No. SJC-13194

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

ROGER M. KLIGLER & ALAN STEINBACH,
Plaintiffs-Appellants,

v.

MAURA T. HEALEY, IN HER OFFICIAL CAPACITY AS THE ATTORNEY GENERAL OF THE COMMONWEALTH OF MASSACHUSETTS & MICHAEL O'KEEFE, IN HIS OFFICIAL CAPACITY AS DISTRICT ATTORNEY OF CAPE & ISLANDS DISTRICT,
Defendants-Appellees,

Appeal from the Suffolk County Superior Court
Civil Action No. 2016-03254-F
The Honorable Mary K. Ames, Judge Presiding

BRIEF *AMICUS CURIAE* OF CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS SUPPORTING DEFENDANTS-APPELLEES AND AFFIRMANCE

CATHERINE GLENN FOSTER
STEVEN H. ADEN
KATIE GLENN
NATALIE M. HEJRAN
CAROLYN MCDONNELL
AMERICANS UNITED FOR LIFE
1150 Connecticut Ave., N.W.
Suite 500
Washington, DC 22036
Steven.Aden@aul.org
Telephone: 202-741-4917

ANDREW BECKWITH
Counsel of Record
MASSACHUSETTS FAMILY INSTITUTE
401 Edgewater Place
Suite 580
Wakefield, MA 01880
andrew@mafamily.org
Telephone: 781-569-0400
BBO No. 657747

Counsel for Amicus Curiae

CORPORATE DISCLOSURE STATEMENT

Amicus curiae Christian Medical & Dental Associations has no parent corporations or stock that a publicly held corporation can hold.

RULE 17(c)(5) DECLARATION

No party's counsel authored any part of this brief. No person or entity other than *amicus curiae* and its counsel contributed any money intended to fund the preparation or submission of this brief. *Amicus curiae* and its counsel do not represent and have not represented one of the parties to the present appeal in another proceeding involving similar issues. *Amicus curiae* and its counsel were not a party and did not represent a party in a proceeding or legal transaction that is at issue in the present appeal.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Legislation

Other Authorities

Lonny Shavelson & Carol Parrot, *Adding Phenobarbital to the D-DMA and DDMA Medication Protocols for Medical Aid in Dying*, Am. Clinicians Acad. on Med. Aid in Dying 1 (Jan. 12, 2021), https://www.acamaid.org/wp-content/uploads/2021/12/1-12-21-Adding-phenobarbital-to-DDMA-protocols.pdf 28, 30

Madison K. Kilbride & Steven Joffe, *The New Age of Patient Autonomy: Implications for the Patient-Physician Relationship*, 320 JAMA 1973 (2018) 14

Marilyn Golden & Tyler Zoanni, *Killing Us Softly: The Dangers of Legalizing Assisted Suicide*, 3 Disability & Health J. 16 (2010) 23, 25, 34

Me. Dep't of Health and Hum. Servs., *Death with Dignity Annual Report for Calendar Year 2020* (Mar. 1, 2021) 33

N.J. Off. of the Chief St. Med. Examin'r, *New Jersey Medical Aid in Dying for the Terminally Ill Act: 2020 Data Summary* (n.d.) 28

Nat'l Council on Disability, *The Danger of Assisted Suicide Laws*, Bioethics and Disability Series (2019), *available at* https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf ..... passim

Neil M. Gorsuch, THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA (2006) 13, 14

Or. Pub. Health Div., *Oregon Death with Dignity Act: 2020 Data Summary* (2021) ..... passim

S. Sinmyee et al., *Legal and Ethical Implications of Defining an Optimum Means of Achieving Unconsciousness in Assisted Dying*, 74 Anaesthesia 630 (2019) 32

Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BioScis. 424 (2017) 29, 32

Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in* Gonzales v. Oregon, 15 Temp. Pol. & Civ. Rts. L. Rev. 323 (2006) 26, 37

STATEMENT OF INTEREST OF *AMICUS CURIAE*[1]

Christian Medical & Dental Associations (CMDA), founded in 1931, is a non-profit national membership organization consisting of various healthcare professionals including doctors, dentists, as well as students in the various healthcare disciplines. With approximately 16,000 members, the mission of CMDA is to educate, encourage and equip Christian healthcare professionals to glorify God. As part of that mission, CMDA provides a public voice on bioethics and healthcare policy. CMDA members regularly care for individuals with terminal disease and commonly engage with their patients regarding end-of-life care.

[1] *Amicus curiae* are filing this brief pursuant to Mass. R. App. P. 17(a)(2).

SUMMARY OF ARGUMENT

Under Massachusetts law, physicians are subject to prosecution for manslaughter if they engage in assisted suicide.[2] Appellants seek a declaration that physicians who participate in assisted suicide are not subject to prosecution for manslaughter in certain circumstances. Such a declaration essentially would decriminalize a medically and ethically contentious practice with no government oversight. Decriminalization, however, presumes physicians are acting "in accordance with a medically acceptable standard of care . . . [in] prescrib[ing] medication for a competent, terminally ill, adult patient, who subsequently ingests the medication, ending his or her own life." Announcement, Docket Entry no. 4. Yet the medical premises of the issue statement are flawed. There is no medically acceptable standard of care for assisted suicide. *Amicus curiae* files this brief to explain why assisted suicide, whether decriminalized through a judicial decision or legalized by statute, does not have a medical standard of care. Accordingly, this court should affirm the Superior Court's decision and reject Appellants' attempt to manufacture a criminal liability exemption for physician-assisted suicide.

[2] Throughout this brief, "assisted suicide" refers to physician-assisted suicide, which Appellants have termed "medical aid in dying" (MAID).

ARGUMENT

I. JUDICIAL DECRIMINALIZATION OF ASSISTED SUICIDE HAS INADEQUATE SAFEGUARDS THAT DO NOT CREATE A MEDICAL STANDARD OF CARE.

A. Limited Legalization of Assisted Suicide Was Recent and Depends Upon Statute.

The United States assisted suicide movement has its historical foundation in the late 1800s in social Darwinism theory and eugenics. Neil M. Gorsuch, THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA 33–34 (2006). According to now-U.S. Supreme Court Associate Justice Neil Gorsuch, "[m]any feared that America was itself headed toward degeneracy. . . The remedy often touted for such concerns was the sterilization and killing of unfit members of society—with or without their consent." *Id*. at 33. The infamous 1927 case, *Buck v. Bell*, highlights the rationale behind the early assisted suicide movement. 274 U.S. 200 (1927). In *Buck*, the Supreme Court upheld Virginia's forced sterilization of a "feeble-minded" woman because "[t]hree generations of imbeciles are enough." *Id*. at 207. Eugenics proponents exploited *Buck*'s logic to urge euthanasia of "imbeciles and sufferers from incurable diseases," "the hopelessly diseased and the congenitally deformed and deficient," and "unproductive members [of society]." Gorsuch, *supra*, at 34–35 (citations omitted).

Following World War II, the United States assisted suicide movement lost momentum as the world learned about Nazi Germany's atrocious euthanasia

practices against the elderly, persons with disabilities, and the "racially unwanted." *Id*. at 36–38 (citation omitted). "Americans increasingly drew connections between medical killing in the Third Reich and the euthanasia movement in the United States, and they judged Germany harshly for how it treated the most vulnerable of its members of society." *Id*. at 37.

The assisted suicide movement reemerged in the 1960s and 1970s in the United States. During this period, the Supreme Court found that the legal right to privacy encompassed birth control and abortion. *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (extending the right to distribute contraceptives to unmarried persons); *Roe v. Wade*, 410 U.S. 113 (1973) (finding the right of privacy extended to the decision to terminate one's pregnancy). Around the same time, medicine transitioned from a paternalistic approach, in which the doctor knew and decided the best medical interests of his patient, to a patient autonomy approach, in which a patient had the right to accept or decline recommended treatment. Madison K. Kilbride & Steven Joffe, *The New Age of Patient Autonomy: Implications for the Patient-Physician Relationship*, 320 JAMA 1973 (2018). Consequently, "[e]uthanasia [and assisted suicide] advocates sought to take advantage of this changing cultural climate and began to argue their position less in terms of social or biological progression, as they had done previously, and more in terms of individual autonomy and privacy." Gorsuch, *supra*, at 38.

In modern terms, "[e]uthanasia involves an intentional act by a person (usually a physician) to end a person's life for compassionate reasons." Brian L. Mishara & David N. Weisstub, *Premises and Evidence in the Rhetoric of Assisted Suicide and Euthanasia*, 36 Int'l J. L. & Psychiatry 427, 427 (2013). Although assisted suicide has the same historical foundation as euthanasia, it is medically distinguishable:

> Assisted suicide is a specific type of suicide, that is, killing oneself intentionally. Adding the word "assisted" to describe the suicide implies that another person provided assistance, by providing the means, by providing information about how to commit suicide, or both. In practice, assisted suicide generally involves providing lethal substances that one ingests in order to die.

Id. Both euthanasia and assisted suicide "differ from refusing treatment and withdrawing life sustaining treatment, where a 'natural' death occurs without life being maintained by 'artificial' means." *Id*.

Today the legality of assisted suicide depends upon state law. There is no assisted suicide right under the United States Constitution. *Washington v. Glucksberg*, 521 U.S. 702, 706, 710–719 (1997) (holding nothing in "our Nation's history, legal traditions, and practices" give rise to a due process right to assisted suicide); *Vacco v. Quill*, 521 U.S. 793, 797, 801–807 (1997) (finding New York's assisted suicide ban was different in causation and intent from refusal of life-sustaining medical treatment and, thus, did not violate the Equal Protection Clause). Multiple state courts similarly have rejected the argument that their respective state

constitution creates a "right" to assisted suicide. *Myers v. Schneiderman*, 85 N.E. 3d 57, 65 (N.Y. 2017) (citing cases).[3] As the Supreme Court found in *Glucksberg*, "[i]n almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life." 521 U.S. at 710 (citing *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 280 (1990)). Only nine states and the District of Columbia have legalized assisted suicide and they "have done so only through considered legislative action" and with patient safeguards.[4] Notably, these statutes do not change underlying restrictions on assisted suicide; they "simply . . . carve out an exception for one profession [*i.e.*, physicians] to assist in suicides." Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 Hum. Life Rev. 51, 53 (2018).

In fact, "in the years since Oregon legalized assisted suicide, more states have affirmatively enacted laws to ban the practice than have passed laws to legalize it;

[3] Although Montana has not recognized a patient's right to assisted suicide, the Montana Supreme Court held physicians may raise a statutory "consent" defense against homicide charges in assisted suicide cases. *Baxter v. State*, 354 Mont. 234, 239, 251 (Mont. 2009). Unlike assisted suicide statutes, the Montana holding does not require assisted suicide reporting or informed consent safeguards. Consequently, there is no state data or government oversight for assisted suicide in Montana.

[4] *Myers*, 85 N.E. 3d at 65; *see* Cal. Health & Safety Code §§ 443 to 443.9 (2016); Colo. Rev. Stat. §§ 25-48-101 to 25-48-123 (2016); D.C. Code §§ 7-661.01 to 7-661.16 (2017); Haw. Rev. Stat. §§ 327L-1 to 327L-25 (2019); Me. Stat. tit. 22 § 2140 (2019); N.J. Stat. §§ 26:16-1 to 26:16-20 (2019); N.M. Stat. §§ 24-7C-1 to 24-7C-8 (2021); Or. Rev. Stat. §§ 127.800 to 127.897 (2017); Vt. Stat. tit. 18 §§ 5281 to 5293 (2013); Wash. Rev. Code §§ 70.245.010 to 70.245.903 (2009).

about 200 assisted-suicide bills have failed in more than half the states." *Id*. In Massachusetts, assisted suicide bills have failed in the past few years. S. 1225, 190th Gen. Ct., Reg. Sess. (Mass. 2017); S. 1208, 191st Gen. Ct., Reg. Sess. (Mass. 2019); S. 2745, 191st Gen. Ct., Reg. Sess. (Mass. 2020). In the current legislative session, bills have stalled in the legislative Joint Committee on Public Health. H. 2381, 192d Gen. Ct., Reg. Sess. (Mass. 2021); S. 1384, 192d Gen. Ct., Reg. Sess. (Mass. 2021). In this regard, Massachusetts, like most states, has rejected attempts to decriminalize assisted suicide.

Where legal, assisted suicide protocol depends on state statute. These statutes go beyond a common law standard of care and generally include eligibility and residency requirements, mandatory reporting, reflection periods, and informed consent disclosures and forms. *See*, *e.g.*, Cal. Health & Safety Code §§ 443.1 to 443.9; Wash. Rev. Code §§ 70.245.010 to 70.245.903. Oregon[5] lists numerous mandatory safeguards, such as:

- Residency requirements, Or. Rev. Stat. § 127.805(1)[6];
- Determination by both an attending physician and consulting physician that the patient suffers from a terminal disease, *id*.;

[5] Oregon was the first state to legalize assisted suicide, and states often model assisted suicide legislation after Oregon's statute.

[6] Pro-assisted suicide plaintiffs have challenged Oregon's residency requirements. *Gideonse v. Brown*, No. 3:21-cv-1568-AC (D. Or. filed Oct. 28, 2021).

- Witness of the medication request by at least two individuals, with restrictions on who may qualify as a witness, including an exclusion on the patient's attending physician from acting as a witness, *id*. § 127.810;

- Physician-provided informed consent disclosures, including the patient's medical diagnosis, potential risks of the lethal drug, and feasible alternatives to assisted suicide, *id*. § 127.815(c);

- In limited instances, referral of the patient for counseling, *id*. § 127.825;

- An oral and written drug request, *id*. § 127.840(1);

- Reiteration of the oral request no less than fifteen days after the initial oral request, *id*. § 127.840(1)

- Physician documentation of information in the patient's medical record, including the patient's diagnosis and medication requests, *id*. § 127.855.

Judicial decriminalization of assisted suicide in Massachusetts would have none of these statutory safeguards.

Assisted suicide statutes do not create a standard of care for Massachusetts physicians engaging in assisted suicide. Massachusetts courts cannot criminally enforce assisted suicide statutes of another jurisdiction. Similarly, Massachusetts physicians need not, and often cannot, follow another jurisdiction's statutory safeguards for assisted suicide. Oregon law, for example, requires that a patient's written request for medication is signed, dated, and substantially follows a state-prescribed form. Or. Rev. Stat. § 127.810(1). Massachusetts has no such state-prescribed form. Massachusetts also does not have an annual statistical report on assisted suicide and does not require physicians to report their assisted suicide

activities. *But cf. id*. § 127.865 (requiring Oregon physicians to report on their assisted suicide practices and the Oregon Health Authority to make an annual statistical report of this information). Neither could Massachusetts physicians alter contract and insurance laws to prevent patient coercion in contracts and insurance policies. *But cf. id*. § 127.870(1) (invalidating "a contract, will or other agreement" affecting a person's ability to make or rescind a request for lethal drugs under the Oregon statute); *id*. § 127.875 (prohibiting insurance or annuity policies affecting a patient's request for lethal medication under Oregon law). Judicial decriminalization of assisted suicide also would not have limiting language stating "[n]othing in [the law] shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia," *But cf. id*. § 127.880 (including this limiting language in Oregon's assisted suicide statute to protect patients from active euthanasia).[7]

Judicial decriminalization of assisted suicide would not have these safeguards, which are statute specific. As Compassion & Choices, a leading assisted suicide advocacy organization, discusses, "[t]hese core [statutory] safeguards ensure that individual patient preferences, needs and values are honored, and guide all clinical

[7] Assisted suicide proponents notably have challenged California's assisted suicide law, arguing that under federal disability rights laws, the state must permit active euthanasia of individuals with disabilities who cannot self-ingest lethal drugs. *Shavelson v. Cal. Dep't of Health*, No. 3:21-cv-6654-VC (N.D. Cal. am. compl. filed Nov. 12, 2021); *see* Cal. Health & Safety Code § 443.18 ("Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia.").

decisions, including the decision to use [assisted suicide]." *Understanding Medical Aid in Dying*, Compassion & Choices, https://compassionandchoices.org/end-of-life-planning/learn/understanding-medical-aid-dying/ (last visited Feb. 4, 2022). To be clear, as the following sections show, no statutory safeguards are sufficient when the primary and intentional objective of the practice is death. However, judicial decriminalization would not even have the semblance of these statutory "safeguards."

B. It Is Difficult to Ensure Patient Competency and Informed Consent in Assisted Suicide.

At both the medication request and time of ingestion stages, there are serious competency and informed consent concerns for assisted suicide patients. Unfortunately, "[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms." Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-assisted Suicide*, 36 Int'l J. L. & Psychiatry 461, 461 (2013). "[A]round 25-50% of patients who have made requests for assisted suicide showed signs of depression and 2-10% of patients who have received physician-assisted suicide were depressed." *Id.* at 466; *see also* Linda Ganzini et al., *Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey*, 337 BMJ 1682 (2008) (finding 25% of surveyed Oregon patients who had requested lethal medication had clinical depression and the "[statute] may not adequately protect all

mentally ill patients"). These patients' "desire for hastened death is significantly associated with a diagnosis of major depression." *Id*. Their psychiatric disability also may impair decision-making, "such as the decision to end one's life." *Id*.

Even with the high rates of depression in patients considering assisted suicide, counseling referrals are uncommon. Foster, *supra*, at 54. In Oregon in 2020, for example, assisted suicide physicians prescribed lethal drugs to 370 patients yet only referred three patients for counseling – less than one percent. Or. Pub. Health Div., *Oregon Death with Dignity Act: 2020 Data Summary* 7 (2021). Even during counseling, psychiatrists have limited ability in diagnosing depression. One study shows that "[o]nly 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide." Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-assisted Suicide*, 153 Am. J. Psychiatry 1469 (1996).

As discussed above, all assisted suicide statutes require two witnesses to attest to a patient's capacity at the time of the medication request. All jurisdictions but Vermont require that "one of the two witnesses must be unrelated to the patient and must not receive any benefits upon his or her death." Foster, *supra*, at 53; *see* Vt. Stat. tit. 18 § 5283(a)(4). In those jurisdictions, "no requirements are in place for the second witness to be disinterested in any way—the two witnesses could be an heir

and his cousin or an heir and his best friend." *Id.* In this case, there are no requirements for witnesses to attest to the patient's capacity at the medication request, nor are there safeguards against an heir or coercive family caregiver from being present when the patient requests medication.

Unfortunately, assisted suicide doctors do not provide oversight during the actual ingestion process.[8] As bioethicist Wesley J. Smith writes, "once the prescription is written, there are no further protections. At no point does the law require [a physician or other healthcare provider] to be at the bedside. Nothing needs to be done to ensure that the patient is competent or to prevent coercion." Wesley J. Smith, CULTURE OF DEATH: THE AGE OF "DO HARM" MEDICINE 130 (2d ed. 2016). The National Council on Disability acknowledges this issue, indicating "there is no way for authorities to know whether the lethal dose was self-administered and consensual." Nat'l Council on Disability, *The Danger of Assisted Suicide Laws*,

[8] *Amicus curiae* also wish to clarify that not all patients ingest the lethal medication. In 2020 in Washington, for example, pharmacies dispensed lethal medication to 340 patients, but only have reports of 252 patients ingesting the drug cocktail, or 74% of dispensed medications. Wash. Disease Control & Health Stats., *2020 Death with Dignity Act Report* 6 (Oct. 21, 2021). 677 Californian patients received prescriptions for assisted suicide drugs, but only 401 patients, or 59.2%, died following ingestion of the drugs. Cal. Dep't of Pub. Health, *California End of Life Option Act: 2020 Data Report* 4 (July 2021). Oregon, which has the most complete statistical data, shows a 66% patient ingestion ratio to prescriptions over the history of its statute. Or. Pub. Health Div., *supra*, at 5. Although some statutes require drug disposal of unused lethal medication, there often is no oversight to ensure proper drug disposal. *See*, *e.g.*, Cal. Health & Safety Code § 443.20; Wash. Rev. Code § 70.245.140.

Bioethics and Disability Series 37 (2019), *available at* https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf.

In California, a physician or health care worker only was present 41.1% of the time when the patient ingested the drugs. Cal. Dep't of Pub. Health, *supra*, at 8. In Oregon in 2020, the prescribing physician only was present when the patient ingested the lethal medication 11.8% of the time while a non-prescribing healthcare worker was present in 22.4% of cases. Or. Pub. Health Div., *supra*, at 12. Without a prescribing physician or healthcare worker, there is no medical oversight over the ingestion process or lethal outcome. This is concerning as there are no requirements that a disinterested person, or even anyone at all, witness the patient's death. Marilyn Golden & Tyler Zoanni, *Killing Us Softly: The Dangers of Legalizing Assisted Suicide*, 3 Disability & Health J. 16, 20 (2010). Judicial decriminalization of assisted suicide, which has fewer patient protections than those in an assisted suicide statute, would inadequately address these competency and informed consent concerns.

C. "Terminally Ill" Is an Indefinite Term and Does Not Create a Standard of Care.

The issue statement does not define "terminally ill," and the term's ambiguity undercuts patient safety. Generally, "terminally ill is used to describe a patient's condition," and often means a "progressive life-limiting disease with a prognosis of months or less." David Hui et al., *Concepts and Definitions for "Actively Dying," "End of Life," "Terminally Ill," "Terminal Care," and "Transition of Care": A*

Systematic Review, 47 J. Pain Symptom Mgmt. 77 (2014). However, even though the term is used in medical settings, medical professionals and scholars often inconsistently define "terminally ill" and other end-of-life terms. Consequently, there often is confusion about terminal illness and end-of-life medical care. *Id*.

Other Massachusetts statutes defining "terminal illness" do not give guidance for assisted suicide. The statutes define the term differently depending upon the context, often giving different time periods, such as six-months, eighteen-months, and twenty-four-months prognoses. *See*, *e.g.*, Mass. Gen. Laws ch. 111 § 227 (2012), ch. 127 § 119A (2018), ch. 175 § 212 (2013). These "terminal illness" definitions are specific to their respective statutes and do not apply to other laws. Notably, in the statute relating to distribution of information regarding availability of palliative care and end-of-life options, the statute has limiting language against assisted suicide. *Id*. ch. 111 § 227(c) ("Nothing in this section shall be construed to permit a healthcare professional to offer to provide information about assisted suicide or the prescribing of medication to end life.").

In the assisted suicide context, many jurisdictions that permit the practice have modeled their "terminal disease" or terminal illness definition after Oregon's definition, to "mean[] an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." Or. Rev. Stat. § 127.800(12). The statute excludes persons who would

qualify "solely because of age or disability." *Id*. § 127.805(2). This case, however, does not include a time limitation for "terminal illness," require that a second physician medically confirm the prognosis, or exclude patients who only qualify for assisted suicide based solely upon age or disability.

Even under the Oregon definition, there still is uncertainty surrounding the term. The National Council on Disability discusses that "[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed as terminally ill will die within 6 months. Actually, it is common for medical prognoses of a short life expectancy to be wrong." Nat'l Council on Disability, *supra*, at 21. Similarly:

> [I]t is extremely common for medical prognoses of a short life expectancy to be wrong. Studies indicate that only cancer patients show a predictable decline, and even then, it is only in the last few weeks of life. With every disease other than cancer, prediction is unreliable. Prognoses are based on statistical averages, which are nearly useless in determining what will happen to an individual patient. Thus, the potential reach of assisted suicide is extremely broad and could include many people who may be mistakenly diagnosed as terminal but who have many meaningful years of life ahead.

Golden, *supra*, at 21. Unfortunately, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival." Nat'l Council on Disability at 22. In one United States study of assisted suicide patients suffering from ALS (amyotrophic lateral sclerosis, commonly known as "Lou Gehrig's disease"), "[d]espite the best efforts of experienced ALS clinicians, predicting a 6-month survival for patients with ALS is challenging. The

largest number of days between first oral request [for lethal medication] and death was 615 days." Leo H. Wang et al., *Death with Dignity in Washington Patients with Amyotrophic Lateral Sclerosis*, 87 Neurology 2117, 2120 (2016). Thus, "terminal illness" is ambiguous and risks irreversible, lethal consequences for patients.

II. CURRENT UNITED STATES ASSISTED SUICIDE PRACTICES HAVE NO MEDICAL STANDARD OF CARE.

A. Assisted Suicide Pharmacology Is Not Standardized.

There is no standardized drug nor required dosage for assisted suicide. "Of course, there is no federally approved drug for which the primary indication is the cessation of mental or physical suffering by the termination of life." Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in* Gonzales v. Oregon, 15 Temp. Pol. & Civ. Rts. L. Rev. 323, 339 (2006). Federally, the Food and Drug Act regulates pharmaceuticals and requires "that both 'safety' and 'efficacy' of a drug for its intended purpose (its 'indication') be demonstrated in order to approve the drug for distribution and marketing to the public." *Id*. at 340. Lethal medication could never meet the safety or efficacy requirements for treating mental or physical ailments.

Under state law, "[e]xisting Death with Dignity laws do not specify what medicine(s) physicians must prescribe for patient self-ingestion to peacefully end life, assuming physicians know best." Carol Parrot & Robert Wood, *Physician Assisted Dying in Washington State: A Primer for Participating Physician and*

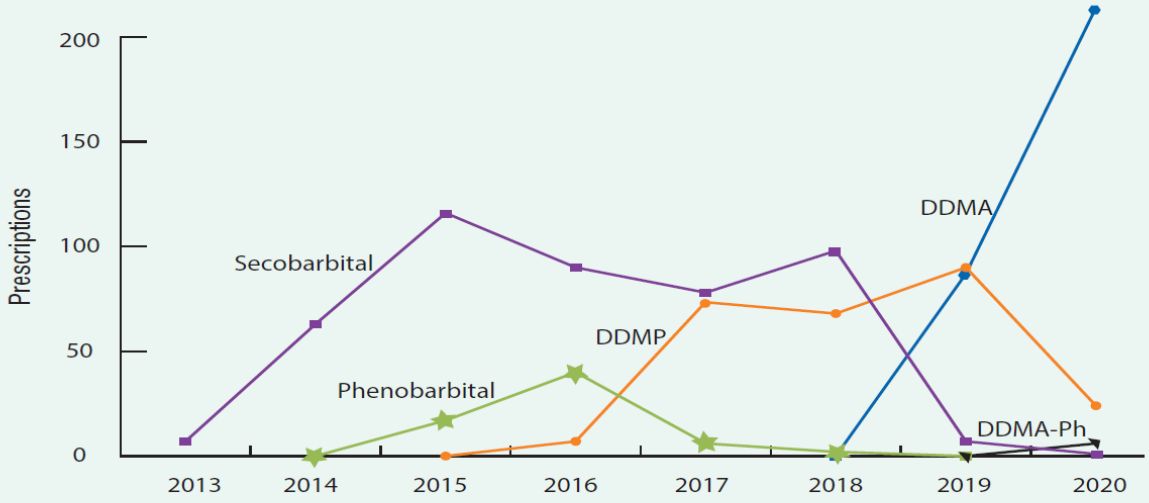
Pharmacists 1, 2 (Dec. 15, 2020), End of Life Wash., https://endoflifewa.org/wp-content/uploads/2020/12/Physicians-Primer-update-12.15.20.pdf; *see* Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, The Atl. (Jan. 22, 2019), https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/ ("No medical association oversees aid in dying, and no government committee helps fund the research. In states where the practice is legal, state governments provide guidance about which patients qualify, but say nothing about which drugs to prescribe."). Consequently, assisted suicide proponents have experimented their lethal drugs on end-of-life patients with "no government-approved clinical drug trial, and no Institutional Review Board oversight when they prescribed the concoction to patients." Dear, *supra*.

With no government-approved lethal drug cocktail, and restrictions on conducting deadly research on patients, assisted suicide pharmacology is not standardized. As assisted suicide doctors admit, "[s]ince the beginnings of U.S. medical aid in dying in 1997, there has been a need to refine and improve aid-in-dying pharmacology—in efficacy, reliability, time-to-sleep, time-to-death, patient tolerance, simplicity, cost, and availability." Lonny Shavelson & Carol Parrot, *Adding Phenobarbital to the D-DMA and DDMA Medication Protocols for Medical Aid in Dying*, Am. Clinicians Acad. on Med. Aid in Dying 1, 1 (Jan. 12, 2021),

https://www.acamaid.org/wp-content/uploads/2021/12/1-12-21-Adding-phenobarbital-to-DDMA-protocols.pdf.

For 2020 alone, New Jersey notes eight different death-inducing drug cocktails among reported prescriptions. N.J. Off. of the Chief St. Med. Examin'r, *New Jersey Medical Aid in Dying for the Terminally Ill Act: 2020 Data Summary* 7 (n.d.). Oregon lists seven drug compounds plus an "Other" category of lethal drugs that have been prescribed for assisted suicide in the state. Or. Pub. Health Div., *supra*, at 11. As shown by this graph from Oregon's 2020 assisted suicide report, the composition of lethal drugs has been especially erratic in recent years as assisted suicide doctors continually change the pharmacology:

Figure 3: Medication used in DWDA ingestions, 2013-2020



Id. at 7.

The rapid changes in pharmacology are partially due to barbiturate supply issues. Originally, assisted suicide physicians used "short-acting barbiturates, since these drugs were rapidly absorbed, promptly resulted in sleep, and overdoses uniformly caused death." Parrot, *supra*, at 3. "Neurologically, barbiturates essentially put patients to sleep by slowing down the brain's electrical activity . . . breathing slows down and can eventually cease, leading to death. Each barbiturate varies in how fast acting and how long lasting they are, creating major differences [in] a patient's consciousness or pain during death." Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BioScis. 424, 427 (2017). Due to price gouging of secobarbital and pentobarbital in 2016, however, short-acting barbiturates were no longer a feasible option in price or supply for physician assisted suicide. *Id*. at 429–430; *see* Parrot, *supra*, at 3.

Physicians briefly tried a chloral hydrate, phenobarbital, and morphine sulfate compound drug to cause lethal respiratory failure. Parrot, *supra*, at 3. Robert Wood, the medical director at End of Life Washington, told patients that "[w]e know this is going to put you to sleep, and we're pretty sure it's going to kill you." Dear, *supra*. However, the drug "was deemed unacceptable by patients and families." Parrot, *supra*, at 3. As *The Atlantic* reported, the assisted suicide doctors' experimental drug compound "worked, but with a tragic catch: In a few cases, the chloral hydrate

burned people's throats, causing severe pain just at the time they expected relief." Dear, *supra*.

In 2016, assisted suicide physicians crafted DDMP2 and DDMP, lethal mixtures of digoxin, diazepam, morphine sulfate, and propranolol that produced respiratory and cardiac failure. Parrot, *supra*, at 3. Around the same time, a California assisted suicide doctor experimented with D-DMA, which includes digoxin, diazepam, morphine sulfate, and amitriptyline. *Id*. However, D-DMA "requir[es] more family participation when there is no trained support person at bedside to prepare the medications." *Id*.

Afterwards, "[p]hysicians working with End of Life Washington . . . modified the D-DMA regimen into DDMA for simplicity, ordering the powders in the same doses but dispensed together in one glass bottle as DDMA, to be ingested all at once." *Id*. Oregon data shows assisted suicide patients only have used DDMA since 2018 and, as of 2020, it was the most common death-inducing drug. Or. Pub. Health Div., *supra*, at 7.

Currently, there is a new push by assisted suicide physicians to alter the drug formula again by adding phenobarbital, a barbiturate with sedative properties. Shavelson, *supra*, at 1. The American Clinicians Academy on Medical Aid in Dying, which assisted suicide proponents founded following a February 2020 assisted suicide conference, supports a pharmacology change to DDMAPh, which includes

phenobarbital. *Currently Recommended Aid-in-Dying Pharmacology*, Am. Clinicians Acad. on Med. Aid in Dying 1, 1 (June 22, 2021), https://www.acamaid.org/wp-content/uploads/2021/12/6-22-21-Aid-in-Dying-Pharmacology-Recommendation-1.pdf ("ACAMAID Recommendation"). According to Oregon's 2020 report, however, "[t]here is not yet sufficient data on the new drug combination [using phenobarbital] to estimate its effectiveness." Or. Pub. Health Div., *supra*, at 8.

Depending upon the drug composition, the procedure for ingesting the lethal medication may include two or three steps. Under DDMAPh, for example, a patient takes antiemetic medications (for nausea and vomiting) thirty minutes ahead of time. Then the patient or her helper mixes the DDMAPh powder into four ounces of clear liquid. The patient must then ingest the mixture within two minutes so that she does not fall unconscious partway through the dose. ACAMAID Recommendation, *supra*, at 2–3. Patients may follow a similar procedure for other lethal drug compounds where a patient ingests an antiemetic, waits a prescribed time, and then ingests the "slurry" of powdered drugs and liquid. David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259, 261 (2016).

After taking the lethal cocktail, patients fall unconscious and, after a time, die from drug overdose. In Oregon in 2020, the duration between ingestion and unconsciousness ranged from one to forty-five minutes, with a median time of five

minutes. Or. Pub. Health Div., *supra*, at 13. The duration between ingestion and death, however, was erratic, ranging from six minutes to eight hours, with a median time of fifty minutes. *Id*.

The problem is that the lethal drugs are experimental and come with risks. For all forms of assisted suicide, there is "a relatively high incidence of vomiting (up to 10%), prolongation of death (up to 7 days), and reawakening from coma (up to 4%), constituting failure of unconsciousness." S. Sinmyee et al., *Legal and Ethical Implications of Defining an Optimum Means of Achieving Unconsciousness in Assisted Dying*, 74 Anaesthesia 630, 630 (2019). "The pervasive belief that [assisted suicide] drugs are guaranteed to provide for a peaceful and painless death must be dispelled; modern medicine cannot yet achieve this," and assisted suicide is not "as clean as [it] appear[s], even with the US's medicalization efforts during the 1980s." Riley, *supra*, at 427. In this regard, assisted suicide pharmacology is not standardized, has no government oversight, and is accompanied by serious risks.

B. Low Rates of Assisted Suicide and Inadequate Reporting Requirements Create Insufficient Data to Standardize the Practice.

There is limited data because assisted suicide is rare. Oregon was the earliest state to legalize the lethal practice and has reported data since 1998, but, as of January 22, 2021, 1,905 patients have died from ingesting a lethal dose of medication under the statute. Or. Pub. Health Div., *supra*, at 9. Between 2016 and 2020, 1,816 California patients have died from assisted suicide. Cal. Dep't of Pub. Health, *supra*,

at 3. In 2020, California reported 401 patient deaths from lethal medication, the highest number among jurisdictions with legalized assisted suicide. *Id*. at 4. Washington reports 252 patients died from lethal medication while Oregon had 245 patients die from ingesting the drug cocktail. Wash. Disease Control & Health Stats., *2020 Death with Dignity Act Report* 6 (Oct. 21, 2021); Or. Pub. Health Div., *supra*, at 3. Other states report even lower numbers. In 2020, Maine had thirty patients die from assisted suicide. Me. Dep't of Health and Hum. Servs., *Death with Dignity Annual Report for Calendar Year 2020* 5 (Mar. 1, 2021). Over a two-year period between 2019 and 2021, Vermont reports only 17 patients have died from these lethal prescriptions. Vt. Dep't of Health, *Report Concerning Patient Choice at the End of Life* 3 (Jan. 15, 2022).

Even with these numbers, there is a "substantial lack of data, including both quantitative and qualitative data, on the medical and demographic profiles of people who have sought and used assisted suicide." Nat'l Council on Disability, *supra*, at 33. There has been little research on assisted suicide in the United States, and the assisted suicide statutes have strict privacy and confidentiality requirements that prevent comprehensive analysis from the little data available. *Id*.

Existing data is further limited because there is no way to "assess the extent of nonreporting or noncompliance with the law's purported safeguards." *Id*. at 34. The statistical data is solely based on forms filled out and filed by assisted suicide

physicians and pharmacies that dispense the lethal drug cocktails. *Id*. "[D]octors are unlikely to report their own lack of compliance with the law . . . [and] the state has no way for the public, family members, or other healthcare professionals to report suspected problems, nor even a means of investigating mistakes and abuse." *Id*. Thus, there is inadequate data to standardize assisted suicide practices in the United States.

C. Assisted Suicide Is Contrary to the Physician's Role as a Healer and Places the Patient in a Vulnerable Position.

Assisted suicide erodes the integrity and ethics of the medical profession. In *Washington v. Glucksberg*, the Supreme Court found "[t]he State also has an interest in protecting the integrity and ethics of the medical profession." 521 U.S. at 731. "'[P]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer' . . . [and] could . . . undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming." *Id*. at 731. Assisted suicide "undermines the physician's primary directive . . . to *first, do no harm*." Golden, *supra*, at 19 (quotations omitted) (omission and emphasis in original). The practice has other deleterious effects, such as "destroy[ing] the trust between the patient and doctor." *Id*. (quotations omitted). Assisted suicide, "[u]nder the pretense of providing compassion, relieves a physician of his or her primary responsibility . . . to safeguard [patients' lives] and to provide comfort to the suffering. It is the ultimate patient abandonment." *Id*. (quotations omitted)

(alterations and omissions in original); *see also* Courtney S. Campbell, *Mortal Responsibilities: Bioethics and Medical-Assisted Dying*, 92 Yale J. Biology & Med. 733, 737 (2019) (noting in assisted suicide, "[t]he healing vocation of the physician is diminished to the role of efficient, and morally neutral, *technician*.") (emphasis in original).

Appellants argue that the "doctor's action is a result of thoughtful consideration to ensure that [assisted suicide] is an appropriate option for a specific patient under the medical standard of care." Opening Br. of Appellants 24. Yet patients may engage in "doctor shopping," where a patient will seek a different physician if a first physician refuses or denies prescribing lethal drugs to the patient. Nat'l Council on Disability, *supra*, at 27. More concerning is that, as of 2020, Oregon data shows that the median duration of an assisted suicide patient-physician relationship was eight weeks. Or. Pub. Health Div., *supra*, at 12. Current and previous Oregon data shows that the patient-physician relationship has lasted as little as one or even zero weeks. *Id*.

Another problem with assisted suicide, and its perceived compassion to "aid" patients in dying is that "the desire to die arises out of serious illnesses or disabilities." Smith, *supra*, at 117. This creates "a two-tiered system for measuring the worth of human life" according to bioethicist Wesley J. Smith. *Id*. In this stratified system:

> The young and vital who become suicidal would receive suicide prevention—and the concomitant message that their lives are worth living. At the same time, the suicides of the debilitated, sick, and disabled, and people with extended mental anguish—the "hopelessly ill"—would be shrugged off as merely a matter of choice. Such a value system would not only reflect a distorted value about the worth of human life but also send a lethal message to the weak and infirm that their lives are not worth living.

Id. The National Council on Disability echoes Smith, noting that under legalized assisted suicide, "people's lives, particularly those of people with disabilities, will be ended without their fully informed and free consent, through mistakes, abuse, insufficient knowledge, and the unjust lack of better options." Nat'l Council on Disability, at 14–15. Although states have tried to place safeguards into statutes, "[n]o safeguards have ever been enacted or proposed that can prevent this outcome." *Id*. at 15.

State reports show that patients seek assisted suicide not for pain management, but because of the challenges of living with severe illnesses or disabilities. In 2020, only 32.7% of Oregon patients and 38.4% of Washington patients cited "[i]nadequate pain control, or concern about it" as a reason for choosing assisted suicide. Or. Pub. Health Div., *supra*, at 12; Wash. Disease Control & Health Stats., *supra*, at 10. Rather, the top five reasons for assisted suicide in both Oregon and Washington were the following:

- Less able to engage in activities making life enjoyable (94.3% in Oregon, 90.6% in Washington);

- Losing autonomy (93.1% in Oregon, 89.6% in Washington);
- Loss of dignity (71.8% in Oregon, 74.8% in Washington);
- Burden on family, friends/caregivers (53.1% in Oregon, 58.6% in Washington);
- Losing control of bodily functions (37.6% in Oregon, 48.8% in Washington).

Id. Data shows Oregon patients historically have ranked pain lower than autonomy and dignity categories. Or. Pub. Health Div., *supra*, at 12. These unfortunately are "psychological issues that are all-too-familiar to the disability community." Nat'l Council on Disability, *supra*, at 37.

In other words, patients usually do not seek assisted suicide for pain management. Rather, they seek assisted suicide because of disability and quality of life concerns, under the perception that "a patient is deprived of dignity when he is made to feel dependent and helpless as the end of life approaches." Aden, *supra*, at 324. "This is a kind of rhetorical gamesmanship; [assisted suicide proponents] define dignity according to their own philosophical presupposition that dignity depends on autonomy." *Id*. Yet there is no "right to decide one's own life is worthless . . . it presupposes that human life may lack value, and that the decision whether it does is best left to the individual." *Id*. Accordingly, assisted suicide, a practice that lethally and discriminatorily judges patients' quality of life based upon their terminal illnesses and disabilities, has no place in medicine.

CONCLUSION

There is no medical standard of care for assisted suicide. The court should reject Appellants' attempt to decriminalize assisted suicide and affirm the Superior Court's decision.

Respectfully submitted,

CATHERINE GLENN FOSTER
STEVEN H. ADEN
KATIE GLENN
NATALIE M. HEJRAN
CAROLYN MCDONNELL
AMERICANS UNITED FOR LIFE
1150 Connecticut Ave., N.W.
Suite 500
Washington, DC 22036
Steven.Aden@aul.org
Telephone: 202-741-4917

ANDREW BECKWITH
Counsel of Record
MASSACHUSETTS FAMILY INSTITUTE
401 Edgewater Place
Suite 580
Wakefield, MA 01880
andrew@mafamily.org
Telephone: 781-569-0400
BBO No. 657747

Counsel for Amicus Curiae

February 16, 2022

CERTIFICATE OF COMPLIANCE

Certificate of Compliance with Type-Volume Limit,
Typeface Requirements, and Type-Style Requirements

1. I hereby certify, pursuant to Mass. R. App. P. 16(k), that this brief complies with the Massachusetts Rules of Appellate Procedure, including, but not limited to, the type-volume limit of Mass. R. App. P. 20(a)(2)(C) because it contains 6,288 words, excluding the parts exempted by Mass. R. App. P. 20(a)(2)(D).

2. I also certify that this brief complies with the form requirements of Mass. R. App. P. 20(a)(1) and the type style requirements of Mass. R. App. P. 20(a)(4) because it has been prepared in a proportionally-spaced typeface using Microsoft Word 2016 in 14-point Times New Roman.

I further certify that this PDF file was scanned for viruses, and no viruses were found on the file.

ANDREW BECKWITH
Counsel of Record
MASSACHUSETTS FAMILY INSTITUTE
401 Edgewater Place
Suite 580
Wakefield, MA 01880
andrew@mafamily.org
Telephone: 781-569-0400
BBO No. 657747

Counsel for Amicus Curiae

February 16, 2022

CERTIFICATE OF SERVICE

I certify that on February 16, 2022, I electronically filed the foregoing brief with the clerk via e-fileMA, and served the counsel of record for the other parties either via e-fileMA or first-class mail:

JONATHAN M. ALBANO
Jonathan.albano@morganlewis.com
NATHANIEL P. BRUHN
Nathaniel.bruhn@morganlewis.com
MORGAN, LEWIS & BOCKIUS LLP
One Federal Street
Boston, MA 02110
Counsel for Plaintiffs-Appellants

KEVIN DÍAZ
kdiaz@compassionandchoices.org
COMPASSION & CHOICES
101 SW Madison Street, Unit 8009
Portland, OR 97207
Counsel for Plaintiffs-Appellants

MARIA GRANIK
Maria.Granik@mass.gov
JULIE E. GREEN
Julie.Green@mass.gov
OFFICE OF THE ATTORNEY GENERAL
One Ashburton Place
Boston, MA 02108
Counsel for Defendants-Appellees

JOHN KAPPOS
jkappos@omm.com
BO MOON
bmoon@omm.com
O'MELVENY & MYERS LLP
610 Newport Center Drive, 17th Floor
Newport Beach, CA 92660
Counsel for Plaintiffs-Appellants

ELIZABETH A. SWEENEY
OFFICE OF THE DISTRICT ATTORNEY
Cape & Islands District
3231 Main Street
PO Box 455
Barnstable, MA 02630
Counsel for Defendants-Appellees

/s/ Andrew Beckwith
ANDREW BECKWITH
Counsel of Record
MASSACHUSETTS FAMILY INSTITUTE
401 Edgewater Place, Suite 580
Wakefield, MA 01880
andrew@mafamily.org
Telephone: 781-569-0400
BBO No. 657747
Counsel for Amicus Curiae