

VACCO v. QUILL

No. 95-1858

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DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County, Petitioners, v. TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D., Respondents.

Type: Brief

Prior History: [*1] On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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Title

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN NURSES ASSOCIATION, AND THE AMERICAN PSYCHIATRIC ASSOCIATION, ET AL. AS AMICI CURIAE IN SUPPORT OF PETITIONERS

Text

INTRODUCTION AND INTEREST OF AMICI

The right to control one's medical treatment is among the most important rights that the law affords each person. The associations of health care professionals who are submitting this brief strongly support the recognition and enforcement of that right. Health care professionals are committed to their ethical and legal [*7] obligations to honor patient requests to withhold or withdraw unwanted life-prolonging treatment and to provide patients with all medication necessary to alleviate physical pain, even in circumstances where such medication might hasten death. Through these means, patients can avoid entrapment in a prolonged, painful, or overly medicalized dying process.

The decision below, however, takes the unprecedented step of invalidating a law that prohibits patients from obtaining the assistance of a physician in killing themselves. The court of appeals would confer upon health care professionals the awesome responsibility of deciding who, among the many patients who would request physician-assisted suicide, are eligible to receive it. The power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides both medicine and nursing. It is a power that most physicians and nurses do not want and could not control. Once established, the right to physician-assisted suicide would create profound danger for many ill persons with undiagnosed depression and inadequately treated pain, for whom physician-assisted suicide rather than good palliative [*8] care could become the norm. At greatest risk would be those with the least access to palliative care--the poor, the elderly, and members of minority groups.

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The American Medical Association (“AMA”), the American Nurses Association (“ANA”), the American Psychiatric Association (“APA”), and 43 other national specialty and state medical societies that are submitting this brief¹ represent hundreds of thousands of health care professionals who care each day for millions of Americans. Our members have deep compassion for those who are suffering the pain and torment of chronic or terminal illness. We have learned much in recent years about palliative care. Our experience is that a desire for physician-assisted suicide does not persist in patients who receive good palliative care.

Amici acknowledge that many patients today do not receive proper treatment for their pain, depression, and psychological distress. Nevertheless, physician-assisted [*9] suicide is not the right answer to the problem of inadequate care. Although for some patients it might appear compassionate intentionally to cause death, institutionalizing physician-assisted suicide as a medical treatment would put many more patients at serious risk for unwanted and unnecessary death. Rather than recognize a right to physician-assisted suicide, our society should recognize instead the urgent necessity of extending to all patients the palliative care they need and redouble our efforts to provide such care to all.

HEALTH CARE BACKGROUND

To explain more fully the bases for amici’s position, we begin with a discussion of important aspects of caring for seriously ill patients who request physician-assisted suicide that were misapprehended by the court below.

A. Commitment To Patient Autonomy

The health care professions’ ethical commitment to the principle of patient autonomy plays a vital role in providing patients with the ability to control their course of treatment. This commitment is expressed, for example, in Opinion 2.20 of the AMA Code of Medical Ethics: Opinion 2.20 provides, in part, that “the principle of patient autonomy requires that physicians [*10] respect the decision to forgo life-sustaining treatment of a patient who possesses decisionmaking capacity.” AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics: Current Opinions § 2.20 (App. 11a-12a); see also ANA, Code for Nurses with Interpretive Statements § 1.1 (App. 19a) (patients “have the moral right to determine what will be done with their own person” and “to accept, refuse, or terminate treatment without coercion”).

Opinion 2.20 has great significance for patients near the end of life. To those who fear unwanted medical intervention in the dying process, the message of Opinion 2.20 is that a patient need not accept, and physicians must not impose, a medical treatment that the patient does not want. As a practical matter, this means that a patient can refuse not only mechanical interventions such as respirators, feeding tubes, or dialysis, but also chemotherapy, antibiotics, or any other treatment that would have the effect of prolonging the patient’s life. App. 12a. Through such means, persons suffering from chronic diseases (such as multiple sclerosis or amyotrophic lateral sclerosis), as well as terminal diseases, can plan with their physicians which [*11] life-sustaining treatment to accept.

Opinion 2.20 unequivocally establishes that “physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care” and, significantly, that this obligation “includes providing palliative treatment even though it may foreseeably hasten death.” App. 13a; see also App. 19a-20a (ANA Position Statement on Promotion of Comfort and Relief of Pain in Dying Patients). The recognition that physicians should provide patients pain medication sufficient to ease their pain, even where that may serve to hasten death, is vital to ensuring that no patient suffer from physical pain.

¹ Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief. The parties’ letters of consent have been filed with the Court. A brief description of each amicus appears as Appendix A to this brief.

The principle of patient autonomy, however, has never been understood to give patients the right to every procedure or treatment they might demand. For example, physicians need not provide futile treatment--that is, treatment that has no reasonable chance of helping the patient. Code of Medical Ethics § 2.035 (App. 15a). Similarly, physicians should not provide patients with treatments that are known to be ineffective or harmful. Such limitations are important. If a patient may demand and receive anything from a health [*12] care professional, individuals who practice the healing arts will cease being professionals.

B. Physician-Assisted Suicide

Long viewed as outside the realm of legitimate health care, physician-assisted suicide occurs "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." Code of Medical Ethics § 2.211 (App. 11a); AMA Council on Ethical and Judicial Affairs, Physician-Assisted Suicide, 10 *Issues in L. & Med.* 91, 92 (1994). The practice involves physicians intentionally providing patients with the means for suicide, such as prescribing barbiturates in an amount certain to cause death and for the purpose of causing death. See, e.g., Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 *New Eng. J. Med.* 691 (1991).

The ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics. Its roots are as ancient as the Hippocratic Oath that a physician "will neither give a deadly drug to anybody if asked for it, nor . . . make a suggestion to this effect," and the merits of the ban have been debated repeatedly in this nation [*13] since the late nineteenth century. Most recently, the AMA has reexamined and reaffirmed the ethical prohibition against physician-assisted suicide in 1977, 1988, 1991, 1993, and 1996. ² Physician-assisted suicide remains "fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." Code of Medical Ethics § 2.211 (App. 11a). Other health care professions have similar tenets. See, e.g., App. 19a (ANA Position Statement on Assisted Suicide). Physicians and nurses have the ability to respond sensitively to the concerns of seriously ill and dying patients and can meet their patients' needs without acceding to requests for suicide.

C. Requests for Physician-Assisted Suicide

1. Implicit in the Second Circuit's Opinion is the view that many of those who request suicide do so to avoid excruciating [*14] pain, and that health care professionals can do nothing compassionate in response other than to offer death. There is no evidence, however, that increasing numbers of patients are dying in severe pain. To the contrary, "the potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts." AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 *JAMA* 474, 475 (1996). The pain of most terminally ill patients can be controlled throughout the dying process, without heavy sedation or anesthesia. *Id.*; see, e.g., Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 *J. Pall. Care* 25, 26 (1993); Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 *J. Pain & Symp. Mgmt.* 289 (1991); Levy, *Pharmacologic Treatment of Cancer Pain*, 335 *New Eng. J. Med.* 1124 (1996). For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or weeks of life to prevent the patient from experiencing severe [*15] pain. N.Y. State Task Force, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40 & n.21 (1994). Notably, when pain medication is properly administered, for most patients the risk of respiratory depression that hastens death is minimal. N.Y. State Task Force at 162.

² AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 *JAMA* 474, 477 (1996). Most recently, in the aftermath of the decision below, the AMA's House of Delegates in June 1996 overwhelmingly endorsed a recommendation to affirm the ban on physician-assisted suicide.

Given the increasing ability to control pain, it is not surprising that the demand for physician-assisted suicide does not come principally from those seeking relief from physical pain. A recent study of such requests in Washington State found that "neither severe pain nor dyspnea was a common patient concern, suggesting that intolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia." Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996). This finding is consistent with a report from *Compassion-in-Dying*, see Preston & Mero, *Observations Concerning Terminally Ill Patients Who Choose Suicide*, 4 J. Pharm. Care & Pain Symp. Control 183, 187 (1996) ("in no patient was pain the primary reason for suicide"); with other studies of patients and physicians, see Emanuel et al., *Euthanasia and [*16] Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 Lancet 1805, 1809 & nn.6, 12 (1996) ("patients experiencing pain were not inclined to euthanasia or physician-assisted suicide"); as well as with studies of Holland's experience, see Van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 Lancet 669, 672 (1991) (relief from pain was mentioned as a factor in fewer than half of cases, and was the sole factor in only five percent of cases).

This is not to say that all patients have access to and actually receive adequate pain relief and good palliative care. They do not. The delivery of such care is "grossly inadequate" today, and efforts to make such care universally available have not yet succeeded. N.Y. State Task Force at 43-47; Connors et al., *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 JAMA 1591 (1995). There are many obstacles to the delivery of adequate pain management. These include a lack of professional training and knowledge, misconceptions about the risk of addiction and respiratory depression associated with pain medication, inadequate [*17] communication (reflecting both inadequate attention from health care professionals and undue reluctance of patients and their families to use pain relief medication), and concern over criminal or licensure actions against the prescribing physicians. N.Y. State Task Force at 44-47; AMA Council, 275 JAMA at 476. Of further concern, individuals treated at centers that served predominantly minority patients are more likely than others to receive inadequate pain treatment; the same is true for elderly and female patients. N.Y. State Task Force at 44 & n.37. Yet for "many patients, pain and suffering could be alleviated using medications and techniques that have been widely publicized and require only modest resources." *Id.* at 35. There is, in short, compelling evidence of the need to ensure that all patients have access to quality palliative care, but not of any need for physician-assisted suicide to control pain.

2. Most patients that request suicide do so out of concerns that, in the future, their pain may become intolerable, they may suffer a loss of dignity and become dependent upon others, or they will excessively burden their families. Back et al., 275 JAMA at 921; [*18] Emanuel et al., 347 Lancet at 1807. The suffering that such concerns may cause is real. But if the anticipatory and existential nature of that suffering is recognized and addressed, it can often effectively be alleviated. Foley, 6 J. Pain & Symp. Mgmt. at 289-90; N.Y. State Task Force at x, 181.

Concerns about the future loss of control, loss of dignity, or pain frequently can be met by reassuring the patient of a continuing commitment to attentive comfort care and by assisting the patient to comfort an underlying and unspoken fear of death. "Many patients and physicians displace anxieties about death onto the circumstances of dying: pain, dependence, loss of dignity, and the unpleasant side effects of medical treatments. Focusing on or becoming enraged at the process distracts from the fear of death itself." Hendin, *Suicide, Assisted Suicide, and Euthanasia: Lessons from the Dutch Experience*, Summary of Testimony Presented to House Subcommittee on the Constitution 1 (1996). A full approach to palliative care addresses spiritual and existential feelings as well as personal and social burdens, using a team approach that draws on social workers and pastors as well as physicians and [*19] nurses. Clinicians with experience assisting dying patients to confront such concerns report that the desire for death passes, and that patients say they have found unexpected meaning in their lives that makes their final days worth living. E.g., Cundiff, *Euthanasia Is Not the Answer* 29-39 (1992).

The anxieties that can accompany serious illness are often complicated, however, by the onset of depression. Depression is the single factor found to be a significant predictor of the desire for death. Emanuel et al., 347 *Lancet* at 1809; Chochinov et al., *Desire for Death in the Terminally Ill*, 152 *Am. J. Psych.* 1185, 1190 (1995). In one study of 44 terminally ill patients, all but one of the eleven patients with "clinical depressive illness" expressed some wish for death, while none of the remaining 33 expressed such a wish. Brown et al., *Is it Normal for Terminally Ill Patients to Desire Death?*, 143 *Am. J. Psych.* 208, 210 (1986); see also Conwell & Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 *New Eng. J. Med.* 1100, 1101 (1991) ("of 44 patients in the later stages of cancer, only 3 had considered suicide, and each of them had [*20] a severe clinical depression"); AMA Council, 275 *JAMA* at 475; Chochinov et al., 152 *Am. J. Psych.* 1185. In this regard, those with terminal or chronic illness are no different than others who express suicidal wishes. Most who commit suicide suffer from depression or some other diagnosable psychiatric illness, which generally is treatable. Hendin, *Suicide and the Request for Suicide: Meaning and Motivation*, [*35 Duq. L. Rev.* 285, 285 \(1996\)](#); N.Y. State Task Force at 13, 180.

It is clear that "a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression." Chochinov et al., 152 *Am. J. Psych.* at 1190. For example, "the elderly appear to be more prone than younger victims to take their lives during the type of acute depressive episode that responds most effectively to available, modern treatments." Conwell & Caine, 325 *New Eng. J. Med.* at 1101. Nevertheless, most physicians fail to recognize depression, thereby precluding the opportunity for effective treatment. *Id.* at 1101-02.

3. The demand for physician-assisted suicide [*21] among the terminally ill is thus best understood not as a necessary response to untreatable pain uniquely felt by the dying, but in the broader context of requests for suicide generally. "Among all suicides, only two percent to four percent are terminally ill." N.Y. State Task Force at 12. Moreover, while severe chronic or terminal illness is a risk factor for suicide, "only a small percentage of terminally ill or severely ill patients attempt or commit suicide." *Id.* at 9, 13. And those patients are similar to physically healthy individuals who contemplate suicide--they "are usually suffering from a treatable mental illness, most commonly depression." *Id.*

Thus, contrary to the Second Circuit's most basic premise, terminal illness does not present a special case for physician-assisted suicide. Patients with chronic or terminal illness who seek physician-assisted suicide are typically depressed or anticipating extreme suffering. Their needs and concerns are ones that health care professionals can meet with compassionate care. There may be, even in a system that provides optimal palliative care to all patients, individuals whose pain may not be treatable absent sedation and whose wish [*22] for physician-assisted suicide to avoid sedation is sincere. But the number of such individuals is likely to be very small, and the social cost of accommodating their preference for physician-assisted suicide over sedation and withdrawal of treatment is likely to be high. For reasons that follow, even if physician-assisted suicide were thought appropriate for such patients, no one can predict with any confidence that physician-assisted suicide, if authorized by the state, could reliably be limited to them.

D. The Inherent Difficulty In Regulating Physician-Assisted Suicide

Proponents of physician-assisted suicide agree that lines must be drawn between categories of individuals for whom physician-assisted suicide is to be deemed acceptable or unacceptable. The Second Circuit purported to restrict physician-assisted suicide narrowly to those who were "in the final stages of terminal illness." *Pet. App.* 4a. In *Washington v. Glucksberg*, No. 96-110, the Ninth Circuit permitted physician-assisted suicide for all of those with a "terminal illness." *Pet. App.*, No. 96-110, at A-113 to A-114. Both courts expressly limited their holdings to the provision of physician-assisted suicide [*23] (*Pet. App.* 32a-34a & n.3; *Pet. App.*, No. 96-110, at A-104), but the Ninth Circuit candidly expressed its doubt that any reasonable distinction could be maintained

between physician-assisted suicide and voluntary euthanasia. The "critical line," the Ninth Circuit stated, was between the "voluntary and involuntary termination of an individual's life." *Id.* at A-100.

The Second Circuit acknowledged concern about "abuses found in the Netherlands," but expressed confidence that New York would be able to "establish rules and procedures to assure that all choices are free of such pressures." *Pet. App.* 33a; see also *id.* at 34a n.4. There is no realistic basis for such confidence. Callahan & White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 83 (1996). Existing rules limiting physician-assisted suicide are not being followed today. AMA Bd. of Trustees, *Euthanasia/Physician-Assisted Suicide: Lessons in the Dutch Experience*, 10 *Issues in L. & Med.* 81 (1994). For example, the study of euthanasia and physician-assisted suicide commissioned by the Dutch government showed that approximately one in four cases of euthanasia [*24] did not qualify as voluntary under the guidelines. Van der Maas et al., 338 *Lancet* at 671; Kass & Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 Duq. L. Rev. 395, 412-13 & nn.29-30 (1996). Different social circumstances in the United States make effective regulation even less likely here than in Holland. See AMA Bd. of Trustees, 10 *Issues in L. & Med.* at 88-89. Difficulties inherent in the regulation of physician-assisted suicide suggest that even strenuous efforts to regulate such a practice will not succeed.

1. The Second Circuit placed principal reliance on its assumption that physician-assisted suicide could be restricted to those in the last stages of a terminal illness. An initial difficulty arises, however, even in identifying the eligible class. Available evidence suggests "that physicians' predictions of expected remaining life are generally inaccurate." Callahan & White, 30 U. Rich. L. Rev. at 46 n.202. For example, while admission to hospice is contingent on a diagnosis of six or fewer months to live, a recent study showed that 15 percent of hospice patients survived longer than six months and eight [*25] percent survived longer than one year. Christakis & Escarce, *Survival of Medicare Patients after Enrollment in Hospice Programs*, 335 *New Eng. J. Med.* 172 (1996); see Lynn et al., *Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duq. L. Rev. 311 (1996). Life expectancy is thus inherently problematic as a criterion for establishing eligibility to exercise a constitutional right.

The lack of clear-cut lines between those who are terminally ill and those who are in the last stages of a terminal illness suggests that any attempt to limit the availability of physician-assisted suicide to the latter would be arbitrary. But the same is true for the line between the terminally ill and the chronically ill. No one can confidently say that the degree of pain or suffering experienced by a person in the last stages of a terminal disease is greater than that experienced by someone at an earlier stage of terminal illness, or by someone who is chronically ill. Moreover, if the pain or suffering is thought to be irremediable, then the longer the patient's life expectancy, logically the more pain and suffering awaits the patient. Kamisar, *Against Assisted Suicide--Even [*26] a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735, 737, 740-41 (1995). There would thus be little to prevent expansion of physician-assisted suicide beyond the confines of the last stages of terminal illness.

The experience in the Netherlands illustrates the difficulty of hewing to particular guidelines. Physician-assisted suicide and euthanasia remain unlawful but are not prosecuted if performed by a physician in accordance with established procedures. Keown, "Some Reflections on Euthanasia in the Netherlands," in *Euthanasia, Clinical Practice and the Law* 193, 197 (Gormally ed., 1994). In one recent, much-discussed case, a physician, who assisted in the suicide of a physically healthy, 50-year-old woman who sought death in the aftermath of the death of her two sons, was acquitted by a three-judge court in Assen of charges that he had violated the Dutch procedures. The Assen case is significant in that it "marked Dutch acceptance of depressed suicidal patients as eligible for assisted suicide or euthanasia," Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 *Issues in L. & Med.* 123, 129 (1994), and thereby demonstrated the difficulty of restricting the [*27] availability of physician-assisted suicide even to those with a physical illness.

2. There are also formidable obstacles to restricting physician-assisted suicide only to those patients who voluntarily request it. First, the fact that many patients do not receive adequate pain relief or suffer from undiagnosed and untreated depression puts undue pressure on them to seek physician-assisted suicide. A substantial percentage of elderly patients suffer mental confusion that also routinely goes undiagnosed. Francis et al., *A Prospective Study of Delirium in Hospitalized Elderly*, 263 JAMA 1097 (1990). Moreover, poor and minority individuals are at the greatest risk for receiving inadequate care and thus may feel the greatest pressure to request physician-assisted suicide.

Pressure to contain health care costs exacerbates the problem. Even if, as one would expect, health care insurers would consciously seek to avoid suggesting to patients or physicians that they consider financial costs in making a decision to hasten death, the continuing pressure to reduce costs can only constrain the availability and quality of palliative care and support services that patients and families [*28] need. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, [*35 Duq. L. Rev.* 455 \(1996\)](#). These limitations on the availability of proper care clearly can place pressure on patients to express a wish for suicide that they might not otherwise feel. As the Chief of the Pain Service at Memorial Sloan-Kettering Cancer Center reports, "we commonly see [requests for physician assisted suicide] dissolve with adequate control of pain and other symptoms." Foley, 6 J. Pain & Symp. Mgmt. at 290.

Providers willing to comply with requests for suicide may be among those least sensitive to the impact of these pressures and least familiar with alternative responses to their patients' needs. A recent study shows that support for physician-assisted suicide was highest among those health care professionals least knowledgeable about pain symptom management and least capable (due to emotional exhaustion) of empathizing with the patient. Portenoy et al., *Determinants of the Willingness to Endorse Assisted Suicide: A Survey of Physicians, Nurses, and Social Workers*, -- *Psychosomatics* -- (forthcoming April 1997); see also Bachman et al., *Attitudes of Michigan Physicians and the Public [*29] toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 *New Eng. J. Med.* 303, 308 (1996) ("doctors who had the least contact with terminally ill patients were the most likely to support the legalization of assisted suicide"). There is thus added reason to doubt that patients seeking physician-assisted suicide would receive adequate palliative care before such a request is granted.

Second, separating the wishes of the patient from those of the family is extremely problematic. One of the most common reasons why patients request suicide is to spare their families and loved ones the burdens and expense of caring for them. See, e.g., Blendon et al., *Should Physicians Aid Their Patients in Dying?*, 267 JAMA 2658, 2660-61 (1992); Emanuel, *Cost Savings at the End of Life: What Do the Data Show?*, 275 JAMA 1907 (1996). But to what extent are these feelings the result of the family's expectations? In one recent study, families of elderly, terminally ill patients were significantly more likely than the patients themselves to express support for physician-assisted suicide. Koenig et al., *Attitudes of Elderly Patients and Their Families [*30] toward Physician-Assisted Suicide*, 156 *Arch. Int. Med.* 2240, 2244 (1996). Families, especially when confronted with the expense and burden of caring for a terminally ill family member, may be beset with conflicting feelings about hastening a family member's death, as recent cases vividly illustrate. E.g., "Countdown to a Suicide," *The New York Times*, Dec. 20, 1995, at A-20 (Delury case). Even those family members consciously committed to preserving their loved one's sense of dignity and autonomy may needlessly acquiesce in or encourage a suicide that could be avoided by assuring the patient that, in their eyes, illness has not compromised his or her dignity. Byock, "Physician-Assisted Suicide Is Not an Acceptable Practice for Physicians," in *Physician-Assisted Suicide: Ethical Positions, Medical Practices, and Public Policy Options* -- (Weir ed., forthcoming May 1997).

Third, experience to date provides little basis for confidence that health care professionals can reliably determine whether patients have provided truly informed consent for assisted suicide. Frank, sensitive, and extended

conversations between physicians and patients are presumptively antecedents to such a determination. [*31] Such conversations would be infinitely more complex than any that regularly occur today. For example, ineffective communication remains a major obstacle to achieving pain management, American Pain Society Quality of Care Committee, Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain, 274 JAMA 1874, 1874 (1995), even though pain relief is plainly a goal shared by both health care professionals and patients. And despite their importance, discussions about advance care planning are rare and poorly handled, therefore hampering effective and responsive end-of-life care. Emanuel, "Advance Directives," in Principles and Practice of Supportive Oncology -- (Berger et al. eds., forthcoming 1996).

The well-established phenomena of transference and countertransference further complicate the problem of relying upon physicians and nurses to identify voluntary requests. Miles, Physicians and Their Patients' Suicides, 271 JAMA 1786 (1994). Particularly when caring for chronically ill, dying, or suicidal patients, caregivers often have "difficulty tolerating such patients' dependency." Id. at 1786 (footnote omitted). Their "feelings [*32] of frustration and inadequacy occasioned by irreversible medical problems" sometimes lead them "to withdraw from such patients or see them as hopelessly or rationally suicidal" when in fact they are not, which "in turn may precipitate suicides." Id. As one physician with extensive experience caring for dying patients has observed "only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying." Miles, quoted in Kass & Lund, [35 Duq. L. Rev. at 418](#).

Health care professionals also experience great frustration at not being able to offer the patient a cure. For some, the ability to offer the patient the "treatment" of assisted suicide may provide a sense of "mastery over the disease and the accompanying feelings of helplessness." Hendin, Seduced by Death, 10 Issues in L. & Med. at 129. This may cause health care professionals or a patient's family to endorse and reinforce requests for suicide more readily than the patient's own ambivalent feelings would warrant. Miles, 271 JAMA at 1786. Published accounts of physician-assisted suicide reveal that even those physicians who [*33] consciously seek only to implement a patient's voluntary request overlook ways in which their recommendation and support of physician-assisted suicide reinforced the patient's decision for death and left unexamined indications that the patient really did not want to die. Hendin, Selling Death and Dignity, 25 Hast. Ctr. Rep. 19 (1995); Hendin, Seduced By Death, 10 Issues in L. & Med. at 125-29.

3. The obstacles to identifying and restricting physician-assisted suicide to those patients who meet criteria of terminality and voluntariness are not likely to be overcome simply by devoting more resources to oversight of treatment decisions. Indeed, the unprecedented intrusion into the physician-patient relationship needed independently to regulate such treatment decisions would be fundamentally inconsistent with the private nature of health care treatment, and all too likely to undermine what progress has been made in decisions to withdraw or withhold life-sustaining treatment and to use effective pain control. Callahan & White, [30 U. Rich. L. Rev. at 67, 80](#).

Transforming physician-assisted suicide into a medical procedure would create momentum in favor of its use that regulation [*34] could not reverse. Were physician-assisted suicide to become a legitimate medical option, then a decision not to select that option would make many patients feel responsible for their own suffering and for the burden they impose on others. Once a patient can choose physician-assisted suicide, it is but a short step to ask a patient why he or she has not done so. Indeed, it seems likely the patient would feel pressure to revisit the question repeatedly, perhaps every day. Many patients thus will "experience--and be helped [by their families or physicians] to experience--their right to choose physician-assisted death as a duty to do so." Kass & Lund, [35 Duq. L. Rev. at 407](#).

SUMMARY OF ARGUMENT

The Second Circuit refused to find that patients have a liberty interest in choosing the time and manner of their death. Pet. App. 16a-20a. It nevertheless invalidated New York's prohibition on assisted suicide to the extent the law prohibits "a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness." Id. at 35a. The court concluded that the law, applied in this fashion, [*35] was "not rationally related to any legitimate state interest." Id. The court therefore found that New York State's ban on assisted suicide violates the Equal Protection guarantee of the Fourteenth Amendment.

In so ruling, the court strained to conclude that it was irrational for a state to distinguish between laws permitting patients to have unwanted medical treatment withheld or withdrawn and laws prohibiting physicians from assisting their patients to commit suicide. In the court's view, both procedures involved the physician in assisting a suicide. The court's attempt to equate the two procedures ignores not only the venerable common law and ethical distinction between the two procedures, but the vital concerns for patient welfare that justify the line drawn by the state.

Although reaching a holding superficially more narrow than that of the Ninth Circuit's ruling (the Second Circuit's holding is restricted to those "in the last stages" of a terminal illness), the Second Circuit's decision is, as a practical matter, every bit as broad as the Ninth Circuit's in its implications and practical import. The Second Circuit never asked whether the new line that it drew is any more [*36] rational than the one it had just erased. The answer, quite simply, is that it is not. The restrictions that the Second Circuit assumed could be imposed on physician-assisted suicide are, in fact, less rational than the state's outright prohibition, and could not be expected to survive comparable constitutional scrutiny.

ARGUMENT

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

The Second Circuit did not find, and no one could reasonably argue, that states do not have a rational basis for prohibiting physician-assisted suicide. The court instead found that it was irrational for New York to prohibit physician-assisted suicide for patients in the last stages of terminal illness while at the same time permitting patients to request that physicians withdraw or withhold life-sustaining treatment. Because the latter involves a physician taking action that hastens a patient's death, the court reasoned that it amounted to physician-assisted suicide. Such precedent made it irrational, in the court's view, for the state to maintain a ban against physician-assisted suicide for [*37] patients in the last stages of terminal illness.

The principal question before this Court, therefore, is whether it is rational for a state to distinguish between patients' requests for physician-assisted suicide and requests for withholding or withdrawing life-prolonging treatment. There are, in fact, many sound reasons for drawing the line New York has adopted that amply support the law as rationally justified. In addition to reversing the lower court's equal protection holding, the Court should also reject the argument, offered in the concurring opinion below, that New York's law should be invalidated and, in effect, remanded to the legislature for further consideration.

A. States Have A Rational Basis For Distinguishing Between Physician-Assisted Suicide And Withholding Or Withdrawing Medical Treatment

The distinction between the right to refuse unwanted medical treatment and physician-assisted suicide reflects a venerable common law tradition, acknowledged and described at length by the Court in [*Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 269-79 \(1990\)](#), that distinguishes between respecting a patient's

right to refuse unwanted [*38] medical treatment on one hand and respecting the state's interest in preventing suicide on the other. Medical treatment performed without the patient's consent historically has been treated as a battery, excusable only in emergency circumstances. *Id. at 270*; Keeton et al., *Prosser and Keeton on the Law of Torts* 39-42, 190 (5th ed. 1984); *Winters v. Miller*, 446 F.2d 65, 68 (2d Cir.), cert. denied, 404 U.S. 985 (1971). The right to refuse treatment is the "logical corollary" of the prohibition against medical treatment without the patient's informed consent. *Cruzan*, 497 U.S. at 270.

Physician-assisted suicide, in contrast, does not involve the imposition of treatment against the patient's will. It does not rest on the same common law antecedents as the right to refuse treatment. Indeed, any assistance in helping another commit suicide has long been prohibited at common law--a fact that this Court expressly observed in *Cruzan* without suggesting that it was inconsistent with the historic tradition of protecting a right to refuse medical treatment. *Id. at 280*. The traditions of the common law alone provide the state [*39] with a rational basis for the distinction it makes.

Second, the common law traditions reflect an important moral and practical difference that the Second Circuit failed to appreciate. The Second Circuit was able to equate withdrawal of medical treatment with physician-assisted suicide only by misconceiving the fundamental difference in the physician's intent in participating in those two acts. In respecting a patient's decision to have treatment withheld or withdrawn, the physician is acting squarely within the historic parameters of the profession. The physician is fulfilling his or her role as someone who responds to the patient's needs by providing medical treatment only to the extent the patient consents. Although the act of withholding or withdrawing medical treatment may lead to death, the intent of the physician in so acting is not to cause death, but to respect the patient's essential right to decide if and when to let the disease process take its course.

Conversely, when the physician responds affirmatively to a request for help in committing suicide, the physician's intent is only to help the patient in taking his or her life. The physician thus acts with intent to kill. [*40] To distinguish between two acts with a similar result based upon the intent of the actor is elemental in the law. *Morissette v. United States*, 342 U.S. 246, 250 (1952) (legal distinctions based on intent are "universal and persistent in mature systems of law"). There can be little doubt that a state acts rationally when it chooses to respect such a distinction in this context.

Third, states could rationally conclude that preserving the ethical boundary as drawn by the medical and nursing professions is important to prevent serious damage to those professions and their ability to serve patients. E.g., *Semler v. Oregon State Bd. of Dental Examiners*, 294 U.S. 608, 612-13 (1935) (state's strong interest in "maintenance of professional standards" permits it to enforce "a general rule even though in particular instances there might be no actual" harm); *Ohralik v. Ohio State Bar Ass'n*, 436 U.S. 447, 460 (1978) (state interest in "maintaining standards among members of the licensed professions" is "particularly strong"); *Shapero v. Kentucky Bar Ass'n*, 486 U.S. 466, 485 (1988) (state "should have considerable latitude to [*41] ban" conduct that "undermines the substantial government interest in promoting the high ethical standards" of a profession) (O'Connor, J., dissenting).

Health care professionals have long understood that with the right to practice comes enormous responsibility. Patients come to physicians and nurses at times of greatest need and vulnerability, depending upon these professionals to respond to their needs capably and faithfully. The rule against physician-assisted suicide is an extraordinarily valuable protection against temptation to seek an immediate solution to a burdensome problem that health care professionals, no less than any other human being, can feel. Many patients may understandably wonder, finding themselves badly injured and in the care of a physician they do not know but who is licensed to assist in taking the lives of patients, whether that physician will truly act only to preserve their lives. Will patients be confident, as they watch a physician draw a dose of morphine, that the physician is committed only

to easing their pain and not to taking their lives? See, e.g., Kass & Lund, [35 Duq. L. Rev. at 408](#). The ban on physician-assisted suicide helps ensure [*42] that patients will never lose the trust that must exist for the physician-patient relationship to flourish.

Fourth, states could reasonably conclude that abandoning the prohibition on physician-assisted suicide will undermine the provision of palliative care to those who need it. Such a step may discourage some patients from seeking adequate pain medication for fear that a request for such medication will initiate a process that could lead to physician-assisted death. States could also conclude that abandoning the prohibition would undermine the professions' overall efforts to expand the provision of palliative care to all patients. Although such efforts would not end if physician-assisted suicide were permitted, the prohibition on physician-assisted suicide provides health care professionals with a tremendous incentive to improve and expand the availability of palliative care.

Similarly, states also could reasonably conclude that preserving the prohibition against physician-assisted suicide is essential to avoid jeopardizing the hard-won advances over the past decade firmly to establish for all patients a right not only to have unwanted medical treatment withheld or withdrawn [*43] but also to receive pain medication sufficient to ease pain, even if that medication might hasten the patient's death. Widespread acceptance of these rights by health care professionals, courts, legislatures, and the public has been dependent upon the recognition and acceptance of the distinction between these rights and physician-assisted suicide. See generally 2 Meisel, *The Right To Die* § 18.18, at 479-85 (2d ed. 1995). If that important boundary is lost, much support for withholding and withdrawing treatment or providing adequate pain medication may be lost as well.

Fifth, states could reasonably conclude that the potential for abuse is significantly greater in the context of physician-assisted suicide than in the case of the withholding or withdrawal of treatment. It is true that the difficulty of identifying truly voluntary requests for physician-assisted suicide has some analogue in the context of requests to withhold or withdraw medical treatment. But the analogy is only partial at best. The right to refuse treatment is a right that applies to all competent, informed individuals at any time. The right articulated by the court below to physician-assisted suicide is one that [*44] purports to be limited to very discrete categories of patients. Such a right requires physicians to make multiple subjective judgments that simply are not required in the typical withholding or withdrawal situation. Moreover, the historic protection for a patient's right to limit what others may do to the patient's body supports a degree of deference to patient decisions to withdraw and withhold treatment that is absent in the case of physician-assisted suicide.

Sixth, honoring the patient's right to refuse unwanted care serves a vital, life-promoting purpose that has no equally strong analogue in permitting physician-assisted suicide. There would be a strong disincentive to accepting life-sustaining treatment if patients and their surrogates knew that, once the treatment were started, it could never be stopped. For example, it may not be until some months after treatment begins before it can be known whether a patient in a vegetative state as a result of an accident will recover consciousness. And even apart from emergency situations, "the decision to initiate treatment is often acceptable to the patient and to the health care professionals because treatment can be withdrawn or [*45] withheld if the patient's condition worsens or the treatment proves intolerable for the patient." N.Y. State Task Force at 147.

Finally, a state could reasonably conclude that, given the difficulty of persuasively defending and enforcing rules that allow some categories of patients, but not others, to obtain physician-assisted suicide, and given the state's unquestioned interest in preventing avoidable suicides, an outright prohibition is best. The artificiality of the line drawn by the panel below is instructive. For example, the panel limited its holding to those who could "self-administer" the lethal drug, in effect distinguishing between physician-assisted suicide and voluntary euthanasia. Pet. App. 35a. But the court never explained how enforcement of that distinction would survive the court's scrutiny. As the Ninth Circuit candidly admitted, "it may be difficult to make a principled distinction

between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician.” Pet. App., No. 96-110, at A-100. Unlike the Second Circuit, the Ninth Circuit “recognized that in some [*46] instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them.” Id. (footnote omitted).

The panel would also limit physician-assisted suicide to those in the “last stages” of a terminal illness. Pet. App. 35a. The rationality of this limit, too, is undefended. As discussed above, physicians are not capable of accurately predicting the amount of time each patient has left to live. More fundamentally, the Second Circuit offered no rationale whatsoever, let alone one that could withstand the degree of scrutiny it applied below, for denying physician-assisted suicide to a terminally ill person in great pain and suffering while simultaneously granting it to a person in the last stages of a terminal illness. Certainly the logic that the Second Circuit used to invalidate the state’s rule--that in allowing withdrawal of treatment the state has already approved physician-assisted suicide--would apply a fortiori to claims by the terminally ill.

Indeed, the Second Circuit’s logic would apply beyond the terminally ill to other patients [*47] as well. There is, based on the Second Circuit’s reasoning, no rational basis for limiting physician-assisted suicide to those, for example, who are chronically ill but nevertheless experiencing great and irremediable pain or suffering. By hypothesis, such patients would be required to endure more pain and suffering than a person in the last stages of a terminal illness if the right to physician-assisted suicide were not extended to them. In such a case, a court might well encapsulate its ruling in words that track nearly verbatim those used below: “What business is it of the state to require the continuation of agony when the result is imminent and inevitable?” Cf. Pet. App. 31a.

Furthermore, a state could rationally conclude that the imposition of a panoply of safeguards, such as those listed in a footnote below (see Pet. App. 34a-35a n.4), would not be effective in regulating physician-assisted suicide. Surely the experience in the Netherlands alone would provide a state with a rational basis for skepticism that such rules could be enforced. The essential confidentiality of the relationship between patients and their physicians and nurses precludes any effective monitoring of [*48] physician-assisted suicide, at least absent a kind of intrusive oversight that states could very rationally wish to avoid. E.g., Callahan & White, [30 U. Rich. L. Rev. at 67](#).

For these reasons, the line drawn by the Second Circuit is no more immune to challenge on rationality grounds than the line the court struck down. Where the problems are as complex and sensitive as the ones at issue here, and where core state interests in protecting the health and welfare of its citizens are at stake, courts should be particularly reluctant to conclude that they can draw a more rational line than the one chosen by the vast majority of state legislatures and reflected in the common law.

B. This Case Is Not Appropriate For A Legislative Remand

This Court also should not adopt Judge Calabresi’s view, expressed in the concurring opinion below, that New York’s law should be invalidated and the legislature required, if it wishes to maintain its prohibition, to reenact the provision or some variation. Pet. App. 35a-62a. Judge Calabresi stated that “when a law is neither plainly unconstitutional . . . nor plainly constitutional, the courts ought not to decide the ultimate validity [*49] of that law without current and clearly expressed statements, by the people or by their elected officials, of the state interests involved.” Pet. App. 51a. Judge Calabresi then concluded that “the rationale for the New York assisted-suicide prohibition has eroded with the passage of time,” that these laws have become obsolete, and in light of this obsolescence should be held unconstitutional. Pet. App. 55a-56a. He left open the possibility, however, that “such prohibitions, or other more finely drawn ones, might be valid, under either or both clauses of the United States Constitution, were New York to reenact them while articulating the reasons for the distinctions it makes” Pet. App. 62a.

Whatever the merits of this approach in other circumstances, the circumstances of this case counsel strongly against its application here. The premise of Judge Calabresi's argument--that New York's law against assisted suicide may simply be a vestige of another era, reflecting only legislative inattention or outdated state interests--is simply incorrect. New York has repeatedly revisited its laws on suicide, assisted suicide, and end-of-life care, and has kept its prohibition against assisted [*50] suicide intact. A brief history of this prohibition illustrates this point.

While assisted suicide has always been a crime in New York State, the legislature has revisited related laws many times. Until 1919, for example, attempted suicide was also a crime. At that time, criminal penalties were removed, and attempted suicide was declared to be a "grave public wrong." Act of May 5, 1919, ch. 414, §§ 1, 2, 1919 N.Y. Laws 1193; [Hundert v. Commercial Travelers' Mut. Accident Ass'n of Am., 279 N.Y.S. 555, 556 \(N.Y. App. Div. 1935\)](#). Then, in 1965, the legislature deleted the "grave public wrong" language and redrafted the prohibition against assisted suicide to make it a separate substantive offense. Pet. App. 40a-41a.

Since 1965, a wide range of related issues have been considered by the New York legislature and courts, issues which have placed the question of assisted suicide squarely before the state's various governmental bodies. In 1981, the New York Court of Appeals held that physicians could lawfully honor patients' requests to terminate medical treatment. [In re Storar, 420 N.E.2d 64 \(N.Y.\)](#), cert. denied sub nom. [Storar v. Storar, 454 U.S. 858 \(1981\)](#). [*51] In 1986, the New York Court of Appeals expanded this concept, holding that "it is the individual who must have the final say in respect to decisions regarding his medical treatment." [Rivers v. Katz, 495 N.E.2d 337, 314 \(N.Y. 1986\)](#).

Responding to Katz, the New York legislature enacted the 1987 Orders Not to Resuscitate Act, which provides competent adults with the right to create an order not to resuscitate. N.Y. Pub. Health Law §§ 2960-2979 (McKinney 1993 & Supp. 1996). In 1990, the legislature went further and permitted a competent person to designate an agent to make health care decisions, including the withdrawal of artificial nutrition and hydration. [N.Y. Pub. Health Law § 2982](#) (McKinney 1993 & Supp. 1996). Through all this activity, the assisted suicide prohibition remained intact. Indeed, the 1990 Act further stated that "this article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law." [N.Y. Pub. Health Law § 2989\(3\)](#) (McKinney 1993 & Supp. 1996). Thus, as recently as 1990, the New [*52] York legislature (1) had before it the question of assisted suicide; (2) indicated that the resuscitation statutes are not intended to permit or promote assisted suicide; and (3) left in place its longstanding prohibition against such acts.

In 1994, the issue was again brought to the attention of the legislature when the New York State Task Force on Life and the Law ("Task Force") submitted its report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994), to the legislature. Although the members of the Task Force held "different views about the ethical acceptability of assisted suicide and euthanasia," they "unanimously recommended that existing law should not be changed to permit these practices." N.Y. State Task Force at xii. The Task Force concluded that "assisted suicide and euthanasia would carry us into new terrain--American society has never sanctioned assisted suicide or mercy killing," and that "the practices would be profoundly dangerous for large segments of the population." *Id.* at vii-viii. The New York State legislature received the report in 1994 and--possibly in reliance on the conclusions contained within it--has left the State's assisted-suicide [*53] statute intact.

More generally, there has been widespread national debate about the propriety of assisted suicide and euthanasia. Oregon, Washington, and California have all recently included assisted suicide referenda on their ballots. Pet. App., No. 96-110, at A-49. The Michigan courts and legislatures have given great consideration to this issue in response to the activities of Jack Kevorkian. See, e.g., [People v. Kevorkian, 527 N.W.2d 714 \(Mich.\)](#)

(holding that Michigan's ban on assisted suicide is constitutional), cert. denied, *115 S. Ct. 1795 (1994)*. As Professor Burt notes, "the current, dramatic public ferment regarding physician-assisted suicide . . . in itself shows that no judicial intervention is now necessary to give visibility and moral salience to the minority claims at stake." Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?* *35 Duq. L. Rev. 159, 180 (1996)*.

The premise of Judge Calabresi's argument--that legislative inattention to New York's prohibition on assisted suicide requires courts to invalidate the law pending further legislative action--is thus not supported by the facts. There [*54] is ample evidence that New York's prohibition against assisted suicide reflects a contemporaneous legislative judgment that the prohibition remains important. The indicia of obsolescence must be far greater to justify the intrusive step of invalidating state law.

The decisions on which Judge Calabresi primarily relies do not support a legislative remand here. In *Abele v. Markle*, *342 F. Supp. 800 (D. Conn. 1972)*, vacated, *410 U.S. 951 (1973)*, Judge Newman, in a concurring opinion, found unconstitutional an 1860 prohibition on abortion because the state "interests which the 1860 legislature was seeking to advance are not today sufficient to justify" a continuing ban. *Id. at 810*. Here, however, the continuing vitality of the state's interests has been eloquently stated in a recent task force report commissioned by the state itself.

The other decisions cited below involved statutes that were ambiguous on the point at issue. Thus, in *Kent v. Dulles*, *357 U.S. 116, 129 (1958)*, the Court concluded that it should not be assumed, without more explicit direction, that Congress had delegated authority to the State Department to impose [*55] the challenged limitations on citizens' passport rights. And in her concurrence in *Thompson v. Oklahoma*, *487 U.S. 815 (1988)*, Justice O'Connor concluded that where state law "authorizes capital punishment for murder, without setting any minimum age at which the commission of murder may lead to the imposition of that penalty" and "quite separately [provides] that 15-year-old murder defendants may be treated as adults in some circumstances," there was a "considerable risk that the Oklahoma Legislature did not realize that its actions would have the effect of rendering" 15-year-olds eligible for the death penalty. *Id. at 857*. In view of that ambiguity, Justice O'Connor was prepared to require that Oklahoma clarify whether a juvenile could, in fact, be executed before such an execution would be permitted. *Id.*

No such ambiguity exists here. The New York law prohibiting assisted suicide is clear on its face.³ And, as the history of this provision makes clear, there is no reason to believe that the New York legislature "did not realize that its actions" (*id.*) had criminalized assisted suicide. In short, there is no basis for a legislative remand.

[*56]

CONCLUSION

For the reasons stated above, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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³ New York law provides that "A person is guilty of manslaughter in the second degree when . . . he intentionally causes or aids another person to commit suicide" and "is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide." *N.Y. Penal Law §§ 125.15*, 120.30 (McKinney 1987).

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APPENDICES

APPENDIX A

AMICI CURIAE

The **American Medical Association (AMA)** is a private, voluntary, non-profit organization of physicians. The AMA was founded in 1847 to promote the science and art of medicine and to improve the public health. The 290,000 members of the AMA practice in all states and in all fields of medical specialization. Among other efforts, the AMA is working with the Robert Wood Johnson Foundation in the development of an education program on advance care planning and palliative medicine designed to reach [*57] every physician and to improve the quality of patient care for individuals at the end of life.

The **American Nurses Association (ANA)** is an association of registered nurses that is dedicated to the advancement of the goals and interests of registered nurses and of the nursing profession generally. It was founded in 1897 to promote the professional and educational advancement of nurses and to establish and maintain a code of ethics for the nursing profession. The ANA has 180,000 members and represents registered nurses in the United States and its territories through its 53 constituent member organizations. The ANA establishes professional standards for nursing practice, nursing education, nursing services and a code of ethical conduct for nurses, and the Association is dedicated to meeting the needs of nurses as well as the needs of patients and families.

The **American Association of Critical-Care Nurses (AACN)** is the world's largest specialty nursing organization with more than 76,000 members. Founded in 1969, the Association now has more than 270 chapters worldwide and is working toward a healthcare system driven by patient's needs where critical care professionals [*58] make their optimal contribution.

The **Hospice Nurses Association (HNA)** was founded in 1986 and is a non-profit professional association. The HNA is an international professional association with a mission of promoting excellence in hospice nursing. The HNA is the nation's largest hospice nursing association and it is governed by an all nurse board of directors.

The **Oncology Nurses Society (ONS)**, incorporated in 1975, is a national organization of more than 25,000 registered nurses specializing in cancer and dedicated to excellence in patient care, teaching, research and education in the field of oncology. The ONS has 185 local chapters that provide community networks for education and peer support. Oncology nurses are at the forefront of promoting quality of life as an essential component of cancer care.

The **American Osteopathic Association (AOA)**, celebrating its centennial in 1997, represents the nation's 40,000 osteopathic (D.O.s). The AOA is organized to advance the philosophy and practice of osteopathic medicine by promoting excellence in education, research, and the delivery of quality and cost-effective health care in a distinct, unified profession. [*59]

The **American Psychiatric Association (APA)**, with approximately 42,000 members, is the nation's leading organization of physicians specializing in psychiatry. The APA follows the ethics standards of the American

Medical Association. Physician-assisted suicide inevitably presents issues concerning the assessment of patient competence, the determination of voluntariness, and the diagnosis and treatment of depression or other mental illness afflicting patients who may request assistance for suicide. As doctors who would be called upon to play a critical role in such matters, the APA's members have a strong interest in this case.

The **American Academy of Hospice and Palliative Medicine (AAHPM)**, originally organized as the Academy of Hospice Physicians in 1988, was established to bring together physicians interested and/or involved in the hospice/palliative care approach to patient care and committed to improvement of care for the dying. The AAHPM is the only such organization in the United States that offers support to physicians dedicated to the advancement of hospice/palliative medicine, its practice, research and education. Its 1,500 member physicians represent nearly all [*60] medical specialties.

The **American Academy of Pain Management** was incorporated in 1988 as a voluntary, not-for-profit organization for the purpose of credentialing multidisciplinary pain practitioners, and to further the practice of pain management through the development of standards, education, and advocacy in the field of pain management. The Academy's Board of Advisors are prominent individuals in their respective disciplines and all are interested in furthering our knowledge and management of pain complaints. The intent of the Academy is to be inclusionary, not restrictive to any specialty, and the goal of the Academy is to bring together the many professionals who work with patients in pain and to assist in the creation of quality services for those individuals.

The **American Academy of Pain Medicine** is a medical specialty society of 900 physicians who specialize in the prevention, evaluation, diagnosis, treatment and rehabilitation of painful disorders. The pain physician serves as a consultant to other physicians but is often the principal treating physician and may provide care at various levels, such as direct treatment, prescribing medication, prescribing rehabilitative [*61] services, performing pain relieving procedures, counseling of patients and families, direction of a multidisciplinary team, coordination of care with other health care providers and consultative services to public and private agencies pursuant to optimal health care delivery to the patient suffering from a painful disorder.

The **American Academy of Orthopaedic Surgeons** is a not-for-profit organization that represents over 17,000 members. The Academy provides educational programs for orthopaedic surgeons, allied health professionals, and the public. The Academy is an advocate for improved patient care.

The **American Academy of Physical Medicine and Rehabilitation** is a national medical specialty society representing more than 5,000 physicians who specialize in physical medicine and rehabilitation (physiatry), the branch of medicine emphasizing the prevention, diagnosis and treatment of disorders that may produce temporary or permanent impairment. Physiatry provides integrated care in the treatment of all neurologic and musculoskeletal disabilities from traumatic brain injury to lower back pain. The specialty focuses on the restoration of function to people with problems [*62] ranging from simple physical mobility issues to those with complex cognitive involvement.

The **Society of Critical Care Medicine (SCCM)** is the premier professional international organization devoted exclusively to the advancement of multidisciplinary critical care through excellence in patient care, education, research and advocacy. The nearly 9,000 members of SCCM -- the intensivists, nurses and allied health professionals involved in the care of the critically ill and injured -- blend their knowledge, skill, and expertise into a coordinated effort to achieve the best possible outcome for the patient.

The **American Academy of Neurology** is a non-profit organization of approximately 14,000 neurologists who practice throughout the United States and beyond. The Academy strives to serve the broad educational needs of its members; to encourage the highest standards of clinical care, education, and research in the field of

neurology; and to advance the specialty of neurology and the well-being of those served by it. The Academy has taken a leadership role in developing substantive and procedural guidelines for patient care and decision-making in such circumstances as persistent [*63] vegetative state, advanced dementia, profound and irreversible paralysis ("locked-in syndrome"), and anencephaly.

The **American Neurological Association** was founded in 1875 and today represents over 1,100 academic neurologists.

The **American Society of Anesthesiologists** was founded in 1905 in New York and currently has more than 34,000 members. It is a scientific and educational association of anesthesiologists that was organized to advance the practice of anesthesiology and to improve the quality of care of the anesthetized patient. It is the largest organization of anesthesiologists in the world.

The **American Society of Clinical Pathologists (ASCP)** is a non-profit medical specialty society organized for educational and scientific purposes. The 75,000 members of the ASCP include board certified pathologists, other physicians, clinical scientists, and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel. ASCP's certifying board registers more than 150,000 laboratory professionals annually.

The [*64] **College of American Pathologists (CAP)** is a medical society serving more than 15,000 physician members and the laboratory community throughout the world. Incorporated in 1947, the College is a not-for-profit organization. CAP is the world's largest association composed exclusively of pathologists and is widely considered to be the leader in laboratory quality assurance. The CAP is an advocate for high quality and cost-effective patient care. The mission of the College is to represent the interests of patients, the public and pathologists by fostering excellence in the practice of pathology worldwide.

The **American Society of Abdominal Surgeons (ASAS)**, founded in 1959, is a private, voluntary, non-profit organization of physicians. Its mission is to develop a strong continuing surgical education program for the unique specialty of abdominal surgery. The 4,000 members of the ASAS practice in all states, Canada, and Mexico.

The **American Association of Clinical Endocrinologists (AACE)** is an international medical association devoted to the field of clinical endocrinology. Its more than 2,500 members are physicians with special education, training and interest in the [*65] practice of endocrinology. AACE members are clinicians and educators in areas such as diabetes, thyroid illnesses, lipid profiles, reproductive disorders, obesity, and nutrition.

The **California Medical Association (CMA)** is a non-profit, incorporated professional association of approximately 33,000 physicians practicing in the State of California. The CMA is the largest state medical association in the country, and the membership includes most California physicians engaged in the private practice of medicine, in all specialties. CMA's primary purposes are ". . . to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, cost-effective health care for the people of California.

The **Medical Society of the State of New York** was organized in 1807 and is incorporated and operated under the state's Not-for-Profit Corporation Law. The Society has approximately 27,000 member physicians, representing physicians in all specialties. The purposes of the Medical Society include: "To enhance the delivery of medical [*66] care of high quality to all people in the most economical manner, and to act to promote and

maintain high standards in medical education and in the practice of medicine in an effort to ensure that quality medical care is available to the public.”

The **Medical Association of the State of Alabama** is a non-profit professional association of licensed physicians representing 5,600 members in the State. The Association was founded in 1873 and it is the premiere medical professional association in the State of Alabama.

The **Arkansas Medical Society** organized in 1875, is a non-profit, professional organization representing 3,857 licensed physicians in the State of Arkansas.

The **Medical Association of Georgia**, formed in 1849, is a non-profit professional association of approximately 7,500 licensed physicians who provide patient care in all aspects of medical practice in the State of Georgia.

The **Illinois State Medical Society** is a non-profit professional association of licensed physicians, residents and medical students, founded in 1840, and representing more than 18,000 members in the State of Illinois.

The **Indiana State Medical Association** is a non-profit, [*67] professional association of licensed physicians founded in 1849, and representing 7,200 physicians in all areas of medical practice in the State.

The **Iowa Medical Society** is a non-profit, professional association of licensed physicians founded in 1860, and representing 4,000 physicians in all areas of medical practice in the State.

The **Louisiana State Medical Society**, founded in 1878 and representing 6,340 physicians and medical students in Louisiana, is a non-profit, tax-exempt professional association. The Louisiana State Medical Society provides leadership for the advancement of the health of the people of Louisiana and is the premier advocate in Louisiana for patients and physicians.

The **Massachusetts Medical Society** is the oldest, continuous non-profit, professional medical association in the United States. Founded in 1781, it represents approximately 16,000 members in the State.

The **Mississippi State Medical Association** is a private, voluntary, non-profit organization, which was founded in 1856 to promote the extension of medical knowledge, the advancement of medical science, the elevation of the standard of medical education, the enactment of [*68] just medical laws and the improvement of public health. The Association’s membership consists of approximately 3,000 physicians licensed to practice medicine in the State of Mississippi.

The **Missouri State Medical Association** is a non-profit professional association of physicians licensed to practice medicine in Missouri and students training in the state’s accredited medical schools. The Missouri State Medical Association was founded in 1850 and currently represents and serves approximately 6,300 members.

The **Montana Medical Association** is a non-profit organization comprised of physician members. The Association was chartered in 1878 and represents 960 licensed physicians in the State of Montana.

The **Nebraska Medical Association** is a non-profit, professional association of licensed physicians founded in 1868, and representing 1,952 members in the State.

The **Medical Society of New Jersey** is the nation’s first medical society, founded in 1766. With more than 9,500 physician members, the Society is the State’s leading voice in the health care field. The Society’s mission is to promote the quality of New Jersey health care and health services for all of [*69] the citizens of the state through leadership and assistance to its physician members.

The **New Mexico Medical Society** is a non-profit, professional association of licensed physicians founded over 100 years ago, and representing 2,800 members in the State.

The **North Carolina Medical Society** is a non-profit, professional association which represents physicians in North Carolina and has approximately 9,000 members. The Society was incorporated by an Act of the North Carolina General Assembly in 1858.

The **Ohio State Medical Association (OSMA)** is a non-profit professional association of approximately 16,000 physicians, medical residents and medical students. OSMA's membership includes physicians in all specialties engaged in the private practice of medicine in the State of Ohio. OSMA's purposes are to: improve public health through education, encourage interchange of ideas among members and maintain and advance the standards of practice by requiring members to adhere to the concepts of professional ethics.

The **Tennessee Medical Association** is a non-profit corporation formed in 1830 and is composed of approximately 6,800 medical doctors licensed in Tennessee, [*70] including medical students and medical residents seeking licensure.

The **Texas Medical Association** is a private, voluntary, non-profit organization of physicians founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and the improvement of public health. It has approximately 34,000 members representing 84% of all licensed physicians practicing in Texas.

The **Vermont Medical Society** is a non-profit professional association of licensed physicians. The Society was founded in 1784 and represents over 1,100 members.

The **Medical Society of the State of Virginia** is a not-for-profit professional association of over 6,500 member physicians representing every medical specialty and proportionally represented throughout Virginia. The mission of the Society is to: preserve, defend and enhance the doctor-patient relationship; promote better health and health care for all Virginians; support the discovery and dissemination of new knowledge of human death and disease; and in all these things to articulate the position of organized medicine, consistent with the highest standards of the medical profession.

The **West Virginia [*71] Medical Association**, founded in 1867, is a non-profit professional Association of licensed physicians and represents 2,100 members in the State.

The **Society of Medical Consultants to the Armed Forces** was formed in 1946. The goals of the society include: assisting in the development and maintenance of the highest standards of medical practice in the Armed Forces; and providing advice and assistance to the Surgeons' General on problems of professional importance in the Armed Forces.

The **American Institute of Life-Threatening Illness and Loss**, a division of the Foundation of Thanatology which was incorporated in 1967 in the State of New York, is dedicated to promoting vastly improved psychosocial and medical care for patients critically ill or dying from (among multiple diseases) cancer, heart disease, AIDS, stroke, end stage renal disease, and emphysema. A major emphasis of the Foundation is on medical education and quality of life studies. Over the past 25 years, the Foundation has held over 115 national symposia and published over 115 related books.

The **National Hispanic Council on Aging** is a private organization that works to promote the well-being of older [*72] Hispanics. It was founded in 1980, and there are approximately 5,000 members throughout the United States, Puerto Rico, and Mexico.

APPENDIX B

OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS AMERICAN MEDICAL ASSOCIATION

Opinion 2.211--Physician Assisted Suicide. Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress, such as those suffering from a terminal, painful, debilitating illness, may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the [*73] end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. Issued June 1994 based on the reports "Decisions Near the End of Life," issued June 1991, and "Physician-Assisted Suicide," issued December 1993; Updated June 1996. (I, IV)

Opinion 2.20 -- Withholding or Withdrawing Life-Sustaining Medical Treatment. The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forgo life-sustaining treatment of a patient who possesses decisionmaking capacity. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not [*74] limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision. A patient may also appoint a surrogate decisionmaker in accordance with state law.

If the patient receiving life-sustaining treatment is incompetent, a surrogate decisionmaker should be identified. Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates. Physicians should provide all relevant medical information and explain to surrogate decisionmakers that decisions regarding withholding [*75] or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) when there is evidence of the patient's preferences and values. In making a substituted judgment, decisionmakers may consider the patient's advance directive (if any); the patient's values about life and the way it should be lived; and the patient's attitudes towards sickness, suffering, medical procedures, and death. If there is not adequate evidence of the incompetent patient's preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being).

Though the surrogate's decision for the incompetent patient should always be accepted by the physician, there are four situations that may require either institutional or judicial review and/or intervention in the

decisionmaking process: (a) there is no available family member willing to be the patient's surrogate decisionmaker, (b) there is a dispute among family members and there is no decisionmaker designated in an advance directive, (c) a health provider believes that the family's decision is clearly not what the patient would have [*76] decided if competent, and (d) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. When there are disputes among family members or between family health care providers, the use of ethics committees specifically designed to facilitate sound decisionmaking is recommended before resorting to the courts.

When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient.

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing palliative treatment even though it may foreseeably hasten death. Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis. [*77] Issued March 1981 (Opinion 2.11: Terminal Illness) and December 1984 (Opinion 2.19: Withholding or Withdrawing Life-Prolonging Medical Treatment: Patient's Preferences). Updated June 1994 based on the reports "Decisions Near the End of Life" and "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patient," both issued June 1991; and Updated June 1996. (I, III, IV, V)

Opinion 2.22 -- Do-Not-Resuscitate Orders. Efforts should be made to resuscitate patients who suffer cardiac or respiratory arrest except when circumstances indicate that cardiopulmonary resuscitation (CPR) would be inappropriate or not in accord with the desires or best interests of the patient.

Patients at risk of cardiac or respiratory failure should be encouraged to express in advance their preferences regarding the use of CPR and this should be documented in the patient's medical record. These discussions should include a description of the procedures encompassed by CPR and, when possible, should occur in an outpatient setting when general treatment preferences are discussed, or as early as possible during hospitalization. The physician has an ethical obligation to honor the resuscitation preferences [*78] expressed by the patient. Physicians should not permit their personal value judgments about quality of life to obstruct the implementation of a patient's preferences regarding the use of CPR.

If a patient is incapable of rendering a decision regarding the use of CPR, a decision may be made by a surrogate decisionmaker, based upon the previously expressed preferences of the patient or, if such preferences are unknown, in accordance with the patient's best interests.

If, in the judgment of the attending physician, it would be inappropriate to pursue CPR, the attending physician may enter a do-not-resuscitate (DNR) order into the patient's record. Resuscitative efforts should be considered inappropriate by the attending physician only if they cannot be expected either to restore cardiac or respiratory function to the patient or to meet established ethical criteria, as defined in the Principles of Medical Ethics and Opinions 2.03 and 2.095. When there is adequate time to do so, the physician must first inform the patient, or the incompetent patient's surrogate, of the content of the DNR order, as well as the basis for its implementation. The physician also should be prepared to discuss [*79] appropriate alternatives, such as obtaining a second opinion (e.g., consulting a bioethics committee) or arranging for transfer of care to another physician.

DNR orders, as well as the basis for their implementation, should be entered by the attending physician in the patient's medical record.

DNR orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient. Issued March 1992 based on the report "Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders," issued December 1990. Updated June 1994. (I, IV)

Opinion 2.035 -- Futile Care. Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, as defined in opinions 2.03 and 2.095, not on the concept of "futility," which cannot be meaningfully defined. Issued June 1994. (I, IV)

Opinion 2.21--Euthanasia. [*80] Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress -- such as those suffering from a terminal, painful, debilitating illness -- may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional [*81] support, comfort care, adequate pain control, respect for patient autonomy, and good communication. Issued June 1994 based on the report "Decisions Near the End of Life," issued June 1991; Updated June 1996. (I, IV)

Opinion 2.06--Capital Punishment. An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring [*82] vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical diagnoses as they relate to competence to stand trial, testifying as to relevant medical evidence during trial,

testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying to the medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; [*83] (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity; and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued. However, if the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. Provision of medical testimony in the reevaluation of the prisoner's legal competence to be executed should be provided by an independent physician examiner. A physician cannot be compelled to provide medical testimony as it relates to legal competence for execution if it is contrary to the physician's personal beliefs.

Organ donation [*84] by condemned prisoners is permissible only if (1) the decision to donate was made before the prisoner's conviction, (2) the donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber, and (3) physicians do not provide advice on modifying the method of execution for any individual to facilitate donation. Issued July 1980. Updated June 1994 based on the report "Physician Participation in Capital Punishment," issued December 1992 (JAMA. 1993; 270: 365-368), and updated June 1996 based on the report "Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed," issued in June 1995. (I)

APPENDIX C

AMERICAN NURSES ASSOCIATION

CODE FOR NURSES WITH INTERPRETIVE STATEMENTS

1.1 Respect for Human Dignity

* * * Clients have the moral right to determine what will be done with their own person; to be given accurate information, and all the information necessary for making informed judgments; to be assisted with weighing the benefits and burdens of options in their treatment; to accept, refuse, or terminate treatment without coercion; and to [*85] be given necessary emotional support.

* * * *

POSITION STATEMENT ON ASSISTED SUICIDE

SUMMARY: The American Nurses Association (ANA) believes that the nurse should not participate in assisted suicide. Such an act is in violation of the Code for Nurses with Interpretive Statements (Code for Nurses) and the ethical traditions of the profession. Nurses, individually and collectively, have an obligation to provide comprehensive and compassionate end-of-life care which includes the promotion of comfort and the relief of pain, and at times, foregoing life-sustaining treatments.

* * * *

POSITION STATEMENT ON PROMOTION OF COMFORT AND RELIEF OF PAIN IN DYING PATIENTS

Summary: The American Nurses Association (ANA) believes that the promotion of comfort and aggressive efforts to relieve pain and other symptoms in dying patients are obligations of the nurse. Nurses should not hesitate to use full and effective doses of pain medication for the proper management of pain in the dying patient. The increasing titration of medication to achieve adequate symptom control, even at the expense of life, thus hastening death secondarily, is ethically justified.

* * * *

POSITION STATEMENT ON [*86] ACTIVE EUTHANASIA

SUMMARY: The American Nurses Association (ANA) believes that the nurse should not participate in active euthanasia because such an act is in direct violation of the Code for Nurses with Interpretive Statements (Code for Nurses), the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide timely, humane, comprehensive and compassionate end-of-life care.

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