Supreme Judicial Court

FOR THE COMMONWEALTH OF MASSACHUSETTS
SJC-13194

ROGER M. KLIGLER & another, Appellants

v.

MAURA HEALEY & another, Appellees

On Appeal From The Suffolk Superior Court

BRIEF OF AMICUS CURIAE
MASSACHUSETTS CITIZENS FOR LIFE, INC.
IN SUPPORT OF APPELLEES AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Massachusetts Citizens for Life, Inc. (MCFL), is a not-for-profit corporation organized under the laws of the Commonwealth. It does not have a parent corporation, nor does it issue stock.

RULE 17(C)(5) DECLARATION

Neither the parties, nor their counsel, authored any part of this brief or contributed any money intended to fund its preparation and submission. Further, no person or entity other than amicus and their counsel contributed any money intended to fund the preparation and submission of this brief. Neither amicus nor their counsel have represented either party to the present appeal in another proceeding involving similar issues, nor have they been a party or represented a party in a proceeding or legal transaction that is at issue in the present appeal.

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STATEMENT OF IDENTITY/INTEREST FOR MASSACHUSETTS CITIZENS FOR LIFE, INC.

MCFL is dedicated to furthering the protection of human life from conception until natural death. As such, MCFL is opposed to the legalization of assisted suicide at issue in this case.

SUMMARY OF THE ARGUMENT

Physician-assisted suicide rejects society's most foundational commitments, devalues all human life, fosters discrimination, violates the Hippocratic Oath, creates a dangerously broad definition of terminal illness, and will inevitably lead to euthanasia and the abuse of vulnerable persons. Palliative care and modern therapeutics offer a morally acceptable solution to the issues that cause some to consider committing physician-assisted suicide.

First, physician-assisted suicide rejects society's most foundational commitments. The Declaration of Independence, the Constitution, the Massachusetts Constitution, the Torah, the Christian Bible, and the Quran all command the protection of life and forbid the killing of innocents. These foundational texts recognize a principle that has been core to every moral and prosperous society in world history: human life is of immeasurable, inherent value, and it must be protected. Any compromise inevitably leads to mass tragedy, and physician-assisted suicide is no compromise of this principle—it is its full-throated rejection. It must be condemned in the strongest possible terms.

Physician-assisted suicide devalues all human life. At its core, the practice is callousness masquerading as kindness. It claims to champion the interests of those most vulnerable: those experiencing pain and suffering, the elderly, and the marginalized. It does exactly the opposite. As described by the *Linacre Quarterly*, "To assert that one values human life, and at the same time to commit suicide is contradictory and illogical. So, to kill oneself . . . necessarily devalues human life. And, because we are all human beings, therefore, every human being is . . . devalued." Daniel P. Sulmasy et al., *Non-Faith-Based Arguments Against Physician-Assisted Suicide And Euthanasia*, 83 LINACRE QUARTERLY 246, 250 (2016) [hereinafter Linacre Quarterly, *Non-Faith-Based Arguments*]. When physician-assisted suicide is treated positively by society, whether by word or by deed, all human life is devalued. As noted by the *Journal of Oncology Practice*, "Words have consequences and laws have greater consequences." Mark A. O'Rourke, M. Colleen O'Rourke, & Matthew F. Hudson, *Reasons to Reject Physician-Assisted Suicide/Physician Aid in Dying*, 10 J. ONCOLOGY PRAC. 683, 684 (2017) [hereinafter O'Rourke, *Reasons to Reject*]. To isolate the consequences of physician-assisted suicide to individuals is to misunderstand the nature of human life, of society, of law, of our institutions, and how all this works together to form our most basic presumptions.

Physician-assisted suicide fosters discrimination. Political philosopher Ryan T. Anderson writes "[e]very human being has intrinsic dignity and immeasurable worth. For our legal system to be coherent and just, the law must respect this dignity in everyone. It does so by taking all reasonable steps to prevent the innocent, of any age or condition, from being devalued and killed. Classifying a subgroup of people as legally eligible to be killed violates our nation's commitment to equality before the law—showing profound disrespect for and callousness to those who will be judged to have lives no longer 'worth living,' not least the frail elderly, the demented, and the disabled." Ryan T. Anderson, *Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality*, HERITAGE FOUNDATION (Mar. 24, 2015), https://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak [hereinafter Anderson, *Always Care*]. Policies that allow for physician-assisted suicide to take place, no matter how nuanced or tailored, create a heinous class system: one group of American citizens is legally eligible to be killed and one group is not. That is because such a class system is not merely *incidental* to the creation of a physician-assisted suicide policy, *it is its purpose*. Accordingly, courts cannot affirm the legitimacy of physician-assisted suicide without affirming discrimination. To affirm the legitimacy of physician-assisted suicide affirms a

violation of the Equal Protection of the law. Americans deserve to be treated equally, and our legal and medical communities must acknowledge their inherent dignity.

The Hippocratic oath recognizes this. Physicians have sworn to it for over two thousand years. The oath requires physicians to refrain from giving their patients "deadly medicine" even if asked, because it is contrary to their role as healers. *See* Laura McPherson, *The History of the Hippocratic Oath*, NORTHEASTERN NURSING BLOG (June 3, 2015), https://absn.northeastern.edu/blog/the-history-of-the-hippocratic-oath; *Code of Medical Ethics*, AM. MED. ASS'N [AMA] § 5.7 (2019), https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf. The Hippocratic oath provides the template for the trust and care that characterizes the physician-patient relationship. Abandoning the principle of "do no harm" from the oath will open the door to practices like euthanasia and degrade the trust that patients place in their healers.

Physician-assisted suicide creates a dangerously broad definition of terminal illness. Massachusetts currently defines terminal illness as one "which can reasonably be expected to cause death within 6 months, whether or not treatment is provided." M.G.L. ch. 111 §227. There are two reasons why this definition will expand and eventually be discarded. First, doctors often have difficulty predicting

the timing of one's death. A Mayo Clinic study found only 20% of such predictions to be accurate. Jane E. Brody, *Tough Question to Answer, Tough Answer to Hear*, N.Y. TIMES (Mar. 6, 2007), https://www.nytimes.com/2007/03/06/health/06mbrody.html. Both proponents and opponents of physician-assisted suicide can agree that determining a patient's qualification for physician-assisted suicide stands on shaky grounds. Second, mental anguish and bodily pain are not limited to those with terminal illnesses. If society accepts that its members can choose death as a way to escape physical and mental anguish, then giving the choice to those without terminal illness but in great pain will be seen as the compassionate thing to do. For these reasons, the definition of terminal illness will continuously expand and the term itself will eventually be discarded.

Euthanasia is a likely result of physician-assisted suicide. We are told that typical physician-assisted suicide candidates are terminally ill and wracked with pain that cannot be addressed. It is compassionate, the argument goes, to support physician-assisted suicide. This is despite the rarity of patients experiencing truly unaddressed pain (as will be discussed with regard to palliative care).

This "compassion" rationale basis for supporting physician-assisted suicide also supports euthanasia. According to the *Linacre Quarterly*, "The Netherlands is an example of the slippery slope on which legalizing physician-assisted suicide

puts us. In the 1980s the Dutch government stopped prosecuting physicians who committed voluntary euthanasia on their patients" and by the 1990s "over 50 percent of acts of euthanasia were no longer voluntary." Linacre Quarterly, *Non-Faith-Based Arguments* at 251. And the Netherlands is not alone. The "Euthanasia consciousness" caught on as Belgium followed suit in 2002. Wesley J. Smith, *Now They Want to Euthanize Children,* WASHINGTON EXAMINER (Sept. 12, 2004), https://www.washingtonexaminer.com/weekly-standard/now-they-want-to-euthanize-children. "The very *first* Belgian euthanasia of a person with multiple sclerosis violated the law; and just as occurs routinely in the Netherlands, the doctor involved faced no consequences. Now Belgium is set to legalize neo-pediatric euthanasia." *Id.* Protecting society's most vulnerable requires acknowledging the insufficient justifications behind physician-assisted suicide and rejecting calls for its legalization. Otherwise, the United States will likely follow the Netherlands and Belgium's path as society's most vulnerable citizens face unprecedented threats to their dignity and their lives.

Physician-assisted suicide also leads to the coercion and abuse of vulnerable persons. There are two reasons for this. First, there will be no reliable way to prevent such encouragement, whether explicit or implicit. Second, physician-assisted suicide financially incentivizes privatized healthcare institutions to end a person's life. Both outcomes are likely, and neither is acceptable.

The Disability Rights Education and Defense Fund supports the premise above. There is significant danger "that many people would choose assisted suicide due to external pressure. Elderly individuals who don't want to be a financial or caretaking burden on their families might take this escape." DISABILITY RIGHTS EDU. & DEF. FUND, *Why Assisted Suicide Must Not Be Legalized* (2009), https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/. "Safeguards" put in place, such as mental evaluations and procedural restraints, are ineffectively administered and inherently flawed. Those requesting physician-assisted suicide often suffer from some form of mental anguish, and such issues can often be relieved by other commonly available means. Nevertheless, help is rarely provided. Physician-assisted suicide "endangers the weak and marginalized in society. Where it has been allowed, safeguards purporting to minimize this risk have proved to be inadequate and have often been watered down or eliminated over time. People who deserve society's assistance are instead offered accelerated death." Anderson, *Always Care*.

Worse still, if physician-assisted suicide is legal, privatized healthcare institutions have a direct financial incentive in the ending of a person's life. J. J. Hanson describes this point in detail. He writes "[i]t is important to see, too, that legalizing assisted suicide introduces government agencies and for-profit insurance companies into everyone's end-of-life decisions—which will result in limiting

everyone's choice. It is already happening to patients trying to pursue treatment for serious illness where assisted suicide is legal. They are being denied coverage for life-sustaining or curative treatment and being offered less expensive assisted suicide drugs instead." J. J. Hanson, *Assisted Suicide Laws Will Pressure Poor, Elderly, Depressed To Die*, THE HILL (Sept. 27, 2017), https://thehill.com/opinion/civil-rights/352757-assisted-suicide-laws-will-pressure-poor-elderly-depressed-to-die.

Nor is physician-assisted suicide a necessary procedure when palliative care and modern therapeutics offer terminal patients a large degree of control over their quality of life. *See* Nessa Coyle, *In Their Own Words: Seven Advanced Cancer Patients Describe Their Experience with Pain and the Use of Opioid Drugs*, 27 J. PAIN & SYMPTOM MGMT. 300, 306 (Apr. 2004). Palliative care treats the symptoms of severe illness, offering pain control that allows patients to take better advantage of their final days. Conversely, physician-assisted suicide robs patients of this potentially fulfilling time. Physician-assisted suicide is not an alternative form of treatment to palliative care, since instead of treating a patient's symptoms, it seeks to end their life. Suicidal thoughts are themselves a treatable medical symptom and allowing physicians to fulfill suicidal thoughts for their patients perverts their role as healer. *See Code of Medical Ethics*, AM. MED. ASS'N § 5.7 (2019), https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-

5.pdf. American Medical Association, Code of Medical Ethics, § 5.7, https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf.

ARGUMENT

I. Physician-assisted suicide rejects society's most foundational commitments.

The Declaration of Independence states, "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776). Our federal Constitution ensures in both the 5th and 14th Amendments that no person shall be deprived of "life, liberty, or property, without due process" of law. U.S. CONST. amends. V, XIV. The Constitution of our Commonwealth reads: "The end of the institution, maintenance, and administration of government, is to secure the existence of the body politic, to protect it, and to furnish the individuals who compose it with the power of enjoying in safety and tranquility their natural rights, *and the blessings of life*" (emphasis added) and that "[a]ll men are born free and equal, and have certain natural, essential, and unalienable rights; among which may be reckoned the right of enjoying and defending their lives." MASS. CONST. preamble & art. I. The Torah ("So God created man in his own image, in the image of God he created him; male and female he created them." Genesis 1:27); Christian

Bible ("Before I formed you in the womb I knew you, and before you were born I consecrated you; I appointed you a prophet to the nations." Jeremiah 1:5); and the Quran ("Whosoever has spared the life of a soul, it is as though he has spared the life of all people. Whosoever has killed a soul, it is as though he has murdered all of mankind." Quran 5:32) all command the protection of life and forbid the killing of innocents.

These foundational texts do not claim to create a principle, but rather to recognize one—a principle that has been core to every moral and prosperous society in world history. Human life is of immeasurable, inherent value, and it must be protected. Any compromise inevitably leads to injustice, mass suffering, and societal collapse, and physician-assisted suicide is no compromise of this principle—it is a full-throated rejection of it, and it must be condemned.

II. Physician-assisted suicide devalues all human life.

At its core, physician-assisted suicide is kindness that acts with great callousness. It claims to champion the interests of those most vulnerable: those experiencing pain and suffering, the elderly, and the marginalized. It does exactly the opposite.

When a physician-assisted suicide occurs, a life is taken forever, and in its wake remains a message for the wider society. As described by the *Linacre Quarterly*, a peer-reviewed academic journal and the official Journal of the

Catholic Medical Association: "subsumed in the action of one killing oneself (or requesting to be killed) is the implied announcement that one's life (human life) is somehow not as valuable as it otherwise would be if one were not in a position to seek one's death (For to value life contradicts the act of killing, and if one values life, one does not commit suicide or ask to be killed.)." *Non-faith-arguments*, Linacre Quarterly at 250. Accordingly, "To assert that one values human life, and at the same time to commit suicide is contradictory and illogical. So, to kill oneself (willfully, i.e., to distinguish this form of suicide from suicide in association with mental illness or other clinical pathology) necessarily devalues human life. And, because we are all human beings, therefore, every human being is (or should be) resentful of his or her life being devalued." *Id*.

Those in favor of physician-assisted suicide respond that killing oneself does *not* devalue life, and even if it does, it only devalues the life of the individual who has sought physician-assisted suicide. Thus, the logic follows that whether an individual wants to undergo physician-assisted suicide is purely their personal business—no one else's life is being devalued. Yet again, these objections fall flat.

First, taking a human life devalues all human life. By logical necessity, physician-assisted suicide requires one to believe that dying is preferable, or is in some way more valuable, than continuing to live. That is an inherent devaluation, because human life is being judged and found wanting.

Second, to suggest that a single instance of physician-assisted suicide does not devalue *all* human life is to fundamentally misunderstand both the law's impact on society and human nature. As the *Linacre Quarterly* notes, "human beings are relational." *Non-faith-arguments*, Linacre Quarterly at 250. Part of what makes us human beings is our relationships with others.

> Indeed the very origin of an individual necessitates the relationship of two other human beings—a mother and a father—and a human being exists in relationships with others by his or her very nature. Human beings then are always, and essentially a part of a community of persons, and as such because of this connection with others (as part of humanity), when another person kills him—or herself or allows him—or herself to be killed, life for every other human being is cheapened (devalued). Such an action says to some degree, that life is not worth it; and although the effect on others may be seemingly miniscule, the more it happens the greater the effect on others (like compounding interest on money).

Id. at 251. It is in this way that the moral implications of actions do, in fact, have serious consequences for others, "even when there appears to be no connection." *Id*.

When society treats physician-assisted suicide positively, whether by word or by deed, all human life is devalued. As noted by the Journal of Oncology Practice, "Words have consequences and laws have greater consequences." O'Rourke, *Reasons to Reject* at 685. Legalizing physician-assisted suicide "may give peace of mind to a few people with terminal illness, who may be unaware of the resources available to them, but it has negative implications and consequences for the many who suffer from terminal illness and the physicians who care for them." *Id*. To isolate the consequences of physician-assisted suicide to individuals

is to misunderstand the nature of human life, of society, of law, of our institutions, and how they all work together to form our most basic presumptions.

III. Physician-assisted suicide fosters discrimination.

One of physician-assisted suicide's worst offenses is the discrimination it encourages. As described by the United States Conference of Catholic Bishops, physician-assisted suicide "creates two classes of people: those whose suicides we spend hundreds of millions of dollars each year to prevent and those whose suicides we assist and treat as a positive good. We remove weapons and drugs that can cause harm to one group, while handing deadly drugs to the other, setting up yet another kind of life-threatening discrimination." *Top Reasons to Oppose Assisted Suicide*, UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (2017), https://www.usccb.org/committees/pro-life-activities/top-reasons-oppose-assisted-suicide.

This sentiment is further illustrated by Ryan T. Anderson, who writes

> Every human being has intrinsic dignity and immeasurable worth. For our legal system to be coherent and just, the law must respect this dignity in everyone. It does so by taking all reasonable steps to prevent the innocent, of any age or condition, from being devalued and killed. Classifying a subgroup of people as legally eligible to be killed violates our nation's commitment to equality before the law—showing profound disrespect for and callousness to those who will be judged to have lives no longer 'worth living,' not least the frail elderly, the demented, and the disabled. Anderson, *Always Care*.

The latter point is essential. Any policy that allows for physician-assisted suicide to occur, no matter how nuanced or tailored, inevitably creates a heinous class system: one group of American citizens is legally eligible to be killed, and one group is not. That is because such a class system is not merely *incidental* to the creation of a physician-assisted suicide policy, *it is its purpose*. Thus, those most in need of the law's protection would be denied it, a clear violation of equal protection of the law.

Writing for the *Disability and Health Journal*, Diane Coleman of the Disability Rights Group "Not Dead Yet" made the following argument:

> The primary underlying practical basis for the physician's determination that the individual is eligible for assisted suicide is the individual's disabilities and physical dependence on others for everyday needs, which is viewed as depriving them of what nondisabled people often associate with 'autonomy' and 'dignity,' and may also lead them to feel like a 'burden.' This establishes grounds for physicians to treat these individuals completely differently than they would treat a physically able-bodied suicidal person.

Diane Coleman, *Assisted Suicide Laws Create Discriminatory Double Standard For Who Gets Suicide Prevention And Who Gets Suicide Assistance: Not Dead Yet Responds To Autonomy, Inc*, 3 DISABILITY AND HEALTH J. 39 (2010).

Coleman continues to clarify exactly what is occurring: a violation of the Equal Protection of the law. She writes "Not Dead Yet's central argument is that legalized assisted suicide sets up a double standard for how health care providers, government authorities, and others respond to an individual's stated wish to die."

Id. Some "people get suicide prevention and others get suicide assistance, and the difference between the two groups is the health status of the individual." *Id.*

One cannot affirm physician-assisted suicide's legitimacy without affirming discrimination. Affirming the legitimacy of physician-assisted suicide is inextricable from affirming an Equal Protection violation. All Americans deserve to be treated equally, and our legal and medical communities must acknowledge their inherent dignity. Otherwise, as legal philosopher John Finnis states, physician-assisted suicide allows "some people to sit in judgment on the life of another human person, to judge that person's life worthless, and so to authorize themselves or others to carry out that person's request for death." 3 John Finnis, *Human Rights and Common Good*, THE COLLECTED ESSAYS OF JOHN FINNIS, at 259 (2011). This outcome is unacceptable.

IV. Physician-assisted suicide violates the Hippocratic oath.

The Hippocratic oath has provided a code of ethics to physicians since 400 B.C. Laura McPherson, *The History of the Hippocratic Oath*, NORTHEASTERN NURSING BLOG (June 3, 2015), https://absn.northeastern.edu/blog/the-history-of-the-hippocratic-oath. Depending on the translation employed, it requires that physicians "give no deadly medicine to any one if asked," or "abstain from all intentional wrong-doing and harm." *Id.*; ENCYC. BRITANNICA, *Hippocratic oath* (Dec. 4, 2019), https://www.britannica.com/topic/Hippocratic-oath. Regardless of

the translation used, physician-assisted suicide violates the Hippocratic oath. Prescribing lethal medicine upon the patient's request is explicitly giving "deadly medicine" to someone who asked for it. Further, being a necessary part of purposely ending a person's life is intentionally causing harm to their body.

For thousands of years, the Hippocratic oath has formed the template for physician behavior. Its themes are represented in the AMA's Code of Medical Ethics, where the Code dictates that physicians "[s]hould not abandon a patient once it is determined that cure is impossible." *Code of Medical Ethics*, AM. MED. ASS'N § 5.7 (2019), https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf. Causing the patient to die once a terminal prognosis is announced is a paradigm of abandonment, as they are abandoning the patient's whole life. This is why the Code, consistent with the Hippocratic oath, suggests continued care and pain control instead of physician-assisted suicide. *Id.*

If physician-assisted suicide is legalized in Massachusetts, two results are likely. The first is that physicians will have to violate their sworn code of ethics by providing lethal drugs with the knowledge that the patient will use them to end their own life when they have already sworn not to. Alternatively, the Hippocratic oath employed within Massachusetts will have to be changed to allow physicians to prescribe lethal drugs with the knowledge that the patient's death is not only possible but likely to occur. This abandons the principle of "do no harm" and

would have disastrous effects, such as opening the door to practices like euthanasia and degrading the trust that patients place in their healers. It would be difficult for a patient to put their life into the hands of a physician who supports the unnecessary deaths of their patients, as the specter of abuse would hangover even the most caring of physicians.

V. Physician-assisted suicide creates a dangerously broad definition of terminal illness.

Once society accepts the fundamental premise of physician-assisted suicide—that people have the right to choose the time and manner of their death—the definition of "terminal illness" will inevitably be broadened and stretched to cover those without an end-stage disease. There are two reasons for the eventual evolution: (1) doctors often have difficulty predicting the timing of one's death and (2) mental anguish and bodily pain are not limited to those with terminal illnesses.

Massachusetts currently defines terminal illness or condition as one "which can reasonably be expected to cause death within 6 months, whether or not treatment is provided." M.G.L. ch. 111 §227. Unfortunately, the prognosis for end-stage diseases is often incorrect. Both proponents and opponents agree that accurately predicting how long a patient has to live is challenging. Dr. Neil S. Kaye, *Doctors Can't Predict Time of Death, So How Can They Aid in Suicide*, DELAWARE ONLINE, (Mar. 6, 2020, 5:00 AM EDT).

https://www.delawareonline.com/story/opinion/contributors/2020/03/06/doctors-cant-predict-time-death-so-how-can-they-aid-suicide/4957712002/. Hinging a patient's qualification for physician-assisted suicide—a matter of life and death—on such unstable metrics is an unnerving prospect. And for the proponents of physician-assisted suicide, the oft-inaccurate prognosis is an arbitrary roadblock for those who desire to end their lives.

These concerns are not hypothetical. In 2017, a bill in New Mexico defined "terminal illness" as "a disease or condition that is incurable and irreversible and that in accordance with reasonable medical judgment will result in death within a reasonably foreseeable period of time." It mentioned no time period. In 2009, a New Hampshire bill defined "terminal illness" as "an incurable and irreversible condition . . . [that] will result in premature death." Again, no mention of a time frame. *Assisted Suicide and Euthanasia: Beyond Terminal Illness*, UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (Feb. 19, 2018), https://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/SuicideNonterminal2018.pdf.

Furthermore, if society believes that assisted suicide is a legitimate method to end one's suffering, then it is difficult to see why only those with terminal illness should have access to PAS. In fact, a prominent pro-PAS organization, Final Exit Network, claims that "mentally competent adults who suffer from a

terminal illness, intractable physical pain, chronic or progressive physical disabilities, or who face loss of autonomy and selfhood through dementia, have a basic human right to choose to end their lives when they judge their quality of life to be unacceptable" in their mission statement. Compassion & Choices, another pro-PAS organization, believes that dementia should be classified as a terminal illness. ("Instead of treating dementia like the terminal illness it is, medical technology may draw out the dying process—often without considering the patient's preferences.") *Transforming How People With Dementia Die*, Compassion & Choices (n.d.), https://compassionandchoices.org/resource/about-compassion-choices/. Opening the door for PAS will inevitably lead to broadening the definition of "terminal illness." Given the rationale behind PAS, there is no logical reason why it should be cabined to those with less than six months to live. Proponents of PAS argue that PAS will be reserved for those in the most dire circumstances, but it is a promise they cannot keep.

VI. Physician-assisted suicide will lead to euthanasia.

The most common arguments in favor of physician-assisted suicide center around compassion for the individual. As we are told, the typical candidates for physician-assisted suicide are terminally ill and wracked with pain that cannot be addressed. Surely, therefore, having compassion means supporting physician-assisted suicide.

Even though such degree of pain rarely exists, if it does (as is discussed in the following section), the rationale of "compassion" as a basis for supporting physician-assisted suicide supports euthanasia.

As discussed in the *Journal of Oncology Practice*, the compassion arguments for physician-assisted suicide fall short "because quality medical care to relieve suffering for the terminally ill is readily available and widely used." O'Rourke, *Reasons to Reject* at 684. Further, every ethical argument to justify physician-assisted suicide also justifies euthanasia. "How about a request for euthanasia for the person unable to swallow the tablets? How about a request for euthanasia from a health care power of attorney for a person unable to consent? How about minors? How about the severely depressed?" *Id.* at 685. Justifying physician-assisted suicide for some opens the door to justifying physician-assisted suicide and euthanasia for many.

This conclusion is not merely hypothetical—it is backed by research. According to the *Linacre Quarterly*, "The Netherlands is an example of the slippery slope on which legalizing physician-assisted suicide puts us. In the 1980s the Dutch government stopped prosecuting physicians who committed voluntary euthanasia on their patients" and by the 1990s "over 50 percent of acts of euthanasia were no longer voluntary." *Non-faith-arguments*, Linacre Quarterly at 251. As sobering as this is, it was still only the *beginning* of the slope. The *Linacre*

Quarterly continues: "In 2001 euthanasia was made legal. And in 2004 it was decided that children also could be euthanized." *Id.*

In response to these events, Wesley J. Smith, a lawyer, author, and senior fellow at the Discovery Institute's Center on Human Exceptionalism, wrote in an article for the *Weekly Standard* that: "It took the Dutch almost 30 years for their medical practices to fall to the point that Dutch doctors are able to engage in the kind of euthanasia activities that got some German doctors hanged after Nuremberg. For those who object to this assertion by claiming that German doctors killed disabled babies during World War II without the consent of parents, so too do many Dutch doctors: Approximately 21 percent of the infant euthanasia deaths occurred without the request or consent of parents. Moreover, since when did parents attain the moral right to have their children killed?" Wesley J. Smith, *Now They Want to Euthanize Children*, WASHINGTON EXAMINER (Sept. 12, 2004), https://www.washingtonexaminer.com/weekly-standard/now-they-want-to-euthanize-children.

This sequence of events, though deeply distressing, is not rare. Smith continues to describe how the same horrors have occurred in a neighboring country: Belgium. "Euthanasia consciousness is catching . . . . The very *first* Belgian euthanasia of a person with multiple sclerosis violated the law; and just as occurs routinely in the Netherlands, the doctor involved faced no consequences.

Now Belgium is set to legalize neo-pediatric euthanasia. Two Belgian legislators justify their plan to permit children to ask for their own mercy killing on the basis that young people 'have as much right to choose' euthanasia as anyone else." *Id.*

Who could blame the Netherlands and Belgium for these tragedies? Their actions are, in fact, the logical conclusion of accepting physician-assisted suicide. Twisted definitions of compassion and bodily autonomy have been weaponized to harm those society must protect. Smith concludes: "Why does accepting euthanasia as a remedy for suffering in very limited circumstances inevitably lead to never-ending expansion of the killing license? Blame the radically altered mindset that results when killing is redefined from a moral wrong into a beneficent and legal act." *Id.* It creates a slippery slope and a line-drawing dilemma. "[L]aws and regulations erected to protect the vulnerable against abuse come to be seen as obstructions that must be surmounted. From there, it is only a hop, skip, and a jump to deciding that killing is the preferable option." *Id.*

Some argue that these events could never occur in the United States because our laws are far more restrictive. Sadly, this position is entirely unrealistic. As the *Linacre Quarterly* correctly notes: "if there is no moral or philosophical basis for PAS laws in the common good, then there is no telling how far changes to PAS laws will go in the future, and no stopping the changes." *Non-faith-arguments*, Linacre Quarterly at 252.

Physician-assisted suicide leads to euthanasia. Protecting society's most vulnerable requires acknowledging the intellectual emptiness behind justifications for physician-assisted suicide and rejecting calls for its legalization. Otherwise, the United States will follow the path of the Netherlands and Belgium, and society's most vulnerable citizens will face unprecedented threats to their dignity and their lives.

VII. Physician-assisted suicide will lead to the coercion and abuse of vulnerable persons.

If physician-assisted suicide is legalized, vulnerable persons will be coerced and abused for two reasons: first, there will be no reliable way to keep some individuals from being encouraged, either explicitly or implicitly, to undergo one; and second, privatized healthcare institutions will have a direct financial incentive to end a person's life. Both outcomes are guaranteed, and neither is acceptable.

First, if physician-assisted suicide is legalized, there will be no reliable way to keep some individuals from being encouraged, either explicitly or implicitly, to undergo one. These include the elderly, those who require expensive treatments, those suffering from mental health issues such as depression, and others. As described by the Disability Rights Education and Defense Fund, there is a significant danger "that many people would choose assisted suicide due to external pressure. Elderly individuals who don't want to be a financial or caretaking burden on their families might take this escape." DISABILITY RIGHTS EDU. & DEF. FUND,

Why Assisted Suicide Must Not Be Legalized (2009), https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/. Referring to Oregon's "Death With Dignity" legislation, "the percentage of reported Oregon cases attributed to patients' reluctance to burden their families has risen alarmingly. It totaled 12 percent in 1998, but increased to 26 percent in 1999, then 42 percent in 2005, and 45 percent in 2007." *Id.* Nothing in the Oregon law will protect patients when there are family pressures, whether financial or emotional, which distort patient choice." *Id.* Worse still, elder abuse is widespread, particularly in the United States, and the perpetrators are often family members. *Id.*

"Safeguards" put in place provide little comfort for those concerned about the oversights certain to occur with physician-assisted suicide. "The impact of pressures to choose assisted suicide was illustrated when Rob Miller, Director of the pro-assisted suicide group Compassion & Choices of Washington, commented on the death of Linda Fleming, the first reported death under Washington State's assisted suicide law. When asked if he knew that Fleming, who was divorced, had had financial problems, had been unable to work due to a disability, and was forced to declare bankruptcy in 2007, Miller said he was unaware of all that, but that her case presented 'none of the red flags' that would cause his organization to reconsider supporting her suicide request." *Id.*

Another alleged safeguard that physician-assisted suicide laws often include is that a patient must be given a prognosis of six months or less to live to qualify. For reasons described by J. J. Hanson, a cancer survivor, in his article *Assisted suicide laws will pressure poor, elderly, depressed to die*, "people with serious or terminal illnesses outlive their prognoses every day. After I was diagnosed with grade 4 glioblastoma multiforme (GBM), I was expected to live for only four months. The surgeon said my cancer was inoperable and three different doctors told me there was nothing they could do. I would have easily met the criteria for accessing assisted suicide if I lived in a state like Oregon or California, where assisted suicide is legal." J. J. Hanson, *Assisted Suicide Laws Will Pressure Poor, Elderly, Depressed To Die*, THE HILL (Sept. 27, 2017 04:53 PM EDT), https://thehill.com/opinion/civil-rights/352757-assisted-suicide-laws-will-pressure-poor-elderly-depressed-to-die.

Hanson further notes the reality that psychological evaluations for those considering physician-assisted suicide are often skipped. "A serious or terminal diagnosis, illness-induced disability, or a fear of being a burden can cause clinical depression in a significant number of patients. But, the 2016 Oregon Health Report shows that in Oregon only 4 percent of patients considering ending their lives were referred for psychological evaluation — yet a 2008 study showed that 25 percent of patients requesting assisted suicide suffered from major depressive disorder.

These numbers suggest that persons with mental illness could well be prescribed a death-too-soon, rather than treatment for depression." *Id.*

Ryan T. Anderson expresses similar concerns. He writes that the people "most likely to be assisted by a physician in their suicide are suffering not simply from a terminal illness, but also from depression, mental illness, loneliness, and despair." Anderson, *Always Care*. Dr. Paul McHugh, University Distinguished Service Professor of Psychiatry at Johns Hopkins University School of Medicine and Psychiatrist-in-Chief at Johns Hopkins Hospital from 1975 to 2001, highlights that "with physician-assisted suicide, many people—some not terminally ill, but instead demoralized, depressed and bewildered—die before their time." Paul McHugh, *Dr. Death Makes a Comeback*, THE WALL STREET JOURNAL (January 22, 2015), http://www.wsj.com/articles/paul-mchugh-dr-death-makes-a-comeback-1421970736. This sad reality led Dr. Leon Kass—a medical doctor, philosopher, and former chairman of the President's Council on Bioethics—to explain that physician-assisted suicide "is, in fact, the state's abdication of its duty to protect innocent life and its abandonment especially of the old, the weak, and the poor." Leon R. Kass, *Dehumanization Triumphant*, FIRST THINGS (August 1996), http://www.firstthings.com/article/1996/08/002-dehumanization-triumphant.

Dr. Herbert Hendin, professor at New York Medical College professor, and Dr. Kathleen Foley, professor at Cornell University's medical school, write that

"Researchers have found hopelessness, which is strongly correlated with depression, to be the factor that most significantly predicts the wish for death." Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective,* 106 MICH. L. REV. 1613, 1622 (2008). Most concerning of all, "Mental illness raises the suicide risk even more than physical illness. Nearly 95 percent of those who kill themselves have been shown to have a diagnosable psychiatric illness in the months preceding suicide. The majority suffer from depression that can be treated. This is particularly true of those over fifty, who are more prone than younger victims to take their lives during the type of acute depressive episode that responds most effectively to treatment." HERBERT HENDIN, SEDUCED BY DEATH: DOCTORS, PATIENTS, AND ASSISTED SUICIDE, 34–35 (W.W. Norton ed., 1998). When those who are physician-assisted suicide "are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears." Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, MICH. L. REV. 1613, 1622 (2008). Accordingly, "Patients requesting suicide need psychiatric evaluation to determine whether they are seriously depressed, mentally incompetent, or for whatever reason do not meet the criteria for assisted suicide." *Id.* at 1622.

This research shows that those who request physician-assisted suicide often suffer from some form of mental anguish. It also shows that other means can relieve these challenges, yet help is not provided. None of the procedures put in place to protect the vulnerable from physician-assisted suicide once implemented have succeeded. As Ryan T. Anderson concludes, physician-assisted suicide "endangers the weak and marginalized in society. Where it has been allowed, safeguards purporting to minimize this risk have proved to be inadequate and have often been watered down or eliminated over time. People who deserve society's assistance are instead offered accelerated death." Anderson, *Always Care*.

Worse still, if physician-assisted suicide is legal, privatized healthcare institutions have a direct financial incentive to end a person's life. J. J. Hanson describes this point in detail, writing "[i]t is important to see, too, that legalizing assisted suicide introduces government agencies and for-profit insurance companies into everyone's end-of-life decisions—which will result in limiting everyone's choice. It is already happening to patients trying to pursue treatment for serious illness where assisted suicide is legal. They are being denied coverage for life-sustaining or curative treatment and being offered less expensive assisted suicide drugs instead." J. J. Hanson, *Assisted Suicide Laws Will Pressure Poor, Elderly, Depressed To Die*, THE HILL (Sept. 27, 2017 04:53 PM EDT), https://thehill.com/opinion/civil-rights/352757-assisted-suicide-laws-will-pressure-

poor-elderly-depressed-to-die. The United States Conference of Catholic Bishops seconds this point, noting that "[s]ome patients in Oregon and California have received word that their health insurance will pay for assisted suicide but will not pay for treatment that may sustain their lives." *Top Reasons to Oppose Assisted Suicide*, UNITED STATES CONFERENCE OF CATHOLIC BISHOPS (2017), https://www.usccb.org/committees/pro-life-activities/top-reasons-oppose-assisted-suicide.

Under a legalized regime of physician-assisted suicide, healthcare providers would be able to go even further than assigning a dollar value to human life—already a morally repulsive idea—and assign a dollar value to a person's death. "Physician-assisted suicide will create perverse incentives for insurance providers and the financing of health care. Assisting in suicide will often be a more 'cost-effective' measure from the bottom-line perspective than caring for patients. In fact, some advocates of PAS and euthanasia make the case based on saving money." Anderson, *Always Care*.

The legalization of physician-assisted suicide would coerce and abuse vulnerable persons. Many of those suffering from depression and other mental disorders or illnesses may choose to undergo physician-assisted suicide, even though undergoing treatment would likely reduce their desire to die significantly. The checks put in place have shown to be fatally and inherently ineffective. Worse

still, the healthcare system will have a direct financial incentive for vulnerable persons to die. This will compromise care, healthcare culture, and lead to the maltreatment of suffering patients.

VIII. Palliative care and modern therapeutics offer a better solution than physician-assisted suicide.

As the appellant frames it, physician-assisted suicide is necessary to afford a patient peace of mind and a greater sense of control over their terminal condition. *See* Reply Brief of Appellants at 11. The patient's fear often relates to the pain associated with their condition—the prospect of unmanageable pain causes them to seek options such as physician-assisted suicide. *See* Linacre Quarterly, *Non-Faith-Based Arguments* ("[M]any requests for PAS are no longer related to or initiated because of intolerable pain, but because of fear of such intolerable pain."). However, where patients seek greater control over their quality of life, palliative care and modern therapeutics offer a better solution than physician-assisted suicide.

Palliative care involves the treatment of symptoms caused by severe illness, including intense pain. *What Are Palliative Care and Hospice Care?*, NATIONAL INSTITUTE ON AGING (n.d.), https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care. With modern medical methods, pain is largely controllable through appropriate medication. *See* Nessa Coyle, *In Their Own Words: Seven Advanced Cancer Patients Describe Their Experience with Pain and the Use of*

Opioid Drugs, 27 J. PAIN & SYMPTOM MGMT. 300, 306 (2004) (describing how, for one patient, "[o]nce the pain was relieved it was the most beautiful experience of [their] life, to be able to participate and control the pain" (internal quotations omitted)). These medications allow the patient a great degree of control over their own pain while increasing their quality of life. In comparison, physician-assisted suicide seeks not to enhance the patient's life, but to end it.

Somewhat contradictorily, the appellant contends that physician-assisted suicide is both an alternative to palliative care *and* necessary treatment for terminal patients. *See* Opening Brief of Appellants at 27 (arguing that there is no meaningful distinction between physician-assisted suicide and other end-of-life options and that the patient's right to accept medical treatment requires they be allowed to request physician-assisted suicide). This contains two errors. First, physician-assisted suicide cannot be viewed as simply an alternative to palliative care. *Id.* Second, the appellant errs by characterizing physician-assisted suicide as "treatment" at all. *Id.*

Physician-assisted suicide and other end-of-life options such as palliative care cannot be treated as alternatives because they seek to accomplish different goals. Palliative care is focused on increasing the patient's quality of life through symptom management. *See What Are Palliative Care and Hospice Care?*, NATIONAL INSTITUTE ON AGING (n.d.), https://www.nia.nih.gov/health/what-are-

palliative-care-and-hospice-care ("Palliative care is meant to enhance a person's current care by focusing on the quality of life for them and their family."). As the appellant points out, the goal of physician-assisted suicide is to end the patient's life, rather than increase its quality. Opening Brief of Appellants at 28. Instead of easing the patient's pain so that they can better experience their own life, physician-assisted suicide robs them of the opportunity to live out their last days in fulfillment. Palliative care and modern medical therapeutics offer to control pain while not shortening the patient's life.

Since the effect of physician-assisted suicide is not to treat the patient's illness, their symptoms, or their pain, but simply to end their life, it cannot properly be characterized as medical "treatment." The American Medical Association supports this position in their *Code of Medical Ethics*, where they find that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer." *Code of Medical Ethics*, AM. MED. ASS'N § 5.7 (2019), https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf. Rather than treatment, physician-assisted suicide is exactly what the name suggests: suicide. Like suicide more generally, physician-assisted suicide is more likely to be requested because of depression, mental illness, or feelings of hopelessness than because of the symptoms directly associated with a terminal illness. *See* Herbert Hendin and Kathleen Foley, *Physician-Assisted Suicide in*

Oregon: A Medical Perspective, 106 Mich. L. Rev. 1613, 1622 (2008); Nessa Coyle, *In Their Own Words: Seven Advanced Cancer Patients Describe Their Experience with Pain and the Use of Opioid Drugs*, 27 J. PAIN & SYMPTOM MGMT. 300, 306 (2004). These mental affections are each treatable through medical methods themselves, and suicidal thoughts are generally thought to be a symptom requiring urgent medical care. Kara B. Fehling and Edward A. Shelby, *Suicide in DSM-5: Current Evidence for the Proposed Suicide Behavior Disorder and Other Possible Improvements*, 11 FRONT. PSYCHIATRY (2021) ("Suicide is one of the most pressing public health concerns facing modern society."); Mayo Clinic, *Are you thinking about suicide? How to stay safe and find treatment*, https://www.mayoclinic.org/diseases-conditions/suicide/in-depth/suicide/art-20048230 (urging those contemplating suicide to seek "immediate help"). The court should not sanction the substitution of a medical symptom requiring urgent care for medical treatment when actual treatments in the form of palliative care or medical therapeutics are available.

CONCLUSION

For all the above reasons, amicus Massachusetts Citizens or Life, Inc., urges this honorable Court to reject physician-assisted suicide and affirm the judgment of the court below that it violates Massachusetts law.

Respectfully submitted,

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Dated: February 11, 2022

CERTIFICATE OF COMPLIANCE
PURSUANT TO RULE 16(k) OF THE
MASSACHUSETTS RULES OF APPELLATE PROCEDURE

I, hereby certify that the foregoing brief complies with the rules of court that pertain to the filing of briefs, including, but not limited to:

Mass. R. A. P. 16 (a)(13) (addendum);

Mass. R. A. P. 16 (e) (references to the record);

Mass. R. A. P. 18 (appendix to the briefs);

Mass. R. A. P. 20 (form and length of briefs, appendices, and other documents); and

Mass. R. A. P. 21 (redaction).

I further certify that the foregoing brief complies with the applicable length limitation in Mass. R. A. P. 20 because it is produced in the proportional font Times New Roman at size 14 with one-inch margins and contains 7,315 total non-excluded words.

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CERTIFICATE OF SERVICE

Pursuant to Mass.R.A.P. 13(d), I hereby certify, under the penalties of perjury, that on February 11, 2022, I have made service of this Amicus Brief upon the attorney of record for each party by the Electronic Filing System on:

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