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Cover Page Footnote

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I would like to thank Professor Deborah Denno for her thoughtful guidance and my father for his unwavering support.

NOTES

THE CRIMINALIZATION OF TREATING END OF LIFE PATIENTS WITH RISKY PAIN MEDICATION AND THE ROLE OF THE EXTREME EMERGENCY SITUATION

*Gina Castellano**

This Note examines the legality of physicians treating patients near the end of life with risky pain medication, specifically during an extreme emergency situation. The issues discussed include whether such treatment should be criminalized and, if criminalized, what standard should be used to determine culpability. This Note proposes that physicians should not be shielded from the criminal justice system, but that the standard of double effect intent should be expressly adopted in the adjudication of such cases.

INTRODUCTION

> I don't know if there's any way for me to describe to you how intense the heat was .... It was relentless. It was suffocating. It made it extremely difficult to breathe. And with the heat came the terrible smell from all of the human waste and the fact that we didn't have water.[1]

Dr. Anna Pou, quoted above, appeared on *60 Minutes* on September 24, 2006, to defend her actions at Memorial Medical Center in New Orleans during the devastation of Hurricane Katrina. As Katrina headed toward New Orleans, Dr. Pou, a head and neck surgeon who specializes in cancer treatment, began her shift at Memorial Medical Center.[2] She remained at the hospital for four days.[3]

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1. *60 Minutes: Was It Murder? Doctor, Two Nurses Were Accused of Murdering Patients* (CBS television broadcast Sept. 24, 2006) [hereinafter *Was It Murder?*], *available at* http://www.cbsnews.com/stories/2006/09/21/60minutes/printable2030603.shtml (quoting Dr. Anna Pou) (internal quotations omitted).

2. *See id.*

3. *See id.* Dr. Pou remained with her patients even though she was offered the chance to leave. *Id.*

Lifecare Hospitals leased the seventh floor of Memorial Medical Center to operate a long-term acute care unit.[4] The doctor assigned to the Lifecare patients did not show up during the hurricane, so Dr. Pou and two nurses did the best they could to treat as many patients as possible.[5] "[W]ith New Orleans flooded, a credit union being looted across the street and gunshots heard outside, hospital staff members had concluded that some patients were simply not going to leave the building alive."[6] At least thirty-four patients died at Memorial Medical Center in the days following Hurricane Katrina.[7]

On July 17, 2006, Dr. Pou and nurses Cheri Landry and Lori Budo were arrested in connection with four counts of second-degree murder stemming from the health care of four terminally ill patients at Memorial Medical Center.[8] Following the arrest, the only information available regarding the murder charges came from news reports and the affidavit for the arrests released by the office of Louisiana Attorney General Charles C. Foti.[9] The four patients included a paralyzed 61-year-old male who weighed 380 pounds, an 89-year-old female who suffered from dementia and gangrene, a 90-year-old female who appeared stable before the storm, and a fourth patient about whom there is no specific information.[10]

The arrest affidavit alleged that Dr. Pou committed second-degree murder "on or about September 1, 2005, by intentionally killing multiple patients by administering or causing to be administered, lethal doses of morphine sulphate (morphine) and/or midazolam (Versed), at Memorial Medical Center."[11] The affidavit ended with the findings of the forensic pathologist who reviewed the medical results and test analyses of the four patients who died. According to the affidavit, the forensic pathologist "advised that in all four cases it appeared that a lethal amount of morphine was administered."[12] Furthermore, it was alleged that "none of the four patients were being administered morphine or midazolam for their routine pharmaceutical care requirements."[13]

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4. Affidavit of Virginia B. Rider at 1 (July 2006), *available at* www.nola.com/katrina/pdf/072006_nolacharges.pdf.

5. *See Was It Murder?*, *supra* note 1.

6. Christopher Drew & Shaila Dewan, *Louisiana Doctor Said to Have Faced Chaos*, N.Y. Times, July 20, 2006, at A18.

7. *See id.*

8. *See* Adam Nossiter & Shaila Dewan, *Patient Deaths in New Orleans Bring Arrests*, N.Y. Times, July 19, 2006, at A1.

9. *See* Affidavit of Virginia B. Rider, *supra* note 4; *see also* National News, Wash. Post, Nov. 21, 2006, at A5 (describing the district judge as being "frustrated by the time he has spent on this case" and telling prosecutors that the doctor and nurses "should be charged or exonerated").

10. *See* Denise Grady, *Medical and Ethical Questions Raised on Deaths of Critically Ill Patients*, N.Y. Times, July 20, 2006, at A18.

11. Affidavit of Virginia B. Rider, *supra* note 4, at 1.

12. *See id.*

13. *Id.*

At a press conference following the arrests, Mr. Foti said, "This is plain and simple homicide."[14] Dr. Pou defended herself vehemently: "I do not believe in euthanasia. I don't think that it's anyone's decision to make when a patient dies . . . . What I do believe in is comfort care and that means that we ensure that they do not suffer pain."[15]

It is impossible to understand what Dr. Pou and nurses Landry and Budo were thinking as they made medical decisions for the hospital's sickest patients during a national emergency. Although what was going through their heads may never be publicly known, and the reports of what exactly went on at Memorial Medical Center are sketchy, a doctor at a nearby hospital, faced with a similar horrific situation, shed light on the situation with his recollections:

> At Charity Hospital, not far from where Dr. Pou was working, I and nearly 60 other staff doctors, nurses, and residents were stuck in a hospital without electricity, without water, without food, for five days with about 340 patients, 50 of them critically ill. We had no ability to use ventilators, so we had to squeeze ambu bags by hand to get air into their lungs. We had no monitoring equipment, no X-ray, no laboratory, no dialysis. Compounding all this, we were unable to have families at the bedside—or even available by phone—to participate in treatment decisions for the sickest patients. It was very, very difficult.[16]

Dr. Pou's lawyer, Richard T. Simmons, Jr., explained to reporters the situation at Memorial Medical Center:

> [T]he sickest patients could not have been evacuated on the inflatable boats being used. . . . [T]o take patients to the roof for helicopter rescues, orderlies had to squeeze them through a 3-foot-by-3-foot hole in a hospital wall and push them on gurneys up the ramps of the parking garage before carrying them onto the roof.[17]

The reports of the incident give the rest of the world a sense of the dire situation that Dr. Pou faced. Yet without being there and being responsible for other lives, it is almost impossible to prove what decisions Dr. Pou made and what her intent was when making those decisions. On July 24, 2007, a grand jury refused to indict Dr. Pou.[18]

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14. *See* Nossiter & Dewan, *supra* note 8.

15. *See Was It Murder?*, *supra* note 1. Dr. Pou continued, "No, I did not murder those patients. . . . I've spent my entire life taking care of patients. I have no history of doing anything other than good for my patients. I do the best of my ability. Why would I suddenly start murdering people? This doesn't make sense." *Id.*

16. Ben deBoisblanc, *It Was Heroism, Not Homicide, During Katrina*, Time.com, July 25, 2006, http://www.time.com/time/nation/printout/0,8816,1218776,00.html. Dr. deBoisblanc is a critical care expert who cared for fifty critically ill patients for five days during the hurricane. *See id.*

17. Drew & Dewan, *supra* note 6. It can be inferred that this was not an option for the 380-pound paralyzed male patient.

18. Adam Nossiter, *Grand Jury Won't Indict Doctor in Hurricane Deaths*, N.Y. Times, July 25, 2007, at A10; *see also* Mary Foster, *Prosecutor Drops Case Against 2 Nurses in Four Post-Katrina Deaths*, Wash. Post, July 4, 2007, at A7. The charges against nurses Lori

This Note analyzes the legality of a doctor's decision to use risky pain medication in treating critically ill patients during an extreme emergency. In examining the legality of physicians aggressively treating patients in a manner that may ultimately cause death, the intent of the physician is the general standard used to determine culpability.[19] Intent, as defined by Black's Law Dictionary, is "the state of mind accompanying an act." Criminal intent is defined as "[a]n intent to commit an actus reus without any justification, excuse, or other defense." Intent to kill is "[a]n intent to cause the death of another."[20]

It is acknowledged that intent is a vague standard. In Louisiana, "second-degree murder is the killing of a human being when the offender has a specific intent to kill or to inflict great bodily harm."[21] As defined by statute, "Specific criminal intent is that state of mind which exists when the circumstances indicate that the offender actively desired the prescribed criminal consequences to follow his act or failure to act."[22] Thus, if the case against Dr. Pou had gone to trial, to convict her the prosecution would have had to prove beyond a reasonable doubt that she actively desired to kill her patients. This Note does not speculate as to Dr. Pou's intent during her actions; instead Dr. Pou's story will serve as the backdrop to the challenge of analyzing end of life medical decisions during extreme emergency situations.

This Note concludes that, however difficult it is to determine a physician's intent, it is the most practical standard to use in determining a physician's culpability with regard to the deaths of his or her patients. The caveat is that the doctrine of double effect must be employed during the extreme emergency situation.[23] In brief, double effect provides that an actor with good intentions is not responsible for the unintended bad effects.[24] Practically, in the case of Dr. Pou, as long as she intended to ease the pain of her patients and not cause death, even though death resulted, she would not be culpable. The opposition to the double effect intent standard, as it will be referred to in this Note, is great. Some argue that double effect allows people to get away with murder by professing that they only intended to ease pain, while their actual intent was to kill.[25] Others argue that the intent to ease pain is either the same as simply intending to put one

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Budo and Cheri Landry were dropped earlier in July 2007. Jim Avila & Mary Kate Burke, *Katrina Doctor Not a Murderer, Grand Jury Says*, ABC News, July 24, 2007, http://abcnews.go.com/TheLaw/story?id=3409526.

19. *See, e.g.*, Vacco v. Quill, 521 U.S. 793, 801–02 (1997).

20. Black's Law Dictionary 825–26 (8th ed. 2004).

21. *See* La. Rev. Stat. Ann. § 14:30.1 (2007).

22. La. Rev. Stat. Ann. § 14:10. This Note relies on the Louisiana definition of intent.

23. *See infra* Part II.B.1.

24. *See* Edward C. Lyons, *In Incognito—The Principle of Double Effect in American Constitutional Law*, 57 Fla. L. Rev. 469, 471 (2005); Susan Nuccetelli & Gary Seay, *Relieving Pain and Foreseeing Death: A Paradox About Accountability and Blame*, 28 J. L. Med. & Ethics 19, 20 (2000).

25. *See* Thomas A. Preston, *Physician Involvement in Life-Ending Practices*, 18 Seattle U. L. Rev. 531, 539 (1995).

out of one's misery or inclusive of double intent both to cause pain and to kill.[26]

This Note evaluates the ethical and policy reasons for criminalizing such action and whether or not intent to hasten death should remain the standard in an extreme emergency situation. Part I of this Note examines the legal status of end of life decisions—specifically euthanasia, physician-assisted suicide, terminal sedation, and risky pain medication. The legal analysis will serve not only as background information to the controversy surrounding end of life decisions but also as a means of emphasizing the role of intent in drawing the line between what is and is not criminalized in the U.S. judicial system. Part II focuses on the controversy surrounding the criminalization of death-hastening pain medication and the standard of determining criminality, namely double effect intent. Finally, Part III of this Note uses the legal analysis provided in Part I and the controversy presented in Part II to determine how the legal system must react during the next extreme emergency situation. This Note concludes that criminalizing the use of ultimately fatal pain medication is necessary to protect patients, but must be based on the double effect intent standard so as to provide protection for the brave physicians who choose to stay and attend to patients during extreme emergency situations. It is hoped that such a combination places enough faith in both the medical profession and the legal system to achieve the unity between the two that is necessary in handling extreme emergency situations.

The issue of physician culpability for patients' deaths during extreme emergency situations has yet to be analyzed in academia. The failed indictment against Dr. Pou has removed it from further consideration by the criminal justice system. This issue is pressing to society today, as the Unites States is confronted with terrorism, avian flu, and natural disasters. It is urgent that the law find a solid basis with which to address these horrific situations in a legal, fair, and organized manner. This Note aims to prompt a discussion among both the medical community and the legal system to ensure that doctors are properly advised and patients adequately protected before another horrific emergency occurs.

I. EUTHANASIA, PHYSICIAN-ASSISTED SUICIDE, TERMINAL SEDATION, AND PAIN MEDICATION

Part I focuses on the legality of end of life decisions. Most notably, this part analyzes treatment of physician-assisted suicide by the U.S. Supreme Court and the legal gray area of terminal sedation and risky pain medication. As will become apparent, intent of the physician is the theme that governs the criminalization of end of life situations such as euthanasia, physician-assisted suicide, terminal sedation, and risky pain medication.

26. *See* Norman L. Cantor, *On Hastening Death Without Violating Legal and Moral Prohibitions*, 37 Loy. U. Chi. L.J. 407, 423 (2006).

This Note addresses the spectrum of situations, attempting to locate where valid medical treatment crosses the line to criminal conduct.

One can view both terminal sedation and risky pain medication as not involving the intent to cause death. However, as per its definition, intent to cause death is an essential element of euthanasia. Physician-assisted suicide is possibly the murkiest area, specifically because the act is done by the patient, so the intent of the patient and not that of the physician is most relevant. These distinctions provide the structure for the legal spectrum of the end of life decisions, which are explored below. Part I ends with the presentation of the argument for and against criminalizing risky pain medication. The legal status of the other three situations is raised in Parts II and III to provide analogies and determine the necessity of the intent element.

A. *Euthanasia*

Euthanasia is the administration of a lethal agent to a patient by another person to relieve "the patient's intolerable and incurable suffering."[27] Euthanasia falls to the far side of the spectrum, representing illegal conduct. Within the broad definition of euthanasia, there are three specific categories. The "more acceptable form" of euthanasia is active voluntary euthanasia, where a person acts to end the patient's life at the request of the patient.[28] Nonvoluntary euthanasia refers to the situation where the patient is unable to consent to the lethal agent due to either temporary or permanent incompetence.[29] "[I]nvoluntary euthanasia is where the patient is competent but has not consented to the treatment."[30] No form of euthanasia is legal in the United States, as all involve the intent to kill.

The strongest argument against euthanasia is the slippery slope. If active voluntary euthanasia is allowed, heath-care providers may slide from "simply assisting terminally ill patients meeting strict criteria who want to end their lives . . . to more insidious conduct, such as the 'mercy' killing of helpless and disabled individuals who have not consented, or who are incapable of consenting to being euthanized."[31] So the slippery slope argument is that if voluntary euthanasia is decriminalized it will lead to the acceptance of nonvoluntary and involuntary euthanasia.[32]

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27. Code of Ethics E-2.21 (Am. Med. Ass'n 2005), *available at* http://www.ama-assn.org/ama/pub/category/8458.html.

28. Stephen W. Smith, *Evidence for the Practical Slippery Slope in the Debate on Physician-Assisted Suicide and Euthanasia*, 13 Med. L. Rev. 17, 23 (2005).

29. *Id.* at 23–24.

30. *Id.* at 24.

31. Michael E. Clark, *Oregon's Death with Dignity Act and Alleged Patient Euthanasia After Hurricane Katrina—The Government's Role*, Health Lawyer, Feb. 2006, at 1, 5 (2006). In 1994, Oregon's Death with Dignity Act (ODWDA) legalized assisted suicide. *See infra* Part I.B.

32. *See, e.g.*, Washington v. Glucksberg, 521 U.S. 702, 732–33 (1997) ("[T]he State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. . . . Thus, it turns out that what is couched as a limited right to

B. *Physician-Assisted Suicide*

Physician-assisted suicide occurs when a physician provides the necessary means and/or information to enable a patient to commit suicide.[33] Physician-assisted suicide is only legal in one state, Oregon.[34] The constitutionality of a patient's right to die exemplifies the struggle with the legality of physician-assisted suicide, the value of the patient's will in the debate, and the current law on the issue in the United States.

In 1997, the Supreme Court held in *Washington v. Glucksberg* that there is no constitutional right to suicide or to assisting suicide.[35] In *Glucksberg*, the Court decided that the state of Washington's ban on assisted suicide did not violate the Due Process Clause of the Fourteenth Amendment.[36]

In *Vacco v. Quill*,[37] another physician-assisted suicide case decided the same term as *Glucksberg*, plaintiffs argued that, because New York allowed refusal of life-sustaining treatment, New York's assisted suicide ban violated the Equal Protection Clause.[38] The Supreme Court rejected this argument, holding that the state's ban on assisted suicide and the statute permitting patients to refuse medical treatment were consistent and did not "draw any distinctions between persons."[39] The Court also noted the differences in causation and intent that separate refusal of lifesaving treatment from physician-assisted suicide.[40]

'physician-assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and contain.").

33. Code of Ethics E-2.211 (Am. Med. Ass'n 2005), *available at* http://www.ama-assn.org/ama/pub/category/8459.html.

34. *See infra* notes 41–49 and accompanying text; *see also* Code of Ethics E-2.211 (Am. Med. Ass'n) ("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.").

35. *Washington*, 521 U.S. at 728 ("The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.").

36. *See id.* at 728. "[T]he asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause." *Id.* at 735; *see also* Norman L. Cantor & George C. Thomas III, *The Legal Bounds of Physician Conduct Hastening Death*, 48 Buff. L. Rev. 83, 86 (2000) ("While the Supreme Court ruled that continued punishment of assistance to suicide withstands federal constitutional challenge, the Court by no means ended debate about the precise legal bounds of diverse techniques for facilitating death or about the soundness of current legal distinctions.").

37. 521 U.S. 793 (1997).

38. *See id.* at 798.

39. *Id.* at 800 ("*Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide.").

40. *See id.*

In 1994, Oregon became the first state to legalize assisted suicide.[41] Under Oregon's Death with Dignity Act,[42] strict criteria must be followed in order for a patient to receive from a physician the controlled substances that will cause the patient's death.[43] A patient must have an incurable, irreversible disease that will cause death within six months.[44] The patient's request must be voluntary and informed, and a second physician must confirm the first physician's conclusions.[45] Lastly, but perhaps most importantly, "physicians may dispense or issue a prescription but may not administer it."[46]

In 2001, U.S. Attorney General John Ashcroft attempted to limit legal assisted suicide in Oregon by issuing an interpretive rule that stated that physician-assisted suicide violated the federal Controlled Substances Act.[47] The Supreme Court ruled, however, that the attorney general does not have the "power to effect a radical shift of authority from the States to the Federal Government to define general standards of medical practice in every locality."[48] So, in the end, physician-assisted suicide was upheld in Oregon solely on federalism grounds.[49]

Physician-assisted suicide also presents a slippery slope argument: If physician-assisted suicide is legal, it will not be a last resort, but instead become a preferred course of treatment and lead to euthanasia.[50] Professor Stephen Smith attempts to refute the slippery slope argument.[51] Professor Smith, after analyzing the full reports located on the Oregon Department of Human Services web site,[52] did not observe an increase in voluntary or involuntary euthanasia.[53] He does admit, however, that his conclusions may be premature and that more evidence may emerge that offers support for the slippery slope argument.[54]

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41. *See* Gonzales v. Oregon, 546 U.S. 243, 249 (2006) ("ODWDA, which survived a 1997 ballot measure seeking its repeal, exempts from civil or criminal liability state-licensed physicians who, in compliance with the specific safeguards in ODWDA, dispense or prescribe a lethal dose of drugs upon the request of a terminally ill patient.").

42. Or. Rev. Stat. Ann. §§ 127.800–.995 (West 2003).

43. *See Gonzales*, 546 U.S. at 250–51.

44. *See* Or. Rev. Stat. Ann. §§ 127.800(12), 127.805(1).

45. *See id.*

46. *See Gonzales*, 546 U.S. at 252.

47. *Id.* at 253–54.

48. *Id.* at 275.

49. *See id.*

50. *See* Smith, *supra* note 28, at 24. Some people go even further and argue that the acceptance of physician-assisted suicide will result in "Nazi-style death camps." *Id.* at 23.

51. *See id.* at 43–44.

52. *See* Oregon Death with Dignity Act, http://www.dhs.state.or.us/publichealth/chs/pas/pas.cfm (last visited Sept. 4, 2006).

53. *See* Smith, *supra* note 28, at 44.

54. *See id.*

C. *Terminal Sedation*

Terminal sedation is the "administration of sedatives sufficient to render a dying patient somnolent during the remainder of the dying process."[55] There are three general categories of terminal sedation.[56] The first is sedation accompanying the removal of life support.[57] The second "involves deep sedation to unconsciousness or stupor toward the end stage of a dying process."[58] The last, and most controversial, is the same as the second method except no artificial nutrition or hydration is provided once the patient in unconscious.[59] The actual cause of death is uncertain.[60]

The third type of terminal sedation requires the most complex legal analysis. Although there is no legal precedent, terminal sedation advocates, who argue that terminal sedation is legal, focus on the intent of the physician: relieving suffering and not causing death.[61] Others are not convinced by the intent distinction and argue that "the actual intention of the cooperating physician is probably not just to relieve suffering."[62] As will become apparent, much of the debate over terminal sedation revolves around the same issues as risky pain medication, namely whether or not the intent of the physician should be the standard for criminalization. This Note only examines the criminalization of administering lethal doses of pain medication, but most of the arguments presented apply to terminal sedation as well.

D. *End of Life Care and Pain Medication*

The administration of pain medication to a terminally ill patient is legal. There are, of course, a few notable exceptions that can turn normal end of life care into a risky practice, especially if death-hastening drugs are used. Legally, health-care providers are allowed to treat pain with medication even when that medication poses a risk of hastening a patient's death.[63]

A brief general overview of the medicine used to treat patients suffering great pain is necessary. Opioid analgesics are the main drugs used to manage cancer-related pain.[64] Morphine is an opioid.[65] The most serious

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55. Cantor & Thomas, *supra* note 36, at 138.
56. *See* Cantor, *supra* note 26, at 418–20.
57. *Id.* at 418.
58. *Id.* at 419.
59. *Id.* at 420.
60. *Id.* ("The underlying disease, the sedation, and dehydration accompanying cessation of ANH [artificial nutrition and hydration] are all candidates for cause of death.").
61. *See, e.g.*, Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post* Glucksberg *and* Quill, 29 Am. J.L. & Med. 45, 52 (2003) (arguing that in *Vacco v. Quill* the U.S. Supreme Court laid the "legal groundwork" for terminal sedation).
62. Cantor, *supra* note 26, at 421.
63. *See* Norman L. Cantor, *Twenty-Five Years After* Quinlan*: A Review of the Jurisprudence of Death and Dying*, 29 J.L. Med. & Ethics 182, 186 (2001).
64. *See* Ann Alpers, *Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying*, 26 J.L. Med. & Ethics 308, 310 (1998).
65. *See id.*

adverse effect of the administration of strong opioids is respiratory depression.[66] In treating pain, physicians also routinely use benzodiazepines, for example, Versed.[67] When opioids are combined with benzodiazepines, they "act to cause more severe respiratory depression and a simultaneous drop in blood pressure."[68]

In administering pain medication, physicians must follow certain guidelines. "These guidelines require that any risky pain relief be necessary—i.e., that the pain be intractable; that less dangerous, but effective analgesics not exist; and that the dosage be titrated upward in a careful fashion."[69] More important possibly than adherence to the technical guidelines is the intent of the health-care provider: "The practice is generally considered acceptable, even if it does help end a life—provided that the intention is strictly to relieve pain, not cause death. Basically, it's O.K. if you happen to grease the skids for poor old uncle as long as you didn't really mean to."[70] In a case like that of Dr. Pou, a jury would have to find that she actively desired the death of her patients.[71]

The use of potent pain medication to relieve the suffering of a patient is considered "an integral part of medical responsibility."[72] Many medical sources argue that the use of opioid analgesics is a safe and necessary practice and that patients build tolerance to the substances.[73]

In determining how to legally handle risky pain medication during an emergency situation, two debates must be addressed. First, there is the view that medical judgment and not the criminal justice system should determine the manner in which doctors treat their patients.[74] If this view is accepted, the criminal justice system is excluded, doctors are shielded from criminal liability, and patients are at the mercy of their doctors' decisions.

If the criminal justice system retains its authority in regulating behavior, the second debate—which standard should be used to determine culpability—must be resolved. Determining the standard during the extreme emergency situation is thoroughly complex. If the physician intends death, the answer is clear: the physician has performed some form

66. *See id.*; Howard Brody, *Physician-Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice*, *in* Law at the End of Life: The Supreme Court and Assisted Suicide 101, 106 (Carl E. Schneider ed., 2000) (noting that "the dosage level at which one can achieve pain relief and the level at which respiratory depression might occur are much farther apart than traditionally has been appreciated").

67. *See* Alpers, *supra* note 64, at 310.

68. *Id.*

69. Cantor, *supra* note 63, at 186.

70. Denise Grady, *The Fuzzy Gray Place in the Killing Zone*, N.Y. Times, Aug. 13, 2006, at WK3.

71. *See supra* notes 21–22 and accompanying text.

72. Cantor & Thomas, *supra* note 36, at 110; *see also* Lois Shepherd, *Assuming Responsibility*, 41 Wake Forest L. Rev. 445, 446 (2006) (arguing that responsibilities to the suffering are "primitively" understood and need to be further explored and taken more seriously).

73. *See, e.g.*, Cantor & Thomas, *supra* note 36, at 110.

74. *See, e.g.*, Phebe Saunders Haugen, *Pain Relief for the Dying: The Unwelcome Intervention of the Criminal Law*, 23 Wm. Mitchell L. Rev. 325, 363 (1997).

of euthanasia, which is illegal in the United States.[75] However, determining intent becomes all the more complicated in extreme emergency situations. In feeling a compulsion to act because a patient is suffering extreme pain, a physician may not have the time, equipment, or staff necessary to follow proper protocol. Furthermore, a physician may be fearful for his or her own life and not just the life of the patient he or she is presently treating, as well as all patients and staff in the hospital.

Part II of this Note examines the controversy over which legal standard should apply to criminalizing end of life risky pain medication cases. Incorporated into each issue is the possibility that the traditional arguments may lean more to one side than the other, or even be inapplicable, in extreme emergency situations.

II. THE CRIMINALIZATION OF ADMINISTERING RISKY PAIN MEDICATION AND THE UNCHARTED TERRITORY OF THE EXTREME EMERGENCY SITUATION

This part analyzes the arguments for and against criminalizing risky pain treatment and the debate over using double effect intent as a standard. The controversy has not yet reached the Supreme Court, although it has been discussed in the Court's dicta and concurring opinions regarding other end of life issues.[76] As such, the controversy is based on public policy arguments and ethical considerations. The following analysis applies these arguments to the extreme emergency situation, exploring its effect on the debate.

A. *The Controversy over Criminalizing Risky Pain Treatment*

This section analyzes the general controversy over criminalization, namely whether the criminal law of the United States is clear enough to determine whether a physician commits a crime in prescribing pain medication or if medical judgment in such a situation should be somewhat shielded from the reach of the law. Part II.A.1 presents the argument formerly embraced by Louisiana Attorney General Charles C. Foti that the use of aggressive pain medication by Dr. Pou and nurses Landry and Budo is homicide and must be treated as such by the state criminal justice system.[77] The justification for this argument lies in the belief that such actions must be criminalized due to the traditional rubric of protecting patients and, more broadly, the American stance against euthanasia. Part II.A.2 presents the argument that criminal law should not encroach upon the medical judgment of physicians, with justifications lying in the expertise of the profession and the belief that criminalizing leads to the under treatment of pain.

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75. *See supra* Part I.A.

76. *See* Vacco v. Quill, 521 U.S. 793, 801–02 (1997); Washington v. Glucksberg, 521 U.S. 702, 737–38 (1997) (O'Connor, J., concurring).

77. *See* Nossiter & Dewan, *supra* note 8.

1. Criminal Law Prohibits End of Life Decisions and Protects Patients

a. *Murder Is Murder*

Just as euthanasia and physician-assisted suicide are illegal in the United States, save in Oregon,[78] the argument can be made that criminal law should govern the risky pain treatment of patients by their physicians. In past cases, as discussed in Part II.B.2.b of this Note, traditional state criminal murder statutes have been used to determine the culpability of physicians in treating their patients with risky pain medication.[79] As such, it can be argued that the Louisiana second-degree murder statute would have applied in the case of Dr. Pou if it had gone to trial. The Louisiana statute defines second-degree murder as the killing of a human being when the offender has a specific intent to kill or to inflict great bodily harm.[80] There are no specifications on the mechanism that must be used; morphine is the same as a gun.[81] All that is necessary to determine culpability is for the jury to find that the physician had the specific intent to kill his or her patients.[82] If Dr. Pou had gone to trial and the prosecution had proved that she actively desired to kill her patients, she would have been convicted of second-degree murder and would have been punished under the traditional system accordingly.

b. *The Consequences: If This Treatment Is Not Criminalized, the Slippery Slope Will Lead to Euthanasia*

The argument for criminalizing such behavior centers on the belief that, if not criminalized, the lives of near-death patients will be jeopardized by the acts of their physicians. The same arguments made against physician-assisted suicide can be made against legalizing the use of death-hastening pain medication.[83] Doctors will begin to substitute their judgment for that of their patients, and the slippery slope will eventually transform the use of aggressive pain medication into euthanasia.[84] Another argument is that, if only medical judgment or the rule of double effect is used as a parameter, those doctors with truly bad intentions may easily slip through the cracks.[85] The "escape the blame" argument, where a physician intends death but simply says he or she intended to relieve pain, would, in effect, allow a

78. *See supra* notes 41–49 and accompanying text.

79. *See, e.g.*, State v. Naramore, 965 P.2d 211, 213 (Kan. Ct. App. 1998).

80. *See supra* notes 21–22 and accompanying text.

81. *See supra* notes 21–22 and accompanying text.

82. *See supra* notes 21–22 and accompanying text. It should also be noted that "[a]lthough jurisdictions may differ in the details, all states criminalize homicidal behavior and, depending on a prosecutor's decision and the facts of the case, a physician may be criminally liable for any act that grossly deviates from the standard of care and results in a patient's death." Alpers, *supra* note 64, at 310.

83. *See supra* notes 31–50 and accompanying text.

84. *See id.*

85. *See* Cantor & Thomas, *supra* note 36, at 86.

murderer to go unpunished and subject patients to the mercy of physicians who do not have patients' best interests at heart.[86]

c. *No Deviation Is Necessary During the Extreme Emergency Situation*

As Louisiana Attorney General Foti made clear in a press release, the criminalization argument embraces the belief that no special standard is necessary during the extreme emergency situation.[87] The slippery slope presents the same problems during normal conditions as it does during the extreme emergency situation. Patients are to be protected regardless of the state of affairs, and the traditional state criminal statutes are adequate to handle the matter—extreme emergency or not.

2. Criminal Law Is Not Adequate: Medical Judgment Must Reign Supreme to Protect Physicians and Patients Alike

Doctors and commentators have expressed the view that a doctor's decision regarding his or her patient's pain medication at the end of life stage, as long as it is made in good faith, should be free from criminal liability.[88] In terms of the extreme emergency situation, physicians have been vocal in responding to the Dr. Pou story and defending her medical judgment.[89] Part II.A.2.a discusses the views of the medical profession, first generally in regard to the criminalization of risky pain medication and then specifically in regard to the case of Dr. Pou. Part II.A.2.b analyzes the consequences for patients of criminalizing such action and the likelihood that criminalizing will increase the levels of unbearable pain that patients will have to face during the end of life stage.

a. *The Sentiment of the Medical Profession*

In the literature focusing on the use of pain medication, doctors assert the view that aggressive pain treatment is necessary and expected of the medical profession: "[I]t is malpractice for physicians caring for severely ill patients not to know how to use pain medicine, and not to use it aggressively when a patient is dying in pain."[90]

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86. *See id.*

87. *See supra* text accompanying note 14.

88. *See, e.g.*, Haugen, *supra* note 74, at 363.

89. It should be noted that some commentators considered Dr. Pou's actions mercy killing. *See, e.g.*, Dr. Anna Pou-hero or murderer?, http://nhsblogdoc.blogspot.com/2006/09/dr-anna-pou-hero-or-murderer.html (Sept. 26, 2006, 16:52 GMT). Mercy killing is prohibited in the United States, based on the notion that "[a] ban on mercy killing is arguably a reminder of social veneration for life, even though compassion for a suffering, dying person may tempt a health care provider or other observer to relieve that suffering by any means possible, especially when the patient is requesting such relief." Cantor, *supra* note 26, at 409.

90. Dr. Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas*, 57 Alb. L. Rev. 693, 694 (1994); *see also* Washington v. Glucksberg, 521 U.S. 702, 748 (1997) (Stevens, J., concurring) ("[F]or some patients, it would be a physician's refusal to dispense

It can be argued that it is simply not the role of prosecutors to bring charges against physicians making good faith decisions when treating pain and suffering.[91] The justification for this argument lies not only in the expertise of the medical profession but also in the duties owed to the patient. "Patients in these extreme circumstances require and are entitled to the fearless, aggressive efforts of their doctors to control their final pain and suffering."[92]

The President's commission report, written during the Reagan administration, also defers to the medical judgment of doctors, noting that physicians are not held to have violated the law when using potent pain treatment because society places "importance o[n] defining physicians' responsibilities regarding these choices and o[n] developing an accepted and well-regulated social role that allows the choices to be made with due care."[93] If the patient is terminal and there is no further treatment or actions that can be taken to extend the life, then it is difficult to see how the physician "deprive[s the patient] of meaningful life by the act."[94] The physician is no doubt involved in the death, but "it is the disease that deprives life."[95]

In addition, the medical profession has set out its views on extreme emergency situations.[96] For example, the Louisiana State Medical Society strongly supported Dr. Pou:

> [T]he Louisiana State Medical Society . . . is confident that Dr. Pou performed courageously under the most challenging and horrific conditions and made decisions in the best interest of her patients. Her recent statements regarding the events clearly show her dedication to providing care and hope to her patients when all hope seemed abandoned.[97]

Other doctors proclaimed that Foti's allegations were "absurd" and, if true, doctors would be charged with murder every day "because we use

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medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the [physician's] healing role.").

91. *See* Haugen, *supra* note 74, at 363. In reference to the use of morphine, Haugen argues, "[H]ow best, how much, and when to administer [it] are peculiarly medical decisions, with which the criminal law should not interfere, except in the most extraordinary of cases." *Id.* at 364.

92. *Id.* at 363.

93. President's Comm'n for the Study of Ethical Problems in Med. and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatments: Ethical, Medical and Legal Issues in Treatment Decisions 79 (1983).

94. *See* Preston, *supra* note 25, at 540.

95. *Id.* Professor Preston suggests that a central problem with the relationships between physicians and the death of their patients is the language used to describe the role of the physician. *Id.* at 543. Physicians deny association with their patients' death because they do not want to come close to the word "kill," and as a result the proper "linguistic expressions" do not exist to describe the role of physicians in end of life treatment. *Id.*

96. The only resources available at this time are the general arguments that physicians made surrounding the Dr. Pou case.

97. Press Release, Floyd A. Buras, President, La. State Med. Soc'y (Sept. 27, 2006), *available at* http://www.lsms.org/Newsroom/LSMS%20Stmt%20on%20Anna%20Pou.pdf.

these drugs in combination all the time to give comfort."[98] Others alleged that the problem during and in the aftermath of Hurricane Katrina was not the doctors who provided treatment and care but those who did not; in such a horrific situation, the treatment administered by Dr. Pou, they argue, was not only proper but necessary.[99]

b. *Patients Suffer If Such Treatment Is Criminalized*

Adding to the argument against criminalizing a physician's use of aggressive pain medication is that such criminalization will adversely affect doctors' performance in treating their patients. A vital issue in the medical field is the under treatment of pain.[100] It is currently possible, through medical advances, to relieve as much as ninety percent of all patient pain, yet more than fifty percent and possibly as much as seventy to eighty percent of such pain is not alleviated.[101] Medication is patient specific. Thus, what works for one does not work for another.[102] Doctors have to decide how to treat each individual specifically. The reasons for the under treatment of pain include, but are not limited to: fear of discipline, misunderstanding of addiction, government antidrug policies, and inadequate education of health-care professionals.[103]

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98. deBoisblanc, *supra* note 16. Dr. Steven Miles, a professor of Medicine at the University of Minnesota and expert on the care of terminal patients expressed that he was "'fundamentally unconvinced of the framing of the story . . . [and] not inclined to believe this is a euthanasia scenario or a physician-assisted suicide scenario.'" Grady, *supra* note 10. The Director of the Center for Bioethics at the University of Minnesota, Jeffrey Kahn, expressed his belief that "'[i]t's hard . . . to see the wisdom of prosecuting in a case like this . . . . This is talking about being in extremis, in the worst possible conditions.'" *Id.*

99. deBoisblanc, *supra* note 16 ("In the wake of Katrina if a patient had died in a hospital *without* evidence of having received comfort care, I would question *that* treatment.").

100. *See* Stephen J. Ziegler & Nicholas P. Lovrich, Jr., *Pain Relief, Prescription Drugs, and Prosecution: A Four-State Survey of Chief Prosecutors*, 31 J.L. Med. & Ethics 75 (2003).

101. *See* Beth Packman Weinman, *Freedom from Pain: Establishing a Constitutional Right to Pain Relief*, 24 J. Legal Med. 495, 503–04 (2003); *see also* Amy J. Dilcher, *Damned If They Do, Damned If They Don't: The Need for a Comprehensive Public Policy to Address the Inadequate Management of Pain*, 13 Annals Health L. 81, 81–82 (2004).

102. *See* Ziegler & Lovrich, *supra* note 100, at 76 ("A dosage that works for one patient suffering from chronic pain or for a patient near the end of life may be wholly inappropriate for another, particularly when considering the length of treatment, the patient's underlying illness or condition, and the pharmacokinetics of opioids."); *see also* Dilcher, *supra* note 101, at 116 ("Clinicians suggest that there is no maximal or optimal quantity of an opioid analgesic drug for either chronic or cancer pain. The appropriate dose is one that relieves the patient's pain without causing adverse side effects. In some instances, patients with severe cancer pain may require 1200 to 1800 milligrams of oral morphine per day, while other cancer patients may require a greater dosage of intravenous morphine at 1000 to 4500 milligrams per hour." (citations omitted)).

103. *See* Weinman, *supra* note 101, at 508; *see also* Dilcher, *supra* note 101, at 85–86; Jeffrey Wishik, *Chronic Pain: Medical and Legal Aspects*, R.I. Bus. J., Nov.–Dec. 2004, at 23, 40 ("Fear of regulatory, disciplinary, and even criminal sanctions for over prescribing opioids is pervasive among physicians."). For more on the under treatment of pain in America, see Ben A. Rich, *The Politics of Pain: Rhetoric or Reform?*, 8 DePaul J. Health

Physicians fear the consequences of administering high doses of pain medication, and as a result patients needlessly suffer.[104] "[C]onsiderable anecdotal evidence . . . has shown that some terminally ill cancer patients have been medicated inadequately for pain, because their doctors have feared being subjected either to criminal investigation or to an inquiry from the state's medical licensing board."[105]

Besides the effect that the fear of criminal or medical board investigations has on the patient's care, it also has a significant effect on the doctors. Although it is not the case that large numbers of physicians are punished, "the impact of the process on those physicians who are only investigated, or only charged but not disciplined, or only warned or cautioned but not penalized is severe."[106] Reportedly, one physician took early retirement as a result of an investigation into his prescriptions for pain medication.[107]

Pain is a crucial consideration under ordinary circumstances, but is of extra significance during an extreme emergency situation. During an extreme emergency situation, a doctor may be forced to work in substandard conditions with inadequate equipment, insufficient staff support, and threats to his or her health and safety. In such a situation, pain may become unbearable for some patients. For example, Dr. Pou spoke of providing "comfort care" during the days at the hospital.[108] One hundred degree temperatures likely caused already poor medical conditions to worsen and pain levels to rise dramatically.[109]

Another problem may be that pain can go completely untreated during an emergency situation. Referring to the attempt to criminalize Dr. Pou's actions, one commentator suggested that "[t]here are a lot of doctors who have a lot of problems with this . . . . It's going to have an impact on a lot of people, because nobody is going to want to stay for a storm again."[110] If doctors choose to leave during an extreme emergency, all pain can go untreated. On the other hand, in an extreme emergency situation a doctor

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Care L. 519 (2005). For an analysis of under treatment by nurses, see Marybeth Scanlon, *Providing End-of-Life Care in Connecticut: Should Nurses Fear Liability?*, 5 Quinnipiac Health L. J. 35, 40–43 (2001).

104. *See* Haugen, *supra* note 74, at 364.

105. *Id.* at 342. "To allow a patient to experience unbearable pain or suffering is an unethical medical practice, and physicians should not allow exaggerated fears of legal action to deter them from providing dying patients with aggressive, intensive palliative care." *Id.* at 363. The notable cases discussed in Part II.B.2.b may prove that physicians' fears are well justified.

106. Sandra H. Johnson, *Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act*, 24 J.L. Med. & Ethics 319, 320 (1996).

107. *See* Weinman, *supra* note 101, at 510.

108. *See supra* note 15 and accompanying text.

109. *See supra* note 1 and accompanying text. A comparison should be made with the Capute case analyzed in Part II.B.2.b.

110. Drew & Dewan, *supra* note 6.

who truly intends death may literally get away with murder if there is no documentation and no witnesses to prove otherwise. [111]

B. *Determining the Proper Standard for Drawing the Line Between Medicine and Murder*

At present, there is no definitive legal analysis of the acceptable treatment of a dying patient's pain with risky pain medication. "[P]alliative care guidelines tend to call for effective pain medication without specifying whether there is an upper boundary, such as a dosage that will surely hasten death."[112] Without a definitive dosage, criminalization of the administration of risky pain medication, where a physician does not admit to intending to cause death, must rest on inferences and deductions based on the facts of the specific case. Part II.B.1 presents the argument for using intent as the proper standard, specifically as applied through the philosophical doctrine of double effect, which the Supreme Court embraced in its end of life decisions.[113] Part II.B.2 presents the arguments against using intent as the proper standard, focusing on the fear that the doctrine of double effect masks the true intent of a bad actor. Part II.B.2 concludes with the practical problems of determining intent as illustrated by past specific cases of doctors and nurses being investigated and/or charged with murder in relation to aggressive use of pain medication.

1. Intent Is the Proper Standard

A physician's intent to cause the death of his or her patient by using risky pain medication is the standard employed by the state of Louisiana to determine whether or not the physician murdered the patient.[114] Although intent is widely used in order to determine culpability, determining an actor's intent is a difficult and sometimes impossible feat. However, if a lesser standard is used, the medical profession might not be able to function; deaths of patients are an unavoidable element of the medical profession, and, as such, the high standard of intent is necessary.[115] The basic intent standard, however, is sometimes qualified with regard to the medical profession. Supreme Court dicta suggest that the principle of double effect is recognized within American jurisprudence and should be employed when determining the culpability of a physician in regard to his or her patient's death if caused by terminal sedation or pain treatment.[116]

111. *See supra* Part II.A.1.b.
112. *See* Cantor, *supra* note 26, at 427.
113. *See* Vacco v. Quill, 521 U.S. 793, 801–02 (1997).
114. *See supra* notes 21–22 and accompanying text.
115. *See infra* note 121 and accompanying text.
116. *See, e.g.*, *Vacco*, 521 U.S. at 801–02.

a. *The Principle of Double Effect*

The principle of double effect is traced back historically to Thomas Aquinas.[117] The doctrine proposes that in particular situations, it is "permissible *unintentionally* to cause foreseen 'evil' effects that would not be permissible to cause *intentionally*."[118] There are four elements of the modern doctrine of double effect: (1) the agent only intends to bring about a good; (2) foreseeable harms are unintended and not a means to that good; (3) the intended means is morally permissible; and (4) the intended good is proportionate to the unintended harm.[119]

Ethicists in both medical and nonmedical[120] fields use the principle of double effect to justify certain actions.[121] Although pertinent to other areas, the principle of double effect may be considered essential to the field of medicine: "[W]ithout it, surgery, for example, would be ethically unacceptable."[122] One notable caveat to the use of double effect justification is that it should not be applied unless the actor has absolutely no other alternative but to cause a harm in the attempt to fulfill a duty to bring about a good.[123] Additionally, an evil action cannot be the means of securing a good consequence.[124]

The principle of double effect is often invoked to explain why a physician is allowed to administer high doses of opioids that have the effect of causing death sooner than would occur naturally without administration of the opioid.[125] The argument is that when a doctor administers a high dose of morphine, his intent is only to ease the patient's pain and suffering and not to cause death.[126] As such, the double effect doctrine applies, and the doctor is not held morally accountable for the death of the patient.[127]

The doctrine of double effect can be viewed as good public policy because "it allows physicians to provide adequate palliative care without

117. *See* Lyons, *supra* note 24, at 471 (citing Philip E. Devine, *Principle of Double Effect, in* The Cambridge Dictionary of Philosophy 44, 44–45 (Robert Audi ed., 1995)).

118. *Id.*

119. *See* Nuccetelli & Seay, *supra* note 24, at 20. For a more theoretical explanation of the four elements, see Lyons, *supra* note 24, at 482 (requiring that the act be "ethically neutral, if not praiseworthy").

120. The standard example is when a pilot drops a bomb on a village to destroy a munitions factory. *See* Richard S. Kay, *Causing Death for Compassionate Reasons in American Law*, 54 Am. J. Comp. L. 693, 712 (2006). The pilot's intention is to shorten the war and save lives. *Id.* It is a foreseeable consequence that innocent civilians in the village will die as a result of his actions, but the deaths are morally justifiable under the doctrine of double effect. *Id.*

121. Brody, *supra* note 66, at 105.

122. *Id.*

123. Daniel P. Sulmasy, Commentary, *Double Effect—Intention Is the Solution, Not the Problem*, 28 J.L. Med. & Ethics 26, 28 (2000).

124. *See* Kay, *supra* note 120, at 694.

125. *See* Alpers, *supra* note 64, at 319.

126. *See, e.g.*, Vacco v. Quill, 521 U.S. 793, 801–02 (1997).

127. *See* Alpers, *supra* note 64, at 319.

engaging in clearly illegal conduct."[128] The other options would either be to allow intentional death or not to allow physicians to treat patients aggressively when the treatment may cause death.[129] The former is murder and the latter would leave patients without adequate pain relief.[130] Therefore, the doctrine of double effect allows both the legal standard of intent to remain in place and the public policy emphasis on reducing a patient's pain to remain a role of the physician.[131]

b. *The Supreme Court and the Role of Intent*

The Supreme Court's reasoning in *Glucksberg* and *Vacco* has provoked significant debate over the role of intent in end of life decision making. According to former Chief Justice William Rehnquist, who wrote the majority opinion in both cases,

> [A] physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them.... The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain.[132]

In his opinion, Chief Justice Rehnquist noted the role of intent as a means to differentiate two actions that have the same result but deserve different moral and criminal accountability.[133] The writings lead to the conclusion that the majority opinion subscribes to the principle of double effect.[134] The concurring opinions go even further than invoking the principle of double effect and leave open the question of a constitutional right to choosing end of life treatment.[135]

Justice Sandra Day O'Connor concurred in the judgments of *Vacco* and *Glucksberg* because she agreed that there is no fundamental right to suicide, but she notably saw "no need" to reach the question of "whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent

128. McStay, *supra* note 61, at 54.
129. *See id.*
130. *See id.*; *see also supra* Part II.A.2.
131. *See* McStay, *supra* note 61, at 54.
132. Vacco v. Quill, 521 U.S. 793, 801–02 (1997) (comparing a physician who withdraws life-sustaining treatment or provides aggressive pain medication with a doctor who assists a suicide and thus intends death).
133. *See id.* at 802–03 ("Put differently, the law distinguishes actions taken 'because of' a given end from actions taken 'in spite of' their unintended but foreseen consequences.").
134. *See, e.g.*, Rebecca Dresser, *The Supreme Court and End-of-Life Care: Principled Distinctions or Slippery Slope?*, *in* Law at the End of Life: The Supreme Court and Assisted Suicide, *supra* note 66, at 83, 88.
135. *See id.*

death."[136] Both Justices Ruth Bader Ginsburg and Stephen Breyer joined Justice O'Connor's concurrence in part.[137]

Professor Rebecca Dresser argues that the opinions, taken together, suggest a constitutionally protected right to receive adequate palliative care.[138] Professor Dresser goes on to emphasize the importance of the decisions for physicians and patients alike.[139] Although Professor Dresser's arguments for a constitutionally protected right to receive adequate palliative care seem to be a bit of a stretch considering the Justices' reservations about overstepping the breadth of the questions posed before them,[140] her reasoning for the importance of a right to palliative care is crucial and lends itself to the argument against criminalization of risky pain medication and in favor of medical judgment. According to Professor Dresser, with a right to adequate palliative care, patients gain more authority to determine their end of life treatment options and the clinicians are shielded from liability.[141] "At a minimum, [the Supreme Court Justices'] opinions indicate that patients' constitutional rights would be violated if physicians forgoing life-sustaining treatment or administering risky palliative care were prosecuted for those actions."[142] Professor Dresser notes, importantly, that the Justices fell short of setting up a framework for determining when potentially deadly pain medication is illegal.[143]

c. *Alternatives to the Double Effect Justification: Responsibility Without Culpability*

Professors Susan Nuccetelli and Gary Seay argue that the principle of double effect does not justify the actions of physicians hastening death with pain medication, specifically because physicians are aware of the consequences and are thus responsible.[144] Even drawing that conclusion, Professors Nuccetelli and Seay question whether such physicians should be

136. Washington v. Glucksberg, 521 U.S. 702, 736, 737–38 (1997) (O'Connor, J., concurring). Justice Sandra Day O'Connor also appears to subscribe to the doctrine of double effect, noting that patients in both Washington and New York can receive palliative care even when such care "hastens death." *See* Michael P. Allen, *Justice O'Connor and the "Right to Die": Constitutional Promises Unfulfilled*, 14 Wm. & Mary Bill Rts. J. 821, 828 (2006) ("At the most basic level, Justice O'Connor's opinion can be cited for the proposition that there may be a constitutional due process right to palliative care (i.e., pain management) at the end of life. . . . In *Glucksberg*, pain management leading even to death might be a constitutionally protected right.").

137. *Glucksberg*, 521 U.S. at 789 (Ginsburg, J., concurring); *id.* at 789 (Breyer, J., concurring).

138. *See* Dresser, *supra* note 134, at 83 (including both pain medication that could hasten death and terminal sedation).

139. *See id.*

140. *See, e.g.*, *Glucksberg*, 521 U.S. at 737–38 (O'Connor, J., concurring).

141. *See* Dresser, *supra* note 134, at 88.

142. *Id.* at 87–88.

143. *See id.* at 88.

144. *See* Nuccetelli & Seay, *supra* note 24, at 21.

held morally accountable for the deaths.[145] They therefore analyze other options for justifying palliative care.

Professors Nuccetelli and Seay propose a "Principle of Conflicting Duties": A person is exempt from blame when he simultaneously fulfills one and violates another moral duty.[146] If the duties fulfilled and violated are equal and the person does his best to fulfill the first duty and cannot prevent leaving the second obligation unfulfilled, his or her actions are justified.[147] Although this proposed analysis seems to justify the physician's actions, Professors Nuccetelli and Seay argue that it does not.[148] According to the authors, a physician has co-existing, conflicting duties to extend life and relieve pain, neither of which can be dismissed.[149] Unlike a situation where not fulfilling a duty is excusable because another duty is fulfilled, "[w]hen moral duties are special duties such that an agent is obligated to fulfill them even if he is unable to do so, he could not be exempt from blame by the Principle of Conflicting Duties."[150]

One assumes that in coming to this conclusion Professors Nuccetelli and Seay would find no justification for a physician who causes death through the use of pain medication while only intending to ease pain. Yet, somewhat troublingly, the professors take no stand on the issue.[151] While noting that some obligations cannot be dismissed, they "do not rule out the possibility that one or another of these duties might sometimes be overridden in the clinical context where the requirements of humane and compassionate care warrant it."[152] This conclusion might actually serve as an appropriate standard for use during extreme emergency situations. It is possible that Professors Nuccetelli and Seay's condition of the "humane and compassionate care" is satisfied during the emergency situation, where the situation is dire for all, not just the patients. However appropriate such a standard may be, the authors, in rejecting double effect, subscribe to the notion that the physician intends death, based on the assumption that a skilled professional can foresee the consequences of his or her actions.[153] Just like many other professionals, physicians are faced with tremendous risks everyday and to presume intent, solely because a physician is a

145. *Compare* Nuccetelli & Seay, *supra* note 24, at 22 (noting that there are certain situations where there are general moral duties and people do not have that much control), *with* Sulmasy, *supra* note 123, at 27 ("No serious proponent of the [rule of double effect] says that someone who has hastened the death of a patient is not *responsible* for that outcome.").

146. *See* Nuccetelli & Seay, *supra* note 24, at 22.

147. *See id.*

148. *See id.* at 23.

149. *See id.* at 22.

150. *Id.* at 23.

151. *See id.* at 24.

152. *Id.* ("[T]he clinician must take into account all of her relevant professional obligations in that situation and weigh them in deciding how to do what is best for that patient, *all things considered*, given *his* values and beliefs, with a reasonable assessment of what the quality of his remaining life is likely to be.").

153. *See supra* note 144 and accompanying text.

physician, would be a mistake. Such a high standard would be both unfair and unworkable.

Professor Roger Magnusson proposes another alternative to the doctrine of double effect. Using the metaphor of "the devil's choice,"[154] Professor Magnusson describes "a moral dilemma that arises in circumstances where choice itself is perverse and not choosing is not an option."[155] In applying this concept to the field of medicine, where there is no "right choice," it is imperative that the standards of medical ethics not be silent but instead help the physician to determine and act upon the "least perverse alternative."[156] Although Magnusson's point seems valid, it does not translate well to criminal law. According to the legal system, one either follows or breaks the law—there is no in-between. Unless there exists a rubric to which both the medical profession and the criminal justice system adhere for determining first the "least perverse alternative" and deciding not to criminalize it, such a proposal will not be effective.

Professor Magnusson also proposes invoking the necessity defense when a physician is faced with the devil's choice.[157] The necessity defense is only appropriate, according to Professor Magnusson, when the choices were "perversely constrained so that [the physician] felt compelled to adopt a compassionate course even though this had a life-shortening effect."[158] As long as the physician has administered "recognized, analgesic drugs" and done so "in dosages that were a proportionate response to the patient's suffering," the action of hastening death is justified.[159] Professor Magnusson believes the necessity defense is a better alternative to analyzing the culpability of the physician.[160] As the necessity defense presupposes that the physician intended to cause the death,[161] it is outside the scope of this Note. It may be relevant in future extreme emergency situations, when a physician, in stark contrast to Dr. Pou, admits that he or she caused patients' deaths but nonetheless seeks exoneration. The physician's intent to end an individual's life, however, lends itself much more to euthanasia than to "comfort care," especially given the American stance against euthanasia.[162] This point, although outside the reach of this Note, deserves adequate consideration by the criminal justice system.

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154. *See* Roger S. Magnusson, *The Devil's Choice: Re-thinking Law, Ethics, and Symptom Relief in Palliative Care*, 34 J.L. Med. & Ethics 559, 564 (2006).

155. *Id.*

156. *See id.* at 565.

157. *See id.* at 566.

158. *Id.*

159. *Id.* at 567.

160. *See id.* ("The defense of necessity immunizes palliative care practices that accord with accepted and responsible professional practice, while permitting law and ethics to better acknowledge the gravity and consequences of these end-of-life decisions.").

161. *See id.* at 566.

162. *See supra* Part I.A.

2. Intent Is Not the Proper Standard

Intent as the standard to determine culpability, specifically as applied through the doctrine of double effect, has many adversaries.[163] The argument against the double effect intent standard centers on the idea that intent is too high and difficult of a standard to prove and is dangerous to the lives of patients.[164]

a. *The Doctrine of Double Effect Allows for Murder*

Challenges to finding a justification for hastening death with pain medication abound. Objections to the doctrine of double effect include arguments that the doctrine originated with the Roman Catholic religion, whose tenet that intentionally causing death is always wrong does not enjoy universal acceptance.[165] In addition, critics argue that intent is too difficult to determine, so people are held responsible for both the intended and unintended consequences of their actions.[166] Finally, the double effect theory is critiqued for its reliance on the physician's intent, rather than that of the patient.[167]

Other challenges are that the principle of double effect is an avenue to escape blame even when the physician intended death.[168] The argument is that physicians are experts and when they act, they know the consequences of their actions: "If a physician knows with a high degree of probability that an act will result in death, the physician who performs that act intends the death, regardless of a stated primary intent to relieve pain."[169] The argument against use of the doctrine of double effect folds neatly into the argument that hastening death with pain medication is murder.[170]

Some believe that the intent to relieve horrible suffering of a dying patient is inherently commingled with the intent to put that patient "out of his misery."[171] Also, basing culpability on intent is problematic because "[t]he palliative care provider either strains to keep his or her mind off what may be the real objective of hastening death or later simply asserts that his or her mind was so tuned."[172]

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163. *See, e.g.*, McStay, *supra* note 61, at 54; Preston, *supra* note 25, at 539.
164. *See infra* note 166.
165. *See* McStay, *supra* note 61, at 54.
166. *See id.*
167. *See id.*
168. *See, e.g.*, Preston, *supra* note 25, at 539.
169. *Id.*
170. *See supra* Part II.A.1.
171. *See* Cantor, *supra* note 26, at 423 (arguing that "distinguishing intent to relieve suffering from intent to cause death is a mission impossible"); *see also* Grady, *supra* note 70 ("Anyone who has watched a lingering, painful decline knows that the urge to provide comfort is often mixed with a wish that it would just be over. Boundaries can blur, and breach, in desperate moments. Moral concern can rise when dosages do.").
172. Cantor & Thomas, *supra* note 36, at 115.

Professor Norman Cantor argues that intent alone is not the standard of criminal law and bases his arguments on the Model Penal Code's provisions.[173] The Model Penal Code defines murder as purposefully or knowingly causing the death of another human being or recklessly causing death "under circumstances manifesting extreme indifference to the value of human life."[174] Cantor argues accordingly that the intent to relieve pain "does not exculpate a person for a killing";[175] the mens rea of knowingly causing death is sufficient to find murder, despite the objective of relieving pain. "In short, even with a primary intention to relieve suffering, a physician does not have carte blanche to administer pain relief medication that risks hastening death."[176]

Professor Cantor, however, does note the concurring opinions of the Supreme Court Justices in *Glucksberg* and *Vacco*, and admits that they appear to indicate the opposite viewpoint—specifically that intent to ease pain is relevant.[177] He argues that this interpretation of the law seems incorrect because such reasoning would allow a person to commit suicide by having a vital organ removed if his or her primary intention is to save another person's life.[178] Furthermore, he argues that it is harder to distinguish such action from euthanasia when euthanasia is defined as the administration of a lethal agent to a patient by another person to relieve "the patient's intolerable and incurable suffering."[179] Cantor's point is well taken, yet as previously discussed, intent to cause death by a lethal agent is not defined. In Dr. Pou's case, medical professionals stated that the mixture of medications could be lethal depending on the dosage and incremental increases.[180] If a medication's potential lethality is left undefined, then once again, the determining factor of culpability lies solely in the intent of the actor.

b. *Practical Problems with Finding Intent*

In addition to the argument that intent is not the proper standard because it is too high of a threshold and allows bad actors to get away with murder, there also exists the argument that it is simply too difficult to prove. The case law indicates that the law is not as clear as some have suggested. The following are a few notable descriptions of cases illustrating the ambiguous

173. *See* Cantor, *supra* note 26, at 423–25.

174. Model Penal Code § 210.2(1)(6) (1985).

175. Cantor, *supra* note 26, at 425.

176. *Id.* (noting, however, that the endorsement is only "dictum in concurring opinions").

177. *See id.* (referring to the concurrences of Justices Sandra Day O'Connor, David Souter, and Stephen Breyer in *Vacco v. Quill*, 521 U.S. 702, 736–38 (1997)).

178. *See id.* at 426.

179. *Id.* at 427 (citing Code of Ethics E-2.21 (Am. Med. Ass'n 1996), *available at* http://www.ama-assn.org/ama/pub/category/8459.html); *see also* Cantor & Thomas, *supra* note 36, at 113 (noting that proponents of legalizing active euthanasia argue that it has already been legalized through risky pain treatment).

180. *See supra* Part II.A.2.a.

nature of prosecuting doctors and nurses for risky pain medication.[181] The grand jury's failure to indict Dr. Pou simply adds to this list.

In 1981, nurse Anne Capute was charged with murdering a suffering patient with a large dose of morphine.[182] Capute was a hospital licensed practical nurse.[183] She had carefully documented her actions.[184] Capute administered 195 milligrams of morphine within seven hours of her patient's death.[185] The district attorney alleged that Capute intended to kill.[186] During the murder trial, her defense attorneys argued that disease caused the patient's death.[187] Capute spoke for herself: "No one here . . . not yourselves, not my lawyer, not the district attorney, can possibly imagine the pain and agony she was going through because they weren't there. But I was."[188] The jury deliberated and acquitted Capute of murder.[189] Accordingly, the prosecutors failed to prove beyond a reasonable doubt that Capute intended death. Given her testimony, it is easy for a layperson to understand how the prosecutor lost the case.

Another case involved the criminal investigation of Sharon LaDuke, a registered nurse in New York.[190] LaDuke was investigated for administering an unspecified large dose of Fentanyl, an anesthetic, to a seventy-six-year-old patient with lung disease and pneumonia.[191] The patient's family supported the nurse's actions but an investigation was initiated, and LaDuke was fired even though the investigation produced insufficient evidence to charge her with murder.[192]

In Connecticut, a cardiothoracic surgeon ordered a resident to deliver a morphine dose of seventeen times the last one administered to the patient.[193] The patient's death was ruled a homicide, yet the state's attorney did not prosecute the surgeon "due to lack of proof of his criminal

181. In the United States, most chief prosecutors are elected officials, serving both as a law enforcement official and officer of the court. *See* Stephen J. Ziegler, *Physician-Assisted Suicide and Criminal Prosecution: Are Physicians at Risk?*, 33 J.L. Med. & Ethics 349, 349 (2005). Prosecutors are often described as "'gatekeepers' to the administration of justice" because they have the discretion to determine whether a person gets charged with a crime. *See id.* In deciding whether or not to charge a person with a crime, the primary factor influencing the prosecutor is whether he believes that he can secure a conviction. *See* Ziegler & Lovrich, *supra* note 100, at 78. "If the distinction between aggressive pain relief and hastened death is a point of contention among physicians and ethicists, what can we expect from prosecutors who are likely less knowledgeable about pain relief and end-of-life care?" *Id.* at 76–77.

182. *See* Haugen, *supra* note 74, at 354.

183. *See* Scanlon, *supra* note 103, at 52.

184. *See* Haugen, *supra* note 74, at 354.

185. *See id.*

186. *See* Scanlon, *supra* note 103, at 52–53.

187. *See id.* at 53.

188. *Nurse Calls Overdoses an Effort to Ease Pain*, N.Y. Times, Oct. 22, 1981, at A24.

189. *See* Scanlon, *supra* note 103, at 53.

190. *See id.* at 54.

191. *Id.*

192. *Id.*

193. *See id.* at 55.

intent."[194] The last case is clearly less persuasive than those of Capute and LaDuke, yet the inability to prove intent may demonstrate that there was none—although other inferences are possible and justified.

Perhaps the most potent case is that of Dr. Lloyd Naramore, a Kansas physician, who was charged with the attempted murder of Ruth Leach and the first-degree murder of Chris Willt.[195] Ruth Leach was a seventy-eight-year-old cancer patient, who was degenerating quickly.[196] The morphine patches being used were not strong enough and Naramore, after discussions with the Leach family, administered Versed, a painkiller, and Fentanyl.[197] Leach's respiration slowed, and Naramore told the family he could reverse the effects with a different drug, Narcan.[198] The nurse assisting Naramore testified that she believed Narcan was only used in cases of an overdose.[199] Naramore then spoke with Leach's son who said that he did not want the doctor to hasten his mother's death. Naramore then decided to remove himself from the case.[200] Leach was transferred at her son's request to another hospital, where she died a few days later.[201]

Willt was an eighty-one-year-old obese diabetic with a history of heart disease.[202] He suffered a severe stroke, and Naramore believed him to be brain dead.[203] Although Willt had some movement, Naramore diagnosed it as seizure activity and, after obtaining the opinion of a second doctor, he stopped mechanical ventilation.[204]

A jury found Naramore guilty of attempted murder and first-degree murder and sentenced him to concurrent terms of five to twenty years.[205] However, his convictions were later reversed on appeal.[206] In his appeal, Naramore argued that there was insufficient evidence to support his convictions: "[T]he State's experts conceded the amounts given to Mrs. Leach did *not* indicate a clear intent to kill."[207] Two physicians involved in the treatment of the patients and three other physicians testified that Naramore's treatment was "medically appropriate."[208] The Kansas Court of Appeals held that there was strong testimony that Naramore's actions

194. *Id.* at 55–56.
195. State v. Naramore, 965 P.2d 211, 213 (Kan. Ct. App. 1998).
196. *Id.* at 213–15.
197. *Id.*
198. *Id.* at 215.
199. *Id.*
200. *Id.*
201. *Id.*
202. *Id.* at 216.
203. *Id.*
204. *Id.* at 217.
205. *Id.* at 213.
206. *Id.* ("We can find no criminal conviction of a physician for the attempted murder or murder of a patient which has ever been sustained on appeal based on evidence of the kind presented here.").
207. *Id.* at 221.
208. *Id.* at 223. The prosecution brought in three physicians who disagreed with the defense witnesses' testimony that Dr. Lloyd Naramore's treatment was medically appropriate. *Id.*

were within the bounds of good medical practice, and as such the conviction must be overturned.[209]

The outcomes of these pain treatment cases seem comparable to those of euthanasia and physician-assisted suicide. Studies show that both active voluntary euthanasia and physician-assisted suicide occur frequently, and yet there are very few prosecutions.[210] It seems reasonable that the outcomes of physician-assisted suicide cases and medication cases are similar. In physician-assisted suicide cases when physicians stand trial, convictions are extremely rare.[211] Juries often ignore the specific instructions of the judge and revert to a traditional judgment of right and wrong.[212] "In the rare instances when health care providers have been accused of criminal behavior in using analgesics, the prosecutions or attempted prosecutions have usually foundered on the difficulty of showing that the substances in fact hastened death."[213]

Given these examples, it is hard to imagine that the Louisiana prosecutor handling Dr. Pou's case ever believed he stood a good chance of victory. Unlike the case of Naramore, Dr. Pou did not have much time to think, talk to family, or prepare a plan of action. Much like Capute, Dr. Pou spoke about the pain the patients were suffering and the "comfort care" she provided.[214] The role of the extreme emergency situation undoubtedly makes the prosecutor's job of proving intent to kill much more difficult.

C. *The Role of the Extreme Emergency Situation: The Problem of Finding Intent*

There is no legal research available applying the role of intent to the extreme emergency situation. However, it is easy to understand how determining intent becomes even more difficult in such a situation. A physician acting under ordinary circumstances faces difficult decisions, and undoubtedly that physician's mind is full of both medically based and compassionate thoughts. However, in that situation, the administration of the hospital is functioning and all technology, staff, and medication is standard. In these cases, determining intent may be difficult, but not impossible.

In an extreme emergency situation, the doctor may not know the patient, the patient's medical history, the specialty area of the patient's disease, or even the patient's name.[215] Furthermore, documentation of medication

209. *Id.* ("When there is such strong evidence supporting a reasonable, noncriminal explanation for the doctor's actions, it cannot be said that there is no reasonable doubt of criminal guilt.").

210. *See, e.g.*, Kay, *supra* note 120, at 694.

211. *See id.*

212. *See id.*

213. Cantor & Thomas, *supra* note 36, at 111.

214. *See supra* note 15 and accompanying text.

215. *See supra* note 16 and accompanying text.

dosages is most likely not accounted for.[216] It is plain that each side of the double effect argument can be heightened in this situation: The physician may be acting only with the intent to rid the patient of his or her suffering, although it is possible that the physician is more likely to intend death because he or she believes that death in a more painful manner is certain to occur.

1. Possible Solutions to Consider for the Future

Part II of this Note analyzes the debate over criminalizing risky pain medication and the intent/double effect standard used to determine culpability. The role of the extreme emergency situation is analyzed where possible to understand if and how the debate should change in such horrific conditions. The arguments presented above provide some basis for the legal standard that must be used during the extreme emergency situation. As discussed, the problem is that there is no existing framework for physicians to follow during an extreme emergency situation. Both the medical profession and the criminal justice system of each state need to converge in order to produce the proper standard of care that is to be expected of physicians during an extreme emergency situation.

a. *Medical Judgment as the Law*

It is possible that during an extreme emergency situation, medical judgment should be the law. More specifically, if criminal law should not interfere with medical judgment,[217] perhaps the law should categorically except doctors who work during extreme emergency situations from criminal liability. In thinking that the doctors who leave during such situations are the problem,[218] perhaps the law ought to pay deference to the doctors who risk their own lives and stay to help during a terrorist attack or a tsunami. In such a situation, the law could presume that the probability that the doctor who decides to stay and help patients intends to hurt people is most likely very low. The medical judgment stance supports the argument that the medical profession should be shielded from criminal liability in providing pain medication.[219]

The opposition to the medical judgment shield argument is that a doctor who chooses to work during a hurricane or a terrorist attack should in no way feel leeway to substitute his judgment for that of the patient. Specifically, even if the doctor believes that death by pain medication would be preferable to a bombing or drowning, it is not the doctor's decision to make. Therefore, the categorical exception may allow too much

216. *See supra* note 16 and accompanying text.

217. *See* Haugen, *supra* note 74, at 363.

218. *See supra* note 99 and accompanying text.

219. *See supra* Part II.A.2.a. However, this view is in direct contrast with the view of some scholars who argue that physicians are experts, know the consequences of their actions, and therefore intend death. *See supra* notes 168–69 and accompanying text.

free reign and thus allow physicians with bad intentions to exaggerate the conditions of an extreme emergency situation to escape criminal liability.

b. *The Status Quo*

Standing in opposition to the medical judgment approach is the status quo approach, which embraces the argument that the judicial system is able to handle such extreme emergency situations because jurors can make the right judgments based on the facts presented, no matter the situation.[220] For example, the cases presented in Part II.B.2.b demonstrate that in most situations intent is hard to prove.[221] Accordingly, the burden rests on the government, and physicians generally are not convicted unless their acts are egregious and they admit to intent to cause death.[222] The jury may be best equipped to handle this determination, as the jury may have been just as devastated by the extreme emergency as the physician and may understand the dire situation. Intent may only be found if it was truly present, and the doctor who intended to ease pain alone will be exonerated.[223] Faith that the criminal justice system will bring about the proper result may be justified.

c. *Finding the Proper Standard During the Extreme Emergency Situation*

If risky pain treatment during the extreme emergency situation is criminalized, as will be assumed for the purposes of this section, the standard for determining culpability may take one of three varieties: (1) embracing the doctrine of double effect intent,[224] (2) holding the medical profession to a higher standard of intent,[225] (3) or allowing dual intent, both to ease pain and cause death.[226]

Intent, as has been discussed, is a high standard and can have some practical difficulties.[227] Double effect intent, which embraces the idea that a physician intends only to ease his patient's pain and not cause death, allows for the standard to remain high, namely at the level of specific intent, while also incorporating the policy reasons of patient pain management,[228] which is crucial during the extreme emergency situation. However, as has been analyzed, the principle of double effect is often opposed as a means of escaping blame for murder, when in truth the physician did intend death.[229]

220. *See supra* notes 78–82 and accompanying text.
221. *See, e.g.*, State v. Naramore, 965 P.2d 211, 223 (Kan. Ct. App. 1998).
222. *See supra* Part II.B.2.b (discussing cases which illustrate the difficulty in obtaining a conviction).
223. *See Naramore*, 965 P.2d at 223 (proving that, even if the jury finds intent, a higher court may be willing to overturn the jury's verdict if the evidence at trial is not explicitly supportive of a finding of intent).
224. *See supra* notes 125–31 and accompanying text.
225. *See supra* note 169 and accompanying text.
226. *See supra* notes 173–76 and accompanying text.
227. *See supra* Part II.B.2.b.
228. *See supra* notes 128–31 and accompanying text.
229. *See supra* notes 168–69 and accompanying text.

Assuming a higher standard for doctors is another possibility, namely that physicians understand the consequences of their actions and thus intend to cause death when administering possibly lethal medications.[230] This argument focuses on the expertise of the profession. However, during an extreme emergency, a physician, such as Dr. Pou, may try to help patients outside of his or her specific area of expertise and proper medicine may be scarce. If this is the case, a higher standard based on the expertise of the profession does not seem reasonable.

Lastly, a physician may have both the intent to ease suffering and cause death, as is suggested by Professor Cantor.[231] Even though a physician intends to ease pain, he or she may know that the patient is going to die and thus remains culpable. During the extreme emergency situation it seems difficult enough to determine a single intent of the physician, let alone a double intent. However, a physician may be so flustered by a situation that he or she is not sure of intent or may possibly intend many things at the same time.

Part III analyzes whether in extreme circumstances, such as where there is unbearable heat, flooding, and decomposing bodies, the analysis should be the same. Should a doctor who risked her life be charged with murder given such unknowns? On the other hand, does a doctor treating a patient during extreme conditions deserve special treatment, when some doctors face these decisions every day, such as when they treat cancer and AIDS patients?

III. RELIANCE ON THE DOCTRINE OF DOUBLE EFFECT WITH DEFERENCE TO MEDICAL JUDGMENT

The controversy presented by a case like Dr. Pou's and the possibilities for resolving such a controversy as presented in Part II of this Note constitute a well-balanced debate. The role of the extreme emergency situation tips the scale toward a mechanism to provide greater protection for both patients and physicians. As such, this Note argues that during an extreme emergency situation, the administration of risky pain medication must be criminalized based on the standard of double effect intent. Thus, the status quo should remain, but the principle of double effect should be expressly adopted, providing deference to the medical judgment of the physicians who risk their lives during horrific situations such as Hurricane Katrina. Part III.A presents the reasons that a categorical exception from criminalization is unworkable as it provides no protection for patients. Part III.B explains how the doctrine of double effect is necessary to protect physicians while still protecting patients.

230. *See supra* note 169 and accompanying text.
231. *See supra* notes 173–76 and accompanying text.

A. *Criminal Law Must Play a Role in Protecting Patients During the Extreme Emergency Situation*

The argument for a categorical exemption[232] holding medical judgment during an extreme emergency beyond the reach of law is unacceptable. Shielding a section of society from the criminal justice system is too drastic and dangerous a course to follow. A state's criminal justice system is in place and should be respected. The worry that physicians will not adequately treat pain and may even choose to leave during an extreme emergency does not tip the debate enough to completely protect all physicians from the reach of the law. The choice is between a patient suffering extreme pain or being murdered. As such, there is not much of a choice.

Furthermore, this argument rests largely on faith in the judicial system. Prosecutors, as officers of the court, are presumed not to charge people with meritless crimes. Although there may be times when the system has failed, the entire system would have to be replaced if prosecutors are not seeking justice. If society cannot trust prosecutors to proceed only with charges for which they have sufficient evidence, the criminal justice system, whether during ordinary times or an emergency, will not function as a safeguard. Therefore, it should be expected and required that prosecutors act with the same diligence in trying cases during an extreme emergency situation.

Lastly, the high standard of determining culpability and the low rates at which physicians are actually investigated and/or charged provide a basis to accept criminalization.[233] Since physicians are charged very rarely and found guilty even less often because of the high burden of proof during normal times, it can be assumed that during an extreme emergency situation, where prosecutors and juries have also lived through the tragedy and understand the horrible conditions faced by the doctor, the number of charges and convictions may be even lower. The story of Dr. Pou is now the best example of this.

B. *Embracing the Doctrine of Double Effect to Protect Physicians*

The doctrine of double effect must be embraced by the judicial system as the arguments for the application of the principle are most pertinent in dealing with the extreme emergency situation. If a doctor risks his or her life to attend to the sick and dying during a terrorist attack, there exists more reason to believe that he or she intended solely to ease suffering and not to cause death.

As such, criminalizing pain treatment based on the standard of double effect intent is proper and necessary during the extreme emergency situation.[234] Assuming that a doctor knows for sure that pain medication

232. *See supra* Part II.C.1.a.

233. *See supra* notes 210–13 and accompanying text.

234. *See, e.g.*, Grady, *supra* note 10 ("'It's a narrow gray line. Nobody knows how we would react under extreme circumstances.'" (quoting Dr. Mark Siegler)).

will hasten death under unbelievably dire circumstances is not acceptable. As has been described in this Note and by reports worldwide, the extreme emergency situation caused by Hurricane Katrina left Memorial Medical Center in utter disarray.[235] The patients' regular treating physicians were not present, the temperature was above 100 degrees, and the smell of dead bodies permeated the air.[236] To assume that any physician can diagnose or treat a patient with certainty under these extreme circumstances is simply an assumption that cannot and should not be made. Furthermore, some deference must be given to the medical profession. A doctor's expertise should not lead one to assume that he or she knows with certainty, and thus intends, the consequences of every action. The Supreme Court has indicated that it supports the principle of double effect.[237] So should Louisiana and all other states.

Furthermore, only with an acceptance of double effect intent will the issue of pain and doctor abandonment be addressed. If a doctor's intent to ease suffering is not accepted by the criminal justice system, the epidemic of under treatment of pain will only worsen. Furthermore, if a doctor fears criminal liability for treatment because he or she is assumed to know the consequences of all of his or her actions, there would be no real reason for the doctor to continue to treat patients in extreme emergency situations, thus exacerbating the problem of doctors fleeing during such situations.

CONCLUSION

The case of Dr. Pou and the controversy that surrounded it makes it obvious that the role of physicians during extreme emergency situations is a precarious one. These doctors risk their lives in treating patients and, although not physically injured, must cope with the severe mental anguish inherent in such horrible situations. Doctors may still fear for their lives, as hurricanes, terrorist attacks, or other calamities continue and reports of what is to come remain unclear. Furthermore, their families may also be in jeopardy. In such a situation, the law must be clear so as to provide a means of protection and assurance for both patients and doctors. Patients must receive adequate treatment, and doctors must not be charged for honestly trying to ease patients' suffering.

In conclusion, aggressive pain medication during the extreme emergency situation must remain criminalized but culpability must be based on the double effect intent standard.

235. *See supra* note 1 and accompanying text.
236. *See supra* note 1 and accompanying text.
237. *See supra* note 132 and accompanying text.