COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

NO. SJC-13194

DR. ROGER M. KLIGLER and DR. ALAN STEINBACH,

Plaintiffs-Appellants,

v.

MAURA T. HEALEY, in her official capacity as the Attorney General of the Commonwealth of Massachusetts, and MICHAEL O'KEEFE, in his official capacity as District Attorney of Cape & Islands District,

Defendants-Appellees.

On Appeal from the Suffolk County Superior Court
Civil Action No. 16-3254F

BRIEF OF EUTHANASIA PREVENTION COALITION USA AS AMICUS CURIAE IN SUPPORT OF MAURA T. HEALEY AND MICHAEL O'KEEFE AND FOR AFFIRMANCE

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**Pro hac vice* motion pending

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CORPORATE DISCLOSURE STATEMENT

Euthanasia Prevention Coalition USA is a nonprofit corporation based in Hartford, Connecticut, with no parent corporation and no stockholders.

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IDENTITY AND INTEREST OF *AMICUS CURIAE*[1]

Euthanasia Prevention Coalition USA is a national network that opposes euthanasia and assisted suicide, supporting positive measures to improve the quality of life of people and their families. Through public and legal advocacy, the Coalition works to preserve and enforce legal protections and ethical guidelines prohibiting euthanasia and assisted suicide, educates the public on the harms and risks associated with euthanasia and assisted suicide, and advocates for society's most vulnerable before legislatures and the courts on issues related to euthanasia and assisted suicide.

To those ends, the Coalition has a profound interest in preserving the "well settled" distinction between "withdrawing or refusing life-sustaining medical treatment" and "attempting suicide." *Guardianship of Doe*, 583 N.E.2d 1263, 1270 (Mass. 1992). Appellants would have the Court eviscerate that distinction. The Coalition files this amicus brief to explain why the Court should reject that demand.

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[1] No counsel for a party authored this brief in whole or in part. No one other than *amicus curiae* and their counsel made any monetary contribution to fund the preparation or submission of this brief. And neither *amicus curiae* nor its counsel represents or has represented one of the parties in this or any other proceeding involving similar issues.

SUMMARY OF ARGUMENT

There is no fundamental right to physician-assisted suicide in the Massachusetts Constitution. This Court looks to whether an alleged right is deeply rooted in tradition and history to determine whether a previously unrecognized right is fundamental; the Court only looks to more recent developments to decide whether a certain class has been denied access to already established rights. *Infra*, at 11–16.

Here, Appellants seek to establish a previously unrecognized right to "medical aid in dying," where a doctor prescribes lethal medication for use in committing suicide. *Infra*, at 21–25. But the widespread prohibition—not acceptance—of assisted suicide is deeply rooted in Massachusetts' and the Nation's history and tradition. *Infra*, at 16–20. And the vast majority of states and secular medical associations still oppose it today. *Infra*, at 16–17, 34–36.

Creating a right to physician-assisted suicide would not be a mere expansion of the right to refuse life-saving treatment. The right to reject treatment is based on the common-law right to reject a battery. And death occurs, if at all, by natural causes. *Infra*, at 25–28. Assisted suicide is different: it *invites* the intrusion of a lethal agent into the patient's body, intentionally causing death. *Infra*, at 28–33.

Finally, Appellants are wrong to suggest a constitutional right to assisted suicide could be limited to a narrow class of people. And that would create problems courts are not equipped to solve. *Infra*, at 36–40.

ARGUMENT

I. Like its federal counterpart, Massachusetts' Constitution does not include a right to physician-assisted suicide.

A. Physician-assisted suicide is not a fundamental right under state substantive-due-process provisions.

1. Even after *Goodridge*, *Obergefell*, and *Moe*, only those rights that are deeply rooted in history and tradition qualify as fundamental.

Appellants argue that the Massachusetts common law's blanket prohibition on assisted suicide violates "the fundamental right of self-determination and individual autonomy in the context of end-of-life medical care." Opening Br. 32. Rather than identify specific constitutional provisions, Appellants broadly assert their "privacy" and "liberty rights under the Massachusetts Constitution," Opening Br. 5, and invoke Massachusetts' "constitutional guarantee of due process," Reply Br. 14. So they appear to raise a substantive-due-process claim under the relevant provisions of Massachusetts' Declaration of Rights.

"Where a statute unjustifiably burdens the exercise of a fundamental right protected by [those provisions], the standard of review . . . is strict judicial scrutiny." *Gillespie v. City of Northampton*, 950 N.E.2d 377, 382 (Mass. 2011). Importantly, a "fundamental right is one that is 'deeply rooted in this Nation's history and tradition,' and 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if they were sacrificed.'" *Id.* at 382–83 (quoting *Washington v. Glucksberg*, 521 U.S. 702, 720–721 (1997)) (cleaned up).

Physician-assisted suicide cannot qualify as a fundamental right under that test, and Appellants do not claim that it can. Nor do they offer any other test for deciding whether a fundamental right exists. Instead, they argue only that "history and tradition" cannot "govern[] what constitutes a fundamental right," otherwise "interracial and same-sex marriages would still be illegal." Opening Br. 30–31 (citing *Goodridge v. Dep't of Pub. Health*, 798 N.E.2d 941 (Mass. 2003), *Obergefell v. Hodges*, 576 U.S. 644 (2015), and *Loving v. Virginia*, 388 U.S. 1 (1967)). But that doesn't follow.

The Supreme Court has "long held the right to marry is protected by the Constitution." *Obergefell*, 576 U.S. at 664. And for almost 100 years, the Court "has reiterated that the right to marry is fundamental under the Due Process Clause." *Id.* (collecting cases). That's true "as a matter of history and tradition." *Id.* at 671. So the courts in *Obergefell*, *Goodridge*, and *Loving* did not frame the question they answered as whether the right to marry is fundamental—it is. Instead, those courts framed the question as whether there was a "sufficient justification for excluding the relevant class from the right." *Id.* Or as this Court put it, for "depriv[ing] individuals of access" to the right "because of a single trait." *Goodridge*, 798 N.E.2d at 958. But no one denied that the right to marry is "deeply rooted in this Nation's history and tradition." *Glucksberg*, 521 U.S. at 720–721.

That explains why this Court applied *Glucksberg*'s history-and-tradition test in *Gillespie* almost eight years *after* the Court had decided *Goodridge*. And it explains why the Court continues to cite that test for determining whether a fundamental right exists after *Obergefell*. *See Commonwealth v. Wilbur W.*, 95 N.E.3d 259, 267 (Mass. 2018) (noting that a "fundamental right is one that is deeply rooted in this Nation's history and tradition") (quoting *Gillespie*, 950 N.E.2d at 382).

Obergefell's invitation to look beyond "history and tradition" to decide whether "new groups" should be allowed to "invoke rights once denied," applies *after* a fundamental right—deeply rooted in history and tradition—has been established. 576 U.S. at 671. And the same goes for *Goodridge*'s dicta[2] that "history must yield to a more fully developed understanding of the invidious quality of the discrimination." *Goodridge*, 798 N.E.2d at 958. That's true when the court only purports to decide whether a law discriminates against a class by "depriv[ing] [them] of access" to a fundamental right. *Id.* But *Goodridge* never blesses looking beyond history and tradition to decide whether a fundamental right exists in the first place.

[2] Because the Court ultimately concluded that Massachusetts' ban on same-sex marriage did "not survive rational basis review," the Court explicitly did *not* decide whether the case "merit[ed] strict judicial scrutiny." *Goodridge*, 798 N.E.2d at 961.

And that's especially true for assisted suicide. *Obergefell* conceded that *Glucksberg*'s insistence on defining fundamental rights "in a most circumscribed manner, with central reference to specific historical practices . . . may have been appropriate for the asserted right there involved (physician-assisted suicide)." 576 U.S. at 671. That "reference of approval" and "brief defense" of *Glucksberg* explains why courts continue to apply it—not *Obergefell*—to reject claims that physician-assisted suicide is a fundamental right. *Morris v. Brandenburg*, 356 P.3d 564, 578 (N.M. Ct. App. 2015), *aff'd,* 376 P.3d 836 (N.M. 2016).

For example, in *Myers v. Schneiderman*, New York's highest court cited *Glucksberg*'s survey of "history, legal traditions, and practices" and its holding that "the asserted right to assistance in committing suicide is not a fundamental liberty interest," to support the court's own conclusion that physician-assisted suicide does not "fall[] within the ambit of [the] broader state protection" offered by New York's state constitution. 85 N.E.3d 57, 63 (N.Y. 2017) (per curiam) (cleaned up).

Similarly, in *Brandenburg*, the New Mexico Supreme Court reaffirmed and applied "the *Glucksberg* approach with respect to physician aid in dying . . . because unlike [cases like] *Obergefell*, which had as a tradition the fundamental right to marry," courts "do not have such a tradition to fall back on regarding physician aid in dying." 376 P.3d at 848.

In their reply brief, Appellants try to analogize this case to a 1981 case involving Medicaid abortion funding. Reply Br. 14–17 (discussing *Moe v. Sec'y of Admin. & Fin.*, 417 N.E.2d 387 (Mass. 1981)). But that analogy fails for the same reasons the analogy to *Obergefell* and *Goodridge* fails. By 1981, courts considered "a woman's right to make the abortion decision privately" to be well established. 417 N.E.2d at 398. So when three Medicaid-eligible pregnant women challenged restrictions on Medicaid funding that "prevent[ed] them from obtaining abortions," *id.* at 396, they did not "assert either an absolute right to have abortions or an equivalent right to have their abortions subsidized by the State," *id.* at 400.

Instead, their claim was "more limited." *Id.* at 400. Unlike other family-planning and pregnancy-related services, "[o]nly subsidies for abortions [were] conditioned on a showing that the procedure [was] necessary to prevent death." *Id.* at 401. And it was "this unique treatment which the plaintiffs claim[ed] [was] unconstitutional." *Id.* Their claim was "thus limited to an assertion of the right to have abortions nondiscriminatorily funded." *Id.* (cleaned up).

And this Court ruled in their favor on that more limited basis. "While the State retains wide latitude to decide the manner in which it will allocate benefits, it may not use criteria which discriminatorily burden the exercise of a fundamental right." *Id.* Accordingly, when the Court ultimately held the challenged "funding restriction burden[ed]

the plaintiffs' fundamental right of choice," *id.* at 402, it did *not* purport to recognize a brand new "right to have their abortions subsidized by the State," *id.* at 400. That was never the plaintiffs' claim. *Id.*

As with *Obergefell* and *Goodridge*, the question in *Moe* wasn't whether a fundamental right existed—it was whether the plaintiffs had been discriminatorily denied access to a preexisting fundamental right. Here, by contrast, the question is whether a *new* fundamental right to "ingest lethal prescribed medication" exists. Opening Br. 11. To answer that question, the Court must ask whether the alleged right is "deeply rooted in this Nation's history and tradition." *Gillespie*, 950 N.E.2d at 382. And the answer to that question is a resounding, "No."

2. Criminal bans on assisted suicide are deeply rooted in our history and tradition; an alleged "right to die" is a modern invention.

"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." *Glucksberg*, 521 U.S. at 728. That was true in 1997 when the Supreme Court decided *Glucksberg*. *Id.* at 710 ("In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide."). And it remains true today. "Nine states and the District of Columbia have passed legislation to allow" physician-assisted suicide. Attorney General's Br. 39. But the "vast majority of states" still prohibit it. Cody Bauer, *Dignity in Choice: A Terminally Ill*

Patient's Right to Choose, 44 MITCHELL HAMLINE L. REV. 1024, 1040 & n.111 (2018) (listing 43 states, of which only three—Maine, New Jersey, and New Mexico—have since legalized it).

Physician-assisted suicide remains prohibited in Massachusetts, "where it has failed to secure majority support either in the Legislature or at the ballot box." Attorney General's Br. 39. And "no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction." *Compassion in Dying v. Washington*, 49 F.3d 586, 591 (9th Cir. 1995).[3]

"The States' assisted-suicide bans are not innovations." *Glucksberg*, 521 U.S. at 710. "Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life." *Id.* "Indeed, opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal, and cultural heritages." *Id.* at 711 (surveying "over 700 years" of "Anglo-American common-law tradition" that has punished or disapproved of "both suicide and assisting suicide").

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[3] Thus, even if this Court were to look beyond history and tradition to determine whether a fundamental right exists—as the trial court did—the Court still should affirm the trial court's conclusion that it does not. RAIII/356 ("However, the evidence before the Court does not sufficiently establish that the prohibition on MAID represents an outmoded viewpoint and that therefore the distinction established in our case law between MAID and other end of life options should be disregarded.").

Importantly, state "prohibitions against assisting suicide never contained exceptions for those who were near death." *Glucksberg*, 521 U.S. at 714. To the contrary, our laws have long recognized that the "lives of all are equally under the protection of the law, and under that protection to their last moment." *Blackburn v. State*, 23 Ohio St. 146, 163 (1872). "The life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live." *Id.*

And that has long been the law in Massachusetts. The "earliest reported case addressing the subject was the 1816 Massachusetts jury charge in *Commonwealth v. Bowen*." Thomas J. Marzen et al., *Suicide: A Constitutional Right?* 24 DUQUESNE L. REV. 1, 72 (1985). Bowen stood trial "on the charge that, while a prisoner he had persuaded a man in the next cell, who was about to be executed, to preempt the execution of the sentence by hanging himself." *Id.* at 74. On that charge, Chief Justice Parker instructed the jury that "if the murder of one's self is [a] felony," as it was at the time, then "the accessory is equally guilty as if he had aided and abetted in the murder" of one man by another. *Id.* (quoting *Bowen's Trial* at 51–52, *reprinted in, Commonwealth v. Mink*, 123 Mass. 422, 428 (1877)). "And if one becomes the procuring cause of death, though absent, he is [an] accessory." *Id.*

It did not matter if Bowen had "merely" been "instrumental in procuring the murder of a culprit within a few hours of death by the sentence of the law." *Commonwealth v. Bowen*, 13 Mass. 356, 360 (1816). The man's imminent execution wasn't relevant because "there is no period of human life which is not precious as a season of repentance." *Id.* And the jury was "not to consider . . . that but a small portion of [his] earthly existence could, in any event, remain to him." *Id.*

At the time, a 1660 law "required ignominious burial of a suicide's corpse in a highway with 'a Cart-load of Stones laid upon the Grave as a Brand of Infamy, and as a warning to others.'" Marzen, *supra*, at 65 (quoting *The General Laws and Liberties of Massachusetts Colony* (1672), *reprinted in* THE COLONIAL LAWS OF MASSACHUSETTS 137 (W. Whitmore ed. 1887)). "That statute, though fallen into disuse, continued in force until many years after the adoption of the Constitution of the Commonwealth." *Mink*, 123 Mass. at 426.

Seven years after Bowen's trial, the Legislature finally repealed it—possibly out of respect "for the feelings of innocent surviving relatives." *Mink*, 123 Mass. at 429. But despite the resulting possibility "that suicide is not technically a felony in this Commonwealth," it's remained "unlawful and criminal as *malum in se*." *Id.* And even after the general abolition of common-law crimes in 1852, four Justices of this Court "ruled in the same way as *Commonwealth v. Bowen* on the same issue." Marzen, *supra*, at 182 (citing an unreported case).

"There have been no subsequent cases or statutes to cast doubt upon the conclusion that this remains the law of Massachusetts today." *Id.* at 184. Quite the opposite. Describing *Bowen* as "centuries-old Massachusetts common law," this Court recently reaffirmed the "principle that a defendant might be charged and convicted of a homicide offense merely for 'repeatedly and frequently advising and urging a victim to destroy himself,' with no physical assistance." *Commonwealth v. Carter*, 115 N.E.3d 559, 569 (Mass. 2019) (quoting *Bowen*, 13 Mass. at 356) (cleaned up). Bowen's jury ultimately acquitted him. *Id.* at 570. "But the legal principle that procuring a suicide 'by advice or otherwise' may constitute a homicide is clear from the instructions reported in *Bowen*." *Id.* (quoting *Bowen*, 13 Mass. at 359).

Given this deeply rooted history and tradition of *criminalizing* assisted suicide, this Court cannot say that the *practice* of assisted suicide is so "deeply rooted in this Nation's history and tradition," and "implicit in the concept of ordered liberty," that "neither liberty nor justice would exist if [a right to it] were sacrificed." *Gillespie*, 950 N.E.2d at 382–83 (quoting *Glucksberg*, 521 U.S. at 720–721). "Unless the [Court] is to be a floating constitutional convention, [it] should not invent a constitutional right unknown to the past and antithetical to the defense of human life that has been a chief responsibility of our constitutional government." *Compassion in Dying*, 49 F.3d at 591.

3. Medical aid in dying—prescribing lethal drugs to a patient considering suicide—is assisted suicide.

Appellants can't escape this history and tradition by arguing that physician-assisted suicide is "fundamentally different" from "medical aid in dying." Reply Br. 5. Citing a handful of states and organizations that use the phrase, Reply Br. 6–7, Appellants insist that "medical aid in dying" is different because it is "defined narrowly" as a practice in which a physician prescribes a lethal drug to end the life of a terminally ill patient, Reply Br. 5. "Assisted suicide," on the other hand, encompasses all forms of "suicide committed by someone with assistance from a third person." Reply Br. 6. But Appellants' claim that the phrases describe "fundamentally different" conduct is wrong as a matter of fact and law.

Factually, the American Medical Association recently reaffirmed that "'physician assisted suicide' describes the practice" of "physician provision of lethal medications" with "the greatest precision." Report 2 of the American Medical Association's Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide* 2 (2019), perma.cc/ZUW9-X5YR. As the AMA defines it, "[p]hysician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." *Id.* at 9. For example, "the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit

suicide." *Id.* By contrast, the phrase "aid in dying" is over-inclusive in both directions: it "could be used to describe either euthanasia or palliative/hospice care at the end of life." *Id.* at 2. And that "degree of ambiguity is unacceptable for providing ethical guidance." *Id.*

Having rejected the phrase "aid in dying," the AMA voted in 2019 "by a 71% majority to reaffirm [its] opposition to physician assisted suicide, again noting that it is 'fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.'" Frederick J. White, *AMA Says 'No' to Physician-Assisted Suicide*, REALCLEARHEALTH (July 5, 2019), perma.cc/7M7S-MDDV (quoting AMA Ethics Opinion E-5.7).

Legally, courts have shown less concern for terminology, but they have been equally clear that patients do not have a fundamental right to their doctors' help in committing suicide—even if that help "only" includes prescribing a lethal dose of medication to a patient considering suicide. For example, in *Glucksberg* the lower court had struck down a state's assisted-suicide ban "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians." 521 U.S. at 709 (cleaned up). And the Supreme Court reversed that decision based on the "consistent and almost universal tradition" of rejecting a right to assisted suicide, "even for terminally ill, mentally competent adults." *Id.* at 723.

Likewise, in *Vacco v. Quill* the Supreme Court rejected an equal-protection challenge brought by a group of physicians who wanted to "prescribe lethal medication for [their] 'mentally competent, terminally ill patients.'" 521 U.S. 793, 797 (1997). Distinguishing that form of assisted suicide from the right to reject medical treatment, the Court observed that "a patient [who] refuses life-sustaining medical treatment . . . dies from an underlying fatal disease or pathology," whereas "a patient [who] ingests lethal medication prescribed by a physician . . . is killed by that medication." *Id.* at 801.

In the 25 years since *Glucksberg* and *Vacco*, state appellate courts have consistently rejected an alleged right to physician-assisted suicide even when the claimed right is "limited" to so-called "aid in dying." *Myers*, 85 N.E.3d at 62 ("Aid-in-dying falls squarely within the ordinary meaning of the statutory prohibition on assisting a suicide."); *Morris*, 376 P.3d at 838 (rejecting argument that a "mentally competent, terminally ill patient has a constitutional right" to a prescription for lethal medication); *Donorovich-Odonnell v. Harris*, 241 Cal. App. 4th 1118, 1124 (2015) (rejecting right to "physician aid-in-dying," defined as "prescribing a lethal dose of drugs a patient may or may not have filled or take"); *Sampson v. State*, 31 P.3d 88, 90 (Alaska 2001) (rejecting request to declare manslaughter statute "invalid to the extent that it prevents mentally competent, terminally ill individuals from obtaining prescribed medication to self-administer for the purpose of hastening

death"); *Krischer v. McIver*, 697 So. 2d 97, 99 (Fla. 1997) (rejecting right of a "competent adult, who is terminally ill, immediately dying and acting under no undue influence, . . . to hasten his own death by seeking and obtaining from his physician a fatal dose of prescription drugs and then subsequently administering such drugs to himself").

These more recent decisions follow a long line of state court decisions affirming criminal convictions for providing the means for committing suicide—regardless of whether the accused was present or physically administered the lethal dose himself.

For example, in *People v. Roberts*, the appellant had been convicted of first-degree murder based on his confession that he had "mixed poison with water and placed it within [his wife's] reach, but at her request." 178 N.W. 690, 692 (Mich. 1920). In upholding that conviction, the Michigan Supreme Court held that when the appellant had "mixed the paris green[4] with water and placed it within reach of his wife to enable her to put an end to her suffering by putting an end to her life, he was guilty of murder by means of poison within the meaning of the statute, even though she [had] requested him to do so." *Id.* at 693. "By this act he deliberately placed within her reach the means of

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[4] Paris green was a highly toxic, green powder created by Victorian-era chemists "who found that mixing copper with arsenic resulted in a dye that was brighter and longer-lasting than other greens in the market." Marco Sumayao, *Paris Green: The Trendy Color that Killed Many in Victorian Society*, ESQUIRE (March 3, 2018), perma.cc/C9E6-DTC5.

taking her own life, which she could have obtained in no other way by reason of her helpless condition." *Id.*[5]

Against this backdrop, Appellants' claim that "medical aid in dying" is "fundamentally different" from other forms of assisted suicide fails. Reply Br. 5. When physicians "prescribe medication that [their] patient[s] can self-ingest to hasten the time of their death," *id.*, they deliberately place within their patients' reach the means of taking their own lives, *Roberts*, 178 N.W. at 693. Thus, medical aid in dying "falls squarely within the ordinary meaning" of statutory and common-law "prohibition[s] on assisting a suicide." *Myers*, 85 N.E.3d at 62.

B. Physician-assisted suicide is not protected by the right to reject medical treatment because the distinction between the two remains well settled.

Appellants don't argue that a right to physician-assisted suicide is deeply rooted in history and tradition. *Supra* at 12. And for good reason. *Supra* at 16–20. Instead, they argue that this Court's decisions recognizing a right to reject medical care are based on the "fundamental right of self-determination and individual autonomy," and that physician-assisted suicide "implicates" that broader right. Opening Br. 32.

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[5] *Accord Blackburn*, 23 Ohio St. at 151 (affirming murder conviction and jury instructions stating it was "not necessary" that the defendant "should stand by and deliver" the poison to the suicidal victim, nor was it was "necessary that she should have received it from his hand . . . if he provided it for her where she could receive it, and so informed her").

"Of course, the law does not permit suicide." *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 635 n.29 (Mass. 1986). "Thus, the law does not permit unlimited self-determination, nor give unqualified free choice over life." *Id.* Moreover, the distinction between "withdrawing or refusing" medical treatment and "attempting suicide" remains "well settled." *Guardianship of Doe*, 583 N.E.2d at 1270.

1. Unlike the right to reject medical treatment, physician-assisted suicide does not implicate the common-law right to reject a battery.

Appellants insist that, "irrespective of tradition and . . . history," the common-law ban on physician-assisted suicide violates a terminally ill patient's "fundamental right of self-determination" because, under Massachusetts law, "terminally ill patients may avoid prolonged suffering during the dying process, even if their decisions may hasten death." Opening Br. 31–32. That argument has been tried and failed before.

The *Glucksberg* plaintiffs made the same argument, contending that "the constitutional principle behind recognizing [a] patient's liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication." 521 U.S. at 725. But the Supreme Court rejected it because the right to reject medical treatment was "not simply deduced from abstract concepts of personal autonomy." *Id.* It was based on the "common-law rule that forced medication was a battery" and on the

"long legal tradition protecting the decision to refuse unwanted medical treatment." *Id.* That made the Court's assumption that the Constitution protects the right to reject medical treatment "entirely consistent with this Nation's history and constitutional traditions." *Id.*

Likewise, "[t]his Court has recognized the right of a competent individual to refuse medical treatment" based on their "common law right to determine for themselves whether to allow a physical invasion of their bodies." *Norwood Hosp. v. Munoz*, 564 N.E.2d 1017, 1021 (Mass. 1991). *Accord Myers*, 85 N.E.3d at 63 ("the right to refuse treatment is a consequence of a person's right to resist unwanted bodily invasions"). "There is implicit recognition in the law of the Commonwealth, as elsewhere, that a person has a strong interest in being free from nonconsensual invasion of his bodily integrity." *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977) (citing, *inter alia*, *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891)). And that interest in being free from nonconsensual invasion "is now explicit in this Commonwealth." *Brophy*, 497 N.E.2d at 633.

Absent "an emergency or an overriding State interest, medical treatment of a competent patient without his consent is said to be a battery." *Matter of Spring*, 405 N.E.2d 115, 121 (Mass. 1980). Even in a medical setting, "[t]o compel any one . . . to lay bare the body, or to submit it to the touch of a stranger, without lawful authority, is an indignity, an assault, and a trespass." *Botsford*, 141 U.S. at 252. So this

Court has "recognize[d] a general right in all persons to refuse medical treatment in appropriate circumstances." *Saikewicz*, 370 N.E.2d at 427.

This Court also has said that the right to reject medical treatment is based in part on "the unwritten constitutional right of privacy found in the penumbra of specific guaranties of the Bill of Rights." *Id.* at 424. But even the right to privacy's application in this context is based on the right of patients to preserve their "right to privacy *against unwarranted infringements of bodily integrity*." *Id.* (emphasis added). *Accord Brophy*, 497 N.E.2d at 634 ("A significant aspect of this right of privacy is the right to be free of nonconsensual invasion of one's bodily integrity."); *Spring*, 405 N.E.2d at 119 (a person's "constitutional right of privacy . . . may be asserted to prevent unwanted infringements of bodily integrity"). So the right to be free from unwanted invasions of bodily integrity is central to the right to reject medical treatment.

Assisted suicide is different. "The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection." *Glucksberg*, 521 U.S. at 725. And that makes sense. "A person may refuse life-sustaining medical treatment because the treatment itself is a violation of bodily integrity." *People v. Kevorkian*, 527 N.W.2d 714, 732 n.59 (Mich. 1994). "Suicide enjoys no such foundational support, however." *Id.* "When one acts to end one's life, it is the intrusion of the lethal agent that violates bodily integrity." *Id.*

Indeed, courts have long held that violating another person's bodily integrity is permissible to *stop* a suicide attempt. "At common law, even a private person's use of force to prevent suicide was privileged." *Cruzan by Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 298 (1990) (Scalia, J., concurring). And this Court has long endorsed that approach: "Every one has the same right and duty to interpose to save a life from being so unlawfully and criminally taken, that he would have to defeat an attempt unlawfully to take the life of a third person." *Mink*, 123 Mass. at 429. So while the right to be free from unwanted invasions of bodily integrity supports a right to reject medical treatment, it does not support an alleged right to physician-assisted suicide.

2. Unlike rejecting medical treatment, physician-assisted suicide sets in motion the death-producing agent while intending to cause the patient's death.

Given the vastly different bodily-integrity interests at stake, it is "well settled that withdrawing or refusing life-sustaining medical treatment is not equivalent to attempting suicide." *Guardianship of Doe*, 583 N.E.2d at 1270. *Accord Norwood Hosp.*, 564 N.E.2d at 1022 ("Declining potentially life-saving treatment may not be viewed properly as an attempt to commit suicide."). But that only "partially" explains why courts have so "consistently adopted [this] well-established distinction." *Myers*, 85 N.E.3d at 63. "The distinction [also] comports with fundamental legal principles of causation and intent." *Vacco*, 521 U.S. at 801.

Causation. "First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication." *Id.* Stated differently, "refusing treatment involves declining life-sustaining techniques that intervene to delay death." *Myers*, 85 N.E.3d at 63. And that "decision result[s] in the shortening of life *by natural causes*." *Saikewicz*, 370 N.E.2d at 426 n.9 (emphasis added). "Aid-in-dying, by contrast, involves a physician actively prescribing lethal drugs for the purpose of *directly causing* the patient's death." *Myers*, 85 N.E.3d at 63 (emphasis added).

Courts recognize the very real "difference between choosing a natural death summoned by an uninvited illness or calamity, and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying." *Kevorkian*, 527 N.W.2d at 728–29. "In fact, the first state-court decision explicitly to authorize withdrawing lifesaving treatment noted the 'real distinction between the self-infliction of deadly harm and a self-determination against artificial life support.'" *Vacco*, 521 U.S. at 803 (quoting *In re Quinlan*, 355 A.2d 647, 665 (N.J. 1976)).

Relatedly, "the notion that there is a difference between action and inaction is not unfamiliar to the law." *Kevorkian*, 527 N.W.2d at 728. And that difference also helps explain the distinction courts draw between suicide and rejecting medical treatment: "whereas suicide

involves an affirmative act to end a life, the refusal or cessation of life-sustaining medical treatment simply permits life to run its course, unencumbered by contrived intervention." *Id.*

That "long-recognized distinction between action and forbearance" also explains why courts treat the physician's role differently in the two contexts. *Sampson*, 31 P.3d at 99. When a physician "honors a dying patient's request to withdraw life-sustaining medical treatment, the patient's underlying disease or pathology runs its course and causes death." *Id.* And "death is hastened" only by "the physician's *failure* to continue treatment." *Id.* (emphasis added). "In sharp contrast," when "a physician assists a terminally ill patient by prescribing medication to hasten the patient's death, the death is caused by the patient and is abetted by the physician's *affirmative* actions." *Id.* (emphasis added). The physician's role "is not treatment in the traditional sense," it is an "affirmative act designed to cause death—no matter how well-grounded the reasoning behind it." *Krischer*, 697 So. 2d at 102.

Intent. Second, a physician who withdraws "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." *Vacco*, 521 U.S. at 801 (cleaned up). "A doctor who assists a suicide, however, must, necessarily and indubitably, intend primarily that the patient be made dead." *Id.* at 802 (cleaned up).

"Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not." *Id.* And "[t]here is a marked difference between refusing medical treatment, even if doing so will hasten death, and seeking treatment which has for its exclusive purpose the taking of one's life." *Morris*, 376 P.3d at 848. "Absent an intent to die, there can be no suicide." *Guardianship of Doe*, 583 N.E.2d at 1270. And as this Court has "previously held, a 'death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion *nor intended* by the patient.'" *Id.* (quoting *Brophy*, 497 N.E.2d at 638) (emphasis added).

"Given these general principles, it is not surprising that many courts . . . have carefully distinguished refusing life-sustaining treatment from suicide." *Vacco*, 521 U.S. at 803. Massachusetts is far from alone in this regard. "*Many* courts have recognized this distinction." *Id.* at 804 n.8 (emphasis added) (citing 31 state and federal cases, including *Guardianship of Doe* and *Brophy*). "Similarly, the overwhelming majority of state legislatures have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted life-saving medical treatment by prohibiting the former and permitting the latter." *Id.* at 804–05.

Appellants would have this Court hold that these courts and legislatures are all wrong. Opening Br. 27–29. They claim there is "no meaningful distinction" between physician-assisted suicide and "other end-of-life options." Opening Br. 27. Specifically, they claim that when doctors withhold hydration and nutrition and apply palliative sedation, "death is the intended consequence," and "death is certain." *Id.* at 28.

But that argument misses the point. Stated simply, two things distinguish a patient's refusal of life-sustaining treatment from suicide: "(1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death." *Saikewicz*, 370 N.E.2d at 426 n.11.

In other words, a patient can refuse medical treatment without intending to die. But a patient who knowingly ingests lethal medication "necessarily" intends to die. *Vacco*, 521 U.S. at 802. And even when a patient who refuses treatment does intend to die, that intent never aligns with the setting in motion of the "death producing agent" because death is still attributable to natural causes. *Saikewicz*, 370 N.E.2d at 426 n.11; *Brophy*, 497 N.E.2d at 638. Again, not so with assisted suicide. A patient who ingests lethal medication *does* "set the death producing agent in motion with the intent of causing his own death." *Saikewicz*, 370 N.E.2d at 426 n.11. That's what makes it suicide.

II. Far from resolving the debate over physician-assisted suicide, constitutionalizing the issue would embroil the Court in equally thorny issues for years to come.

A. Especially in the absence of agreement in the relevant community, the legislature—not the Court—should decide hard issues rooted in questions of social policy.

"By extending constitutional protection to an asserted right or liberty interest," courts, "to a great extent, place the matter outside the arena of public debate and legislative action." *Glucksberg*, 521 U.S. at 720. This Court "must therefore exercise the utmost care" whenever it is "asked to break new ground in this field." *Id.* (cleaned up).

This Court exercised such caution in *Brophy* when it held that a patient in a persistent vegetative state has a right to stop treatment. 497 N.E.2d at 638. That holding was "consistent with the view of sound medical practice taken by the representative bodies of the [AMA], the Massachusetts Medical Society, and that of many ethicists and physicians." *Id.*

Physician-assisted suicide, by contrast, has not garnered anything close to that level of support from the medical community. The AMA remains firmly opposed. *Supra* at 22. And while the Medical Society recently adopted a position of "neutral engagement," it has made clear that it "did not establish" a "position of support for related legislative efforts." Mass. Med. Soc'y, *Testimony Relative to House 2381 & Senate 1208, an Act Relative to End of Life Options: Hearing Before the Joint Committee on Public Health* (Oct. 1, 2021), perma.cc/DWQ4-TM6X.

Among the handful of major U.S. medical societies that have taken a position on the issue, these two positions—firm opposition and studied neutrality—represent the full spectrum of positions. Mayo Clinic researchers recently published a "comprehensive analysis of such statements." Joseph G. Barsness et al., *US Medical and Surgical Society Position Statements on Physician-Assisted Suicide and Euthanasia: A Review*, BMC MED. ETHICS 2 (2020), perma.cc/BJ5K-V6NE. And among "a total of 150 distinct secular US medical and surgical professional societies," the researchers found less than 10 percent of them had published a statement on physician-assisted suicide (PAS). *Id.* at 2–3.[6] "No society had a statement overtly in support of PAS." *Id.*

"Societies with opposing statements view PAS as contrary to the physician's role in the general US society, do not view death as a right, and view that patient autonomy is an insufficient reason for legalization of PAS." *Id.* at 4. The American College of Physicians' statement typifies those views: "Physician-assisted suicide requires physicians to breach specific prohibitions as well as the general duties of beneficence and nonmaleficence. Such breaches are viewed as inconsistent with the physician's role as healer and comforter." *Id.* at 4–5 (cleaned up).

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[6] One group, the American Society of Anesthesiologists, may have been included by mistake. That group had stated its opposition to physician participation in *executions*. Am. Soc'y of Anesthesiologists, *Statement of Physician Nonparticipation in Legally Authorized Executions* (approved Oct. 18, 2006, reaff'd Oct. 13, 2021), perma.cc/8XMP-D35Y.

Against this backdrop, making up a right to physician-assisted suicide would *not* be "consistent with the view of sound medical practice taken by the representative bodies of the American Medical Association" and similar groups. *Brophy*, 497 N.E.2d at 638. Instead, such a holding "would run the risk of arrogating to [the Court] those powers to make social policy that as a constitutional matter belong only to the legislature." *Krischer*, 697 So. 2d at 104.

B. Creating a constitutional right to physician-assisted suicide would make it impossible to set necessary safeguards.

Among the secular medical societies that have taken a position on the issue, both "studied neutrality statements" and "opposing statements . . . warn of a slippery slope of long-term risks that PAS legalization may incur." Barsness, *supra*, at 5. "Such long-range consequences include broadened use of PAS for nonterminal conditions and use of PAS in favor of palliative care." *Id.* These and other challenges inherent in setting necessary safeguards in this area—even legislatively—supports the State's conclusion that there are "ample rational bases to support the prohibition of physician-assisted suicide." Attorney General's Br. 45–54. And as other courts have recognized, if the law in this area "were changed by judicial opinion, these extensive safeguards would not be in place." *Donorovich-Odonnell*, 241 Cal. App. 4th at 1140.

Appellants disagree, arguing that the right they seek is a "very narrow" one, and that it would be limited to a narrow class of people. Opening Br. 30 ("adult, terminally ill patient[s]" who are "mentally competent" and able to "self-ingest" the lethal medication).

But that response proves too much. By arguing that the Court "should recognize a right to physician-assisted suicide that could be exercised only by mentally competent, terminally ill adults who are capable of self-administering lethal drugs prescribed by their physicians," Appellants "tacitly acknowledge both that assisted suicide generally poses a significant risk of harm to potentially vulnerable persons and that a corresponding need exists for state regulation except in the narrow class of cases that they view to be relatively risk-free." *Sampson*, 31 P.3d at 96.

If this Court "were to recognize an absolute, fundamental right to physician aid in dying," though, "*constitutional questions would abound* regarding legislation that defined terminal illness or provided for protective procedures to assure that a patient was making an informed and independent decision." *Morris*, 376 P.3d at 857 (emphasis added). "If the assistance in committing suicide is a constitutionally protected right, then how do [courts] draw a constitutional line as to who can exercise that right?" *Krischer*, 697 So. 2d at 108 (Harding, J., concurring) (cleaned up).

For example, all terminal patients are—or are likely to become—disabled: that is, to require assistance with major life activities such as walking, working, eating, speaking, and breathing. 42 U.S.C. § 12102. The Coalition and like-minded disability-rights organizations strongly believe that "[t]o give someone, including a physician, the right to assist a person with a severe disability in killing himself or herself is discrimination based on a disability." *Krischer*, 697 So. 2d at 102 (quoting *amicus curiae* brief of The Advocacy Center for Persons with Disabilities, Inc.). Creating such an alleged right "lessens the value of a person's life based on health status and subjects persons with severe physical and mental disabilities to undue pressure to which they may be especially vulnerable." *Id.* (quoting same amicus brief).

At the same time, proponents of assisted suicide have argued that limiting the right to patients who can self-ingest the lethal drugs "discriminates against people who are physically unable to administer aid-in-dying medication." *Shavelson v. Cal. Dep't of Health Care Servs.*, No. 21-CV-06654-VC, 2021 WL 4261209, at *1 (N.D. Cal. Sept. 20, 2021). Constitutionalizing the issue would invite lawsuits from patients and advocates on both sides of the debate.

So too for the line that would allegedly limit physician-assisted suicide to the terminally ill. If, as Appellants maintain, "there is no significant difference between the right to assisted suicide and the right to reject unwanted life-saving treatment, it is fairly clear that, once

established, the right to assisted suicide would not be limited to the terminally ill." Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 741 (1995). "For the right of a person to reject life-sustaining medical treatment has not been so limited." *Id. Accord Saikewicz*, 370 N.E.2d at 427 ("[W]e recognize a general right *in all persons* to refuse medical treatment in appropriate circumstances.") (emphasis added).

For the same reasons, if this Court finds a right to physician-assisted suicide based on the right to reject medical treatment, it is not clear the Court would be able to limit its availability to the mentally competent. This Court has held "that the substantive rights of the competent and the incompetent person *are the same* in regard to the right to decline potentially life-prolonging treatment." *Saikewicz*, 370 N.E.2d at 423 (emphasis added). "Recognition of this principle of equality requires understanding that in certain circumstances it may be appropriate for a court to consent to the withholding of treatment from an incompetent individual." *Id.* at 428. Given that, if the Court constitutionalizes a right to physician-assisted suicide, the same "principle of equality" could be cited to support a court's consent to the administration of lethal medication to an incompetent individual. *Id.*

* * *

A legislature that finds itself too far down this slippery slope at least has the ability to adjust course in a single legislative session. Not so for the courts, which are bound by *stare decisis* and limited to deciding the issues and cases that come before them. The best way to avoid entangling the courts in these and equally thorny issues for years to come—indeed the only way—is to preserve the "well settled" distinction between "withdrawing or refusing life-sustaining medical treatment" and "attempting suicide." *Guardianship of Doe*, 583 N.E.2d at 1270.

CONCLUSION

This Court should affirm the judgment below.

Respectfully submitted,

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RULE 16(K) CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that this brief complies with all of the rules of court that pertain to the filing of amicus briefs, including, but not limited to, the requirements of Rules 16 and 20 of the Massachusetts Rules of Appellate Procedure. This brief complies with Mass. R. App. P. 20(a)(2)(C) because it has been produced in proportionally spaced typeface using Century Schoolbook 14-point font and, excluding the parts of the brief exempt by Mass. R. App. P. 20(a)(2)(D), contains 7,313 words.

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CERTIFICATE OF SERVICE

I hereby certify that on February 16, 2022, I electronically filed the foregoing amicus brief with the Clerk of the Court for the Massachusetts Supreme Judicial Court, which will accomplish service on counsel for all parties through the Court's electronic filing system. I further certify that I have served copies of the brief by email on the following counsel of record for the parties:

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