law, Policies limiting suicide to the terminally ill, for **example, would** be inconsistent with the notion that suicide is **a** compassionate choice for patients who are in pain or suffering. **As** long as the policies hinge on notions of pain or suffering, they are uncontainable; neither pain nor suffering can be gauged objectively, nor are they subject to the kind of judgments needed to fashion coherent public policy. **Euthanasia** to **cover** those **who are** incapable of consenting would also be a likely, if not inevitable, extension of any policy permitting the practice for those who **can** consent.
- **These** concerns are heightened by experience in the Netherlands, **where** the practices have been legally sanctioned. Although Dutch law requires an explicit request for euthanasia by the patient, a national study in the Netherlands **found** that of approximately **3300** deaths annually resulting from mercy killing, 1,000 deaths from euthanasia occurred without an explicit request. Moreover, in some cases, doctors have provided assisted suicide in response to **suffering** caused soiely by psychiatric illness, including severe depression.

Caring for Severely Ill Patients

- **Professional** medical **standards** should recognize the provision of effective pain relief and palliative care, including treatment for depression or referral for treatment, as **a** basic obligation all physicians **owe** to their patients. The legal prohibition against assisted suicide and euthanasia should also guide professional standards of conduct.
- Physicians should **seek** their patients' participation in decisions about withdrawing or withholding life-sustaining treatment early enough in the course of illness to **give** patients a meaningful opportunity to have their wishes and values respected.
- Health care professionals have a duty to offer effective-pain relief and symptom palliation to patients when necessary, in accord with sound medical judgment and the most advanced approaches available.

- New York State statutes **and** regulations **should be** modified to increase the availability of medically necessary analgesic medications, including opioids. This should be done in **a** balanced manner that acknowledges the importance of avoiding drug diversion. Chapter 8 sets forth specific recommendations for legal reform.

- Physicians, nurses, and patients must be **aware** that psychological and physical dependence on pain medication are distinct phenomena. Contrary to a **widely** shared misunderstanding, psychological dependence on **pain** medication rarely occurs in terminally ill patients. While physical dependence is more common, proper adjustment of medication can minimize **negative effects.**

- The provision of appropriate pain relief rarely **poses** a serious **risk** of respiratory depression. Moreover, the provision of pain medication is ethically and professionally acceptable even when **such** treatment **may** hasten the patient's death, **if** the medication is intended to alleviate pain and **severe** discomfort, not to cause death, and is provided in accord with **ac**cepted medical practice.

- The education of health care professionals about **pain** relief and palliative care must be improved. Training in **pain** relief and palliative care should be included in **the** curriculum of nursing schools, medical schools, residencies, **and** continuing education for health care professionals.

- Hospitals and other health care institutions **should** explore **ways** to promote effective pain relief and palliative care, and to remove existing barriers to **such** care.

- Public education is crucial to enhance pain relief practices. Like many health care professionals, patients and families often have an exaggerated sense of the **risks** of pain medication, and are reluctant to seek treatment for pain. **Nurses** and physicians should create an atmosphere that will encourage patients to seek relief of **pain.** Strategies for pain relief should also maximize patients' sense of control.

- Insurance companies and others responsible for health care financing should promote effective pain and symptom management and address barriers that exist for some patients,

- Health care professionals should be familiar with the characteristics of major depression and other common psychiatric illnesses, as well as the possibility for treatment. Major clinical depression is generally treatable, and can be treated effectively even in the absence of improvement in the underlying disease. Patients should also receive appropriate treatment for less severe depression that often accompanies terminal illness.

- Physicians should create an atmosphere within which patients feel comfortable expressing suicidal thoughts. Discussion with a physician or other health care professional about suicide can identify the need for treatment and make the patient feel less isolated. This discussion does not prompt suicide; on the contrary, talking with health care professionals often decreases the risk of suicide.

- When a patient requests assisted suicide or euthanasia, a health care professional should explore the significance of the request, recognize the patient's suffering, and seek to discover the factors leading to the request. These factors may include insufficient symptom control, clinical depression, inadequate social support, concern' about burdening family or others, hopelessness, loss of self-esteem, or fear of abandonment.