COMMONWEALTH OF MASSACHUSETTS

Supreme Judicial Court

SUFFOLK, SS. NO. SJC-13194

ROGER M. KLIGLER & ANOTHER,
Plaintiffs-Appellants,
v.
MAURA HEALEY & ANOTHER,
Defendants-Appellees.

ON APPEAL FROM A JUDGMENT OF THE SUPERIOR COURT

BRIEF OF ATTORNEY GENERAL MAURA HEALEY AND DISTRICT ATTORNEY MICHAEL O'KEEFE

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STATEMENT OF THE ISSUES

1. Whether the Superior Court correctly found that physicians who engage in physician-assisted suicide (PAS) [1] may be prosecuted for involuntary manslaughter.
2. Whether the Superior Court properly determined that Massachusetts's common law of involuntary manslaughter is not unconstitutionally vague as applied to PAS.
3. Whether the Superior Court correctly concluded that access to PAS is not a fundamental constitutional right protected by due process or equal protection principles.
4. Whether the Superior Court correctly decided that Plaintiffs had not carried their burden to show that there is no conceivable rational basis for prohibiting PAS.

[1] The medical profession generally refers to the practice as "physician-assisted suicide" (PAS). Plaintiffs, however, use the term "medical aid in dying" (MAID). In 2018, the American Medical Association's Council on Ethics and Judicial Affairs reiterated its belief that "ethical deliberation and debate is best served" by using the term "physician-assisted suicide" rather than the more ambiguous "aid in dying" terminology. RAII/329. Defendants use the term PAS, derived from the AMA's "more precise" language (*id.*; RAIII/88), except where quoting Plaintiffs' filings or the Superior Court's decision. Regardless of the label adopted, there is no dispute that what is contemplated is providing seriously ill, adult patients with a lethal drug that they can take to end their life.

STATEMENT OF THE CASE

Plaintiffs seek a declaration that PAS is not a criminal offense in Massachusetts. In the alternative, they request a declaration that the prosecution of physicians who provide lethal medication to mentally competent, terminally ill adults is unconstitutional. Defendants submitted, and the Superior Court agreed, that Massachusetts law holds otherwise. That can be changed by the Legislature or by the public through the initiative process, but neither has done so to date. Until such a change in the law occurs, this issue is properly left to elected Executive Branch officials to decide whether and how to proceed should the plaintiffs take the actions contemplated.

This is an appeal from the Superior Court's judgment, issued on December 31, 2019, granting Defendants' motion for summary judgment on Counts I-IV and VI of the complaint. ADD-85.

Plaintiffs' complaint, filed in the Suffolk Superior Court on October 24, 2016, asserts six causes of action. Count I seeks "a declaration that manslaughter charges are not applicable to physicians who follow a medical standard of care and write a prescription to terminally ill, competent adults who request such aid and may choose to self-administer the medication consistent with the practice of [MAID]," RAI/24-25; Count II alleges that Massachusetts's common law of

involuntary manslaughter is impermissibly vague under the Massachusetts Constitution, RAI/25-26; Count III claims that the application of manslaughter law to MAID impermissibly infringes on Plaintiffs' fundamental privacy right, RAI/26-27; Count IV alleges that the application of manslaughter law to MAID is an unconstitutional restriction on Plaintiffs' fundamental liberty interests, RAI/27-28; Count V alleges that applying the criminal law to physicians for providing information and advice regarding MAID impermissibly restricts their freedom of speech, RAI/28-29; Count VI asserts that Massachusetts law violates Plaintiffs' right to equal protection because it impermissibly distinguishes between MAID (which is prohibited) and the withdrawal of life-sustaining treatment, including stopping nutrition and hydration (which is permitted). RAI/29-30.

The Superior Court denied Defendants' motion to dismiss the complaint for failure to state a claim for declaratory relief on May 25, 2017. RAI/11. After conducting discovery, the Parties filed cross-motions for summary judgment, with Plaintiffs moving for summary judgment on Counts V and VI, and Defendants moving for summary judgment on all counts. The court held a hearing on these motions on March 26, 2019. RAIII/229-334. Pursuant to the court's subsequent order, the parties submitted supplemental briefs addressing the impact on Count I

of the Court's opinion in *Commonwealth v. Carter*, 481 Mass. 352 (2019), cert. denied sub. nom., *Carter v. Massachusetts*, 140 S. Ct. 910 (2020) (*Carter II*).

On December 31, 2019, the Superior Court granted Defendants' motion for summary judgment on Counts I-IV and VI, and Plaintiffs' motion on Count V. [2] The court emphasized its "immense compassion for Dr. Kligler's desire to avoid a potentially painful death and for Dr. Steinbach's desire to ease his patients' suffering." ADD-63. However, the court concluded that "plaintiffs' arguments concerning the right to utilize MAID [were] unavailing." *Id*.

STATEMENT OF FACTS

Plaintiffs' discussion of "End of Life Care" (Appellants' Brief ["Br."] 8-10) does not present undisputed facts, but rather is part of their argument – disputed by Defendants – that PAS is similar to other, legal, end-of-life care options, including palliative sedation. Accordingly, Defendants discuss the differences between PAS and palliative sedation in Section V.C. below, as part of their argument that a

[2] Defendants acknowledged that Plaintiffs have a right to talk about PAS, to advocate for its adoption and to explain to patients the features and advisability of the practice. ADD-72. The Superior Court concluded that "providing advice and information about MAID is permitted in the Commonwealth." ADD-63. Accordingly, Defendants do not appeal the Superior Court's ruling on Count V.

rational basis exists for prohibiting PAS while allowing other type of end-of-life care.

The Superior Court ruled based on the following undisputed facts. Dr. Kligler is diagnosed with stage 4 metastatic castrate-resistant prostate cancer, a condition for which he has been treated since July, 2016. RAI/16. He desires to receive a lethal prescription from a physician and believes that obtaining such medication will allow him to "to live his final days knowing that, if his suffering becomes too great due to his cancer, he has the option of ending his life peacefully." RAI/15; *see also* RAI-Impounded/536-37. While Dr. Kligler is not currently terminally ill, Defendants acknowledge that "the prognosis for cancer patients can quickly turn negative." Appellants' Br. 6.

Dr. Kligler desires to avail himself of a practice whereby "physicians who follow a medical standard of care . . . [may] write a [lethal] prescription to terminally ill, competent adults who request such aid and choose to self-ingest medication." Appellants' Br. 5. He anticipates that he will be unable to obtain the requested prescription from a Massachusetts physician because of such a physician's fear of criminal prosecution. *Id.* at 7. Co-plaintiff Dr. Steinbach is willing to provide Dr. Kligler with a lethal prescription but refrains from doing so because he too fears prosecution. *Id.* at 8.

Defendants do not question the good faith of either Plaintiff. Nevertheless, they have concluded in their official capacities that the contemplated practice is not immune from prosecution in Massachusetts. Consequently, they have declined to commit not to prosecute Dr. Steinbach should he provide the requested prescription.

SUMMARY OF THE ARGUMENT

This Court should affirm the Superior Court's grant of summary judgment to Defendants on Counts I-IV and VI. First, doctors who engage in PAS are not insulated from criminal prosecution in Massachusetts. A physician's act of writing a lethal prescription for a patient who uses it to commit suicide constitutes wanton or reckless conduct causing death and may therefore result in prosecution under the common law of involuntary manslaughter. *Infra* Section II, pp. 17-29. Second, there is nothing vague about the application of involuntary manslaughter law to PAS because it does not differ from applying the elements of involuntary manslaughter to any other reckless action that brings about a death. *Infra* Section III, pp. 29-31. Third, access to PAS is not a fundamental constitutional right subject to strict judicial scrutiny. PAS is materially different from a patient's recognized right to reject unwanted life-sustaining treatment, and the practice has never been recognized as a fundamental right by an appellate court in

Massachusetts or any other United States jurisdiction. *Infra* Section IV, pp. 31-39. Fourth, because PAS does not implicate a fundamental constitutional right, its prohibition in Massachusetts may be sustained upon any conceivable rational basis. Plaintiffs have failed to show that there is no conceivable basis for the prohibition of PAS, because the record discloses ample conceivable bases, including, among others, the difficulty of ascertaining the patient's competence to request a lethal prescription or the terminal nature of an illness; the availability of alternatives for addressing end-of-life pain; concerns about the integrity of the medical profession; and the absence of any recognized medical standard of care for PAS in Massachusetts. Thus, the current prohibition on PAS in Massachusetts is constitutional, and it remains for the Legislature to decide whether or not the practice should be legalized. *Infra* Section V, pp. 39-58.

ARGUMENT

I. Standard of Review.

This Court reviews a grant of summary judgment *de novo* and "may affirm the judgment on any ground supported by the record." *Roman v. Trustees of Tufts Coll.*, 461 Mass. 707, 711 (2012). "The standard of review of a grant of summary judgment is whether, viewing the evidence in the light most favorable to the nonmoving party, all material facts have been established and the moving party is

entitled to a judgment as a matter of law." *Wolsfelt v. Gloucester Times*, 98 Mass. App. Ct. 321, 324 (2020). A moving party is entitled to summary judgment "where a nonmoving party, who bears the burden of proof, has no reasonable expectation of proving an essential element of the claim." *Williams v. Steward Health Care Sys., LLC*, 480 Mass. 286, 290 (2018).

II. The Unregulated Practice of Physician-Assisted Suicide Is Not Categorically Insulated From Potential Criminal Liability.

In Count I of their complaint, Plaintiffs seek a declaration "that physicians who follow a medical standard of care and write lethal prescriptions to competent, terminally ill adults who may choose to self-administer the medication . . . cannot be criminally prosecuted for common law involuntary manslaughter." ADD-67. Defendants continue to assert that Plaintiffs are not entitled to declaratory relief with respect to Count I because they seek an advisory opinion on the application of criminal law to PAS based on hypothetical circumstances. *See, e.g., Bunker Hill Distrib., Inc. v. District Att'v for the Suffolk Dist.*, 376 Mass. 142, 145 (1978) (in the absence of live controversy or threatened prosecution, claim for declaratory judgment dismissed because it sought no more than an advisory opinion). As the discussion below makes clear, manslaughter is a highly fact-specific crime. *See, e.g., Commonwealth v. Carter*, 474 Mass. 624, 634 (2016) (*Carter I*); *Ariel A. v. Commonwealth*, 420 Mass. 281, 287 n.7 (1995). Plaintiffs' complaint does not,

nor could it, reflect all the factual permutations surrounding patient capacity to exert free will, survival prognoses, treatment options, or prosecutorial discretion in the application of manslaughter law to physicians who knowingly participate in PAS. *See Bunker Hill*, 376 Mass. at 146 (finding that an as-applied challenge to a statute prohibiting obscenity "would best be resolved in a criminal proceeding when and if the Commonwealth decided to prosecute"). If the Court does consider it on the merits, however, Plaintiffs' claim in Count I should be rejected because the elements of involuntary manslaughter are in fact applicable to PAS.

On appeal, Plaintiffs advance the same three arguments that the Superior Court properly found unavailing (*id*. at 6): 1) that the doctor does not cause death because the patient self-ingests the prescribed medication; 2) that the doctor's conduct is not wanton or reckless because the doctor's intention is to benefit the patient; and 3) that in dicta in *Carter I*, 474 Mass. 624, and *Carter II*, 481 Mass. 352, the SJC created an exemption from any potential criminal prosecution for PAS. For reasons described below, each of these arguments must fail. Indeed, the elements of involuntary manslaughter may be applied to PAS, such that the practice remains unlawful in Massachusetts.

A. Because the Patient's Death is Foreseeable, the Causation Element of Involuntary Manslaughter Can Be Satisfied in a Physician-Assisted Suicide.

In Massachusetts, involuntary manslaughter is defined through case law rather than by statute.[3] Involuntary manslaughter involves "an unlawful homicide unintentionally caused by wanton or reckless conduct." *Commonwealth v. Catalina*, 407 Mass. 779, 789-792 (1990) (defining involuntary manslaughter in a prosecution based on allegations that victim died from using heroin sold to her by defendant) (citing *Commonwealth v. Welansky*, 316 Mass. 383 (1944)).[4]

The causation element can be satisfied even where intervening conduct by the victim leads to death, as long as this conduct is reasonably foreseeable. *Catalina*, 407 Mass. at 791 (the causal link between the defendant's selling heroin to the victim and her death was not broken by the victim's "intervening conduct of injecting herself") (citing *Commonwealth v. Askew*, 404 Mass. 532, 534 (1989)). Wanton or reckless conduct is "intentional conduct . . . involv[ing] a high degree of likelihood that substantial harm will result to another." *Carter I*, 474 Mass. at 631

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[3] While G.L. c. 265, § 13 prescribes the punishment for manslaughter, it does not define the crime.

[4] *Commonwealth v. Life Care Centers of America, Inc.*, 456 Mass. 826, 832 (2010), supplies another formulation of this definition: "an unlawful homicide unintentionally caused by an act which constitutes such a disregard of probable harmful consequences to another as to amount to wanton or reckless conduct."

(quoting *Commonwealth v. Pugh*, 462 Mass. 482, 496 (2012)). The offense does not require that the defendant intend the resulting death, but only that the defendant intend to do the reckless act. *See Commonwealth v. Levesque*, 436 Mass. 443, 452 (2002). Recklessness[5] may be determined on a subjective basis (the defendant is aware of potential harm) or on an objective basis (a reasonable person would be aware of such potential harm). *See Commonwealth v. Perry*, 34 Mass. App. Ct. 127, 129-130 (1993).

Suicides that are caused by the recklessness (in actions or words) of another person are not shielded from application of the traditional elements of involuntary manslaughter. *See, e.g.*, *Commonwealth v. Atencio*, 345 Mass. 627, 628-629 (1963) (defendants could be convicted of involuntary manslaughter where the victim died of a self-inflicted gunshot in a game of Russian roulette; "the Commonwealth had an interest that the deceased should not be killed by the wanton or reckless conduct of himself and others").[6] *See also Persampieri v.*

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[5] The SJC's "recent practice has been simply to refer to reckless conduct as constituting the conduct that produces liability for what the court has traditionally called wilful, wanton, or reckless conduct." *Sandler v. Commonwealth*, 419 Mass. 334, 335 (1995). Defendants use the term in this shorthand fashion.

[6] Plaintiffs mistakenly rely on the distinction in *Atencio* between drag racing and Russian roulette: because "much is left to the skill, or lack of it, of the competitor" (Appellants' Br. 19), reckless conduct by one driver is not a "sufficiently direct

(footnote continued)

Commonwealth, 343 Mass. 19, 22-23 (1961) (involuntary manslaughter conviction proper where defendant, knowing wife planned to commit suicide, gave her a rifle, loaded it, and demonstrated how to use it); *Commonwealth v. Bowen*, 13 Mass. 356, 359-360 (1816) (defendant could be guilty of murder where he urged a fellow prisoner to commit suicide, so long as the defendant "was instrumental in the death"). That the victim performs the final act (here, ingesting the lethal medication) does not relieve the defendant of criminal responsibility, because this intervening conduct is reasonably foreseeable. *See Catalina*, 407 Mass. at 791.[7]

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cause of the competing driver's death" in drag racing. *Atencio*, 345 Mass. at 630. According to Plaintiffs, the doctor does not cause death in PAS because "so much further action is left to the patient." *Id*. However, the holding of *Atencio* is precisely that an involuntary manslaughter conviction is proper where the defendant's reckless actions caused the victim's self-inflicted death. *See Atencio*, 345 Mass. at 629-30. No skill is required for the patient to fill the prescription and to self-administer the lethal medication; thus, the analogy with drag racing cases distinguished in *Atencio* is a faulty one.

[7] Plaintiffs rely on the language of the trial judge in *Carter*, who found that the victim broke the "chain of self-causation by exiting the vehicle" during his suicide attempt. *Carter II*, 481 Mass. at 362. The SJC found that the defendant then caused the victim's death by instructing him to get back in. *See infra*, p. 25 (quoting *Carter I*, 474 Mass. at 636). Plaintiffs contend that in PAS, by contrast, the patient fills the prescription and self-ingests the medication such that the "'the chain of self-causation' is not broken." Appellants' Br. 18. However, in PAS, the doctor's act of writing the lethal prescription is itself the first and essential link in the chain of events resulting in the patient's death. The patient's actions are reasonably foreseeable intervening causes, which do not negate the doctor's liability.

When patients request a lethal prescription, their intent to commit suicide is clear and their resulting death is foreseeable. Accordingly, the patient's actions do not eliminate the causal connection between the act of writing the prescription and the reasonably foreseeable ensuing death. *Askew*, 404 Mass. at 534 ("[I]ntervening conduct of a third party will relieve a defendant of culpability only if such an intervening response was not reasonably foreseeable."). In PAS, death would not occur without the doctor's purposeful action of providing the patient with the means for committing suicide. Because the patient's self-administration of the lethal medication is a "reasonably foreseeable" intervening cause, the doctor can still be prosecuted for involuntary manslaughter.[8]

B. The Physician's Good Faith Does Not Negate the Recklessness Element of Involuntary Manslaughter as Applied to Physician-Assisted Suicide.

Plaintiffs suggest that where the doctor's actions are "a result of thoughtful consideration" and are intended for the patient's benefit, they cannot be wanton or

[8] Plaintiffs' analogy between the doctor who provides a prescription for a lethal medication and those who sold the carbon monoxide generator and water pump to the victim in *Carter* (Appellants' Br. 18) is entirely misplaced. Both of these objects can be (and generally are) used for purposes other than suicide, and there was no indication in *Carter* that the sellers knew or should have known of the victim's intention to kill himself using the generator and/or pump. By contrast, the doctor writes the prescription for the very purpose of giving the patient the means to commit suicide.

reckless. Appellants' Br. 24. This argument misconstrues the meaning of recklessness as an element of involuntary manslaughter. As previously stated, reckless conduct is "intentional conduct . . . involv[ing] a high degree of likelihood that substantial harm will result to another." *Carter I*, 474 Mass. at 631. The Superior Court correctly found that "[t]he writing of a lethal prescription is an intentional action that, given its very purpose, is highly likely to result in death." ADD-69 (citing *Commonwealth v. Carrillo*, 483 Mass. 269, 287 (2019) ("Where there is specific evidence that the defendant knew or should have known that his or her conduct created a high degree of likelihood that substantial harm will result, the Commonwealth may indeed convict the person who sold or gave the heroin to the decedent of involuntary manslaughter.") (quotations and citations omitted)). Doctors who write a lethal prescription take an action that they know, and that any reasonable person in their position would know, creates "a high degree of likelihood that substantial harm [i.e., death] would result to another." *Carter*, 474 Mass. at 631.[9] Accordingly, this action can be deemed reckless regardless of a

[9] The Plaintiffs' suggestion that, for patients seeking PAS, death is not a substantial harm is unsupported by case law and contrary to the Commonwealth's well-recognized interest in the preservation of life and the prevention of suicide. *See, e.g.*, *Norwood Hosp. v. Munoz*, 409 Mass. 116, 125 (1991). In fact, Plaintiffs' argument is merely an expression of their policy-based view that PAS is the best option for some.

physician's thoughtful consideration or supposedly benevolent motives.

Plaintiffs' insistence that doctors engage in PAS with the intention of providing what the patient wants (*see, e.g.*, Appellants' Br. 24) is an attempt to create a good-faith defense to criminal prosecution. Such a defense could be created by statute, and effectively has been in Oregon, where legislation has authorized PAS. Or. Rev. Stat. Ann. §§ 127.800 – 127.995. But it does not exist in Massachusetts.[10] The patient's consent is also not a defense to involuntary manslaughter under Massachusetts law. *See, e.g.*, *Atencio*, 345 Mass. at 629. *Contrast Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009) (under the state statute establishing a consent defense to homicide, patient consent could constitute a defense to a homicide charge against a physician who engages in PAS).

A defendant's state of mind is relevant only to the general-intent element of involuntary manslaughter, which simply requires proof that the defendant intended to undertake the action that brings about a death. *See, e.g.*, *Commonwealth v. Walker*, 442 Mass. 185, 193, n.16 (2004) ("It is of no consequence that the

[10] The Massachusetts Legislature has never legalized PAS or any variation on the practice, and has in fact indicated a contrary policy. *See* G.L. c. 111, § 227(c) (health care professional not authorized to provide information about assisted suicide or the prescribing of medication to end life); G.L. c. 201D, § 12 (suicide, mercy killing, or affirmative act to end one's own life not authorized in connection with heath care proxies).

defendant may have meant no harm to the victim.") (quotations and citations omitted); *Welansky*, 316 Mass. at 398 ("What must be intended is the conduct, not the resulting harm."). In PAS, the physician intends to write the lethal prescription. However carefully considered, this action is reckless under the law if it is highly likely to result in death. Thus, regardless of whether the doctor intends that the patient take the prescribed medication or merely achieve peace of mind as a result of having the option to do so, the act of writing a prescription can itself be reckless.

C. The Supreme Judicial Court's Decisions in *Carter* Do Not Exempt Doctors Engaged in Physician-Assisted Suicide from Potential Prosecutions for Involuntary Manslaughter.

Plaintiffs contend that the SJC's decisions in *Carter I* and *Carter II* introduced a new element into the law of involuntary manslaughter as applied in the context of suicide: namely, that the defendant "procure" the suicide by "pressuring a vulnerable person" into killing themselves and by "overcoming that person's will to live." Appellants' Br. 20. The Superior Court correctly rejected this argument, finding that the *Carter* cases did not alter the traditional common-law definition of involuntary manslaughter. ADD-68. "Rather, the cases were narrowly focused on whether the use of words alone could constitute involuntary manslaughter." *Id*. Explaining that the defendant's conviction does not offend the First Amendment, the SJC wrote: "The only verbal conduct punished as

involuntary manslaughter has been the wanton or reckless pressuring of a vulnerable person to commit suicide, overpowering that person's will to live and resulting in that person's death. We are therefore not punishing words alone, as the defendant claims, but reckless or wanton words causing death." *Carter II*, 481 Mass. at 367-368.

The defendant in *Carter* was convicted of involuntary manslaughter for verbally encouraging her boyfriend to commit suicide through "a systematic campaign of coercion . . . that targeted the equivocating young victim's insecurities and acted to subvert his will power in favor of her own." *Carter I*, 474 Mass. at 636. After exchanging numerous messages with the victim, in which she urged him to commit suicide and helped him research methods for doing so, the defendant was on the phone with him while he "was in his truck committing suicide" by poisoning himself with carbon monoxide. *Carter II*, 481 Mass. at 358. At one point, the victim got out of the truck, essentially abandoning his suicide attempt. *Id*. at 358-59. The defendant "instructed him to get back in" and did not take any steps to help him after he got back in and "she could hear the sound of the pump [producing carbon monoxide] and the victim's coughing." *Id*. at 359. The Court found in *Carter I* that "there was probable cause to show that the coercive quality of the defendant's verbal conduct overwhelmed whatever willpower the

eighteen year old victim had to cope with his depression, and that but for the defendant's admonishments, pressure, and instructions, the victim would not have gotten back into the truck and poisoned himself to death." 474 Mass. at 635-636. In *Carter II*, the Court affirmed the defendant's conviction, finding that "reckless or wanton words causing death" can be punished as involuntary manslaughter without offending the First Amendment. 481 Mass. at 368.

The Court reached these conclusions without altering traditional manslaughter jurisprudence. Its inquiry focused on whether the defendant's communications with the victim were reckless in the circumstances of the case, a conclusion that the Court had little difficulty reaching. *Carter II*, 481 Mass. at 359-360. The Court also concluded that the evidence was sufficient to support a finding that the defendant's verbal conduct caused the victim's death. *Id*. at 361-363.

By contrast, a doctor's role in PAS is not limited to words, but also involves "the prescription of lethal medication to patients in order to provide them with an otherwise unavailable means to end their own lives." ADD-68. Accordingly, the question considered in *Carter* – whether the defendant's reckless verbal conduct caused the victim's self-inflicted death by means of coercion – is not applicable to PAS. *See Atencio*, 345 Mass. at 630 (where victim shot himself while playing

Russian roulette with defendants, "[i]t would not be necessary that the defendants force the deceased to play or suggest that he play" for them to be convicted of involuntary manslaughter).

Plaintiffs argue that the following dictum in *Carter I* creates an exception to involuntary manslaughter law, insulating PAS from potential prosecution:

> It is important to articulate what this case is not about. It is not about a person seeking to ameliorate the anguish of someone coping with a terminal illness and questioning the value of life. Nor is it about a person offering support, comfort, and even assistance to a mature adult who, confronted with such circumstances, has decided to end his or her life.

Carter I, 474 Mass. at 636. However, this passage addresses issues not presented in *Carter* and therefore not decided by the SJC at all. What is more, the inference that "assistance" here means the writing of a prescription by a doctor, in the narrow circumstances defined by PAS laws in a handful of states that permit the practice, is entirely unfounded. There is no basis to conclude that the SJC intended for these words to be interpreted so broadly. Indeed, in *Carter II*, the Court changed the wording of the dictum as follows:

> [T]his case does not involve the prosecution of end-of-life discussions between a doctor, family member, or friend and a mature, terminally ill adult contemplating the difficult personal choices that must be made when faced with certain physical and mental suffering brought upon by impending death. Nor does it involve prosecutions of general discussions about euthanasia or suicide targeting the ideas themselves.

481 Mass. at 368 (citations omitted). The Court removed the only reference to conduct (i.e., the ambiguous word "assistance"), altering the dictum to refer only to constitutionally protected communications that Defendants have never claimed were unlawful. This revision demonstrates that the *Carter* dicta are inapplicable to PAS, in which physicians' non-verbal conduct (i.e., writing the lethal prescription) is criminal. *See* ADD-68.

III. Massachusetts's Common Law of Involuntary Manslaughter Is Not Unconstitutionally Vague as Applied to Physician-Assisted Suicide.

Count II of the complaint alleges that involuntary manslaughter law is impermissibly vague under the Massachusetts Constitution. ADD-64. On appeal, Plaintiffs argue that involuntary manslaughter law is unconstitutionality vague when applied to PAS because, in that context, "men of common intelligence must necessarily guess at its meaning." Appellants' Br. 27. As Plaintiffs recognize, a criminal offense must be defined "[1] with sufficient definiteness that ordinary people can understand what conduct is prohibited and [2] in a manner that does not encourage arbitrary and discriminatory enforcement." *Kolender v. Lawson*, 461 U.S. 352, 357 (1983); *see* Appellants' Br. 25 (quoting *Commonwealth v. Jasmin*, 396 Mass 653, 655 (1986)). The Superior Court correctly rejected Plaintiffs' vagueness argument because the application of involuntary manslaughter to PAS fulfills both of these constitutional requirements. ADD-70.

There is clear common-law precedent in Massachusetts for involuntary manslaughter liability where a defendant's wanton or reckless conduct involved a high degree of likelihood that substantial harm would result specifically in the form of a victim's own suicide. *Persampieri*, 343 Mass. at 22-23; *Atencio*, 345 Mass. at 627-28; *Bowen*, 13 Mass. at 359. The doctor's act of writing a lethal prescription can, like the defendant's conduct in each of the cited cases, lead to the patient's foreseeable suicide, thus causing death. Furthermore, even if the principal objective of PAS were not the patient's death but the patient's peace of mind, there is still "a high degree of likelihood that substantial harm will result" (*Carter I*, 474 Mass. at 631) to patients from placing lethal medications in their hands.[11] In sum, "ordinary people can understand" (*Kolender*, 461 U.S. at 357) that PAS is prohibited in Massachusetts.

Neither does the application of involuntary manslaughter law to PAS encourage "arbitrary and discriminatory enforcement." *Kolender*, 461 U.S. at 357.

[11] Obviously, the facts will vary from case to case. For example, juries must decide what the defendant knew or should have known and whether defendant caused the victim's death. But juries must make such factual determinations in all criminal cases. It does not render the concept of involuntary manslaughter, or any other crime, unconstitutionally vague. *Cf. United States v. Zhen Zhou Wu*, 711 F.3d 1, 14 (1st Cir. 2013) (criminal law not void for vagueness "because it may at times be difficult to prove an incriminating fact"; only impermissibly vague if "it is unclear as to what fact must be proved" to sustain conviction).

This is not a situation involving a vague statutory provision in the absence of any "judicial construction." *Smith v. Goguen*, 415 U.S. 566, 578 (1974). Nor does the Commonwealth seek "to rely upon prosecutorial discretion to narrow the otherwise wide-ranging scope of a criminal statute's highly abstract general statutory language." *Marinello v. United States*, 138 S. Ct. 1101, 1108 (2018). Instead, the application of involuntary manslaughter law to PAS is consistent with decades of common-law precedent establishing straightforward elements, against which prosecutors and juries can assess fact-specific circumstances. *Cf. Commonwealth v. Balthazar*, 366 Mass. 298, 300 (1974) ("judicial construction of an otherwise ambiguous statute may fulfill the constitutional requirement of specificity"). In sum, there is nothing vague about involuntary manslaughter in the context of PAS.

IV. Physician-Assisted Suicide Does Not Implicate a Fundamental Constitutional Right.

Next, Plaintiffs contend that the common law of manslaughter may not constitutionally be applied to PAS because such application would impermissibly infringe fundamental rights to privacy and liberty protected by the Massachusetts Declaration of Rights, RAI/26-28, and impermissibly distinguish between PAS and the right to refuse life-sustaining treatment, in violation of equal protection principles guaranteed by the Massachusetts Constitution, RAI/29-30. Both claims rest on the premise that PAS implicates a fundamental constitutional right.

Appellants' Br. 27-32. The Superior Court was correct to hold otherwise. ADD-73-80. Plaintiffs offer no legal authority for their claimed fundamental right: no SJC cases recognize a right to demand affirmative medical intervention to end life by suicide, nor has any other court of last resort adopted Plaintiffs' view that PAS is a fundamental right. Accordingly, this Court should affirm the Superior Court's conclusion that the application of the common law of manslaughter, in appropriate circumstances, would not implicate a fundamental right, and, therefore, is only subject to review under the rational basis standard, which it undoubtedly meets.[12]

[12] Notably, nowhere in their opening brief do Plaintiffs state that heightened judicial review, such as strict scrutiny, applies, thereby waiving the argument. *See* Mass. R. App. P. 16(a)(9)(A) ("[t]he appellate court need not pass upon questions or issues not argued in the brief"); *Doe v. Sex Offender Registry Bd.*, 459 Mass. 603, 622 n.19 (2011). This omission is not surprising, because no court has recognized PAS as a fundamental right implicating strict scrutiny review. *See infra* Section IV.A. As the Superior Court correctly recognized, strict scrutiny is limited to circumstances where either "a suspect classification" or "a fundamental right" is implicated, *Finch v. Commonwealth Health Ins. Connector Auth.*, 459 Mass. 655, 668-69 (2011); otherwise, rational basis serves as the standard of review. *Rushworth v. Registrar of Motor Vehicles*, 413 Mass. 265, 271-272 (1992); ADD-80. *See infra* Section V (describing and applying rational basis review). Plaintiffs do not argue that a "suspect classification" is involved; thus, this argument is also waived. Accordingly, Defendants address only the claim that PAS constitutes a fundamental right.

A. Physician-Assisted Suicide Is Not the Equivalent of a Patient's Right to Reject Medical Treatment.

Plaintiffs seek to show that PAS is a fundamental right principally by equating it with a patient's recognized right to reject medical treatment. Appellants' Br. 29-30.[13] The Superior Court correctly rejected this false equivalence, which is unsupported by any decision holding that an *intervention* undertaken for the purpose of bringing about death, at the time of a patient's choosing, is lawful. ADD-76-77.

The SJC has recognized that each person has a "strong interest in being free from nonconsensual invasion of his bodily integrity." *Superintendent of the Belchertown State Sch. v. Saikewicz*, 373 Mass. 728, 739 (1977); *see also Lane v. Candura*, 6 Mass. App. Ct. 377, 378 (1978) (right of the patient to decline lifesaving amputation upheld). Thus, the SJC has affirmed the right of a patient to reject chemotherapy to prolong life, concluding that "the patient's right of privacy and self-determination is entitled to enforcement" where there was "no State interest sufficient to counterbalance a patient's decision to decline life-prolonging

[13] Plaintiffs also seek to equate PAS with accepted end-of-life medical alternatives, such as palliative sedation. Since the claimed equivalence with legal end-of-life alternatives does not implicate any claim of a fundamental right (as opposed to a claim of equal protection), this contention is addressed in the discussion of rational basis review in Section V.C, below.

medical treatment" in the circumstances of the case. *Saikewicz*, 373 Mass. at 759; *see also Brophy v. New Eng. Sinai Hosp., Inc.*, 398 Mass. 417, 419, 438-439 (1986) (upholding substituted judgment of person in persistent vegetative state that artificial maintenance of life be discontinued). But no Massachusetts court has held that the right to decline medical treatment embraces affirmative medical intervention for the explicit purpose of advancing death. *See Norwood Hosp.*, 409 Mass. at 125 ("Declining potentially life-saving treatment may not be viewed properly as an attempt to commit suicide."); s*ee also Myers v. Schneiderman*, 85 N.E.3d 57, 63 (N.Y. 2017) (recognizing that New York courts have "consistently adopted the well-established distinction between refusing life-sustaining treatment and assisted suicide").

Yet even this protection of a patient's right of bodily integrity sometimes gives way to countervailing public interests. The SJC has affirmed a judgment requiring treatment of a child for leukemia notwithstanding the opposition of his parents. *See Custody of a Minor*, 375 Mass. 733, 735-736 (1978). In doing so, the Court identified underlying state interests that dictated the outcome, including the state's "interest in the preservation of life." *Id.* at 754-755. *See also Norwood Hosp.*, 409 Mass. at 124-127 (recognizing the state's interest in preserving life, preventing suicide, and maintaining the integrity of the medical profession);

Commissioner of Corr. v. Myers, 379 Mass. 255, 257 (1979) (affirming order compelling "unconsenting, competent, adult prisoner to submit to life-saving hemodialysis treatments and related medications," notwithstanding patient's "interest in bodily integrity and right of privacy"). Here, what is dispositive is that the SJC has never extended the privacy right of bodily integrity beyond a right to reject treatment, which itself "is not absolute," *Norwood Hosp.*, 409 Mass. at 125, drawing a clear line beyond which a patient's legal rights do not extend.

B. A Patient Does Not Have a Fundamental Right to Engage a Physician to Provide a Lethal Prescription.

Plaintiffs cannot rely upon the privacy right of bodily integrity to establish a fundamental right to PAS, because the right encompasses only rejecting medical treatment. Nor do Plaintiffs provide any other persuasive basis to recognize PAS as a fundamental constitutional right. The Superior Court began by observing that, according to the Supreme Court, there is no fundamental right to PAS under the federal Constitution. ADD-73; *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997). In *Glucksberg*, the Court held that a Washington state law prohibiting assisted suicide did not violate the substantive due process rights of physicians who wished to provide lethal medications to their competent, terminally ill patients. 521 U.S. at 728. In *Vacco*, decided the same day, the Court rejected Plaintiffs' contention that a New York law against assisted

suicide, as applied to PAS, violated the Fourteenth Amendment's Equal Protection Clause by treating mentally competent, terminally ill patients seeking to self-administer prescribed lethal medication differently from mentally competent, terminally ill patients who refused life-saving medical treatment. 521 U.S. at 799-809.

The Superior Court also correctly noted that "[n]o [state] appellate court has held that there is a constitutional right to physician aid in dying." ADD-75 (quoting *Morris v. Brandenburg*, 376 P.3d 836, 839 (N.M. 2016)). Indeed, since *Glucksberg* and *Vacco* were decided, state appellate courts have either held, or reaffirmed, that PAS does *not* implicate a fundamental right under their respective state constitutions. *See, e.g.*, *Morris*, 376 P.3d at 847-55; *Myers*, 85 N.E.3d at 64; *Donorovich-Odonnell v. Harris*, 241 Cal. App. 4th 1118, 1135-40 (Cal. Ct. App. 2015) ("Plaintiffs have cited no authority from any jurisdiction suggesting assistance of a third party in committing suicide is an interest fundamental to personal autonomy"); *Sampson v. State*, 31 P.3d 88, 92-95 (Alaska 2001); *Krischer v. McIver*, 697 So.2d 97, 104 (Fla. 1997).

Plaintiffs contend the Superior Court incorrectly limited its analysis of whether PAS implicates a fundamental right to asking only whether PAS is "deeply rooted in this Nation's history and tradition." Appellants' Br. 27, 30-31.

Defendants share Plaintiffs' view that fundamental rights are not limited only to those recognized in the eighteenth century.[14] But the Superior Court did not focus exclusively on history and tradition; rather, it recognized that "in identifying fundamental rights, a court may consider evolving social views in addition to history and tradition." ADD-78-79 (citing *Obergefell v. Hodges*, 576 U.S. 644, 664, 671 (2015) and *Goodridge v. Dep't. of Pub. Health*, 440 Mass. 309, 328 (2003) ("history must yield to a more fully developed understanding of the invidious quality of the discrimination")). Thus, it appropriately considered both historical traditions and modern developments when it concluded that "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." ADD-79.

The Supreme Court's reluctance to deem rights "fundamental" plays an important role in reinforcing the separation of powers. In considering expansion of substantive due process, "guideposts for responsible decision making in this

[14] *See, e.g., Eisenstadt v. Baird*, 405 U.S. 438 (1972) (contraception); *Roe v. Wade*, 410 U.S. 113 (1973) (abortion); *Goodridge v. Dep't. of Pub. Health*, 440 Mass. 309 (2003) (same-sex marriage).

uncharted area are scarce and open-ended." *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992). When asserted privacy rights or liberty interests are newly endowed with constitutional protection, they are placed "outside the arena of public debate and legislative action." *Glucksberg*, 521 U.S. at 720. Other courts too have recognized that "[b]ecause the controversy surrounding physician-assisted suicide is so firmly rooted in questions of social policy, rather than constitutional tradition, it is a quintessentially legislative matter." *Sampson*, 31 P.3d at 98; *see also McIver*, 697 So.2d at 104; *Myers*, 85 N.E.3d at 65.

The SJC has likewise refused to expand substantive due process protections to claimed rights far more consistent with fundamental historic views than PAS. *See, e.g.*, *Williams v. Secretary of the Executive Office of Human Servs.*, 414 Mass. 551, 563 (1993) (no fundamental right to receive desired mental health services); *Tobin's Case*, 424 Mass. 250, 252-253 (1997) (worker's compensation benefits not a fundamental right); *Matter of Tocci*, 413 Mass. 542, 548 n.4 (1992) (no fundamental right to practice law); *Commonwealth v. Henry's Drywall Co.*, 366 Mass. 539, 542 (1974) (no fundamental right to pursue one's business).

Like the claimed rights in the foregoing cases, PAS too is a matter more appropriately left to the political processes. Indeed, the Legislature has considered numerous proposals to legalize PAS, but has not enacted legislation in response.

See, e.g., 2020 SB 2745; 2017 HB 1194; 2017 SB 1225. Most recently, such bills were referred to the Joint Committee on Public Health on April 13, 2021. *See* https://malegislature.gov/Committees/Detail/J16/192/Bills (2021 SB 1384; 2021 HB 2381). Nine states and the District of Columbia have passed legislation to allow PAS.[15] It remains prohibited by law in other states, including Massachusetts, where it has failed to secure majority support either in the Legislature or at the ballot box. RAIII/28. In sum, the Superior Court was correct to conclude that there is no basis to accord PAS the status of a fundamental constitutional right.

V. Because There is No Fundamental Right of Access to Physician-Assisted Suicide, Its Prohibition is Subject Only to Rational Basis Review, Which It Easily Satisfies.

The Superior Court correctly decided that the Commonwealth's prohibition of PAS "meets the rational basis test for both due process and equal protection." ADD-80. Rational basis serves as the standard of review because, as explained above, the prohibition does not implicate a fundamental right or discriminate based on a suspect class. *Finch v. Commonwealth Health Ins. Connector Auth.*, 459

[15] Or. Rev. Stat. Ann. §§ 127.800 – 127.995; Wash. Rev. Code §§ 70.245.010 – 70.245.903; Vt. Stat. Ann., tit. 18, ch. 113; Cal. Health and Safety Code part 1.85; Colo. Rev. Stat. §§ 25-48-101 – 25-48-123; D.C. Law 21-182; Hawai'i Revised Statutes Ch. 327L; 22 Maine Rev. Stat. c. 418, § 2140; N.J. Stat. Ann. 26:16-1 et. seq.; 2021 N.M. Laws, ch. 132. *Cf. Baxter*, 224 P.3d at 1222 (recognizing patient's consent as a defense to homicide charges).

Mass. 655, 668-69 (2011) (strict judicial scrutiny is limited to circumstances where either "a suspect classification" or "a fundamental right" is implicated) (citations omitted); *Rushworth v. Registrar of Motor Vehicles*, 413 Mass. 265, 271-272 (1992) (same). Here, there are multiple rational grounds underlying the criminal prohibition of PAS and supporting the distinction between PAS and permissible end-of-life options. Therefore, this Court should affirm the Superior Court's conclusion that the prohibition of PAS in Massachusetts does not violate Plaintiffs' constitutional rights. ADD-84.

A. Under Rational Basis Review, Plaintiffs Must Demonstrate that There is No Conceivable Rational Basis to Support the Prohibition of Physician-Assisted Suicide.

The rational basis standard of review applies both to Plaintiffs' due process claim and to their equal protection claim. *See supra* p. 32, n. 12. *Blue Hills Cemetery v. Board of Registration in Embalming and Funeral Directing*, 379 Mass. 368, 371-72 (1979). This standard is highly deferential and will "recognize every rational presumption in favor of the . . . law's validity." *Doe v. Sex Offender Registry Bd.*, 488 Mass. 15, 170 N.E.3d 1143, 1154 (2021). Although rational basis review is most commonly applied to statutes, it is not limited to review of

purely legislative enactments.[16] Here, "[t]he statute proscribing manslaughter, G.L. c. 265, § 13, is a codification of the common law[.]" *Commonwealth v. Crawford*, 430 Mass. 683, 688 (2000). "The Legislature has exercised its authority over the subject of manslaughter only to the extent of setting the punishment. It has left definition of the crime for the courts." *Id.; see also Commonwealth v. Jarrett*, 359 Mass. 491, 494 (1971) (noting that "[t]here have been numerous instances of a similar statutory treatment of common law crimes."). [17] The usual modes of constitutional analysis nonetheless apply.

The Supreme Court engaged in rational basis review when it held that state laws prohibiting PAS violate neither equal protection, *Vacco*, 521 U.S. at 808-09, nor due process, *Glucksberg*, 521 U.S. at 728. The rational basis standard under the Massachusetts Constitution is the same as that applied in *Vacco* and

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[16] *See, e.g., Commonwealth v. Bailey*, 370 Mass. 388, 394 n.6 (1976) (applying rational basis review to common law "fresh complaint" rule), *overruled on other grounds by Commonwealth v. King*, 445 Mass. 217 (2005); *Universal Adjustment Corp. v. Midland Bank, Ltd.*, 281 Mass. 303, 321 (1933) ("Reasonable classification has always been regarded as the prerogative of the legislative department of government in enacting laws. … Similar flexibility is permissible with respect to general principles of law when applied by the courts with uniformity.") (applying rational basis review to common law doctrine of forum non conveniens).

[17] As previously noted (*supra* at p. 24, n. 10), the Legislature has, however, acknowledged the prohibition on PAS in statutes dealing with end-of-life care.

Glucksberg under the Fourteenth Amendment of the federal Constitution. *See Massachusetts Fed'n of Teachers, AFT, AFL-CIO v. Board of Educ.*, 436 Mass. 763, 777 (2002); *Rushworth*, 413 Mass. at 270. Therefore, the Supreme Court's view that prohibiting PAS is constitutional has a considerable bearing on how the question should be answered in Massachusetts.

With respect to Plaintiffs' equal protection claim, the question is whether the distinction challenged by Plaintiffs – between PAS, which is prohibited, and other end-of-life options such as palliative sedation, which are permitted – is "rationally related to a legitimate State purpose." *Hallett v. Wrentham*, 398 Mass. 550, 557 (1986) (quoting *Paro v. Longwood Hosp.*, 373 Mass. 645, 649 (1977)). A classification such as this one "will be considered rationally related to a legitimate purpose 'if there is any reasonably conceivable state of facts that could provide a rational basis'" for it. *Chebacco Liquor Mart, Inc. v. Alcoholic Beverages Control Commission*, 429 Mass. 721, 723 (1999) (quoting *FCC v. Beach Commc'ns*, 508 U.S. 307, 313 (1993)).

These same essential criteria, though articulated in slightly different terms, apply to Plaintiffs' due process claims. For rational basis review, a statute – or, here, a common law prohibition – will satisfy due process if it "bears a real and substantial relation to the public health, safety, morals, or some other phase of the

general welfare." *Sperry & Hutchinson Co. v. Director of the Div. on the Necessities of Life*, 307 Mass. 408, 418 (1940). In this deferential review, Plaintiffs have "'an onerous burden of proof in establishing the invalidity of the statute'." *Marshfield Family Skateland v. Town of Marshfield*, 389 Mass. 436, 446 (1983) (quoting *Henry's Drywall*, 366 Mass. at 542).

Unless the prohibition of PAS "cannot be supported upon any rational basis of fact that reasonably can be conceived to sustain it, the court has no power to strike it down as violative of the Constitution." *Sperry*, 307 Mass. at 418. In its review, the Court is not limited to a determination of adjudicative facts derived from an adversarial presentation of evidence. *See, e.g., Jane Doe, No. 1 v. Secy. of Educ.*, 479 Mass. 375, 395 (2018) (affirming decision, made on a motion to dismiss, that charter school law was supported by a rational basis). Rather, the Court's function is to discern whether there is a *conceivable* rational basis to support the law. *See, e.g., Marshal House, Inc. v. Rent Control Bd. of Brookline*, 358 Mass. 686, 695-96 (1971) (upholding statutory exemption where "[s]everal plausible reasons for such an exemption have been suggested to us"); *Henry's Drywall*, 366 Mass. at 546 ("we are not required to blind ourselves to *possible* rationales that may have influenced the Legislature") (emphasis added). If there is, the inquiry ends because "it is not the province of the court to sit and weigh

conflicting evidence supporting or opposing a legislative enactment." *Shell Oil v. City of Revere*, 383 Mass. 682, 687 (1981).[18]

Here, the record contains evidence offered by qualified, experienced practitioners on both sides of an ongoing policy dispute.[19] What is dispositive is that Defendants have identified, in this evidence and elsewhere, concerns on which the prohibition of PAS could conceivably and rationally be based. The Court need

[18] In its review, the Court may consider "legislative facts," which are "those facts, including statistics, policy views, and other information, that constitute the reasons for legislation or administrative regulations." Mass. G. Evid. § 201 note subsection (a) (citing *Mass. Fed'n of Teachers*, 436 Mass. at 772). Unlike adjudicative facts, legislative facts "usually are not proved through trial evidence but rather by material set forth in the briefs, the ordinary limits on judicial notice having no application to legislative facts." *Daggett v. Comm'n on Governmental Ethics & Election Pracs.*, 172 F.3d 104, 112 (1st Cir. 1999) (citing Fed. R. Evid. 201 advisory committee note); *see also Moore v. Madigan*, 702 F.3d 933, 942 (7th Cir. 2012) (defining "legislative facts" as "facts that bear on the justification for legislation, as distinct from facts concerning the conduct of parties in a particular case").

[19] Plaintiffs presented expert testimony from Dr. Timothy E. Quill, which appears in the record at RAI/55-241 (*Quill Deposition Transcript ("Depo.")*); RAII/165-220 & RAIII/152-207 (*Quill Declaration ("Dec.")*); RAIII/71-84 & RAIII/208-221 (*Quill Second Dec.*).

Defendants presented testimony from Dr. B. Lachlan Forrow and Dr. Henry Rex Greene. Dr. Forrow's evidence appears at RAI/243-397 (*Forrow Depo.*); RAII/231-72 (*Forrow Disclosure ("Discl.")*); RAII/303-16 (*Forrow Rebuttal Discl.*)); RAIII/86-98 (*Forrow Affidavit ("Aff.")*). Dr. Greene's evidence appears at RAI/399-633 (*Greene Depo.*); RAII/274-301 (*Greene Discl.*); RAII/318-26 (*Greene Rebuttal Discl.*); RAIII/100-07 (*Green Aff.*).

go no further to uphold the prohibition. Indeed, by upholding the prohibition, the Court would properly leave the question of whether PAS should be authorized in Massachusetts for the Legislature to decide.

B. There Are Ample Rational Bases to Support the Prohibition of Physician-Assisted Suicide.

Plaintiffs have the heavy burden to show that prohibiting PAS "cannot be supported upon any rational basis of fact that reasonably can be conceived to sustain it." *Sperry*, 307 Mass. at 418. As discussed below, there are abundant reasons why the prohibition may rationally be maintained under the common law of involuntary manslaughter. *Henry's Drywall Co.*, 366 Mass. at 546.

1. Competence. In defining the practice for which they seek constitutional protection, Plaintiffs limit their definition to adults who are "mentally competent"—both at the time they request a lethal prescription and, later, when they administer it. RAI/15; Appellants' Br. 33-35. Dr. Quill, Plaintiffs' expert witness, agrees that it would be important for a physician who contemplates writing a PAS prescription to evaluate the patient for indications of depression. RAI/168-69. Dr. Steinbach also recognizes that patients can be motivated by depression in end-of-life decisions. RAI-Impounded/397-98.

When reported at all in states where PAS is legal, psychiatric and psychological evaluations of those requesting PAS are rare. In Oregon, between

2014 and 2017, no more than three percent of such patients were referred to psychological evaluation or counseling before being given lethal prescriptions. RAII/280; RAII/359, 368, 379, 392. In both Oregon and Washington, psychological consultation, if it takes place at all, consists of a single, often perfunctory visit, and there is no requirement that family members be consulted. RAII/280.

If the system is ineffectual in determining competence at the time of a request for a lethal prescription, its inability to determine the patient's competence at the time the patient self-administers is greater by orders of magnitude. The doctor who writes the prescription is usually not present. RAII/359, 368, 379, 392. Temporary anger or depression may bring about the irrevocable action. Or the patient may act based on a misunderstood prognosis; ignorance regarding alternatives; financial considerations; perceived strain on survivors; or outright fraud, duress, or other improper persuasion. *See, e.g.*, RAII/236-37, -238-39 (*Forrow Discl.*). These concerns can be addressed effectively through psychological treatment or other support without inviting patients to end their lives prematurely. RAI/287 (*Forrow Depo.*). It is thus rational to conclude that PAS should remain unlawful because a patient's competence to make the decisions involved is sufficiently suspect in a sufficient percentage of cases. *See Sampson*,

31 P.3d at 97 ("[B]y proposing to restrict physician-assisted suicide to mentally competent adults, [plaintiffs] would hinge the exercise of that right on a vague, unverifiable, and subjective standard").

2. Terminal Condition. Plaintiffs would limit PAS to patients who are terminally ill (i.e., whose life expectancy is less than six months). RAI/15-16, 30 (*Complaint*). Yet, it is virtually impossible to predict that a patient will die within six months. RAI/474-77 (*Greene Depo.*). A prediction of death may be accurate within two or three weeks of death, but be suspect when made at an earlier time. RAII/278-79 (*Greene Discl.*) ("Research has shown that physicians cannot predict imminent death sooner than a few weeks before the event . . . . At six months, a fatal outcome is wholly unpredictable other than recognizing the presence of an incurable condition."); RAI/180-81 (*Quill Depo.*) (Dr. Quill acknowledging that it can be "hard to tell sometimes" how long a patient will live). Life expectancy predictions are a product of data that measure treatment results assembled over years and, thus, while they may be statistically valid across a universe of cases, they are unreliable when applied to an individual patient. RAII/278-79 (*Greene Discl.*); RAI/476 (*Greene Depo.*). Moreover, a physician is unlikely to be an accurate judge of a patient's life-expectancy unless the physician is a specialist in the field of the patient's condition. RAII/279 (*Greene Discl.*). Given all of these

uncertainties, any reliance on a prediction of death within six months assigns weight to an unreliable yardstick, and could result in persons who are not terminally ill obtaining lethal prescriptions. For that reason, the prohibition of PAS can rationally be maintained.

3. Availability of Effective Alternatives to Treat End-of-Life Suffering. There is now widespread availability of effective alternatives to relieve end-of-life suffering. "Palliative care," as a field, has grown exponentially in the past 25-30 years; it is mainstream now and continues to improve and develop. RAI/108-09 (*Quill Depo.*). To the extent that patients fear the onset of pain, it is rare that pain cannot be controlled by available medical intervention. RAII/235-36 (*Forrow Discl.*) ("Claims that PAS is required in order to ensure that patients do not experience severe, prolonged physical suffering are demonstrably false."); RAI/224-25 (*Quill Depo.*); RAI-Impounded/69-70 (*Sweeney Depo.*). Much of the time, available procedures are fully effective while the patient remains conscious but not in pain. RAI-Impounded/68-69 (*Sweeney Depo.*). Many patients are unaware of the effectiveness of palliative care. Dr. Forrow, for example, testified to his belief that the "overwhelming majority of people who believe that the option of PAS for them is necessary to ensure that they do not suffer unbearably are

factually wrong about the inevitability of unbearable suffering without PAS." RAI/317.

Dr. Quill, a long-term advocate for the legalization of PAS, *see Vacco*, 521 U.S. at 797, agrees that most end-of-life suffering can be addressed effectively by means of palliative care, although he believes that there will be some "tough cases" that—although not common—will not be adequately addressed by palliative care. RAI/83. Even if a small number of cases were not susceptible to effective pain management, the dangers and uncertainties associated with PAS can nonetheless rationally justify its prohibition.

4. Integrity of the Medical Profession. The SJC has recognized that the State's "interest in protecting the ethical integrity of the medical profession" is among those interests that justify regulation that could interfere with constitutionally-recognized privacy interests. *See Custody of a Minor*, 375 Mass. at 754-55. Physicians have long been seen as healers, comforters, and prolongers of life, not agents of suicide. RAII/232-35 (*Forrow Discl.*); RAII/275-77 ("Ethical norms dating back thousands of years … prohibit engaging in PAS.") (*Greene Discl.*). Many doctors view PAS as inconsistent with their role and purpose. RAII/232 (*Forrow Discl.*). Others may refuse to participate in PAS because of the

absence of reliable standards in place to govern the decision-making process. RAII/237 (*Forrow Discl.*).

Additionally, the unwillingness of many doctors to participate may lead to doctor-shopping, which in turn may increase the risks associated with PAS. With many physicians refusing to accommodate patient requests even if PAS were to be legalized, doctors who are willing to write the prescriptions—perhaps after refusals by other doctors—will be identified and patients will find them. RAII/276-77 (*Greene Discl.*). Data from Oregon show that fifty percent of patients who have received PAS have known the prescribing physician for less than thirteen weeks. RAII/396; RAII/277 (*Greene Discl.*). The lack of a preexisting relationship obviously reduces the prescribing physician's ability to judge the patient's medical condition and the patient's competence and informed decision-making. In addition, a physician who is engaged because they are willing to participate in PAS may be less likely to intervene by counseling the patient about other available end-of-life options in a constructive way. RAII/277 (*Greene Discl.*).

5. Absence of Regulation/Standard of Care. Plaintiffs further define the practice for which they seek protection as limited to physicians prescribing lethal medication "follow[ing] a medical standard of care." RAI/25, 30; Appellants' Br. 36. But Plaintiffs are wrong to assume that there is an applicable "medical standard of care" for PAS in Massachusetts: "PAS is neither a medical treatment nor a medical procedure and thus there can be no applicable medical standard of care." RAII/280-81 (*Greene Discl.*); RAII/312 (*Forrow Rebuttal Discl.*).

General standards of care in medicine do not take into account the unusual challenges posed by PAS, the gravity of what is contemplated, the lack of experience with the subject matter on the part of most doctors who do not practice in fields dealing with end-of-life care, or the complications inherent in deciding whether to grant a given patient's request. As Dr. Forrow explained, "[d]octors could write lethal prescriptions without any training in standards and skills needed to practice PAS," and "[t]he average doctor in Massachusetts does not have the experience and expertise required to provide PAS responsibly, and any reliance on a generalized standard of care does not provide adequate protection for patients." RAII/312 (*Forrow Rebuttal Discl.*); RAII/281 (*Greene Discl.*) (opining that Oregon data reveals that no standard of care is being followed). Significantly, in

states where PAS has been authorized by statute, the statute or associated regulations supply a standard, RAII/312 (*Forrow Rebuttal Discl.*), but if PAS were legalized by a decision of this Court, there would be no analogous standard of care. RAII/237 (*Forrow Discl.*).

Further, the experience with PAS in Oregon shows the difficulty of regulating the practice. In Oregon, reporting requirements are not enforced, and the agency in charge admits that it cannot accurately assess the level of noncompliance among physicians. RAII/421-22. The enormous challenges in regulating the practice of PAS provide a rational basis not to allow it.

6. Arbitrary Decisions. A patient's choice of PAS may be subject to external influences or arbitrary or unjustified factors. RAII/235-37 (*Forrow Discl.*); RAII/277-78 (*Greene Discl.*); RAI-Impounded/513 (*Steinbach Depo.*). The likelihood that fraud, duress, or other improper persuasion will take place in the PAS context is greatly increased by the circumstances that exist when the patient makes the decisions involved. Indeed, at the time of self-administration of the lethal medication the patient may very well be at their most vulnerable and unprotected. Even a fully competent patient can be unduly influenced by concerns about finances or a desire not to burden loved ones. RAI/103-04 (*Quill Depo.*); RAII/239 (*Forrow Discl.*).

The potential for greater impacts on vulnerable groups—the poor, the elderly, minorities, the disabled—is also clearly a concern. RAII/283 (*Greene Discl.*); RAII/323 (*Greene Rebuttal Discl.*). Vulnerable groups are often not effectively served by the medical system; there may be mistaken assumptions that the quality of their lives is such that prolonging them is less important; and they are more vulnerable to financial pressures when considering end-of-life alternatives. RAII/283; RAII/239 (*Forrow Discl.*). The difficulty in ensuring informed, independent patient decisions is thus another rational basis to maintain a prohibition of PAS.

7. Limitations on Eligibility. Were PAS to be authorized, it could be difficult over time to limit it to the specific class of patients posited by Plaintiffs. Experts believe that there will be "efforts in the future to expand [PAS] beyond the restrictions currently in place in the U.S. States that have legalized it," including by eliminating the requirement of competence; the requirement of self-administration; and the requirement of terminal illness (an approach already adopted in Belgium and the Netherlands). RAII/310-11 (*Forrow Rebuttal Discl.*). *See also* RAII/323 (*Greene Rebuttal Discl.*). Dr. Quill himself recognized that there are already those who would eliminate the requirement that the patient be terminally ill (though he rejects such a policy himself). RAI/129, 131-32 (*Quill Depo.*). In sum, it is

rational to maintain the prohibition on PAS thus preserving the fundamental distinction between permissibly alleviating the patients' suffering and unlawfully facilitating their suicide.[20]

C. Physician-Assisted Suicide Is Not Equivalent to Permissible End-of-Life Alternatives and Poses Far Greater Risks.

Finally, Plaintiffs contend that there is no rational basis to distinguish between PAS and end-of-life alternatives that are legal, including voluntary stopping of eating and drinking ("VSED"); withdrawal of life support; and palliative sedation. Appellants' Br. 37-40. They do so on the false premise that there are no differences between PAS and these alternatives because, Plaintiffs contend, each reduces suffering and each may have the consequence of advancing the time of the patient's death.

In fact, PAS and the noted alternatives are materially different in their fundamentals, their purpose, and their associated risks, RAIII/88-91 (*Forrow Aff.*);

[20] Indeed, Plaintiffs cannot reasonably maintain that there is no rational distinction between PAS and other end-of-life options, while also insisting on maintaining a distinction between patients who are terminally ill, competent, and capable of self-administration, who would be eligible for PAS, and those lacking these qualities, who would not. In fact, the rational basis for distinguishing PAS from permissible end-of-life care (*infra* Section V.C) is at least as strong as that for limiting PAS to those who are terminally ill, competent, and physically capable of self-administering the drugs.

RAIII/103-04 (*Greene Aff.*); thus, the distinction in their legal statuses plainly has a rational basis. *Chebacco*, 429 Mass. at 723.

Both VSED and withdrawal of life support differ significantly from PAS because they constitute exercises of the patient's recognized right to discontinue unwanted treatment. *See Saikewicz*, 373 Mass. at 738-40; *Brophy*, 398 Mass. at 429-31; *Norwood Hosp.*, 409 Mass. at 125. The doctors' role, whether they agree with the patient's choice or not, is to try to ensure that any related symptoms are well-controlled. By doing so, doctors fulfill their central responsibility to alleviate suffering without contributing to or accelerating the patient's death from natural causes. RAIII/88-89 (*Forrow Aff.*); RAII/319 (*Greene Aff.*).

Palliative sedation, too, differs significantly from PAS. Palliative sedation is the practice of controlling pain by rendering the patient unconscious, and it is an uncommon choice among a range of alternatives available to control severe symptoms. As Plaintiffs' expert, Dr. Quill, acknowledges, palliative sedation to unconsciousness "is relatively uncommon and is usually used to treat end of life catastrophes from which virtually no one recovers." RAIII/160 (*Quill Dec.*). In contrast, "the vast majority of symptoms can be controlled without obliterating consciousness." RAI/285 (*Forrow Depo.*).

There are critical distinctions between PAS and palliative sedation. Dr. Forrow and Dr. Greene explain that palliative sedation itself (with or without withdrawal of hydration or nutrition) does not cause death; rather, it causes unconsciousness until the underlying disease brings about the patient's death. RAIII/91 ("In the overwhelming majority of cases of palliative sedation, death is caused by things not directly related to dehydration, and this is solidly confirmed by published studies reporting on experiences involving very large numbers of patients across many institutions.") (*Forrow Aff.*, citing studies); RAIII/103-04 (*Greene Aff.*); RAI/490-93 (*Greene Depo.*). Indeed, palliative sedation does not necessarily involve withdrawing hydration and nutrition; rather, as Dr. Greene explains: "[t]he determination of whether to continue to provide each type of treatment is properly a separate decision, and it does not necessarily follow that all must or should be given up in conjunction with palliative sedation." RAII/321-22 (*Greene Rebuttal Discl.*) (providing hydration during palliative sedation is beneficial to help clear toxins); RAI/626-28 (*Greene Depo.*).

The intent and purpose of these permissible end-of-life remedies differ markedly from the intent and purpose of PAS. "When palliative sedation, which is subject to rigorous protocols in medical care facilities, is properly deployed in

accordance with well-established professional standards, the intent is explicitly *not* to 'terminate' the patient's life." RAIII/90 (*Forrow Aff.*); RAII/322 (*Greene Aff.*).

Additionally, the risks associated with PAS are far greater than those that accompany other end-of-life remedies. Palliative sedation and withdrawal of treatment usually occur in controlled environments, such as hospitals or similar facilities, where record-keeping is mandatory, protocols are rigorous, and procedures involve numerous physicians and staff. RAIII/102 (*Greene Aff.*); RAIII/90 (*Forrow Aff.*). There are opportunities for consultation with other physicians and with family members. RAIII/102 (*Greene Aff.*). When palliative sedation is administered, the patient is unquestionably terminally ill, severe symptoms that demand a remedy are objectively apparent, and the patient's competence is more readily ascertainable. RAIII/102 (*Greene Aff.*). Further, comprehensive standards applicable to these therapies are in place. RAIII/90 (*Forrow Aff.*). And because of these controls, the opportunities for improper persuasion or other influences that may result in arbitrary decisions on the part of the patient are virtually non-existent.

In contrast, PAS takes place in any environment that the patient chooses, and hinges on the patient's capacity to make a voluntary, informed decision at the moment of self-administration. PAS does not require the meaningful interaction

that often leads patients to change their mind. RAII/236 (*Forrow Discl.*). Accordingly, there is far more than a rational basis to distinguish between PAS and permissible end-of-life courses of action such as VSED, withdrawal of treatment, and palliative sedation.

CONCLUSION

For the foregoing reasons, the judgment of the Superior Court should be affirmed.

Respectfully submitted,

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Dated: August 20, 2021

CERTIFICATE OF COMPLIANCE

I, Maria Granik, hereby certify that the foregoing brief complies with all of the rules of court that pertain to the filing of briefs, including, but not limited to, the requirements imposed by Rules 16 and 20 of the Massachusetts Rules of Appellate Procedure. The brief complies with the applicable length limit in Rule 20 because it contains 10,922 words in 14-point Times New Roman font (not including the portions of the brief excluded under Rule 20), as counted in Microsoft Word (version: Word 2016).

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CERTIFICATE OF SERVICE

I hereby certify that on August 20, 2021, I served the foregoing document by email on counsel of record for the other parties, as follows:

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ADDENDUM

NOTIFY

COMMONWEALTH OF MASSACHUSETTS

SUFOLK, ss.

SUPERIOR COURT
CIVIL ACTION
NO. 2016-03254-F

ROGER KLIGLER & another[1]

vs.

MAURA T. HEALEY, in her official capacity,[2]
& another[3]

MEMORANDUM OF DECISION AND ORDER ON THE PARTIES' CROSS-MOTIONS FOR SUMMARY JUDGMENT

In recent years there has been growing public acceptance of physician assisted suicide or Medical Aid in Dying (MAID). The practice is now permitted and regulated in Oregon, Washington, Vermont, Colorado, California, Hawaii, Maine, and New Jersey as well as in Washington D.C.[4] Plaintiffs Roger Kligler, M.D., who is suffering from Stage 4 Metastatic Prostate Cancer, and Alan Steinbach, M.D., who treats competent, terminally ill patients (including Dr. Kligler) considering end-of-life issues, filed this action against Attorney General Maura Healey (AG) and Cape and Islands District Attorney Michael O'Keefe (DA) seeking a determination as to whether there is a right to physician assisted suicide or Medical Aid in Dying (MAID) reflected in Massachusetts law and/or the Massachusetts Constitution. Specifically,

[1] Dr. Alan Steinbach.

[2] As the Attorney General of the Commonwealth of Massachusetts.

[3] Michael O'Keefe, in his official capacity as District Attorney of Cape & Island District.

[4] Both the Maine and New Jersey laws went into effect this year (2019). The Court also notes that Montana's Supreme Court determined in 2009 that pursuant to a Montana statute providing a consent defense to homicide, patient consent could constitute a defense to a homicide charge against a physician who engages in MAID. See *Baxter* v. *Montana*, 354 Mont. 234, 224 (2009).

they seek declarations on whether the practice of MAID constitutes involuntary manslaughter and if so, whether application of the law of involuntary manslaughter to MAID violates the Massachusetts Constitution. They also seek a declaration that a physician is free to provide information and advice about MAID to terminally ill patients. The matter is now before the Court on the plaintiffs' Motion for Partial Summary Judgment on their equal protection and free speech claims and the defendants' Cross-Motion for Summary Judgment on All Counts. This court has immense compassion for Dr. Kligler's desire to avoid a potentially painful death and for Dr. Steinbach's desire to ease his patients' suffering, however, the Court concludes, for the reasons discussed below, that the plaintiffs' arguments concerning the right to utilize MAID are unavailing. The Court further concludes that providing advice and information about MAID is permitted in the Commonwealth. Accordingly, the parties' motions are **ALLOWED** in part and **DENIED** in part.

BACKGROUND

Dr. Kligler is diagnosed with Stage 4 Prostate Cancer, which has metastasized to his bones. Dr. Kligler's physician, Dr. Christopher Sweeney, estimates that there is a 50 percent chance that Dr. Kligler will die within five years. Dr. Sweeney further cautions that the prognosis for cancer patients can quickly turn negative. Due to the uncertainty in predicting the course of any cancer, Dr. Sweeney checks Dr. Kligler's condition every three months.

Dr. Kligler wants to consult with his physicians about the full range of end-of-life options and ultimately obtain a prescription for lethal medication. According to Dr. Kligler, such medication will alleviate anxiety related to the dying process and allow him to live his final days confident that if his suffering becomes too great, he may self-administer a prescription that will end his life. Dr. Kligler's desire to have access to the medication stems, in part, from his own

experiences as a physician where he witnessed the suffering of terminally ill patients. Dr. Kligler believes he may be unable to find a doctor in Massachusetts who is willing to provide the prescription due to fear of criminal prosecution.

Dr. Steinbach is a licensed Massachusetts physician. Some of the patients he has cared for have considered end-of-life issues in connection with organ system failure. As of the date of his deposition, Dr. Steinbach did not have any current patients with a six-month prognosis, although he has cared for patients with a six-month or shorter prognosis in the past. Dr. Steinbach wishes, if requested, to provide information regarding, and write prescriptions for, lethal medication for purposes of MAID. He does not currently provide information regarding MAID or write MAID prescriptions because he fears criminal prosecution.

Doctors Kligler and Steinbach filed this action against the AG and the DA on October 24, 2016. Their complaint asserts six counts for declaratory and injunctive relief.

Count I of the complaint seeks a declaration that "manslaughter charges are not applicable to physicians who follow a medical standard of care and write a prescription to terminally ill, competent adults who request such aid and may choose to self-administer the medication consistent with the practice of [MAID]." Complaint at ¶ 43. The plaintiffs define the term MAID in their complaint to mean "the recognized medical practice of allowing mentally competent, terminally ill adults to obtain medication that they may choose to take to bring about a quick and peaceful death." *Id.* at ¶ 2.

Count II asserts that the application of common law manslaughter to a physician who engages in the conduct described above violates the Massachusetts Constitution because the law is impermissibly vague. Counts III and IV allege that the application of common law manslaughter to such a physician impermissibly restricts a patient's constitutional right to

privacy "by interfering with [their] basic autonomy in deciding how to confront their own mortality and choose their own destiny," Complaint at ¶ 51, and impermissibly restricts a patient's fundamental liberty interests, namely, "the right of competent adults to control decisions relating to the rendering of their own health care," *id.* at ¶ 55. Counts II, III, and IV each request a declaration "that physicians who follow a medical standard of care and write a prescription pursuant to the practice of [MAID] to terminally ill, competent adults who request such aid do not violate criminal law, including the common-law crime of manslaughter." Complaint at ¶¶ 47, 52, 57. Each count also seeks an injunction prohibiting the AG and the DA from prosecuting physicians who engage in that conduct.

Count V asserts that the application of common law manslaughter to a physician based on his or her provision of information and advice about MAID to competent, terminally ill patients, who later voluntarily ingest lethal prescribed medication, constitutes an unlawful restraint on the constitutional right to freedom of speech by hindering physicians' ability to discuss medically appropriate end-of-life treatment options. Count V seeks a declaration that giving such advice is not manslaughter and an injunction prohibiting the AG and the DA from prosecuting physicians who inform, advise, or counsel patients about MAID.

Lastly, Count VI asserts that the application of common law manslaughter to physicians who follow a medical standard of care and provide MAID violates the constitutional right to the equal protection of law by treating differently terminally ill adults who wish to receive MAID and terminally ill adults who wish to hasten death by the voluntarily stopping of eating and drinking (VSED), withdrawal of life support, or palliative sedation. Count VI seeks a declaration that physician assisted suicide is not manslaughter as well as an injunction against prosecution.

DISCUSSION

The parties have filed cross motions for summary judgment. The plaintiffs seek summary judgment on their equal protection and free speech claims. The defendants seek summary judgment on all of the plaintiffs' claims. The Court concludes that although the plaintiffs are entitled to summary judgment on Count V, the defendants are entitled to summary judgment on all other counts.[5]

A. Applicability of Common Law Involuntary Manslaughter to MAID (Count I)

Involuntary manslaughter involves "an unlawful homicide unintentionally caused by wanton or reckless conduct." *Commonwealth* v. *Catalina*, 407 Mass. 779, 789 (1990). See also *Commonwealth* v. *Life Care Centers of America, Inc.*, 456 Mass. 826, 832 (2010), quoting *Commonwealth* v. *Gonzalez*, 443 Mass. 799, 808 (2005) (defining involuntary manslaughter as "an unlawful homicide unintentionally caused by an act which constitutes such a disregard of probable harmful consequences to another as to amount to wanton or reckless conduct."). "Wanton or reckless conduct" for purposes of the crime is "intentional conduct, by way either of commission or of omission where there is a duty to act, which conduct involves a high degree of likelihood that substantial harm will result to another." *Catalina*, 407 Mass. at 789, quoting *Commonwealth* v. *Welansky*, 316 Mass. 383, 399 (1944). Whether conduct is reckless or wonton may be determined on a subjective basis (the defendant was actually aware of the potential harm from his or her conduct) or on an objective basis (a reasonable person would be aware of such potential harm). *Commonwealth* v. *Perry*, 34 Mass. App. Ct. 127, 129-130 (1993).

[5] Although the counts in the plaintiffs' complaint reference common law manslaughter, the defendants only contend that physicians who provide MAID may be charged with involuntary manslaughter. They do not contend that voluntary manslaughter or any other crime is applicable. As a result, when analyzing plaintiffs' claims, the parties largely focus on the crime of involuntary manslaughter. The Court does the same.

In relation to Count I, the plaintiffs seek a declaration that physicians who follow a medical standard of care and write lethal prescriptions to competent, terminally ill adults who may choose to self-administer the medication (i.e., who engage in MAID) cannot be criminally prosecuted for common law involuntary manslaughter. The plaintiffs argue that MAID cannot constitute involuntary manslaughter for three reasons. None are availing.

The plaintiffs first argue that two decisions in *Carter v. Commonwealth* stand for the proposition that a defendant who participates in another's suicide can only be liable for involuntary manslaughter if the defendant occasions the suicide by "overcoming the individual's will to live" (i.e., coerces the victim) and that therefore MAID can never constitute involuntary manslaughter because the practice does not involve any coercion. See *Commonwealth* v. *Carter*, 474 Mass. 624 (2016) (*Carter I*); *Commonwealth* v. *Carter,* 481 Mass. 352 (2019) (*Carter II*). The plaintiffs, however, misread the *Carter* decisions.

The two decisions concerned a defendant who was charged and convicted of involuntary manslaughter after she encouraged and directed her boyfriend via cellphone text messages and voice calls to complete a suicide attempt while it was in progress. In *Carter I*, the Supreme Judicial Court (SJC) rejected the defendant's contention that verbally encouraging someone to commit suicide, no matter how forcefully, could not constitute wanton or reckless conduct for purposes of involuntary manslaughter, and held that there was probable cause to sustain the indictment against the defendant because the evidence before the grand jury suggested that she "overbore the victim's willpower" at the moment the victim was expressing reservations about committing suicide.[6] 474 Mass. at 635. The SJC explained that the "defendant's virtual

[6] The victim was using a water pump to generate carbon monoxide in his truck. At one point, the victim expressed reservations about going through with the suicide and got out of the truck. The defendant instructed him to return to the truck and he died shortly thereafter. *Carter I,* 474 Mass. at 625, 629.

presence [via cellphone] at the time of the suicide, the previous constant pressure the defendant had put on the victim [to commit suicide], ... [the victim's] already delicate mental state" and their romantic relationship lent a "coercive quality" to the defendant's words that caused the victim to follow through with his suicide. *Id.* at 634-636. In *Carter II*, the SJC upheld the defendant's conviction for involuntary manslaughter because the evidence showed that: the defendant was the victim's "girlfriend and closest, if not only, confidant in this suicidal planning;" that the defendant "had been constantly pressuring him to complete their often discussed plan, fulfill his promise to her, and finally commit suicide;" and that when the victim abandoned his suicide attempt, the defendant "badgered" him into resuming it and thereafter "did absolutely nothing to help him...." 481 Mass. at 363. The SJC also rejected the defendant's arguments that common law involuntary manslaughter was constitutionally vague as applied to her and that the conviction violated her free speech rights. *Id.* at 363-369.

Neither decision purported to establish a new involuntary manslaughter analysis in the suicide context more generally. Rather, the cases were narrowly focused on whether the use of *words alone* could constitute involuntary manslaughter. MAID comprises of more than words; it involves *conduct* – the prescription of lethal medication to patients in order to provide them with an otherwise unavailable means to end their own lives. Thus, the *Carter* decisions do not, as the plaintiffs contend, suggest that the crime requires coercion in the assisted suicide context.

The plaintiffs next argue that MAID is not punishable as involuntary manslaughter because the act of providing a lethal prescription cannot constitute "wanton and reckless conduct." The Court disagrees. As noted above, "wanton or reckless conduct" for purposes of the crime is "intentional conduct, by way either of commission or of omission where there is a duty to act, which conduct involves a high degree of likelihood that substantial harm will result

to another." *Catalina*, 407 Mass. at 789, quoting *Welansky*, 316 Mass. at 399. See also *Commonwealth* v. *Carrillo*, 483 Mass. 269, 275-277 (2019) (explaining meaning of "wanton or reckless conduct"). The writing of a lethal prescription is an intentional action that, given its very purpose, is highly likely to result in death. Cf. *Carrillo*, 483 Mass. at 287, clarifying scope of *Catalina* ("Where there is specific evidence that the defendant knew or should have known that his or her conduct created a high degree of likelihood that substantial harm will result, the Commonwealth may indeed convict the person who sold or gave the heroin to the decedent of involuntary manslaughter.") (internal quotation marks and citation omitted).

Lastly, the plaintiffs argue that a physician cannot be liable for prescribing lethal medication for purposes of MAID because the patient's self-administration of the medication is an independent intervening cause of death. The Court disagrees. The causation element of involuntary manslaughter can be satisfied even where the intervening conduct by the victim leads to death as long as the intervening conduct was "reasonably foreseeable." *Catelina*, 407 Mass at 791. In the context of MAID, it is reasonably foreseeable that the patient will self-administer the lethal medication, causing his or her own death. Compare *id.* (causal link between defendant's sale of heroin to the victim and the victim's death from the heroin was not broken by the victim's intervening conduct of injecting herself). See also *Carrillo*, 483 Mass. at 287.

B. Vagueness (Count II)

"A statute is unconstitutionally vague if men of common intelligence must necessarily guess at its meaning." *Commonwealth* v. *Crawford*, 430 Mass. 683, 689 (2000). In connection with Count II of their complaint, the plaintiffs maintain that common law involuntary manslaughter is unconstitutionally vague as applied to MAID. This argument is unpersuasive.

"Manslaughter is a common-law crime that has not been codified by statute in Massachusetts. It has long been established in our common law that wanton or reckless conduct that causes a person's death constitutes involuntary manslaughter." *Carter II*, 481 Mass. at 364 (internal quotations and citations omitted). Analogous conduct has been deemed unlawful. See *Catelina* at 407 Mass at 791 (defendant could be charged with involuntary manslaughter for sale of heroin to the victim who died from overdose); *Carrillo*, 483 Mass. at 287 ("Where there is specific evidence that the defendant knew or should have known that his or her conduct created a high degree of likelihood that substantial harm will result, the Commonwealth may indeed convict the person who sold or gave the heroin to the decedent of involuntary manslaughter.") (internal quotation marks and citation omitted); *Commonwealth* v. *Atencio*, 345 Mass. 627, 629 (1963) (individuals who cooperated in bringing about suicide by participation in Russian roulette game could be convicted of involuntary manslaughter). Cf. *Carter II*, 481 Mass. at 364, quoting *Crawford*, 430 Mass. at 689 ("If a statute has been clarified by judicial explanation … it will withstand a challenge on grounds of unconstitutional vagueness."). Thus, the common law provides sufficient notice that a physician might be charged with involuntary manslaughter for engaging in MAID. The law is not unconstitutionally vague as applied to MAID.

As with Count I, the plaintiffs rely on the *Carter* decisions to support their vagueness argument. In *Carter I*, the SJC concluded its decision by stating the following:

> It is important to articulate what this case is not about. It is not about a person seeking to ameliorate the anguish of someone coping with a terminal illness and questioning the value of life. Nor is it about a person offering support, comfort, and even assistance to a mature adult who, confronted with such circumstances, has decided to end his or her life. These situations are easily distinguishable from the present case, in which the grand jury heard evidence suggesting a systematic campaign of coercion on which the virtually present defendant embarked – captured and preserved through her text messages – that targeted the equivocating young victim's insecurities and acted to subvert his willpower in favor of her own.

474 Mass. at 636. Subsequently, in *Carter II*, in rejecting the defendant's contention that her conviction violated her free speech rights, the SJC cited to the above comments in *Carter I* and "reemphasize[d]" that:

> [T]his case does not involve the prosecution of end-of-life discussions between a doctor, family member, or friend and a mature, terminally ill adult confronting the difficult personal choices that must be made when faced with the certain physical and mental suffering brought upon by impending death. Nor does it involve prosecutions of general discussions about euthanasia or suicide targeting the ideas themselves. . . . Nothing in *Carter I*, our decision today, or our earlier involuntary manslaughter cases involving verbal conduct suggests that involuntary manslaughter prosecutions could be brought in these very different contexts without raising important First Amendment concerns.... [T]he verbal conduct targeted here and in our past involuntary manslaughter cases is different in kind and not degree, and raises no such concerns. Only the wanton or reckless pressuring of a person to commit suicide that overpowers that person's will to live has been proscribed.

481 Mass. at 368 & n.15 (internal citations omitted). Based on these comments, the plaintiffs suggest that the decisions have rendered it unclear whether involuntary manslaughter applies to MAID. The plaintiffs, however, misunderstand these passages. Read together and viewed in the context of the issue before the SJC (whether the use of words alone could constitute involuntary manslaughter), it is evident that the SJC's comments were not intended to suggest that MAID may never constitute involuntary manslaughter, but rather to ensure that the *Carter* decisions were not interpreted to prohibit *speech* associated with physician assisted suicide (e.g., a physician informing a terminally ill patient where MAID is legal or advising the patient to travel to a state where MAID is legal).

C. Freedom of Speech (Count V)

With regard to Count V, the plaintiffs assert that the application of common law involuntary manslaughter to a physician based on his/her provision of information and advice about MAID to competent, terminally ill patients, who then voluntarily ingest lethal prescribed

medication, constitutes an unlawful restraint on the constitutional right to freedom of speech by hindering the physician's ability to discuss medically appropriate end-of-life treatment options. As made plain by *Carter II*, the plaintiffs are correct that the law of involuntary manslaughter does not prohibit such provision of information and advice. See *Carter II*, 481 Mass. at 368. Indeed, the Commonwealth does not contend otherwise. Any physician is free to provide information on the jurisdictions where MAID is legal, guidance and information on the procedures and requirements in those jurisdictions, and referrals to physicians who can provide MAID in those jurisdictions. Such conduct, without more, does not constitute involuntary manslaughter.[7] However, this Court declines to issue an injunction because there now appears little or no risk that such prosecutions will occur.

D. Due Process and Equal Protection (Counts III, and IV, and VI)

With regard to Counts III, IV, and VI, the plaintiffs assert that the application of involuntary manslaughter to MAID: (1) impermissibly restricts the plaintiffs' fundamental liberty interests and thereby violates their due process rights; and (2) violates their rights to equal protection because it treats differently terminally ill adults who wish to receive MAID and terminally ill adults who wish to hasten death by VSED, withdrawal of life support, or palliative sedation.[8] As explained below, the Court concludes this is not the case.

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[7] In their complaint, plaintiffs seek, in addition to declaratory relief, an injunction prohibiting the AG and the DA from prosecuting physicians who inform, advise, or counsel patients about MAID. Although "[t]rial judges have broad discretion to grant or deny injunctive relief," "[a] permanent injunction should not be granted to prohibit acts that there is no reasonable basis to fear will occur." *Lightlab Imaging, Inc.* v. *Axsun Techs., Inc.*, 469 Mass. 181, 194 (2014). The Court declines to issue an injunction because there now appears little or no risk that such prosecutions will occur.

[8] As noted above, Count III alleges that application of common law manslaughter to a physician that practices MAID impermissibly restricts the constitutional right to privacy "by interfering with a person's basic autonomy in deciding how to confront their own mortality and choose their own destiny." Complaint at ¶ 51. Count IV similarly alleges that it impermissibly restricts fundamental liberty interests, namely, "the right of competent adults to control

1. *Standard of Review*

In order to determine whether the application of common law involuntary manslaughter to MAID violates the plaintiffs' equal protection and due process rights under the Massachusetts Constitution, the Court must first examine which standard of review is applicable – strict scrutiny review, which is required if a statute burdens a suspect group or a fundamental right, or rational basis review, which is the default form of review. See *Goodridge* v. *Department of Pub. Health*, 440 Mass. 309, 330 (2003) ("Where a statute implicates a fundamental right or uses a suspect classification, we employ strict judicial scrutiny. . . . For all other statutes, we employ the rational basis test.) (internal quotation marks and citation omitted). The plaintiffs argue that strict scrutiny applies because the prohibition against MAID implicates a fundamental right, which they define as "Dr. Kliger's fundamental right of self-determination and individual autonomy in making end-of-life medical decisions. . . ." Pl. Opp. Brief at 5. The Court disagrees.

At the outset, the Court notes that the United States Supreme Court (Supreme Court) has already determined that an individual does not have a fundamental right to MAID under the U.S. Constitution. See *Washington* v. *Glucksberg*, 521 U.S. 702 (1997); *Vacco* v. *Quill*, 521 U.S. 793 (1997). In *Glucksberg*, the Supreme Court held that Washington state's law prohibiting assisted suicide did not violate the substantive due process rights of physicians who wished to provide lethal medications to their competent, terminally ill patients.[9] In so ruling, the Court looked to the "Nation's traditions" to determine whether the right to physician assisted suicide was a fundamental liberty interest protected by the Fourteenth Amendment's Due Process Clause and

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decisions relating to the rendering of their own health care." Id. at ¶ 55. Both the Commonwealth and the plaintiffs appear to treat these Counts as asserting substantive due process claims.

[9] The ban has since been overturned by legislation in that state.

determined that it was not because there was an "almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today." 521 U.S. at 723, 728. The Court explained that even though "many rights and liberties protected by the Due Process Clause [of the Fourteenth Amendment] sound in personal autonomy" not "all important, intimate, and personal decisions" were similarly protected. *Id.* at 727. The Court then went on to apply the rational basis test and conclude that Washington's assisted suicide ban was rationally related to legitimate government interests, including: an unqualified interest in the preservation of human life; an interest in preventing suicide, and in studying, identifying, and treating its causes; an interest in protecting the integrity and ethics of the medical profession; an interest in protecting vulnerable groups (e.g., the poor, the elderly, and disabled persons) from abuse, neglect, and mistakes; and an interest in preventing the societal acceptance of voluntary and involuntary euthanasia. *Id.* at 728-735.

In *Vacco*, decided on the same day as *Glucksberg*, the Supreme Court rejected the plaintiffs' contention that New York's law against assisted suicide, as applied to physician assisted suicide, violated the Fourteenth Amendment's Equal Protection Clause by differently treating mentally competent, terminally ill patients seeking to self-administer prescribed lethal medication and mentally competent, terminally ill patients who refused life-saving medical treatment. 521 U.S. at 799-809. The Supreme Court reiterated that the law did not "infringe fundamental rights" and, applying the rational basis review standard, concluded that the law "follow[ed] a longstanding and rational distinction." Id. at 799, 808. In so ruling, the Supreme Court stated that drawing a distinction between assisting suicide and withdrawing life-sustaining treatment "comports with fundamental legal principles of causation and intent." *Id.* at 801. It explained that:

> 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. . . . Furthermore, 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, pain killing 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. A doctor who assists a suicide, however, must, necessarily and indubitably, intend primarily that the patient be made dead. . . . 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. . . . The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. . . . Put differently, the law distinguishes actions taken because of a given end from actions taken in spite of their unintended but foreseen consequences.

Id. at 801-803 (internal quotation marks and citations omitted).

This Court also notes that since the rulings in *Glucksberg* and *Vacco*, other state appellate courts have either concluded for the first time or reaffirmed that MAID does not implicate a fundamental right. See, e.g., *Morris* v. *Brandenburg*, 376 P. 3d 836 (N.M. 2016); *Myers* v. *Schneiderman*, 31 N.Y.S. 3d 45 (2016); *Donorovich-Odonnell* v. *Harris*, 241 Cal. App. 4th 1118 (2015); *Sampson* v. *State*, 31 P. 3d 88 (Alaska 2001); *Krischer* v. *McIver*, 697 So. 2d 97 (Fla. 1997). Indeed, despite the apparent growing acceptance of MAID, no state appellate court has yet to render a ruling inconsistent with *Glucksberg* or *Vacco*. See *Morris*, 376 P. 3d at 839 ("No appellate court has held that there is a constitutional right to physician aid in dying."); *Baxter* v. *Montana*, 354 Mont. 234, 239 (2009) (finding that a statutory consent defense to a homicide charge could apply to physicians who practiced MAID but declining to address the parties' constitutional arguments).

The plaintiffs acknowledge the rulings in *Glucksberg* and *Vacco* but point to the SJC's recognition in *Goodridge* that the "Massachusetts Constitution is in some instances more

protective of individual liberty interests than is the Federal Constitution" even in instances "where both Constitutions employ essentially the same language." 440 Mass. at 328. See also *Commonwealth* v. *Freeman*, 472 Mass. 503, 505 n.5 (2015). The plaintiffs maintain that, although our Appellate Courts have not directly addressed MAID, the holdings of *Superintendent* v. *Saikewicz*, 373 Mass. 728 (1977) and *Brophy* v. *New Engl. Sinai Hosp.*, 398 Mass. 417 (1986), "make clear that restricting a patient's decision to accept or reject treatment implicates a fundamental right" and that therefore prohibiting MAID implicates a fundamental right because it "restricts a patient's decision to accept a medical treatment." Pl. Opp. Br. at 6-7 (internal quotation marks omitted). However, neither *Saikewicz* nor *Brophy* go as far as the plaintiffs suggest.

Saikewicz concerned a severely mentally handicapped individual who suffered from a form of leukemia, which if left untreated, would likely cause him to die within weeks or several months without pain. 373 Mass. at 731-734. Chemotherapy would temporarily prolong his life but could also result in significant adverse side effects and discomfort. *Id.* The question before the SJC was whether the individual, through his guardian ad litem, could refuse chemotherapy treatment. The SJC held that the individual could do so. *Id.* at 730, 759. In rendering its ruling, the SJC explained that in situations in which a patient refuses medical intervention and treatment both the patient and the State have countervailing interests which must be balanced. *Id.* at 744. The patient has a right "to reject, or refuse to consent to, intrusions of his bodily integrity and privacy" rooted in the common law and in a constitutional right to privacy. *Id.* at 738-740, 745. The State, on the other hand, has an interest in "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the

ethical integrity of the medical profession." *Id.* at 741. The SJC found that in the case before it, the balance favored permitting the individual to forgo treatment. *Id.* at 744-745, 759.

Similarly, in *Brophy*, the SJC held that a patient's guardian could remove a gastrostomy tube through which the patient received nutrition and hydration that artificially continued his life where there was no hope of his recovery from a persistent vegetative state. 398 Mass. at 421-422. It balanced the patient's "right to refuse medical treatment" against the four State interests discussed in *Saikewicz* and concluded that the Commonwealth's interests did not overcome the patient's right, as represented by his guardian, to discontinue treatment. *Id.* at 429-440.

Both of these decisions were narrowly focused on a patient's right to bodily integrity (the freedom to avoid medical treatment as a form of unwanted touching), rather than, as is the case with MAID, a patient's desire to have medical treatment to end his or her life. And in each decision, the SJC was careful not to suggest that the right to refuse medical treatment encompasses or relates to the right to assisted suicide. It took pains to preserve what it viewed as a meaningful distinction between death that results naturally from the withdrawal of medical equipment and death that results from affirmative human efforts. In *Saikewicz*, the SJC, in concluding that the Commonwealth's interest in preventing suicide was "inapplicable" to the case before it, explained that:

> In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (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. . . . Furthermore, the underlying State interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.

373 Mass. at 743 n.11 (internal citation omitted). The SJC similarly explained in *Brophy*:

> [W]e [do not] consider [the patient's] death to be against the State's interest in the prevention of suicide. [The patient] suffers an affliction, . . . which makes him incapable of swallowing. The discontinuance of the G-tube feedings will not be the death producing agent set in motion with the intent of causing his own death .... Prevention of suicide is . . . an inapplicable consideration. . . . A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient. . . . [D]eclining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.

398 Mass. at 439 (internal quotation marks and citations omitted). Significantly, the SJC in *Brophy* also acknowledged that although the "law recognizes the individual's right to preserve his humanity, even if to preserve his humanity means to allow the natural processes of a disease or affliction to bring about a death with dignity," the law "does not permit suicide" and thus, "unlimited self-determination," or "unqualified free choice over life." *Id.* at 434 & n.29.

Neither decision suggests that the principles that underlie the right to refuse medical treatment apply to the affirmative act of taking one's own life with the assistance of a willing physician. Instead, they signal that the SJC, if directly faced with the issue, would rule in a manner consistent with *Vacco* and *Glucksberg*, which also maintained a strong distinction between MAID, and the withdrawal of treatment and palliative care. Compare *Glucksberg*, 521 U.S. at 727 ("That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected."), with *Brophy*, 398 at 434 n.29 (individuals do not have "unlimited self-determination" or an "unqualified free choice over life").

The Court acknowledges that these decisions were issued more than thirty years ago and may not reflect the SJC's current thinking on the issue. Moreover, since *Glucksberg* and *Vacco*, the Supreme Court recognized that in identifying fundamental rights, a court may consider

evolving social views in addition to history and tradition. See *Obergefell* v. *Hodges*, 135 S. Ct. 2584, 2598, 2602 (2015) (noting that "[h]istory and tradition guide and discipline [the fundamental rights] inquiry but do not set its outer boundaries" and explaining that although the *Glucksberg*'s "central reference to specific historical practices" may have been appropriate for the right in that case, it was inconsistent with the Court's approach in discussing "other fundamental rights"). Our own courts have indicated they would perhaps apply this same analysis. See *Goodridge*, 440 Mass. at 328 ("history must yield to a more fully developed understanding of the invidious quality of the discrimination"). But see *Gillespie* v. *Northampton*, 460 Mass. 148, 153 (2011) ("fundamental right is one that is deeply rooted in this Nation's history and tradition") (internal quotation marks omitted); *Doe* v. *Secretary of Educ.*, 479 Mass. 375, 392 n. 29 (2018), citing *Obergefell* 135 S. Ct. at 2598 ("In addition to those rights afforded explicit protection under our Constitution, [h]istory and tradition guide and discipline the process of identifying and protecting fundamental rights implicit in liberty") (internal quotation marks omitted). 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. Compare *Obergefell*, 135 S. Ct. at 2602 (right to same-sex marriage arises, in part, "from a better informed understanding of how constitutional imperatives define a liberty that remains urgent in our own era"). Indeed, although this issue has been repeatedly litigated, the plaintiffs are unable to cite to any jurisdiction where its appellate courts have concluded otherwise.[10]

[10] The Court finds the plaintiffs' reliance on the SJC's decision in *Goodridge* and the Supreme Court's decision in *Obergefell* addressing the right to same-sex marriage unpersuasive. In those cases, the courts were faced with the question of whether a state could exclude certain persons from obtaining state-sanctioned marriage licenses or put differently, whether the constitution required an extension of an already established right. In this case, the plaintiffs seek the declaration of a right that has never been previously recognized for any person.

Accordingly, the Court concludes that a prohibition against MAID does not implicate a fundamental right and that therefore the plaintiffs' due process and equal protection claims are subject to a rational basis review and not a strict scrutiny analysis.

2. *Rational Basis Analysis*

"For due process claims, rational basis analysis requires that [laws] bear[] a real and substantial relation to the public health, safety, morals, or some other phase of the general welfare. . . ." *Goodridge*, 440 Mass. at 330 (internal quotation marks omitted). Similarly, "[f]or equal protection challenges, the rational basis test requires that an impartial lawmaker could logically believe that the classification would serve a legitimate public purpose that transcends the harm to the members of the disadvantaged class." *Id.* (internal quotation marks omitted). See also *Chebacco Liquor Mart, Inc.* v. *Alcoholic Beverages Control Comm'n*, 429 Mass. 721, 723 (1999) ("A classification will be considered rationally related to a legitimate purpose if there is any reasonably conceivable state of facts that could provide a rational basis for the classification.") (internal quotation marks omitted); *Marshfield Family Skateland, Inc.* v. *Marshfield*, 389 Mass. 436, 446 (1983), quoting *Commonwealth* v. *Henry's Drywall Co.*, 366 Mass. 539, 541 (1974) ("a statutory classification will not be set aside as a denial of equal protection or due process if any state of facts reasonably may be conceived to justify it."). In conducting this analysis, the Court does not "weigh conflicting evidence supporting or opposing a legislative enactment." *Shell Oil Co.* v. *City of Revere*, 383 Mass. 682, 687 (1981). The Court concludes that the Commonwealth's prohibition on MAID, meets the rational basis test for both due process and equal protection. [11]

[11] Given the nature of the rational basis analysis, the Court rejects the plaintiffs' assertion that summary judgment in favor of the defendants should be denied because there are "at a minimum, factual disputes relating to" the evidence

First, the Legislature could rationally conclude that difficulty in determining and ensuring that a patient is "mentally competent" warrants the continued prohibition of MAID. There is expert testimony in the record that many patients faced with a diagnosis of terminal illness are depressed, that this depression and accompanying demoralization may interfere with their ability to make a rational choice between MAID and other available alternatives, and that most Massachusetts physicians are unaware of the best practices in responding to requests for MAID given this context. See Forrow Aff., Joint Appendix (J.A.) Ex. 39, at ¶ 14; Greene Aff., J.A. Ex. 40, at ¶ 6; Forrow Disclosure, J.A. Ex. 13, at ¶ 3(a).[12] There is also evidence that the problem of competency is particularly acute at the time at which a patient self-administers the medication because patients may be alone or accompanied by those who support his or her end-of-life decision. See Oregon Health Authority, 2014-17 Data Summaries, J.A. Ex. 20 (prescribing physician present at time of death in the case of only 13.9% of patients in 2014; 10.8% in 2015; 10.1% in 2016; 16.1% in 2017); Green Disclosure, J.A. Ex. 14, at 6; Green Aff., J.A. Ex. 40, at ¶ 11; Forrow Aff., J.A. Ex. 39, at ¶ 22. In such a situation, there is a greater risk that temporary anger, depression, a misunderstanding of one's prognosis, ignorance of alternatives, financial considerations, strain on family members or significant others, or improper persuasion may impact the decision. The concern that the decision will be motivated by financial considerations are potentially heightened when MAID is being used by members of disadvantaged socio-

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the defendants have put forward to support their contention that the prohibition on MAID has a rational basis. See Pl. Opp. Brief at 21.

[12] The Alaskan Supreme Court has expressed similar concerns about competency. It has explained that: "While mental competency is certainly well accepted as a measure for determining when physicians may render life-prolonging medical treatment, it is potentially far more controversial as a measure for determining when a physician is entitled to terminate a patient's life. This is so not only because the prescription of life-ending medication is a unique and absolute form of medical 'treatment,' but also because the mental competency of terminally ill patients is uniquely difficult to determine." *Sampson*, 31 P.3d at 97.

economic groups. See Forrow Disclosure, J.A. Ex. 13, at ¶ 9(d); Greene Depo., J.A. Ex. 7, at 129-130.

Second, the Legislature could rationally conclude that predicting when a patient has six months to live is too difficult and risky for purposes of MAID, given that it involves the irreversible use of a lethal prescription. The Commonwealth put forward expert testimony that while doctors may be able to accurately predict death within two or three weeks of its occurrence, predictions of death beyond that time frame are likely to be inaccurate. See Greene Disclosure, J.A. Ex. 14, at 5 ("Research has shown that physicians cannot predict imminent death sooner than a few weeks before the event. . . . At six months, a fatal outcome is wholly unpredictable other than recognizing the presence of an incurable condition."); Green Aff., J.A. Ex. 40, at ¶ 7; Green Depo., J.A. Ex. 7, 76-79; Forrow Aff., J.A. Ex. 39, at ¶ 17 ("It is crucial to recognize that the limits in any physician's ability to predict a patient's future have *dramatically* different implications when what is at stake is possible referral to hospice, rather than the possible provision of a lethal prescription").[13]

Third, the Legislature could rationally conclude that a general medical standard of care is not sufficient to protect those seeking MAID. The Commonwealth put forward expert testimony that MAID "is neither a medical treatment nor a medical procedure and thus there can be no applicable medical standard of care" and that "[t]he legalization of [MAID] is an attempt to carve out a special case outside of the norms of medical practice." Greene Disclosure, J.A. Ex. 14, at 7. See also Forrow Rebuttal Disclosure, J.A. Ex. 15, at 10 ("In states where [MAID] has been legalized by statute, the standard of care consists of doing it in accordance with regulations

[13] The Court notes that the plaintiffs seek a declaration that would apply to all physicians, even though most physicians likely do not have substantial experience dealing with terminal stages of disease. See Green Disclosure, J.A. Ex 14, at 6.

that the law put in place. There would be no analogous standard of care if [MAID] were legalized by court order. . . . The average doctor in Massachusetts does not have the experience and expertise required to provide [MAID] responsibly. . . ."); Forrow Aff., J.A. Ex. 39, at ¶¶ 19-20.[14] The Commonwealth also put forward evidence that regulating MAID is difficult even where statutory standards, such as those in Oregon, are in place. Its expert opined that: "Data collected [in Oregon] paint[s] a picture of patients receiving [MAID] for whom alternative approaches have not been exhausted. Psychological referrals are scant. The cited basis for requests largely consists of problems that are manageable via palliative care and hospice. What Oregon officials do not do is monitor the actual process for terminating patients. Yet the data that is available is troubling." Green Disclosure, J.A. Ex. 14, at 8. See also Green Aff., J.A. Ex. 40, at ¶ 11.

Lastly, the Legislature could rationally conclude that MAID is not equivalent to permissible alternatives. The Commonwealth introduced expert testimony that both VSED and withdrawal of life support differ significantly from MAID because both VSED and withdrawal of life support concern the recognized right to discontinue unwanted treatment and in neither circumstance does the physician necessarily act for the purpose of causing the patient's death. See Forrow Aff., J.A. Ex. 39, at ¶ 6; Green Disclosure, J.A. Ex. 16, at ¶¶ 1, 10. The doctor's role, particularly in VSED, is to ensure that the patient's symptoms are controlled. Forrow Aff., J.A. Ex. 39, at ¶ 6; Green Disclosure, J.A. Ex. 16, at 10. The Commonwealth also introduced expert testimony that palliative sedation is different from MAID because it does not necessarily involve an intent to shorten life nor does it necessarily cause or hasten death. See Forrow Aff.,

[14] The Court notes that the Vermont Legislature included a regulatory sunset provision in the statute that authorized MAID, 2013 Vt. Acts 39, but then repealed that sunset provision. See 2015 Vt. Acts 27.22. This provides further evidence that a general standard of care is not appropriate for MAID.

J.A. Ex. 39, at ¶ 8; Greene Depo., J.A. Ex. 7, at 92-95; Greene Aff., J.A. Ex. 40, at ¶ 8. Rather, palliative sedation may be conducted in such a fashion as to ensure that the underlying disease, not the sedation is the cause of death. Greene Aff., J.A. Ex. 40, ¶ 8; Forrow Aff., J.A. Ex. 39, at ¶ 9. Finally, the Commonwealth produced expert testimony that the permissible end-of-life alternatives potentially involve far less risk than MAID because they occur in hospitals or other institutions devoted to medical treatment and involve numerous physician and staff personnel, which together provide an environment that lends itself to oversight and responsibility. Forrow Aff. ¶¶ 8, 16; Green Aff., J.A. Ex. 40, ¶ 5. MAID, on the other hand, potentially takes place in an uncontrolled environment, without assurance that the patient will administer the medication when close to death, and without physician oversight.

In light of these legitimate public interests that are served by prohibiting MAID, the Court concludes that the plaintiffs failed to demonstrate a violation of their due process or equal protection rights.[15]

E. Conclusion

In concluding that MAID is not authorized under Massachusetts law, the Court notes that there appears to be a broad consensus that this issue is not best addressed by the judiciary. See, e.g., Morris, 376 P. 3d at 838 (indicating that legality of MAID is an issue for the political branches); Myers, 31 N.Y.S. 3d at 64-65 (same); Donorovich-Odonnell, 241 Cal. App. 4th at 1124-1125, 1140 (same); Sampson, 31 P. 3d at 98 (same); Krischer, 697 So. 2d at 104 (same). MAID raises difficult moral, societal, and governmental questions, the resolution of which require the type of robust public debate the courts are ill-suited to accommodate. Although

[15] The Court acknowledges the countervailing expert testimony provided by the plaintiffs. However, this testimony merely indicates that the plaintiffs' views on MAID are reasonable not that the state's decision to prohibit MAID is without rational basis.

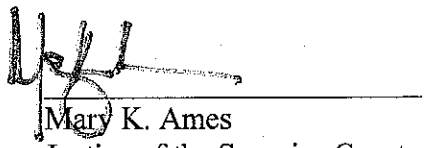
plaintiffs have presented several strong arguments for making MAID a legal option for those suffering from terminal illness, there are equally strong arguments for prohibiting MAID or ensuring that MAID occurs in an environment in which clear, thoughtful, and mandatory standards are in place to protect terminally ill patients who wish to make an irreversible decision. The Legislature, not the Court, is ideally positioned to weigh these arguments and determine whether and if so, under what restrictions, MAID should be legally authorized.

ORDER

For the forgoing reasons:

1. The defendants' motion for summary judgment is **ALLOWED** as to Counts I, II, III, IV and VI, but **DENIED IN PART** as to Count V;
2. The plaintiffs' motion for partial summary judgment is **ALLOWED IN PART** as to Count V but otherwise **DENIED**. The Court declines to issue injunctive relief.

It is further **ORDERED**, **ADJUDGED**, and **DECLARED** that: None of the arguments advanced in this action preclude the defendants from prosecuting physicians who prescribe lethal medication for purposes of Medical Aid in Dying; this, however, does not apply to physicians who provide information and advice on Medical Aid in Dying to terminally ill, competent adults.



Mary K. Ames
Justice of the Superior Court

Dated: December 31, 2019

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

Massachusetts General Laws Annotated
Part IV. Crimes, Punishments and Proceedings in Criminal Cases (Ch. 263-280)
Title I. Crimes and Punishments (Ch. 263-274)
Chapter 265. Crimes Against the Person (Refs & Annos)

M.G.L.A. 265 § 13

§ 13. Manslaughter; punishment; business organization as defendant

Effective: April 13, 2018
Currentness

Whoever commits manslaughter shall, except as hereinafter provided, be punished by imprisonment in the state prison for not more than twenty years or by a fine of not more than one thousand dollars and imprisonment in jail or a house of correction for not more than two and one half years. Whoever commits manslaughter while violating the provisions of sections 102 to 102C, inclusive, of chapter 266 shall be imprisoned in the state prison for life or for any term of years.

Any business organization including, without limitation, a corporation, association, partnership or other legal entity that commits manslaughter shall be punished by a fine of not more than $250,000. If a business organization is found guilty under this section, the appropriate commissioner or secretary may debar the corporation under section 29F of chapter 29 for a period of not more than 10 years.

Credits
Amended by St.1971, c. 426; St.2010, c. 160, § 5, eff. July 15, 2010; St.2018, c. 69, § 127, eff. April 13, 2018.

Notes of Decisions (501)

M.G.L.A. 265 § 13, MA ST 265 § 13
Current through Chapter 26 of the 2021 1st Annual Session.

End of Document

Massachusetts General Laws Annotated
Part I. Administration of the Government (Ch. 1-182)
Title XVI. Public Health (Ch. 111-114)
Chapter 111. Public Health (Refs & Annos)

M.G.L.A. 111 § 227

§ 227. Palliative care and end-of-life options; distribution of information regarding availability

Effective: November 4, 2012
Currentness

(a) As used in this section the following terms shall, unless the context clearly requires otherwise, have the following meanings:

“Appropriate”, consistent with applicable legal, health and professional standards, the patient's clinical and other circumstances and the patient's reasonably known wishes and beliefs.

“Attending health care practitioner”, a physician or nurse practitioner who has primary responsibility for the care and treatment of the patient; provided that if more than 1 physician or nurse practitioner share that responsibility, each of them shall have a responsibility under this section, unless there is an agreement to assign that responsibility to 1 such person.

“Palliative care”, a health care treatment, including interdisciplinary end-of-life care and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care.

“Terminal illness or condition”, an illness or condition which can reasonably be expected to cause death within 6 months, whether or not treatment is provided.

(b) The commissioner shall adopt regulations requiring each licensed hospital, skilled nursing facility, health center or assisted living facility to distribute to appropriate patients in its care information regarding the availability of palliative care and end-of-life options.

(c) If a patient is diagnosed with a terminal illness or condition, the patient's attending health care practitioner shall offer to provide the patient with information and counseling regarding palliative care and end-of-life options appropriate for the patient, including, but not limited to: (i) the range of options appropriate for the patient; (ii) the prognosis, risks and benefits of the various options; and (iii) the patient's legal rights to comprehensive pain and symptom management at the end-of-life. The information and counseling may be provided orally or in writing. Where the patient lacks capacity to reasonably understand and make informed choices relating to palliative care, the attending health care practitioner shall provide information and counseling under this section to a person with authority to make health care decisions for that patient. The attending health care practitioner may arrange for information and counseling under this section to be provided by another professionally qualified individual.

If the attending health care practitioner is not willing to provide the patient with information and counseling under this section, the attending health care practitioner shall arrange for another physician or nurse practitioner to do so or shall refer or transfer the patient to another physician or nurse practitioner willing to do so.

Nothing in this section shall be construed to permit a healthcare professional to offer to provide information about assisted suicide or the prescribing of medication to end life.

(d) The department shall consult with the Hospice and Palliative Care Federation of Massachusetts in developing educational documents, rules and regulations related to this section.

Credits

Added by St.2012, c. 224, § 103, eff. Nov. 4, 2012.

M.G.L.A. 111 § 227, MA ST 111 § 227
Current through Chapter 26 of the 2021 1st Annual Session.

End of Document

Massachusetts General Laws Annotated
Part II. Real and Personal Property and Domestic Relations (Ch. 183-210)
Title II. Descent and Distribution, Wills, Estates of Deceased Persons and Absentees, Guardianship, Conservatorship and Trusts (Ch. 190-206)
Chapter 201D. Health Care Proxies (Refs & Annos)

M.G.L.A. 201D § 12

§ 12. Suicide or mercy killing

Currentness

Nothing in this chapter shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one's own life other than to permit the natural process of dying.

Credits
Added by St.1990, c. 332, § 1.

M.G.L.A. 201D § 12, MA ST 201D § 12
Current through Chapter 26 of the 2021 1st Annual Session.

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