

New York State Task Force on Life & the Law

When Death is Sought - Assisted Suicide and Euthanasia in the Medical Context

PREFACE

Governor Mario M. Cuomo convened the Task Force on Life and the Law in 1984, giving it a broad mandate to recommend public policy on issues raised by medical advances. That mandate included decisions about life-sustaining treatment. Assisted suicide and euthanasia were not on the agenda initially presented to the Task Force. Nor was the prospect of legalizing the practices even remotely part of public consideration at that time.

Recently, however, public debate about the practices has intensified. Although no major efforts to legalize assisted suicide and euthanasia have been launched in New York State, we chose to examine the practices and to release this report in order to contribute to the debate unfolding in New York and nationally.

Since the Task Force's inception, we have proposed four laws to promote the right to decide about medical treatment, including life sustaining measures. Three of those proposals, establishing procedures for do-not-resuscitate orders in health care facilities and in community settings, and authorizing individuals to create health care proxies, are now law. Our fourth proposal for legislation is pending before the New York State Legislature. It would grant family members and others close to the patient the authority to decide about treatment, including life-sustaining measures, for individuals who are too young or too ill to decide for themselves and who have not left advance treatment instructions or signed a health care proxy.

In this report, we unanimously recommend that New York laws prohibiting assisted suicide and euthanasia should not be changed. In essence, we propose a clear line for public policies and medical practice between forgoing medical interventions and assistance to commit suicide or euthanasia. Decisions to forgo treatment are an integral part of medical practice; the use of many treatments would be inconceivable without the ability to withhold or to stop the treatments in appropriate cases. We have identified the wishes and interests of patients as the primary guideposts for those decisions.

Assisted suicide and euthanasia would carry us into new terrain American society has never sanctioned assisted suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill.

They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.

The distinction between the refusal of medical treatment and assisted suicide or euthanasia has not been well-articulated in the broader public debate. In fact, the often-used rubric of the "right to die" obscures the distinction. The media's coverage of individual cases as a way of presenting the issues to the public also blurs the difference between a private act and public policy; between what individuals might find desirable or feasible in a particular case and what would actually occur in doctors' offices, clinics, and hospitals, if assisted suicide and euthanasia became a standard part of medical practice. Public opinion polls, focusing on whether individuals think they might want these options for themselves one day, also offer little insight about what it would mean for society to make assisted suicide or direct killing practices sanctioned and regulated by the state or supervised by the medical profession itself.

We hope that this report will highlight certain critical distinctions and questions for public consideration. We also hope that the report and our recommendations will improve access to pain relief and the palliation of symptoms, not only for those who are terminally ill or contemplating suicide, but for all patients.

We sought the opinions and expertise of many individuals while developing our recommendations. We extend our gratitude to all those who generously lent their time and perspective to our discussion. Four individuals served as consultants in our deliberations: Nessa Coyle, R.N., Jimmie Holland, M.D., Diane Meier, M.D., and Norton Spritz, M.D. The report does not necessarily reflect their personal views about assisted suicide and euthanasia, but it does reflect their experience and insight in caring for those who are severely and terminally ill. We benefitted greatly from their expertise and their participation with us as we explored these difficult questions. We also extend our gratitude to Chris Hyman and Peter Millock who provided invaluable guidance throughout our deliberations.

The Members of the Task Force on Life and the Law

WHEN DEATH IS SOUGHT -- ASSISTED SUICIDE AND

EUTHANASIA IN THE MEDICAL CONTEXT

EXECUTIVE SUMMARY

Over the past two decades, the right to decide about medical treatment,

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

Recent proposals to legalize assisted suicide and euthanasia in some states would transform the right to decide about medical treatment into a far broader right to control the timing and manner of death. After lengthy

deliberations, the Task Force unanimously concluded that the dangers of such a dramatic change in public policy would far outweigh any possible benefits. In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care.

In the course of their research, many Task Force members were particularly struck by the degree to which requests for suicide assistance by terminally ill patients are correlated with clinical depression or unmanaged pain, both of which can ordinarily be treated effectively with current medical

techniques. As a society, we can do far more to benefit these patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or to obtain a lethal injection.

IN GENERAL

* This report, like much of the current debate, focuses solely on assisted suicide and euthanasia by physicians, nurses, or other health care professionals.

* In this report, "assisted suicide" refers to actions by one person to contribute to the death of another, by providing medication or a

prescription or taking other steps. With assisted suicide, the person who dies directly takes his or her own life. In contrast, "euthanasia" refers to direct measures, such as a lethal injection, by one person to end another person's life for benevolent motives. Both practices are distinct from the withdrawal or withholding of life-sustaining treatment in accord with accepted ethical and medical standards.

THE CLINICAL BACKGROUND

* Contrary to what many believe, the vast majority of individuals who are terminally ill or facing severe pain or disability are not suicidal.

Moreover, terminally ill patients who do desire suicide or euthanasia

often suffer from a treatable mental disorder, most commonly

depression. When these patients receive appropriate treatment for

depression, they usually abandon the wish to commit suicide.

* Depression is distinct from the normal feelings of sadness generally

experienced by terminally ill patients. It is a myth that major

clinical depression ordinarily accompanies terminal illness.

* While thoughts about suicide ("suicidal ideation") are a significant

risk factor for suicide, many individuals experience suicidal ideation

but never commit or attempt suicide. These thoughts can be an important

and normal component of coping with terminal illness.

* Uncontrolled pain, particularly when accompanied by feelings of

hopelessness and untreated depression, is a significant contributing

factor for suicide and suicidal ideation. Medications and pain relief

techniques now make it possible to treat pain effectively for most

patients.

* Despite the fact that effective treatments are available, severely and

terminally ill patients generally do not receive adequate relief from

pain. Studies report that over 50 percent of cancer patients suffer

from unrelieved pain, even though patients with cancer are more likely

than other patients to receive pain treatment.

* Numerous barriers contribute to the pervasive inadequacy of pain relief

and palliative care in current clinical practice, including a lack of

professional knowledge and training, unjustified fears about physical

and psychological dependence, poor pain assessment, pharmacy practices,

and the reluctance of patients and their families to seek pain relief.

EXISTING LAW

* Under New York law, competent adults have a firmly established right to

accept or reject medical treatment, including life-sustaining measures.

Competent adults also have the right to create advance directives for treatment decisions, such as a living will or health care proxy, to be used in the event they lose the capacity to make medical decisions for themselves.

* New York is one of two states in the nation that does not currently permit the withdrawal or withholding of life-sustaining treatment from an incapacitated adult patient who has not signed a health care proxy or provided clear and convincing evidence of his or her treatment wishes.

Legislation proposed by the Task Force, under consideration by the New York State Legislature, would permit family members and others close to the patient to decide about life-sustaining treatment in these

circumstances.

* Neither suicide nor attempted suicide is a criminal offense in any state. Like most other states, New York prohibits assisting a suicide.

Euthanasia is barred by law in every state, including New York.

* Suicide assistance generally constitutes a form of second-degree manslaughter under New York law. Euthanasia falls under the definition of second-degree murder, regardless of whether the person consents to being killed.

* The provision of pain medication is legally acceptable even if it may hasten the patient's death, if the medication is intended to alleviate pain or severe discomfort, not to cause death, and is provided in accord with accepted medical standards.

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

ETHICAL ISSUES

* Three general positions about assisted suicide and euthanasia have emerged in the ethical and medical literature. First, some believe that both practices are morally wrong and should not be performed. Others hold that assisted suicide or euthanasia are legitimate in rare and exceptional cases, but that professional standards and the law should not be changed to authorize either practice. Finally, some argue that assisted suicide, or both assisted suicide and euthanasia, should be recognized as legally and morally acceptable options in the care of dying or severely ill patients.

* While many individuals do not distinguish between assisted suicide and euthanasia on ethical or policy grounds, some find assisted suicide more acceptable than euthanasia, either intrinsically or because of differences in the social impact and potential harm of the two practices.

THE TASK FORCE'S RECOMMENDATIONS: CRAFTING PUBLIC POLICY

THE ETHICS OF ASSISTED SUICIDE AND EUTHANASIA

* The members of the Task Force hold different views about the ethical acceptability of assisted suicide and euthanasia. Despite these differences, the Task Force members unanimously recommend that existing law should not be changed to permit these practice s.

* Some of the Task Force members believe that assisted suicide and euthanasia are inherently wrong, because the practices violate society's long-standing prohibition against ending human life. These members believe that one person should not assist another' s death or kill another person, even for benevolent motives.

* Other Task Force members are most troubled by the prospect of

medicalizing the practices. They believe that physician-assisted

suicide and euthanasia violate values that are fundamental to the

practice of medicine and the patient-physician relationship.

* Some Task Force members do not believe that assisted suicide is

inherently unethical or incompatible with medical practice. On the

contrary, they believe that providing a quick, less prolonged death for

some patients can respect the autonomy of patients and demonstrate care

and commitment on the part of physicians or other health care

professionals. Nonetheless, these members have concluded that

legalizing assisted suicide would be unwise and dangerous public policy.

THE SOCIAL RISKS OF LEGALIZATION

* The Task Force members unanimously concluded that legalizing assisted suicide and euthanasia would pose profound risks to many patients. For purposes of public debate, one can describe cases of assisted suicide in which all the recommended safeguards would be satisfied. But positing an "ideal" or "good" case is not sufficient for public policy, if it bears little relation to prevalent social and medical practices.

* No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and

bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.

* The growing concern about health care costs increases the risks presented by legalizing assisted suicide and euthanasia. This cost consciousness will not be diminished, and may well be exacerbated, by health care reform.

* The clinical safeguards that have been proposed to prevent abuse and errors would not be realized in many cases. For example, most doctors

do not have a long-standing relationship with their patients or information about the complex personal factors relevant to evaluating a request for suicide assistance or a lethal injection. In addition, neither treatment for pain nor the diagnosis of and treatment for depression is widely available in clinical practice.

* In debating public policies, our society often focuses on dramatic individual cases. With assisted suicide and euthanasia, this approach obscures the impact of what it would mean for the state to sanction assisted suicide or direct killing under the auspices of the medical community.

* From the perspective of good health, many individuals may believe that they would opt for suicide or euthanasia rather than endure a vastly diminished quality of life. Yet, once patients are confronted with illness, continued life often becomes more precious; given access to appropriate relief from pain and other debilitating symptoms, many of those who consider suicide during the course of a terminal illness abandon their desire for a quicker death in favor of a longer life made more tolerable with effective treatment.

* The Task Force members feel deep compassion for patients in those rare cases when pain cannot be alleviated even with aggressive palliative

care. They also recognize that the desire for control at life's end is widely shared and deeply felt. As a society, however, we have better ways to give people greater control and relief from suffering than by legalizing assisted suicide and euthanasia.

* Depression accompanied by feelings of hopelessness is the strongest predictor of suicide for both individuals who are terminally ill and those who are not. Most doctors, however, are not trained to diagnose depression, especially in complex cases such as patients who are terminally ill. Even if diagnosed, depression is often not treated. In elderly patients as well as the terminally and chronically ill, depression is grossly underdiagnosed and undertreated.

* The presence of unrelieved pain also increases susceptibility to suicide. The undertreatment of pain is a widespread failure of current medical practice, with far-reaching implications for proposals to legalize assisted suicide and euthanasia.

* If assisted suicide and euthanasia are legalized, it will blunt our perception of what it means for one individual to assist another to commit suicide or to take another person's life. Over time, as the practices are incorporated into the standard arsenal of medical treatments, the sense of gravity about the practices would dissipate.

* The criteria and safeguards that have been proposed for assisted suicide

and euthanasia would prove elastic in clinical practice and in law.

Policies limiting suicide to the terminally ill, for example, would be

inconsistent with the notion that suicide is a compassionate choice for

patients who are in pain or suffering. As long as the policies hinge on

notions of pain or suffering, they are uncontainable; neither pain nor

suffering can be gauged objectively, nor are they subject to the kind of

judgments needed to fashion coherent public policy. Euthanasia to cover

those who are incapable of consenting would also be a likely, if not

inevitable, extension of any policy permitting the practice for those

who can consent.

* These concerns are heightened by experience in the Netherlands, where the practices have been legally sanctioned. Although Dutch law requires an explicit request for euthanasia by the patient, a national study in the Netherlands found that of approximately 3300 deaths annually resulting from mercy killing, 1,000 deaths from euthanasia occurred without an explicit request. Moreover, in some cases, doctors have provided assisted suicide in response to suffering caused solely by psychiatric illness, including severe depression.

CARING FOR SEVERELY ILL PATIENTS

* Professional medical standards should recognize the provision of effective pain relief and palliative care, including treatment for depression or referral for treatment, as a basic obligation all physicians owe to their patients. The legal prohibition against assisted suicide and euthanasia should also guide professional standards of conduct.

* Physicians should seek their patients' participation in decisions about withdrawing or withholding life-sustaining treatment early enough in the course of illness to give patients a meaningful opportunity to have their wishes and values respected.

* Health care professionals have a duty to offer effective pain relief and symptom palliation to patients when necessary, in accord with sound medical judgment and the most advanced approaches available.

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

* Physicians, nurses, and patients must be aware that psychological and physical dependence on pain medication are distinct phenomena. Contrary

to a widely shared misunderstanding, psychological dependence on pain medication rarely occurs in terminally ill patients. While physical dependence is more common, proper adjustment of medication can minimize negative effects.

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

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

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

* Public education is crucial to enhance pain relief practices. Like many

health care professionals, patients and families often have an exaggerated sense of the risks of pain medication, and are reluctant to seek treatment for pain. Nurses and physicians should create an atmosphere that will encourage patients to seek relief of pain.

Strategies for pain relief should also maximize patients' sense of control.

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

* Health care professionals should be familiar with the characteristics of

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

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

professionals often decreases the risk of suicide.

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

INTRODUCTION

page 1

Respect for individual choice and self-determination has served as a touchstone for public policies about medical decisions over the past two decades. Designed to promote these values, legal reform has wrought many gains, including clear recognition of a right to refuse life-sustaining measures. Social and clinical practices, however, have changed more slowly, often leaving patients and those close to them without a sense of control over the course of treatment. As a result, the public's fear of a painful death

prolonged by medical advances has not abated. This growing public concern about control at life's end and the emphasis on individual self-determination have brought us to a new crossroads in the realm of medical practice and ethics. For the first time in the United States, assisted suicide and euthanasia are issues of serious and widespread public consideration.

Assisted suicide occurs when one person assists another to take his or her own life, either by providing the means to commit suicide or by taking other necessary steps. Euthanasia entails direct measures, such as a lethal injection, by one person to end another person's life. Euthanasia may be voluntary, performed with

the explicit consent of a competent adult, or it can be performed without consent, in which case it is usually called "nonvoluntary" euthanasia. Euthanasia provided over the patient's objection is generally referred to as "involuntary" euthanasia. Both assisted suicide and euthanasia are distinct from the withdrawal or withholding of life-sustaining treatment.(1)

While assisted suicide and euthanasia can be offered outside the medical context by family members or others, recent debate has focused on these practices by physicians and other health care professionals. Assisted suicide in the medical context is usually provided by giving a prescription or medications to a patient

seeking to end his or her life. A lethal injection would be the most common form of euthanasia provided by doctors.

(1) Some use the term "euthanasia" or "passive euthanasia" to include the wrongful or inappropriate withholding or withdrawal of life- sustaining treatment. This report, like much of the current debate, uses the term "euthanasia" more narrowly, referring only to active measures, such as a lethal injection, to end the patient's life. The Task Force

recognizes that defining the term in this way clarifies its

own intentions, but does not address the complex relationship

between action, omission and moral culpability. For a

discussion of this issue, see chapter 5, pp. 82-93.

Several prominent cases have spurred debate about

physician-assisted suicide and euthanasia. In 1988, in an anonymous

article in the Journal of the American Medical Association, a

physician described how he had given a lethal injection to a young

woman dying of ovarian cancer.(2) The physician had no prior

relationship with the patient and had not discussed the decision

with her. Instead, he decided to provide the lethal injection based

on her mumbled words, "Let's get this over with."

On June 4, 1993, Dr. Jack Kevorkian helped Janet Adkins

commit suicide in a Volkswagen van in a Michigan park. Janet Adkins

was 54 years old and still physically active but was experiencing

the early symptoms of Alzheimer's disease. Kevorkian used a machine he developed that delivered a fatal dose of potassium chloride when Janet Adkins pushed a button. Nineteen other highly publicized deaths have followed with Kevorkian's assistance. Kevorkian has had little previous contact with the patients he assists, many of whom, like Janet Adkins, were not terminally ill. A retired pathologist, it is likely that he has little or no experience in diagnosing depression or treating terminally ill patients. Although some regard Kevorkian as a champion for human rights, he has crystallized the doubts of many about the potential for abuse and the dangers of physician-assisted suicide.

In contrast to Kevorkian, Dr. Timothy Quill had a long-standing relationship with the patient whose death he assisted. Writing about the case in the New England Journal of Medicine in March 1991, Quill explained that he had offered all available medical alternatives to his patient, encouraged her to accept treatment for her condition, and spoke with her at length about her decision before prescribing the barbiturates that would enable her to take her own life.(3)

In February 1993, the Netherlands became the first nation to

establish policies permitting doctors to assist a suicide or to perform voluntary euthanasia. Under Dutch law, physicians cannot be prosecuted for either practice if they follow specified guidelines and report their actions to the coroner in each case. Although assisted suicide and voluntary euthanasia are both legally sanctioned, 85 percent of these cases have been instances of euthanasia. Policies in the Netherlands emerged from growing

(2) "It's Over, Debbie," *Journal of the American Medical*

Association 259 (1988): 272. It remains unclear whether

this anonymous article described a fictitious or an actual case.

(3) T. E. Quill, "Death and Dignity: A Case of

Individualized Decision Making," New England Journal of

Medicine 324 (1991): 691-94.

acceptance of the practice by physicians, and the long-standing

reluctance of prosecutors to enforce the law prohibiting assisted

suicide and euthanasia.

In the United States, legislative referenda to legalize the practices have been considered in several states. In November 1991, Washington State voted on a referendum to legalize "physician aid-in-dying" -- defined to include both assisted suicide and euthanasia. The referendum failed with 54 percent of the public voting against it. If it had passed, Washington would have become the first state in the nation to legalize these activities by physicians or others. In November 1992, voters in California

defeated a similar referendum by the same narrow margin. These votes will no doubt encourage attempts to legalize assisted suicide and euthanasia in other states. At the same time, publicity about Kevorkian and public debate about the practices have prompted other states to strengthen or clarify their laws prohibiting assisted suicide. Four states, including Michigan, enacted laws in 1993 to achieve this goal.(4)

Like the referenda in Washington and California, public opinion polls suggest that the public in the United States is divided on the question of legalizing assisted suicide and

euthanasia. The widespread success of the book *Final Exit*, a how-to on committing suicide, left no doubt, however, that some segment of the public is deeply concerned about the dying process.⁽⁵⁾ A best seller for many months, the book tapped into a well-spring of anxiety about the loss of control at life's end. The book's popularity is a clarion call, signaling that existing social and clinical practices do not give Americans the sense of control they desire.

The need to make decisions about the dying process and the failure to manage technological advances more wisely has also profoundly influenced some segments of the medical profession. For

(4) Under the Michigan law, the statutory prohibition on

assisted suicide will expire no later than December 31, 1994.

The law established a commission to study the issue and

recommend whether the prohibition should be continued,

modified, or abandoned.

(5) The full title of the book is Final Exit: The

Practicalities of Self-Deliverance and Assisted Suicide for

the Dying. It was written by Derek Humphrey, the founder of

the Hemlock Society. A study reported in the New England

Journal of Medicine about the book's impact concluded that,

although the overall suicide rate in New York City had not

changed following the book's publication, suicide by

asphyxiation using a plastic bag, one of the methods

recommended in the book, had increased. Of the 15

individuals reported to have used the book to commit suicide,

most were not terminally ill and six had no history of

medical illness or diagnosed illness at autopsy. P. M.

Marzuk et al., "Increase in Suicide by Asphyxiation in New

York City After the Publication of Final Exit," New England

Journal of Medicine 329 (1993): 1508-10.

page 4

WHEN DEATH IS SOUGHT

physicians, decisions to withhold or to stop treatment, calling for

their intervention in the timing and manner of death, have become

routine. While earlier generations of physicians were trained to

stave off death whenever possible and had few available means at their disposal to do so, physicians today, especially those who are younger, have grown accustomed to the idea that life inappropriately prolonged can also be a defeat for them and for their patients.

The medical community, like the broader society, has therefore reached a crossroads, with some physicians advocating legal change that would permit them to assist their patients to commit suicide under certain circumstances. Despite the fact that assisted suicide is illegal in most states and euthanasia is prohibited throughout the United States, press reports and polls suggest that some physicians already respond to their patients' requests for help by

prescribing medication or providing a lethal injection. The

practice occurs in the private relationship between doctor and

patient, yielding little public information about the frequency or

circumstances of medically assisted suicide or euthanasia.

In New York State, no serious effort to legalize assisted suicide or euthanasia is underway. New York's criminal law prohibits both practices.(6) The health care proxy law, enacted in 1990 to give adults an effective way to exercise the right to decide about treatment, including life-sustaining measures, explicitly states that it is not designed to permit or promote assisted suicide or euthanasia.(7) Pending legislation proposed by the Task Force,

which would allow family members and others close to the patient to decide about treatment for incapacitated patients who have not signed health care proxies, contains a similar statement.(8) Hence, like the law in states across the country, New York law to date has consistently distinguished decisions to forgo life-sustaining treatment from assisted suicide and euthanasia.

The issue of assisted suicide has been posed most directly in New York State by the case involving Dr. Timothy Quill. A resident of Rochester, New York, Quill faced potential criminal and professional sanctions following publication of his article in the New England Journal of Medicine. A grand jury was convened in

Rochester and decided not to indict him. Likewise, the State Board

for Professional Medical Conduct considered the case and chose not

(6) N.Y. Penal law .. 120.30,120.35,12,5.15(3),12,5.25(l)

(McVinney 1987). See chapter 4 for discussion of New York

law.

(7) N.Y. Public Health law, Sec. 2989(3) (McKinney 1993).

(8) New York State Assembly Bill No. 7166, Sec. 2995-q(3) (1994).

INTRODUCTION

page 5

to pursue professional misconduct charges. Writing for the board, a

three member panel concluded that Quill could not have known with

certainty that his patient would use the medication he prescribed

for insomnia to kill herself. In its opinion in the Quill case, the board recognized the important moral and social issues presented by the case and asked the Task Force on Life and the Law to provide guidance for policies in New York State. The Task Force agreed to deliberate about assisted suicide and euthanasia not because of the Quill case itself, but because the case struck a public nerve, echoing broad public concern about the practices.

This report reflects the Task Force's exploration of medically assisted suicide and euthanasia. It examines the clinical, legal, and social context for the current debate about the practices.

Presented in the first half of the report, that information includes important insight about the problem of suicide generally, the reasons that people commit suicide, the capacity of medicine to respond to some of those underlying reasons, and its widespread failure to do so. Chapter Four examines in-depth the law on assisted suicide and euthanasia and the relationship of that body of law to prevailing medical standards. The chapter also discusses whether there is a constitutional right to suicide assistance and euthanasia. Chapter Five sketches the current debate about assisted suicide and euthanasia, exploring the ethical arguments set forth by those who advocate legalizing assisted suicide and euthanasia as well as by those who firmly oppose any such legal change.

The second half of the report presents the Task Force's recommendations for public policy. Those recommendations first address whether the law should be changed to permit assisted suicide and euthanasia. The report also describes the principles that should animate professional medical standards. In the final chapter, the report proposes policies to enhance the treatment provided to dying and incurably ill patients. The debate about assisted suicide and euthanasia has forced a reexamination of the

care provided to terminally and chronically ill individuals; it has highlighted pervasive shortcomings in the clinical response to pain, to suffering arising from treatable causes such as clinical depression, and to requests for suicide assistance. The final chapter of the report proposes specific statutory and regulatory steps to improve access to pain relief, and provides recommendations for clinical practice.

-5-

(Pages 6,7,8 Intentionally left blank)