Supreme Judicial Court

FOR THE COMMONWEALTH OF MASSACHUSETTS

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 *AMICI CURIAE*, THE FOUR ROMAN CATHOLIC BISHOPS OF THE DIOCESES OF MASSACHUSETTS, IN SUPPORT OF AFFIRMANCE

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DECLARATION

Pursuant to Mass. R.A.P. 17(c)(5), the undersigned counsel certifies the following: (a) neither a party to this action nor a party's counsel authored this brief in whole or in part; (b) neither a party to this action nor a party's counsel contributed money that was intended to fund preparing or submitting the brief; (c) no person or entity—other than the *amici curiae*, their members, or their counsel—contributed money that was intended to fund preparing or submitting the brief; and (d) neither the *amici curiae* nor their counsel represents or has represented one of the parties to the present appeal in another proceeding involving similar issues, or were parties or represented a party in a proceeding or legal transaction that is at issue in the present appeal.

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IDENTITIES OF THE *AMICI CURIAE*[1] AND THEIR INTEREST IN THE CASE

Cardinal Seán P. O'Malley, O.F.M Cap., is the Cardinal Archbishop of the Archdiocese of Boston, which is the fourth largest archdiocese in the United States and is home to approximately 1.8 million Catholics.[2] The territory of the Archdiocese of Boston spreads across 144 communities in Eastern Massachusetts and encompasses some 254 parishes, each of which engages in community outreach programs and ministries. There are some 101 Catholic schools that educate more than 32,000 students annually, and the social service outreach within the Archdiocese assists more than 200,000 individuals each year.[3] Five Catholic-affiliated hospitals are situated within the Archdiocese under Steward Healthcare System, LLC.[4]

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[1] Each bishop submits this brief in his individual capacity as the bishop of his respective diocese or Archdiocese, thereby obviating the need for a corporate disclosure statement under Mass. R.A.P. 17(c) and Supreme Judicial Court Rule 1:21.

[2] *See About the Archdiocese of Boston*, ARCHDIOCESE OF BOSTON, https://www.bostoncatholic.org/about (last visited Feb. 14, 2022).

[3] *See id.* (listing number of communities included and individuals reached by social services); *Quick Facts*, CATHOLIC SCHOOLS OFFICE ARCHDIOCESE OF BOSTON, https://www.csoboston.org/about/quick-facts (last visited Feb. 14, 2022) (providing breakdown of school demographics and student achievements).

[4] *See Catholic Hospitals of the Steward Health Care System*, ARCHDIOCESE OF BOSTON, https://www.bostoncatholic.org/health-and-social-services/catholic-hospitals-steward-health-care-system (last visited Feb. 14, 2022).

Most Reverend Robert Joseph McManus, S.T.D., is the Bishop of the Diocese of Worcester, which is a community of 96 parishes, three missions, and approximately 277,150 Catholics.[5] Three Catholic colleges, six high schools/junior high schools, and seventeen elementary schools located within the diocese educate approximately 12,000 students.[6] Catholic Charities of Worcester County, with the support of the Diocese of Worcester, operates the Mercy Centre, a services program assisting over one hundred adults with developmental disabilities.[7] Additionally, in 2021, Catholic Charities of Worcester County, again with the support of the Diocese of Worcester, assisted or provided an estimated: 11,352 individuals with emergency services; 1,067 families with rent and utility assistance; 7,755 individuals with food pantry services; 1,962 families with hygiene products; 2,399 items of clothing to those in need; and 446 students with backpacks full of school supplies.[8]

Most Reverend Edgar M. da Cunha, S.D.V., D.D., is the Bishop of the Diocese of Fall River, which is a community of 76 parishes serving approximately

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[5] *See Office of the Bishop*, DIOCESE OF WORCESTER, *Statistics for Diocese of Worcester*, https://directory.catholicfreepress.org/Worcester-Diocesan-2021-2022/General-Information/85/ & P.J. Kennedy & Sons, THE OFFICIAL CATHOLIC DIRECTORY (2021).

[6] *See id.*

[7] *See What is the Mercy Centre?* CATHOLIC CHARITIES WORCESTER COUNTY, https://www.ccworc.org/mercy-centre/ (last visited Feb. 14, 2022).

[8] *See 2021 Annual Impact Report*, CATHOLIC CHARITIES WORCESTER COUNTY, https://www.ccworc.org/2021-annual-impact-report/ (last visited Feb. 14, 2022) (summarizing assistance provided during 2021).

256,000 Catholics across Southern Massachusetts, Cape Cod, and the Islands.[9] Located within the Diocese of Fall River are a Catholic-affiliated university, four high schools, and sixteen elementary schools that are collectively educating over 20,000 students.[10] There are five homes for the aged and chronically ill serving some 1,411 individuals annually; sixteen centers for social services assisting about 28,882 individuals annually; three residential centers for child care assisting some 1,297 children annually; and a day care center assisting about 25 annually.[11] The Diocese of Fall River also sponsors the Diocesan Health Facilities group, which serves over 800 individuals through five nursing and rehabilitation facilities.[12]

Most Reverend William D. Byrne, S.T.L., is the Bishop of the Diocese of Springfield, which is a community of 79 parishes, seven missions, and 199,289 Catholics.[13] Within the Diocese of Springfield are twelve Catholic elementary schools, two high schools, and two Catholic-affiliated colleges that collectively

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[9] *See DFR Today*, DIOCESE OF FALL RIVER, https://www.fallriverdiocese.org/dfr-today/ (last visited Feb. 14, 2022).

[10] *See Statistic Overview* (as of December 31, 2020), DIOCESE OF FALL RIVER, https://www.fallriverdiocese.org/statistics/ (Educational tab) (last visited Feb. 14, 2022) (providing statistical breakdown of education system within Diocese).

[11] *See id.* (Charitable & Social Institutions tab).

[12] *See About Us*, DIOCESAN HEALTH FACILITIES, https://www.dhfo.org/about-us-diocesan-health-facilities/ (last visited Feb. 14, 2022)

[13] *See About the Diocese*, DIOCESE OF SPRINGFIELD, MASSACHUSETTS, https://diospringfield.org/about/ (last visited Feb. 14, 2022).

educate over 2,500 students.[14] A Catholic hospital is located in the diocese and assists over 250,000 patients annually, as is a health care center that assists over 67,000 patients annually.[15] Further, the Diocese of Springfield has eight centers for social services that assist some 75,000 individuals annually; five homes for the aged assisting about 470 individuals annually; and a day care and extended care center assisting approximately 1,767 individuals annually.[16]

The mission of these *amici* ("the Bishops") is, among other things, to promote, advance, and convey the authentic moral and theological teachings of the Roman Catholic Church and to minister to the spiritual and temporal needs of the faithful and the wider public through charitable works. They carry out this charitable and religious mission in a variety of ways, including by providing: (1) faith formation and education to the faithful, (2) healthcare ministries for the sick, elderly, and infirmed, (3) social services for those in need, (4) prison ministry for the incarcerated, and (5) outreach to vulnerable and marginalized populations.

As faith leaders, the Bishops have long advocated in the public square for policies that promote the common good and protect the inviolability and sanctity of

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[14] *See id.*

[15] *See Diocesan Statistics*, DIOCESE OF SPRINGFIELD, MASSACHUSETTS, https://diospringfield.org/statistics/ (last visited Feb. 14, 2022) (providing statistics as of December 2020).

[16] *See id.*

human life from conception until natural death. The Bishops therefore welcome the opportunity to offer their perspectives to the Supreme Judicial Court with respect to the serious and far-reaching issue of physician-assisted suicide that is at the heart of this action, and they thank the Court for the opportunity to be heard on this most important matter. For the reasons set forth below, the Bishops urge this Court to affirm the December 31, 2019 judgment of the Superior Court.

SUMMARY OF THE ARGUMENT

The Bishops are mindful of their role as *amici curiae*. They are not parties to the case and will not repeat or rehash the same arguments set forth very thoroughly by the parties in their respective appellate submissions. Rather, as *amici*, they will endeavor "to bring a wider perspective that assists [the] court[] in discharging [its] responsibility to non-litigants." J. Albano & D. Salmons, *Practice Tips: Some Thoughts On Amicus Briefs*, 55 BOS. B. J. 9, 9 (Summer 2011) (citing J. Kaye, *One Judge's View of "Friends of the Court*", N.Y. STATE BAR J. at 8, 13 (Apr. 1989)).

The perspectives and positions offered by the Bishops may properly be considered, and even adopted, by this Court, for they are based upon principles of civil law, [17] and although religiously informed, these arguments require no appeal to,

[17] Please note that the Bishops' citation to any particular legal opinion or secondary source in this brief should not be taken as the Bishops' endorsement of any or all of the views, premises, or holdings of that authority. Like all *amici*, the Bishops have utilized in this brief the civil law as it has been formulated and promulgated by the

or reliance upon, religious principles or faith for their cogency or efficacy in this action. Moreover, the fact that certain tenets of the Catholic faith may, at times, coincide with the civil law does not in any way implicate Establishment Clause concerns under the First Amendment of the United States Constitution. *Harris v. McRae*, 448 U.S. 297, 320 (1980).

Accordingly, in urging this Court to affirm the Superior Court's judgment, the Bishops offer the following four observations, which can be summarized as follows:

First, the Court serves an important role as a teacher and shaper of societal customs and norms through its articulation of just and legitimate laws. The appellants—in seeking a judicial declaration that the Massachusetts crime of involuntary manslaughter does not apply to a physician who intentionally prescribes lethal drugs to a terminally ill, competent adult—are asking the Court to drastically alter the common law, which is a source of law that serves a prominent role in forming and influencing societal behaviors, morals, and norms. The appellants' challenge to the common law: (a) contravenes the court's long-standing reluctance to effect a major change in the common law without a clear need for the change, and (b) frustrates the judicial desire to maintain the consistency and reliability of the

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competent civil authorities, and as it has been analyzed by scholars, in order to bring the Bishops' perspectives to the Court in this forum.

common law as a positive and normative influence on culture, morality, and conduct. (Pages 17-23.)

Second, the appellants' contention that the Commonwealth's prohibition of physician-assisted suicide violates a constitutional right of personal autonomy and privacy reflects an exaggerated concept of personal autonomy that does not exist in law or society, and any effort to equate physician-assisted suicide with a recognized constitutional right to refuse life-saving medical treatment does not accord with the law or with the ethical norms applied in the healthcare field—particularly among Catholic-affiliated healthcare institutions. (Pages 23-29.)

Third, the Bishops and the Court—in their own ways and through their unique competencies—share an interest in upholding the sanctity of human life, in protecting vulnerable and disadvantaged groups within society, in safeguarding the integrity of the medical profession, and in preventing suicide. These are well established, judicially-recognized interests that promote the common good. The elimination of the common law prohibition of physician-assisted suicide would undermine each and every one of these interests. (Pages 29-35.)

Last, were the appellants to succeed in this appeal, Massachusetts common law would act to lessen the value of human life—along with the other interests identified above—having grave, long-lasting, and far-reaching negative effects for society. Any decision on the matter would manifest a significant policy change

regarding physician-assisted suicide in the Commonwealth—something that calls for robust public debate over the competing values, morality, and worldviews with respect to this subject matter. Accordingly, this dispute is not amenable to a judicial resolution and would be better addressed through the legislative process, with its mechanisms that ensure political accountability and a full airing, weighing, and determination of the matter by all relevant stakeholders. (Pages 36-39.)

ARGUMENT

I. THERE IS NO BASIS FOR DRASTICALLY AND DETRIMENTALLY RESHAPING THE COMMON LAW IN THIS INSTANCE.

The appellants' first challenge focuses primarily upon the common law. They seek a judicial declaration that common law involuntary manslaughter does not apply to physician-assisted suicide because, they argue, the physician who prescribes a lethal drug to a terminally ill adult does not cause that individual's death and because the physician's conduct is neither reckless nor wanton. (Appellants' Brief at 15-25.) The appellees and the Superior Court have addressed these arguments elsewhere, so the Bishops seek to highlight here: (1) the importance of the common law as a teacher and influencer of societal norms and attitudes, and (2) the reasons why this Court should not accept the appellants' invitation to radically refashion the common law—especially in light of the Court's reluctance to drastically change the common law in the absence of a significant reason for doing so. There is no such

reason for this here, and several relevant indicators from the legislative, professional, and political realms advise against it.

A. The Declaration Sought in this Case Would Effect a Drastic—and Detrimental—Change in the Common Law, a Source of Law that Plays an Important Role in Shaping Cultural Attitudes and Norms Surrounding the Sanctity of Life.

Catholics and Catholic-affiliated organizations serve individuals throughout the Commonwealth every day in an inestimable number of charitable and religious endeavors. Pertinent to this case, they treat those who are sick and infirmed; they care for those who are dying and at the end of life; they minister to those who are poor, vulnerable, and marginalized; they visit those who are shut in and imprisoned; and they assist and advocate for those who cannot advocate for themselves in procuring vital human services. All of these ministries are grounded in a fundamental precept: every human life has intrinsic value, dignity, and sanctity from conception until natural death.

The Catholic Church is not alone in its desire to uphold and protect the inviolability and sanctity of human life; the state shares this interest, too, and protects this interest through law. *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997); *Norwood Hosp. v. Munoz*, 409 Mass. 116, 125-26 (1991). This exhibits a common understanding that the law influences and shapes the conduct, norms, values, morality, and culture of the wider society. *See, e,g., People v. Serravo*, 823 P.2d 128, 139 (Colo. 1992) (noting that "proscriptions of the criminal law generally

reflect the moral prohibitions of the social order"); *State v. Peeler*, 271 Conn. 338, 466, (2004) (Katz, J., dissenting) (discussing how law has power to correct societal biases and prejudices); *State ex rel. Washington State Fin. Comm. v. Martin*, 62 Wash. 2d 645, 673 (1963) (analyzing how the law can be used to "preserve the very society which gives it shape"). Indeed, the common law, which has long been considered a repository of societal norms, customs, values, and morals, has a particular role to play in this regard. *See Remy v. MacDonald*, 440 Mass. 675, 677 (2004) (reiterating that "existing social values and customs and appropriate social policy" are the reference points for assessing civil common law duties).

The power of the law to establish norms of behavior—its "normative" function—is a central feature of the legal system, intended to give court decisions validity, predictability, and reliability within society. *See, e.g., Commonwealth v. Hendricks,* 452 Mass. 97, 103 (2008) (quoting *Commonwealth v. Gallant*, 373 Mass. 577, 580 (1977) (reiterating that a law is not unconstitutionally vague "if it requires a person to conform his conduct to an imprecise but comprehensible normative standard so that men of common intelligence know its meaning."); *Tagami v. City of Chicago*, 875 F.3d 375, 379 (7th Cir. 2017) (noting that the law has historically been designed to protect traditional morals and public order); *United States v. Orthofix, Inc*., 956 F. Supp. 2d 316, 334 (D. Mass. 2013) (urging sentencing judges

to protect the normative force and character of the criminal law in corporate criminal charges).

The declaration sought in this action, if successful, would utilize this normative power of the law to effect a drastic change in the attitudes and conduct of society and erode societal regard for the worth of the lives of the terminally ill, the disabled, and other vulnerable individuals whom the state should protect. *See Glucksberg*, 521 U.S. at 732. By removing physician-assisted suicide from the reach of common law involuntary manslaughter, the Court would normalize the practice of, and engender societal acceptance of, having a physician—a person dedicated to *healing*—actively help a patient kill herself. This is not characteristic of a just and humane society.

B. The Relief Sought by the Appellants Contravenes Judicial Principles that Maintain Stability in the Common Law, and this Case Presents No Justification for a Profound Change in that Law.

An abrogation of the common law crime of involuntary manslaughter as applied to a physician who prescribes a lethal drug to a terminally ill individual would not only undermine the dignity and sanctity of human life, but it would also contravene this Court's long-standing prohibition against making drastic changes to the common law. While the Court assuredly has the prerogative to change the common law and not wait for legislative action, it may do so only "where such changes [are] 'not a drastic or radical incursion upon existing law' and would not

seriously impair an existing interest, disappoint an expectation, or defeat a reliance." *Mone v. Greyhound Lines, Inc.*, 368 Mass. 354, 358-59 (1975) (quoting *Diaz v. Eli Lilly & Co.*, 364 Mass. 153, 167 (1973)). We can observe this judicial reticence in other areas of the common law, as with the Court's long-held reluctance to recognize or expand privileges and exemptions under the common law, *see Chadwick v. Duxbury Pub. Sch.*, 475 Mass. 645, 655-56 (2016); the Court's cautious, circumspect approach to recognizing or rejecting legal duties under the common law in light of "existing values and customs and appropriate social policy," *see Medina v. Hochberg*, 465 Mass. 102, 105-11 (2013); *Leavitt v. Brockton Hosp., Inc.*, 454 Mass. 37, 42 (2009); and the Court's refusal to abrogate or radically change the common law in the absence of a clear statutory mandate to do so. *See Kerins v. Lima*, 425 Mass. 108, 110 (1997).

In this case, no indicators exist—not in societal customs, values, policy, statutes, or otherwise—that would permit the common law to be radically changed in the manner that the appellants seek, i.e., the abolishment of the legal prohibition of physician-assisted suicide. To the contrary, certain relevant indicators of societal customs, values, and policies militate *against* the fundamental re-working of common law to usher in the normalization of physician-assisted suicide in this manner. For example, on the legislative front, several statutory pronouncements cited by the appellees demonstrate the Massachusetts Legislature's policy preference

against physician-assisted suicide, including the clear expression of legislative intent that the healthcare proxy statutes are not to 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." M.G.L. c. 201D, § 12. Consider, too, the legislative mandate that the Commissioner of the Department of Public Health must require certain licensed healthcare entities to inform patients of palliative care and end-of-life care options, while not permitting "a healthcare professional to offer to provide information about assisted suicide or the prescribing of medication to end life." M.G.L. c. 111, § 227.

Similarly, in the medical field, the American Medical Association has reiterated its ethical opinion that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[18] The Massachusetts Medical Society has taken a position of "neutral engagement" on the subject.[19] And in the context of democratic political engagement, Massachusetts voters defeated the most

[18] https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide (last visited Feb. 16, 2022).

[19] https://www.massmed.org/News/Medical-Aid-In-Dying-(MAID)/ (last visited Feb. 16, 2022).

recent referendum initiative to legalize and codify physician-assisted suicide in the Commonwealth.[20]

The Court's jurisprudence and the examples cited above all support the principle that long-established common law, whether criminal or civil, should not be radically altered without a cogent reason to do so, and such a reason is not on offer here. (Appellant Brief at 15-25.) "Courts must generally show restraint in altering existing allocations of risk created by long-tenured common law rules and resist the temptation of experimentation with untested social policies, especially where the individual record and the advocacy of the parties in the context of that record offer little more than abstract justifications." M. Pesando, *Change or Abrogation by Statute or Constitution*, 15A AM. JUR. 2D COMMON LAW § 15 at 741 (2011).

II. THE CONSTITUTION PROVIDES NO BASIS FOR A FUNDAMENTAL RIGHT TO PHYSICIAN-ASSISTED SUICIDE.

A. The Exaggerated Concept of Personal Autonomy Proposed in this Case goes Beyond any such Right Recognized by the Courts.

As part of their constitutional challenge to Massachusetts' prohibition on physician-assisted suicide, the appellants contend, among other things, that a terminally ill individual has a fundamental right—grounded in personal liberty,

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[20] https://www.boston.com/uncategorized/noprimarytagmatch/2012/11/07/assisted-suicide-measure-narrowly-defeated-supporters-concede-defeat/ (last visited Feb. 16, 2022).

privacy, and self-determination—which gives him the autonomy to choose to have a physician prescribe a lethal drug to him. (Appellant Brief at 29-30.) The Superior Court and the appellees responded to this contention, as set forth in the appellate record. The Bishops seek here to highlight that the appellants' formulation of this fundamental right presents an exaggerated, near absolute, autonomy that does not exist under law and could not exist in a functioning, pluralistic society.

That is, the Court's precedents on the subject of end-of-life decision-making have acknowledged that an individual has a *specific* fundamental right to refuse potentially life-saving medical treatment under certain circumstances. *Supt. of Belchertown State Sch. v. Saikewicz*, 373 Mass. 728, 739 (1977); *Brophy v. New England Sinai Hosp., Inc*., 398 Mass. 417, 430-32 (1986). The right is grounded in the common law of informed consent, i.e., a patient's right to preserve bodily integrity by refusing to consent to medical treatment. *Brophy*, 398 Mass. at 430. It also arises out of what the Court has described as an "unwritten and penumbral constitutional right to privacy" located in the Fourteenth Amendment of the United States Constitution. *Id.*

But this right has been specifically limited to encompass the *refusal of medical care*; it does not encompass a personal liberty to commit physician-assisted suicide—something state and federal courts have made abundantly clear. *Brophy*, 398 Mass. at 439; *Norwood Hosp.*, 409 Mass. at 125; *Saikewicz* 373 Mass. at 738,

743, n. 11. Plus, this right is not absolute. It may yield to other interests, such as the state's interest in preserving life, protecting innocent third parties, protecting the integrity of the medical profession, and preventing suicide. *Brophy*, 398 Mass. at 432. And this right cannot be understood to allow an individual to affirmatively choose *any* type of treatment at the end of life—certainly not assisted suicide, which was not even an issue in the cases that recognized and articulated this right. *Brophy*, 398 Mass. at 434, n. 29; *Saikewicz*, 373 Mass. at 744; *Norwood Hosp*., 409 Mass. at 125. "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." *Glucksberg*, 521 U.S. at 727-28. Instead, when dealing with fundamental constitutional due process rights, courts are required to define the privacy interest at issue carefully and specifically, *id.* at 722-24, which this Court has done. The right cannot be expanded and generalized to encompass physician-assisted suicide.

Accordingly, this Court has recognized a specific and limited fundamental right of an adult to refuse medical care under certain circumstances and has circumscribed the contours of that right so as not to frustrate the state's countervailing interests in protecting life, protecting innocent third parties, preventing suicide, and maintaining the integrity of the medical profession. *Brophy*, 398 Mass. at 432.

B. Physician-Assisted Suicide is very Different from Refusing Life-Saving Medical Treatment—a Distinction Long Recognized in the Law and in Medicine.

The formulation of exaggerated autonomy and personal liberty offered in this case is not viable either legally or practically, as set forth above, and neither is the appellants' effort to equate (a) the fundamental right to refuse life-saving medical treatment with (b) physician-assisted suicide. (Appellant Brief at 28-29.) Although they suggest that "there is no meaningful distinction" between physician-assisted suicide and other end of life care options, *id.* at 28, courts and medical professionals have long made meaningful and stark distinctions between physician-assisted suicide and a decision to forego care or choose palliative care at the end of life. This Court, for example, has explained the difference: "[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." *Brophy*, 398 Mass. at 439 (quoting *Matter of Conroy*, 98 N.J. 321, 350-51 (1985)); *see also Norwood Hospital*, 409 Mass. at 125; *Saikewicz*, 373 Mass. at 738, 743, n. 11.

The United States Supreme Court also differentiates between the two: "The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never

enjoyed a similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct." *Glucksberg*, 521 U.S. at 725; *Quill v. Vacco*, 521 U.S. 793, 800-09 (1997). A right to refuse treatment cannot "be somehow transmuted into a right to assistance in committing suicide." *Glucksberg*, 521 U.S. at 725-26.

This distinction is particularly well established and well known to Catholic-affiliated health care organizations and those involved with the care of the sick and individuals at the end of life. For instance, the *Ethical and Religious Directives for Catholic Health Care Services*[21]—published by the United States Conference of Catholic Bishops and made available to Catholic-affiliated healthcare organizations as ethical standards emanating from Catholic teaching on the dignity of the person—makes this distinction clear. In pertinent part, the document says:

> We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options. *Ethical & Religious Directives For Catholic Health Care Services* (6th ed. 2018) at 20.
>
> The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. In this way two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even

[21] By offering this resource to illustrate longstanding ethical principles on this subject matter, the Bishops do not intend to impermissibly broaden the appellate record appendix. Rather, they suggest that the Court may take judicial notice of this information, as other courts have done in other contexts. *See, e.g., Overall v. Ascension*, 23 F. Supp. 3d 816, 825 (E.D. Mich. 2014).

> when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death. *Id.* at 20.
>
> A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden or impose excessive expense on the family or the community. *Id*. at Directive #57.
>
> Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death. *Id*. at Directive #60.
>
> Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. *Id*. at Directive #61 (excerpt).

There is, in short, an extensive body of thought, dating back to St. Thomas Aquinas in the 13th Century, which distinguishes between (a) an act intended to cause a good effect that may permissibly also cause a foreseeable bad effect and (b) an act intended to cause a bad effect. E. Lyons, *In Incognito: The Principle Of Double Effect In American Constitutional Law*, 57 FLA. L. REV. 469, 473-84 (July 2005). This "principle of double effect" comports in part with civil law principles of intent and causation and was adopted by the United States Supreme Court in *Quill v. Vacco*

as a valid means of distinguishing between (a) an individual's decision to refuse life-saving medical treatment and (b) physician-assisted suicide. *Id*. at 477-78; *Quill*, 521 U.S. at 801-03. The declaration sought by the appellants in this action would contravene this established principle, blur these meaningful distinctions, and undercut the practical application of this essential principle in the healthcare setting.

III. THE STATE ADVANCES MANY INTERESTS IN ORDER TO PROTECT SOCIETY AND PROMOTE THE COMMON GOOD; PHYSICIAN-ASSISTED SUICIDE UNDERMINES EVERY ONE OF THEM.

Because physician-assisted suicide does not implicate a fundamental constitutional right, Massachusetts common law involuntary manslaughter need only satisfy the lowest standard of review—rational basis review—to be constitutionally valid. *Coffee-Rich, Inc. v. Comm'r of Pub. Health*, 348 Mass. 414, 422 (1965). The Superior Court and the appellees have addressed how the common law prohibition of physician-assisted suicide is rationally related to a great many state interests in this context. Here, the Bishops seek to emphasize to the Court their concern about threats posed to several of these interests if physician-assisted suicide were to be exempted from the criminal common law.

A. Concern for the Sanctity of Life

We have discussed in this brief the Bishops' interest in protecting the sanctity of human life as a paramount societal good—an interest shared by the state. *Norwood Hosp*., 409 Mass. 116, 125 (1991); *Saikewicz*, 373 Mass. at 741; *Brophy*,

398 Mass. at 432. The articulation of that interest in the law is striking in that the Court does not hesitate to use the phrase “sanctity of all life.” We are told: “The State’s interest in preserving life has “two separate but related concerns: an interest in preserving the life of the particular patient, and an interest in *preserving the sanctity of all life*.” *Norwood Hosp.*, 409 Mass. at 125 (quoting *Matter of Conroy*, 98 N.J. 321, 349 (1985)) (emphasis supplied). This ascribes to human life a “holiness, saintliness, or godliness… a sacred or hallowed character… [or] a sacred thing.” WEBSTER’S COLLEGE DICTIONARY (Random House 1991) at 1188 (defining “sanctity”). But it’s even more than that. The Court has suggested that the state has interest in seeing “that individual decisions on the prolongation of life do not in any way tend to ‘cheapen’ the value which is placed in the concept of living…”. *Saikewicz*, 373 Mass. at 742.

These are powerful statements in the law: human life—a sacred thing—is to be cherished and protected. Physician-assisted suicide, by its very nature, undermines the value of life because it purposefully destroys human life. It broadcasts a message that the lives of those with terminal illness are not to be cherished or protected but are instead to be ended. This cannot but coarsen societal attitudes toward the inviolability of life; a decriminalization of physician-assisted suicide would lead to a normalization in which suicide is seen as one “acceptable” option among others. “Impressionability has often been cited as a factor contributing

to suicides… Is it any less likely, if suicide comes to be ensconced in law as an acceptable option for dealing with human suffering, that many will begin to contemplate it who might otherwise have never considered it? We should be very careful what practices we sanction legally because the law is a teacher." M. Chopko & M. Moses, *Assisted Suicide: Still A Wonderful Life?*, 70 NOTRE DAME L. REV. 519, 540-41 (1995).

The state has a valid interest in preventing such a coarsening of societal attitudes toward the value of human life, *see Gonzales v. Carhart*, 550 U.S. 124, 157 (2007), and keeping in place the common law prohibition against physician-assisted suicide would advance that interest and uphold the value of life.

B. Concern for Vulnerable Individuals

The Commonwealth's prohibition on physician-assisted suicide is also vitally necessary to ensure that vulnerable, disadvantaged populations are not subject to harm or abuses through this practice. The appellees have submitted to the Court data and affidavits outlining the many problems that physician-assisted suicide presents when it comes to: (1) determining the competence of patients to choose this practice, (2) assessing terminal illness, (3) providing alternative care options, (4) detecting financial pressures upon patients, among other things. (Appellee Brief at 45-58; Joint Appx.) But it is noteworthy that concerns for abuses and for vulnerable groups

have been present and persistent for decades. Long ago, the judiciary recognized that

> "legalizing physician-assisted suicide would pose profound risks to many individuals who are ill and vulnerable. . . The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group." New York Task Force 120; *see Compassion in Dying*, 49 F.3d, at 593 ("An insidious bias against the handicapped--again coupled with a cost-saving mentality--makes them especially in need of Washington's statutory protection"). If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.
>
> The State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference." 49 F.3d, at 592. The State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's. *See* New York Task Force 101-102.

Glucksberg, 521 U.S. at 732 (1997) (citing New York Task Force on Life & Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994) at 101-102, 120). "It must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health

care. Those who will be most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered." *Sampson v. State*, 31 P.3d 88, 97 (Alaska 2001) (quoting New York Task Force on Life & Law at 125)). Suicidality has also been highly correlated with mental illnesses such as depression. *See Glucksberg*, 520 U.S. at 730.

Those concerns have not diminished today. To illustrate this, one need only consider the reasonable supposition that individuals who choose physician-assisted suicide tend to be older, *see Glucksberg*, 521 U.S. at 730, in tandem with the unfortunate plight of many in our elderly community here in the Commonwealth. A 2021 report from the Executive Office of Elder Affairs documents that "[i]n [Fiscal Year] 2020, Protective Services received 34,813 reports of elder abuse… Of the total reports received and screened, 63% were screened in for investigation. In FY20 58% of completed investigations were substantiated." Mass. Dept. of Elder Affairs, *Annual Legislative Report: Fiscal Year 2020* (Feb. 2021) at 11.[22] Thus, of the cases that were reported and screened into the Office of Elder Affairs, Massachusetts saw some 12,720 cases of substantiated elder abuse or neglect in fiscal year 2020 among the investigations that were completed.[23] (Keep in mind that this report defines

[22] Available at https://www.mass.gov/doc/elder-affairs-annual-legislative-report-2020/download (last visited Feb. 16, 2022).

[23] This figure assumes that all of the cases that were screened-in for investigation underwent completed investigations.

"elderly" as individuals aged 60 and over.) This sobering figure reminds us that our elderly community is particularly susceptible to abuse and neglect, so we cannot ignore the risk that physician-assisted suicide would pose to that cohort, and others.

C. Concern for Medical Professionals and the Practice of Medicine

The state acts properly when it endeavors to protect "the integrity of the medical profession [and] the proper role of hospitals in caring for such patients." *Saikewicz*, 373 Mass. at 743-44. This is an "ethical integrity" that gives "hospitals and their staffs a full opportunity to assist those in their care." *Norwood Hosp.*, 409 Mass. at 127. Eliminating the common law prohibition of physician-assisted suicide would threaten this integrity. For instance, "[i]f physicians were permitted to kill, the trust patients currently place in them would dissipate. How could one be assured, for instance, that one's doctor held no professional bias in favor of killing rather than exploring treatment alternatives, or even had sufficient familiarity with those alternatives?" Chopko, 70 NOTRE DAME L. REV. at 527.

Adverse financial pressures and incentives, confusion among physicians and patients as to the proper role of the physician as "healer," and a lack of physician training on suitable alternatives to assisted suicide are all concerns attendant to physician-assisted suicide in this setting. *See, e.g., Quill*, 521 U.S. at 808-09 (citing state's legitimate interest in "maintaining physicians' role as their patients' healers" and "protecting vulnerable people from indifference [and] prejudice"); *Sampson v.*

State, 31 P.3d 88, 95-96 (Alaska 2001) (concluding that physician-assisted suicide undeniably means the physician is causing harm to the patient, interfering with the integrity of the medical profession); *Krischer v. McIver*, 697 So. 2d 97, 104 (Fla. 1997) (highlighting that physician-assisted suicide directly contradicts the fundamental ethical obligations physicians owe to their patients); *Blick v. Off. of Div. of Crim. Just*., No. CV095033392, 2010 WL 2817256, 10 (Conn. Super. Ct. June 2, 2010) (remarking that physician-assisted suicide may erode patient trust in the doctor's role as healer).

Not to be forgotten, physicians and other healthcare professionals can also be harmed emotionally and psychologically with the introduction of physician-assisted suicide into their practice of medicine, as they turn away from their traditional role as healer, endure pressure from patients or colleagues to prescribe lethal drugs instead of other appropriate alternatives, and grapple with their responsibility for causing patient deaths. *See* K. Stevens Jr., M.D., F.A.C.R., *Emotional and Psychological Effects of Physician-Assisted Suicide and Euthanasia on Participating Physicians*, 21 ISSUES L. & MED. 187 (Spring 2006).

In summary, all of these legitimate concerns and interests militate against abandoning the Commonwealth's prohibition of physician-assisted suicide.

IV. FOR ALL OF THE REASONS SET FORTH ABOVE, THE RESOLUTION OF THIS ISSUE IS BEST ADDRESSED THROUGH THE LEGISLATIVE PROCESS.

The decriminalization of physician-assisted suicide via judicial declaration—as the appellants seek—would have serious, negative, and long-lasting effects throughout society, as we have recounted above, and as the Superior Court noted in its opinion. It would constitute a social experiment without precedent in the Commonwealth and beyond, without a regulatory program, and without sufficient checks for abuses. The moral, ethical, and medical implications of permitting a physician to legally prescribe lethal drugs to a terminally ill individual call for robust public debate, a balancing of a wide array of societal interests, an expression of competing visions of the common good, political accountability, and the potential forging of compromises. In a word, this is a matter for the legislature.

Although ostensibly a dispute between two private individuals and two public officials, this case necessarily involves the wider public, as suicide has long been held in the American common law tradition as a matter of public concern—a public wrong, as distinct from a private harm. *Glucksberg*, 521 U.S. at 713-14 (and cases cited). The case, and the ramifications flowing from its adjudication, will be far-reaching and impactful. This Court's call for *amici curiae*—literally a call for friends to assist the Court in its work—similarly indicates a recognition of the broad societal concerns inherent in this case.

The issue of physician-assisted suicide, by its nature, necessarily implicates complex matters of medical, ethical, and moral policy. Accordingly, its consideration requires rigorous debate among all interested and affected stakeholders, the public airing of all viewpoints—both lay and expert—and is therefore best handled through the legislative process. The legislature's unique role as a forum for hearing disparate voices and weighing policy effects beyond the facts of a particular case is especially pertinent in this area of the law, in which many of the Court's seminal decisions on end-of-life care involved individuals who were incapacitated and could not speak for themselves in their own cases. *See Saikewicz*, 373 Mass. at 731-33; *Brophy*, 398 Mass. at 421-27; *In re Spring*, 380 Mass. 629, 632 (1980).

The weight of authority across the nation has viewed physician-assisted suicide as a matter best addressed by the legislative branch. *See, e.g., Glucksberg*, 521 U.S. at 720 (cautioning that a judicial declaration on the right to assisted suicide would "place the matter outside the arena of public debate and legislative action"); *People v. Kevorkian*, 527 N.W.2d 714, 733 (Mich. 1994) (stating "complexity of [assisted suicide] does not permit us ... to expand the judicial power of this Court, especially where the question clearly is a policy one that is appropriately left to the citizenry for resolution, either through its elected representatives or through a ballot initiative"); *Sampson v. State*, 31 P.3d 88, 98 (Alaska 2001) (stating that issues of

assisted suicide "flow quickly away from questions of the law and lapse seamlessly into questions of morality, medical ethics, and contemporary social norms. Because 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") (emphasis added); *Morris v. Brandenburg*, 376 P.3d 826, 838 (N.M. 2016) (recognizing complicated issues surrounding assisted suicide "require robust debate in the legislative and the executive branches of government"); *Krischer v. McIver*, 697 So.2d 97 (Fla. 1997) (stating "it is clear that the public policy of this state as expressed by the legislature is opposed to assisted suicide").

A myriad of state supreme courts has been hesitant to venture into this domain where "the core issues presented are fundamentally grounded in questions of policy and how we view ourselves as a society. In a democracy, these questions are best answered by those who must answer to the people for their policy product, not by those who have no accountability to the people." *Kevorkian v. Thompson*, 947 F. Supp. 1152, 1171 (E.D. Mich. 1997) (suggesting plaintiff's request to permit assisted suicide would require the court to venture into "uncharted moral and ethical waters"); *see also Donaldson v. Lungren*, 4 Cal. Rptr. 2d 59, 64 (Cal. Ct. App. 1992) (declining to sanction assisted suicide and cryogenic freezing because "the legal and philosophical problems posed by [plaintiff's] predicament are a legislative matter rather than a judicial one").

Of note, the only state supreme court to permit physician-assisted suicide via court adjudication, Montana, did so based upon an act of the state legislature, i.e., an interpretation of a *statute* that provided consent as a defense to homicide. *Baxter v. Montana*, 224 P.3d 1211 (Mont. 2009) (permitting physician-assisted suicide under MONT. CODE ANN. § 45-2-211, rather than under any state constitutional right). In fact, "[i]n the 20 years since *Glucksberg* was decided, not a single plaintiff has asserted a successful constitutional challenge to an assisted suicide ban." *Myers v. Schneiderman*, 85 N.E.3d 57, 93 (N.Y. 2017); *see also* Thaddeus Mason Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. REV. 267, 287 (2018) (providing "no plaintiff has ever obtained an appellate court ruling that the prohibition of MAID [medical aid in dying] violates a right afforded by state constitution.")

All said, the legislative process is better equipped to address the panoply of issues implicated in this subject, and the Court's deference to that process would be appropriate here and would comport with the Massachusetts Constitution's admonition that "In the government of this commonwealth… the judicial shall never exercise the legislative and executive powers, or either of them: to the end it may be a government of laws and not of men." Mass. Const., Part One, Art. XXX.

CONCLUSION

In light of the points raised in this brief, the four Bishops of the Massachusetts dioceses urge the Court to affirm the judgment of the Superior Court, and they wish the Court well as it undertakes its work in the service of the common good.

Respectfully submitted as *Amici Curiae*,

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CERTIFICATION OF COMPLIANCE

I, Michael J. Kerrigan, 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, 17, and 20 of the Massachusetts Rules of Appellate Procedure. The brief complies with the applicable length limit in Rule 20 because it contains 7,138 words in 14-point Times New Roman font (not including portions of the brief excluded under Rule 20), as counted in Microsoft Word (Word for Microsoft 365).

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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 22, 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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