COMMONWEALTH OF MASSACHUSETTS

APPEALS COURT

No. 2021-P-0156

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

Appellants (Plaintiffs Below),

v.

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

Appellees (Defendants Below),

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

OPENING BRIEF OF APPELLANTS

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I. Statement Of The Issues

This case raises the issues of whether: (1) criminal manslaughter charges apply to physicians who follow a medical standard of care and write a prescription to terminally ill, competent adults who request such aid and choose to self-ingest medication consistent with the practice of Medical Aid In Dying (MAID); (2) the application of common law manslaughter to a physician who engages in prescribing MAID medication violates the Massachusetts Constitution because the law is impermissibly vague; (3) the application of common law manslaughter to physicians who prescribe MAID medication violates Plaintiff's privacy rights under the Massachusetts Constitution; (4) the application of common law manslaughter to physicians who prescribe MAID medication violates Plaintiffs' liberty rights under the Massachusetts Constitution; and (5) the application of common law manslaughter to physicians who prescribe MAID medication violates Plaintiffs' constitutional right to equal protection under the Massachusetts Constitution.

II. Statement Of The Case

This is an appeal of the Superior Court's December 31, 2019 Memorandum of Decision and Order on the Parties' Cross-Motions for Summary Judgment Addendum 47-70; RAIII/339-362 (the "Summary Judgment Order"), granting Defendants' Motion for Summary Judgment as to Counts I, II, III, IV, and VI.

III. Statement Of The Facts

A. Background

1. The Parties

Plaintiff Roger Kligler, M.D. ("Dr. Kligler"), is a retired physician who resides in Falmouth Massachusetts and spent the final 32 years of his career treating patients in the Commonwealth. Dr. Kligler has Stage 4 Metastatic Castrate-Resistant Prostate Cancer. Impounded RAI/26-27 at 20:21-21:14. Stage 4 is the most severe form of cancer. Dr. Kligler's cancer has metastasized to his bones. Impounded RAI/75 at 69:17-22; 69:1-3. Dr. Kligler's physician, Dr. Christopher Sweeney, estimated, at the time of his deposition, that there is a 50 percent chance that Dr. Kligler will die within five years. Impounded RAI/35-37 at 29:20-31:4. Dr. Sweeney further cautions that the prognosis for cancer patients can quickly turn negative. Impounded RAI/72-73 at 66:12-67:12. Due to the uncertainty in predicting the course of any cancer, Dr. Sweeney checks Dr. Kligler's condition every three months. *Id.* at 66:2-6; 67:4-8. Prostate-specific antigen ("PSA") is a diagnostic marker that indicates the existence of prostate cancer cells and allows Dr. Sweeney to monitor the progression of Dr. Kligler's disease. Impounded RAI/19-20 at 13:24-14:13. Dr. Kligler's PSA levels were rising as of Dr. Sweeney's deposition, and continued rising thereafter. Impounded RAI/74 at 68:4-24; Impounded RAI/536, at ¶ 2, Impounded RAI/539-541.

Dr. Kligler wants to consult with his physicians about the full range of end-of-life options and ultimately obtain a prescription for medication that, if he chooses to take, will allow Dr. Kligler to pass peacefully and without further suffering. Like many other terminally ill patients, Dr. Kligler believes that having access to such medication will alleviate his anxiety related to the dying process and allow him to live his final days confident that, if his suffering becomes too great, he has the option to self-ingest a prescription that will end his suffering. Impounded RAI/536-537 at ¶¶ 3-4; Impounded RAI/302-304, at 78:4-80:18. Dr. Kligler's desire to have access to this medication stems from his own experiences as a physician where he witnessed the suffering of terminally ill patients. Impounded RAI/115-118, at 33:15-36:21. Dr. Kligler fears he may not find a doctor in Massachusetts willing to provide the requested prescription due to fear of criminal prosecution. Impounded RAI/537 at ¶ 4.

Plaintiff Alan Steinbach, M.D. ("Dr. Steinbach") is a licensed Massachusetts physician. Some of the patients he has cared for have considered end-of-life issues in connection with organ system failure. Impounded RAI/438-444 at 90:16-92:12. As of his deposition, Dr. Steinbach had no current patients with a six-month prognosis, although he has cared for patients with a six-month or shorter prognosis in the past. Impounded RAI/440 at 92:1-6. In the month before his deposition, one of Dr. Steinbach's patients who was in the six-month window died.

Impounded RAI/440-441 at 92:1-93:11. Another of Dr. Steinbach's patients for whom he has made house calls and who requested assistance with end-of-life issues also died during the pendency of this litigation. Impounded RAI/449-453 at 101:5-104:2. Dr. Steinbach had two patients who are ill who expressed an interest in MAID but who are not yet terminally ill—one received a heart transplant and the other did not have a six-month prognosis. Impounded RAI/485-486 at 137:5-138:14. Dr. Steinbach wishes, if requested, to provide information regarding, and to write prescriptions for, medication for MAID. RAII/162 at ¶ 4. He does not provide information regarding MAID or write MAID medication prescriptions because he fears criminal prosecution under the laws of the Commonwealth of Massachusetts. *Id.*

2. End Of Life Care

There are several options for treating a dying person experiencing severe pain, agitation, or other acute discomfort at the end of life. The most common course is to administer strong narcotics, which, depending upon the cause and source of the pain, may be largely effective in resolving the patient's problems, although often with the unwanted side-effect of decreased mental alertness. RAII/170 at ¶ 13; RAI/88 at 33:10-19. However, even with medical care, 25% of patients die with uncontrolled pain and 21% die with uncontrolled shortness of breath. When normal doses are not sufficient and the patient is in extreme,

unrelieved distress, doctors sometimes increase the level of morphine to where it interferes with respiratory and heart function, even to the point of causing death.

When a terminally ill patient's pain is not relieved with pain medication, to provide relief without causing immediate death, the treating physician may sedate the patient into unconsciousness while withholding hydration and nutrition. RAI/275-280, at 33:4-38:15. The patient eventually has an expedited death from a combination of dehydration, starvation, medication effects causing respiratory depression and hypotension along with the underlying disease. RAI/625-626, at 227:12-228:3. Doctors refer to this process as "terminal sedation" or, more commonly, "palliative sedation," which is a legal and accepted practice in in Massachusetts. RAII/170-171 at ¶¶ 14-15.

A patient's death resulting from withdrawal of life-sustaining treatment is not deemed "suicide" under Massachusetts law, and physicians who follow a patient's direction to withdraw life-sustaining treatment are not prosecuted under Massachusetts law. And this is so even where physicians further administer medications to the patient to alleviate pain and discomfort resulting from the withdrawal of treatment, and even where the foreseeable result of the medication is death. RAI/171-173, RAI/188-189 at ¶¶ 15-17, 19-20, 59. Similarly, a patient's death resulting from palliative sedation is not deemed "suicide" under Massachusetts law, and physicians who follow a patient's wishes for palliative

sedation are not prosecuted under Massachusetts law even though the foreseeable result of end-of-life palliative sedation is death. *Id.*

B. This Lawsuit

On October 24, 2016, Plaintiffs Drs. Kligler and Steinbach sued the Attorney General of the Commonwealth of Massachusetts (the "AG") and the District Attorney of Cape & Islands Districts (the "DA") at the Suffolk County Superior Court. The complaint asserts six counts for declaratory and injunctive relief.

Count I seeks a declaration that "manslaughter charges are not applicable to physicians who follow a medical standard of care and write a prescription to terminally ill, competent adults who request such aid and may choose to self-ingest the medication consistent with the practice of [MAID]." RAI/25 at ¶ 43.

Count II asserts that applying common law manslaughter to a physician who engages in the conduct described above violates the Massachusetts Constitution because the law is impermissibly vague. RAI/25-26 at ¶ 46. Counts III and IV allege that applying common law manslaughter to such a physician impermissibly restricts a patient's constitutional right to privacy "by interfering with [their] basic autonomy in deciding how to confront their own mortality and choose their own destiny," RAI/26 at ¶ 51, and impermissibly restricts a patient's fundamental liberty interests "the right of competent adults to control decisions relating to the

rendering of their own health care," RAI/27 at ¶ 55. Counts II, III, and IV each request a declaration "that physicians who follow a medical standard of care and write a prescription pursuant to the practice of [MAID] to terminally ill, competent adults who request such aid do not violate criminal law, including the common-law crime of manslaughter." RAI/26-28 at ¶¶ 47, 52, 57. Each count also seeks an injunction prohibiting the AG and the DA from prosecuting physicians who engage in that conduct.

Count V asserts that application of common law manslaughter to a physician based on his or her provision of information and advice about MAID to competent, terminally ill adults, who later voluntarily ingest lethal prescribed medication, constitutes an unlawful restraint on the constitutional right to freedom of speech by hindering the physicians' ability to discuss medically appropriate end-of-life treatment options. RAI/28 at ¶ 61. Count V seeks a declaration that giving such advice is not manslaughter and an injunction prohibiting the AG and the DA from prosecuting physicians who inform, advise, or counsel patients about MAID. RAI/29 at ¶ 63.

Last, Count VI asserts that applying common law manslaughter to physicians who follow a medical standard of care and provide MAID medication violates the constitutional right to equal protection of law by treating differently terminally ill adults who wish to receive MAID and terminally ill adults who wish

to hasten death by voluntarily stopping of eating and drinking (VSED), withdrawal of life support, or end-of-life palliative sedation. RAI/29-30 at ¶ 66. Count VI seeks a declaration that providing MAID medication is not manslaughter, and seeks an injunction against prosecution. RAI/30 at ¶ 69.

C. Superior Court's Summary Judgment Order

The parties filed cross motions for summary judgment. Plaintiffs sought summary judgment on their declaratory judgment of no manslaughter (Count I),[1] free speech (Count V), and equal protection (Count VI) claims. The defendants sought summary judgment on all of Plaintiffs' claims. On December 31, 2019, the Superior Court issued its memorandum of decision and order on the parties' cross-motions for summary judgment, concluding that although the plaintiffs are entitled to summary judgment on Count V, the defendants are entitled to summary judgment on all other counts.

IV. Summary Of The Argument

The Superior Court erred in granting summary judgement favoring defendants on Counts I-IV, and VI.

First, the Superior Court erred in determining that common law involuntary manslaughter applies to MAID. A doctor's prescription of MAID medication does

[1] Plaintiff did not initially move for a summary judgment on Count I, but requested that the Superior Court "enter judgment against Defendants on Count I under Mass. R. Civ. P. 56(b) and (c)" during supplemental briefing ordered by the court.

not cause the death of a patient who voluntarily and consciously seeks MAID, fills the prescription, and self-ingests the medication. The patient causes their own death. And the "chain of self-causation" is not broken such that the doctor could then intervene to become the cause of death. Instead, the patient's death is left to the patient alone. The Superior Court also erred in granting summary judgment to defendants because a genuine dispute of material fact exists as to whether the prescribing doctor is wanton or reckless.

Second, in *Carter*, the SJC intentionally distinguished MAID from the facts that supported the charge of involuntary manslaughter, which suggests that common law manslaughter is not applicable to MAID. *Commonwealth v. Carter*, 474 Mass. 624, 637, 52 N.E.3d 1054, 1065 (2016) ("*Carter I*") (citing *Commonwealth v. Orlando,* 371 Mass. 732, 734, 359 N.E. 2d 310 (1977)). Given the SJC distinguished MAID from the facts of *Carter I*, applying involuntary manslaughter to MAID creates a situation where "men of common intelligence must guess" at the scope of involuntary manslaughter, making involuntary manslaughter unconstitutionally vague.

Third, the Superior Court erred in holding that the prohibition against MAID does not implicate a fundamental right. The Superior Court erred because (1) it failed to recognize there is no meaningful distinction between MAID and other end-of-life options; (2) it failed to consider the SJC's recognition in *Brophy* and

Saikewicz that an individual has a fundamental right to accept or reject a medical treatment; and (3) it refused to consider that the denial of a right to make the healthcare decision to have the option of MAID implicates a fundamental right because, in the Superior Court's view, MAID is not "deeply rooted in this Nation's history and tradition."

Last, the Superior Court further erred because even if the rational basis standard applies, Massachusetts's prohibition of MAID would not pass the rational basis test for either due process or equal protection.

V. Argument

The Appeals Court's review of a grant of summary judgment is de novo. *Chambers v. RDI Logistics, Inc.*, 476 Mass. 95, 99, 65 N.E.3d 1, 7 (2016). Summary judgment can be only granted "where, viewing the evidence in the light most favorable to the nonmoving party, there are no genuine issues as to any material fact and the moving party is entitled to judgment as a matter of law." *R.L. Currie Corp. v. E. Coast Sand & Gravel, Inc.*, 93 Mass. App. Ct. 782, 783, 109 N.E.3d 524, 526 (2018). "[The] party moving for summary judgment in a case in which the opposing party will have the burden of proof at trial is entitled to summary judgment if he demonstrates . . . that the party opposing the motion has no reasonable expectation of proving an essential element of that party's case." *Id.*, quoting *Dulgarian v. Stone*, 420 Mass. 843, 846 (1995).

A. The Superior Court Erred When It Determined That Common Law Involuntary Manslaughter Is Applicable To MAID

"Involuntary manslaughter is an unlawful homicide, unintentionally caused…by an act which constitutes such a disregard of probable harmful consequences to another as to constitute wanton or reckless conduct." *Commonwealth v. Carter*, 481 Mass. 352, 364, 115 N.E.3d 559, 569 (2019) ("Carter II"). The elements of involuntary manslaughter are "(1) that the defendant caused the victim's death, (2) that the defendant intended the conduct that caused the victim's death, and (3) that the defendant's conduct was wanton or reckless." *Commonwealth v. Guaman*, 90 Mass. App. Ct. 36, 40, 56 N.E.3d 830, 836 (2016); *see also Commonwealth v. Welansky*, 316 Mass. 383, 55 N.E.2d 902 (1944). The Superior Court erred in determining that common law involuntary manslaughter applies to MAID because the prescribing doctor does not cause the patient's death and the prescribing doctor's conduct is not wanton or reckless.

The Superior Court first erred in finding that a doctor's prescription of MAID medication causes the death of a patient who voluntarily and consciously seeks MAID, fills the prescription, and self-ingests the medication. The patient causes their own death. And the "chain of self-causation" is not broken such that the doctor could then intervene, as did the defendant in *Carter*, to become the cause of death. *Carter II*, 481 Mass. at 362-363.

In *Carter II*, the SJC found that a causal link between defendant's actions and the victim's death was only established when the defendant overpowered the victim's will by instructing him to get back into the gas-infused truck and thus caused his death. *Id.* at 363. The SJC held that the victim broke the "chain of self-causation" by exiting the truck, and when the defendant thereafter overpowered the victim's will by coercing the victim to go back in, the defendant caused the victim's death. *Id.* at 362-363.

There, the victim, who was not terminally ill, and defendant exchanged numerous messages regarding the details of the planned suicide in the days leading to the victim's death. *Id.* at 354. For example, on July 7, 2014, five days before the victim's eventual suicide, defendant advised the victim to google the ways to make carbon monoxide. *Id.* at 355 n.3. The victim "secur[ed] a water pump that he would use to generate carbon monoxide in his closed truck." *Id.* at 357. During the days leading to his suicide, he conducted extensive research, and spoke of [the planned suicide] continually. *Id.* at 362. He secured the generator and the water pump for the suicide. *Id.* "As the victim continued researching suicide methods and sharing his findings with the defendant, the defendant helped plan how, where, and when he would do so, and downplayed his fears about how his suicide would affect his family." *Id.* at 355.

Then on the night of his death, "the victim drove his truck to a local store's parking lot and started the pump. While the pump was operating, filling the truck with carbon monoxide, the defendant and victim were in contact by cell phone." *Id.* at 357-358. At some point, however, "the victim got out of the truck, seeking fresh air, in a way similar to how he had abandoned his prior suicide attempts." *Id.* at 358-359. "[W]hen defendant realized [the victim] had gotten out of the truck, she instructed him to get back in, knowing that it had become a toxic environment…. The victim followed that instruction." *Id.* at 359.

Reviewing this sequence of events, the SJC found significant the fact that defendant "instruct[ed] the victim to get back into the truck" after the victim has gotten out of the truck. *Id.* at 370. Even though there had been multiple text messages with defendant, and even though defendant's text messages during the days leading to the victim's death "constituted wanton or reckless conduct in serious disregard of the victim's well-being," the trial judge found—and the SJC affirmed—"this behavior did not cause his death." *Id.* at 357. In other words, the defendant in *Carter II* would not have been criminally liable for counselling, advising, and encouraging the victim had the victim stayed in the truck on his own and died. That is so because until the victim exited the vehicle, there was a "chain of self-causation." *Id.* at 362. This "chain of self-causation" was, however, broken when the victim exited the truck. *Id.* It was only when "the defendant

overpowered the victim's will" by instructing him to get back into the truck, and "in [a] weakened state [the victim] was badgered back into the gas-infused truck by defendant," that a causal link between defendant's actions and the victim's death was established. *Id.* at 363 ("Once the victim left the truck, the judge found that the defendant overpowered the victim's will and thus caused his death."). As the SJC explained, "until the victim got out of the truck…the victim [was] the cause of his own suicidal actions and reactions," regardless of the many text messages defendant exchanged with the victim. *Id.* at 362.

A patient who fills the MAID medication prescription, and self-ingests the medication causes their own death and the "chain of self-causation" is not broken such that the doctor could then become the cause of a resulting death. Moreover, the standard of care requires the physician to inform the patient they can change their mind and that they do not have to self-ingest even if they obtain a prescription. A doctor who provides a MAID medication prescription is no more criminally liable than the persons who provided the carbon monoxide generator or the water pump to the victim in *Carter II*. There is no indication those who provided the portable generator or the water pump were even charged with any wrongdoing in relation to the victim's death. The doctor does not cause the death of a patient any more than the seller of the generator and water pump caused the death of the victim in *Carter II*.

There is also no causal link if the victim's death is left to the victim alone. For example, in *Commonwealth v. Atencio*, the SJC noted that a driver was not guilty of involuntary manslaughter for participating in a drag race with her competitor because "much [of the competitor's death] is left to the skill, or lack of it, of the competitor," and therefore the accused driver did not cause the death. 345 Mass. 627, 631, 189 N.E.2d 223, 225 (1963). Similarly, a doctor's MAID medication prescription cannot cause the patient's death, because so much further action is left to the patient—she has to fill the prescription and self-ingest the drug to herself to cause her own death.

Second, the Superior Court further erred in concluding that the *Carter* decisions were only "narrowly focused on whether the use of words alone could constitute involuntary manslaughter." Summary Judgement Order at 7. The Superior Court held that because MAID involves more than words, the *Carter* decisions do not suggest that the crime requires coercion in the MAID context. *Id.* The SJC, however, states that the *Carter* case differs from a "person offering support, comfort, and even ***assistance*** to a mature adult who, confronted with such circumstances, has decided to end his or her life." *Commonwealth v. Carter*, 474 Mass. 624, 636, 52 N.E.3d 1054, 1064 (2016)("*Carter I*")(emphasis added). Therefore, in the *Carter* decisions, the SJC did not limit its discussion about MAID to only speech associated with MAID.

In the *Carter* decisions, the current case is easily distinguishable from *Carter* because in MAID the doctor does not "procure[] a suicide" by "pressuring [] a vulnerable person to commit suicide, overpowering that person's will to live." *Carter II*, 481 Mass. at 367. MAID allows a prescription only to a terminally-ill, mentally capable adult patient who requests it—i.e., a patient who already intends to have the option to take the medication if the patient deems her suffering too great to endure, such that self-ingesting is the best choice for her own circumstances. Moreover, the doctor does not "overcome[e] [the patient's] willpower to live" in order to "procure" the patient's death. While a doctor may offer information and counseling regarding various end of life options so the patient may make an informed decision, it is the patient chooses to seek MAID. And while a doctor may even offer a prescription for the MAID medication, it is the patient who chooses to fill the prescription and ultimately to self-ingest the medication. In such a case, there is no "procuring suicide" by the doctor who provides the prescription for the MAID medication. The SJC in *Carter II* noted that "end-of-life discussions between a doctor, family member, or friend and a mature, terminally ill adult confronting the difficult choices that must be made when faced with the certain physical and mental suffering brought upon by impending death" differs from the conduct found criminally liable in *Carter II*. *Id.* at 368 and n. 15.

Similarly, the current case is easily distinguishable from *Persampieri v. Commonwealth*. 343 Mass. 19, 22-23, 175 N.E.2d 387, 389 (1961). There, the petitioner "told his wife that he intended to get a divorce . . . . She then said that she was going to commit suicide. The [defendant] reminded her she had attempted suicide on two prior occasions and said she was 'chicken—and wouldn't do it.'" *Id.* at 22. Petitioner also "loaded the gun for her, at which time he noticed the safety was off," and "handed the gun [] to his wife." And when his wife held the gun against her forehead and unsuccessfully tried to reach the trigger, he told her "Why don't you take off your shoes, then maybe you can reach the trigger." *Id.* at 22-23. She followed that instruction and shot herself, resulting in her death. *Id.* The SJC noted that "[t]he petitioner's wife was emotionally disturbed, she had been drinking, and she had threatened to kill herself. The petitioner, instead of trying to bring her to her senses, taunted her, told her where the gun was, loaded it for her, saw that the safety was off, and told her the means by which she could pull the trigger." *Id.* at 23. Under those circumstances, the SJC held that it had not been error to accept defendant's plea of guilty to charges of manslaughter. *Id.*

Here, the patient who seeks MAID cannot be an "emotionally disturbed" person who exhibits suicidal tendencies. Otherwise the patient would not qualify for MAID under the medical standard of care. Dr. Kligler is transparent in his desire to have MAID available as an end-of-life option. When his cancer

progresses to where he would have six months or less to live, Dr. Kligler intends, by his own volition, to seek a MAID medication prescription. Impounded RAI/536, at ¶ 3; RAIII/336, at ¶¶ 2-3.

A doctor who satisfies Dr. Kligler's request would not be "overcoming [Dr. Kligler's] willpower to live" or forcing him to end his life. And when (and if) Dr. Kligler chooses to self-ingest the MAID medication, Dr. Kligler expects it to be at his own volition and at the time of his choosing. *Id.* at ¶ 4. Under these circumstances, the doctor who provides a MAID medication prescription cannot be penalized for the acts that Dr. Kligler freely and voluntarily performs without duress or any pressure from the doctor. And because there would be no "killing" achieved by "overpower[ing] [Dr. Kligler's] will to live" by the doctor providing the MAID medication prescription, any homicide prosecution against the doctor should not be sustainable. *Carter II*, 481 Mass. at 365 .

Third, the Superior Court also erred in granting summary judgment to defendants because a genuine dispute of material fact exists as to whether the prescribing doctor is wanton or reckless. Summary judgment is only appropriate "where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law." *City Elec. Supply Co. v. Arch Ins. Co.*, 481 Mass. 784, 788, 119 N.E.3d 735, 739 (2019). "In cases where motive, intent, or other state of mind questions are at issue, summary judgment is often inappropriate."

Flesner v. Tech. Commc'ns Corp., 410 Mass. 805, 809, 575 N.E.2d 1107, 1110 (1991).

"The essence of wanton or reckless conduct is intentional conduct, by way either of commission or of omission where there is a duty to act, which conduct involves a high degree of likelihood that substantial harm will result to another." *Commonwealth v. Carrillo*, 483 Mass. 269, 275, 131 N.E.3d 812, 819 (2019). In *Commonwealth v. Carrillo*, the SJC rejected the argument that in Massachusetts, "the distribution of heroin alone is sufficient to support a guilty finding of involuntary manslaughter where the heroin causes the user's death." *Id.* at 824. Rather, the SJC noted that "[u]sually wanton or reckless conduct consists of an affirmative act, like driving an automobile or discharging a firearm, in disregard of probable harmful consequences to another . . . and the harm to another person must be substantial, involving death or grave bodily injury." *Id.* at 820.

Here, a genuine issue of material fact exists as to whether the prescribing doctor's conduct is "in disregard of probable harmful consequences to another." For many doctors, prescribing MAID medication is a way to help a terminally ill patient obtain peace of mind, rather than causing harm or death of the patient. Patients interested in MAID seek to avoid intolerable pain or unbearable suffering, and seek the peace of mind that MAID offers. RAIII/170 at ¶ 46. For others, the

availability of MAID boosts the patient's courage to attempt "longshot" therapies that may leave them in even greater suffering if the therapy fails. RAIII/211 at ¶ 8.

Even if a patient could have their pain adequately treated through palliative care, MAID can offer the additional peace of mind that the patient has an exit more consistent with their values should palliative care fail to treat their pain. *Id.* In requesting and prescribing MAID medication, the immediate goal of both patient and physician may be nothing more than to give the patient a greater sense of control over the process of dying, and both may hope that the patient is never forced to take this final step in order to relieve their suffering. RAIII/164-165, RAIII/171 at ¶¶ 32, 49. Indeed, in the jurisdictions where MAID is permitted, many patients who are prescribed MAID medication never take it. RAIII/171 at ¶¶ 48, 49. Thus, the prescribing doctor is not acting in disregard of probable harmful consequences to the patient. Rather, the doctor carefully considers the potential consequences of the prescription and determines that the patient would benefit from having the prescription and the peace of mind it offers. The doctor's action is a result of thoughtful consideration to ensure that MAID is an appropriate option for a specific patient under the medical standard of care. The doctor's actions are not wanton or reckless.

Therefore, the Superior Court erred in denying plaintiffs-appellants' summary judgment motion and granting summary judgment in defendants-

appellees' favor. At the very least, the evidence on the prescribing doctors' considerations in weighing the pros and cons of MAID, which shows the doctors' conduct would not be wonton or reckless, should have precluded the grant of summary judgment in defendants' favor so this issue of fact could be resolved at trial.

B. Common Law Involuntary Manslaughter Is Unconstitutionally Vague As Applied To MAID

A law is unconstitutionally vague and a denial of due process of law "if it fails to provide a reasonable opportunity for a person of ordinary intelligence to know what is prohibited or if it does not provide explicit standards for those who apply it." *Commonwealth v. Jasmin*, 396 Mass. 653, 655, 487 N.E.2d 1383, 1385 (1986).

While the Superior Court ruled that common law manslaughter is not vague as applied to MAID, it cited no judicial explanation that clarified the statute in that context. *Carter II*, 481 Mass. at 354. Nor do the *Carter* cases, which found manslaughter not unconstitutionally vague as applied to Carter, clarify the statute as applied to MAID. In *Carter I*, the SJC found it "important" to specifically state that MAID is "easily distinguishable" from Carter, where there was an allegation of "a systematic campaign of coercion on which the virtually present defendant embarked—captured and preserved through her text messages—that targeted the equivocating young victim's insecurities and acted to subvert his willpower in

favor of her own." 474 Mass. at 636. Finding the defendant in *Carter* was guilty of involuntary manslaughter, the SJC noted that it was "important to articulate what this case is not about…a person offering support, comfort, and even assistance to a mature adult who, confronted with such circumstances [imminent death], has decided to end his or her life." *Id.*

The vagueness of manslaughter as applied to MAID is demonstrated by the differing interpretations of the *Carter* cases by the Superior Court and the defendants. Defendants argued below that *Carter* permits the broad application of the common law of manslaughter to physicians who provide information and counseling on MAID. RAIII/394. In contrast, the Superior Court stated that "the *Carter* decisions were not interpreted to prohibit *speech* associated with physician assisted suicide (e.g., a physician informing a terminally ill patient where MAID is legal or advising the patient to travel to a state where MAID is legal." Addendum 56; RAIII/348 (emphasis original). The fact that the Superior Court and the Defendants on the one hand, and the Attorney General and the District Attorney on the other hand have differing interpretations on whether the common law of manslaughter, as interpreted in *Carter*, applies to MAID speaks volumes. A person of common intelligence, without the benefit of legal training and knowledge possessed by the Superior Court, the Attorney General, or the District

Attorney, would have no hope of discerning whether the common law of manslaughter would apply to the practice of MAID.

The SJC in *Carter I* has not limited its decision to speech associated with MAID as suggested by the Superior Court. Rather, it states the *Carter* case is distinguishable from "a person offering support, comfort, and even ***assistance*** to a mature adult who, confronted with such circumstances, has decided to end his or her life." *Carter I*, 474 Mass. at 636 (emphasis added). Thus, the SJC has not limited its discussion of MAID to the context of speech associated with MAID. Therefore, Plaintiffs maintain that because the SJC did not resolve the applicability of involuntary manslaughter to MAID, common law manslaughter is unconstitutionally vague as applied to MAID because "men of common intelligence must necessarily guess at its meaning."

C. The Superior Court Erred When It Determined That Prohibiting MAID Does Not Implicate A Fundamental Right

The Superior Court held that a prohibition against MAID does not implicate a fundamental right. The Superior Court erred because (1) it failed to recognize there is no meaningful distinction between MAID and other end-of-life options; (2) it failed to consider the SJC's recognition in *Brophy* and *Saikewicz* that an individual has a fundamental right to accept or reject a medical treatment; and (3) it refused to consider the prohibition of MAID as implicating a fundamental right because MAID is not "deeply rooted in this Nation's history and tradition."

First, there is no meaningful distinction between MAID and other end-of-life options. In palliative sedation in the context of end-of-life care, as in MAID, a patient's death is the intended consequence of the course of treatment. RAIII/159 at ¶ 18. While sedation is used in other contexts, such as trauma, burn, postsurgical, and intensive care, in those cases ventilation, hydration, and nutrition are maintained and death is not intended and does not typically result. *Id.* But in the end-of-life context, hydration and nutrition are withheld by design during the administration of palliative sedation, which results in death. RAIII/159-160 at ¶ 19; RAIII/211-212 at ¶ 9. Likewise, death is certain and intended for voluntary stopping of eating and drinking. RAIII/209, RAIII/212-213 at ¶¶ 5, 10.

While Defendants argue that doctors intend that the patient not suffer when they employ permitted remedies, including end-of-life palliative sedation, the same is true for MAID—the doctor's intent is that the patient not suffer. RAIII/212-213 at ¶ 10; *see also supra* pp. 19-20. In end-of-life palliative sedation to unconsciousness (when the patient declines fluids and a ventilator), removal of life support, and VSED—all of which are legal in Massachusetts—the physician performs an action to assist the patient in reaching the unavoidable result of death and the physician knows that her assistance will result in the patient's death. RAIII/210-211, RAIII/212-213 at ¶¶ 7, 10. The intent of the doctor and the patient

do not distinguish MAID from palliative sedation and other permissible remedies. RAIII/212-213 at ¶ 10.

Nor is MAID distinguishable from end-of-life palliative sedation by the degree of medical intervention. In undergoing palliative sedation, patients do not merely "reject treatment"—palliative sedation "usually requires a subcutaneous or intravenous infusion and intensive involvement by the health care team for observation, monitoring, and support." RAIII/158 at ¶ 16. Criminalizing MAID, therefore, treats patients seeking MAID differently from patients seeking other end-of-life options without justification.

Second, although the SJC has not decided a case involving MAID, Massachusetts has long recognized a terminally ill patient's fundamental right to make her own medical decisions, even if such decisions result in death. For example, in *Superintendent of Belchertown State Sch. v. Saikewicz*, the SJC confirmed that a patient's right to refuse medical treatment was grounded in her right to "human dignity and self-determination." 373 Mass. 728, 370 N.E.2d 417, 424 (1977). Similarly, in *Brophy v. New England Sinai Hosp., Inc.*, the SJC again found that restricting a patient's right to refuse medical treatment impacted the "fundamental principles of individual autonomy." 398 Mass. 417, 430-431, 497 N.E.2d 626, 633 (1986). The Court explained that a person has the right "to make

[his] own decision to ***accept or reject*** treatment, whether that decision is wise or unwise." *Id.* at 430 (citations omitted, emphasis added).

The Superior Court held that the *Brophy* decision "signal[s] that the SJC, if directly faced with the issue, would . . . maintain[] a strong distinction between MAID, and the withdrawal of treatment and palliative care." Addendum 63; RAIII/355 at 17. In concluding this, the Superior Court cited to a footnote in *Brophy*, which notes that individuals do not have "unlimited self-determination" or an "unqualified free choice over life." But MAID does not ask the court to grant a person this broad right. As made clear in Plaintiffs' Motion for Partial Summary Judgment, the question in this case is very narrow—"whether a doctor who determines, according to accepted medical standards, that her adult, terminally ill patient is mentally competent may, at her patient's request, prescribe medication that her patient can self-ingest to hasten the time of their death." RAIII/369. Terminally ill patients have few choices—they face certain death within a short while from an existing, incurable illness. *See* RAIII/369-370 at 1-2. The only choice at issue is the choice of medical treatment during this irreversible dying process.

Third, the Superior Court refused to find that the prohibition on MAID implicates on a fundamental right because a "fundamental right is one that is deeply rooted in this Nation's history and tradition." But if "history and tradition"

governed what constitutes a fundamental right, interracial and same-sex marriages would still be illegal. "For decades, indeed centuries, in much of this country (including Massachusetts) no lawful marriage was possible between white and black Americans." *Goodridge v. Dep't of Pub. Health*, 440 Mass. 309, 327, 798 N.E.2d 941, 958 (2003). And history and tradition have not only prohibited, but often criminalized, same-sex relationships. *See Obergefell v. Hodges*, 576 U.S. 644, 650-656, 663 (2015). Nevertheless, restrictions against interracial and same-sex marriage impinged on fundamental rights. *See id.*; *Loving v. Virginia*, 388 U.S. 1, 12 (1967). "History and tradition . . . do not set [the] outer boundaries" of fundamental rights, and "individuals who are harmed need not await legislative action before asserting a fundamental right." *Obergefell*, 576 U.S. at 644, 648. While the Superior Court acknowledged that rights to same-sex marriage arise "from a better informed understanding of how constitutional imperatives define a liberty that remains urgent in our own era," it refused to recognize that the prohibition of MAID violates a terminally ill patients' fundamental right of self-determination. *Id.* at 671-672.

The same rationale applies to this case—irrespective of tradition and legislative history, Massachusetts's purported prohibition of MAID violates a terminally ill patients' fundamental right of self-determination. Massachusetts has recognized that terminally ill patients may avoid prolonged suffering during the

dying process, even if their decisions may hasten death. *See, e.g.*, *Saikewicz*, 373 Mass. at 742 ("The interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation."); *Brophy*, 398 Mass. at 430-31 ("It is in recognition of these fundamental principles of individual autonomy that we sought, in *Saikewicz*, to shift the emphasis away from a paternalistic view of what is 'best' for a patient toward a reaffirmation that the basic question is what decision will comport with the will of the person involved….").

Therefore, because Massachusetts's purported prohibition against MAID restricts patients' choices against their will, it implicates the fundamental right of self-determination and individual autonomy in the context of end-of-life medical care. *See id.*

D. The Trial Court Erred In Determining That The Commonwealth's Purported Prohibition On MAID Meets The Rational Basis Test For Both Due Process And Equal Protection

For due process claims, rational basis analysis requires that statutes "bear[] a real and substantial relation to the public health, safety, morals, or some other phase of the general welfare." *Goodridge*, 440 Mass. at 330 (citation omitted). For equal protection challenges, the rational basis test requires that "an impartial lawmaker could logically believe that the classification would serve a legitimate public purpose that transcends the harm to the members of the disadvantaged

class." *Id.* Even if the rational basis standard applies, Massachusetts's common law prohibition of MAID would not pass for either due process or equal protection.

As an initial matter, involuntary manslaughter in Massachusetts is a common law crime, and therefore there cannot be any legislative intent. The legislature also has not passed any statute specifically applying the common law crime of involuntary manslaughter to MAID. The Superior Court, therefore, erred by arbitrarily ascribing a legislative rationale where none exists.

Even if, for the sake of argument, it were permissible to ascribe some hypothetical legislative intent to a common law crime, the Superior Court's rationale is flawed. First, the Superior Court erred in finding that the Legislature could rationally conclude that difficulty in determining and ensuring that a patient is "mentally competent" warrants the continued prohibition of MAID. Addendum 66; RAIII/358 at 20. Competency could easily be determined by the patient's doctor because treating physicians are frequently called upon to determine competency of their patients for guardianship and other legal proceedings. MAID should be no different.

The Superior Court first noted that many patients faced with a diagnosis of terminal illness are depressed. But patients who are depressed may nevertheless continue to be competent. Depression is a spectrum from sadness to psychotic

depression, and it is possible for a patient to feel depressed without being suicidal.[2] RAIII/220 at ¶ 25. More important, however, physicians routinely evaluate patients for depression under the current standard of care when handling existing end-of-life care, including patient requests to discontinue life support. RAIII/169 ¶ 44. This holds true for MAID. In the State of Oregon, the physician must also refer the patient to another physician who will confirm the relevant diagnosis, including the patient's mental competence before prescribing MAID medication. Or. Rev. Stat. §127.800-.897. Addendum 71-119.

As to the measurement of competence at the moment of self-ingestion, no other self-ingested prescriptions written by physicians in the Commonwealth bear this requirement. Such a requirement would be inconsistent with the concept of "self-ingestion." Physicians routinely write prescriptions for medications with instructions for self-ingestion which, if taken against the instructions of the physician or pharmacist, could cause serious harm or death. Physicians are not present to monitor whether the patient is competent when they take their medications. Physicians make those determinations when the prescription is written, and upon further check-ups and examinations. That is what the standard

[2] Being depressed at the prospect of dying is not the same as being unable to make medical decisions for oneself.

of care requires. Thus, it is irrational to create a new, additional requirement for self-ingested MAID prescriptions in the Commonwealth.

Second, the Superior Court found that the Legislature could rationally conclude that predicting when a patient has six months to live is too difficult and risky for MAID. Addendum 67; RAIII/359. The Superior Court erred, first because the applicable laws are not statutes enacted by the Legislature. Moreover, this argument does not provide a rational basis for distinguishing between MAID and other permissible end-of-life options, such as VSED and palliative sedation. Each jurisdiction, including Massachusetts, has an established medical standard of care for diagnosing terminal illness. RAIII/177-178 at ¶ 64. And important medical decisions, including life and death decisions, are made based on these diagnoses. RAIII/217 at ¶ 19. In hospice, for example, there is a long tradition of using a definition of terminal illness of six months or less. RAIII/177-178 at ¶ 64. Physicians currently may determine when patients are eligible for palliative sedation. Physicians are accustomed to making these determinations and those physicians who deal most frequently with terminally ill patients—such as oncologists and palliative care doctors—are especially adept at making these determinations. RAIII/217 at ¶ 19. And most importantly, nothing requires a physician to offer MAID if they cannot reasonably determine that the patient is likely to die in the near future. But when that determination can be made, the

Commonwealth allows for the decision to administer palliative sedation—so too should the Commonwealth allow MAID as one option provided to the patient. Moreover, in all jurisdictions that allow MAID, the physician must also refer the patient to another physician to confirm the terminal diagnosis before prescribing MAID medication. *See,* e.g., Or. Rev. Stat. §127.800-.897. Addendum 71-119. The fact that physicians cannot predict with absolute certainty when a particular patient will die is not an impediment to allow other end-of-life options, and it is not a sufficient reason to justify denial of MAID. RAIII/217 at ¶ 19.

Third, the Superior Court found that the Legislature could rationally conclude that a general medical standard of care cannot protect those seeking MAID. Addendum 67; RAIII/359. The Superior Court first noted that the Commonwealth put forward expert testimony that MAID "is neither a medical treatment nor a medical procedure and thus there can be no applicable medical standard of care. *See id*. This expert testimony, however, conflicts with the fact that in all jurisdictions where MAID is authorized, only medical personnel are authorized to prescribe MAID medication. If MAID were not a medical treatment, then anyone could order MAID medication, which is plainly not the case.

The Superior Court further held that regulating MAID is difficult even where statutory standards are in place. Addendum 68; RAIII/360. But the Commonwealth offered no evidence that the specific authorization of MAID in

other jurisdictions has contributed to a decline in the "ethical integrity of the medical profession." *Custody of a Minor*, 375 Mass. 733, 754-55, 379 N.E.2d 1053, 1065-66 (1978); *see Goodridge*, 440 Mass. at 334 (rejecting bare assertion without evidence that forbidding same sex marriage would increase the number of couples entering heterosexual marriages to have children). There is no evidence from Oregon or the other states where MAID is permitted that the medical profession has suffered. MAID is ethically similar to other legal means of respecting a patient's wishes, such as withdrawal of life-sustaining treatment, VSED, or palliative sedation even though doing so hastens the time of death. RAIII/165 at ¶ 33. In fact, doing nothing until patients develop intolerable pain or other forms of unbearable suffering is viewed by many as the inhumane and unethical option. RAIII/170 at ¶ 46.

Last, the Superior Court held that the Legislature (which, again, has not enacted any statutes here applicable) could rationally conclude that MAID is not equivalent to permissible alternatives. Summary Judgement Order at 22. The Superior Court erred because there is no meaningful distinction between MAID and the other end of life options.

The Superior Court noted that VSED and withdrawal of life support differ from MAID because both VSED and withdrawal of life support concern the right to discontinue unwanted treatment and the physicians do not necessarily act to

cause the patient's death. *See id.* But in VSED and withdrawal of life support, the physician performs an action to assist the patient in reaching the unavoidable result of death and the physician knows that her assistance will result in the patient's death. RAIII/210-213 at ¶¶ 7, 10. Thus, the intent of the doctor and the patient do not distinguish MAID from VSED and withdrawal of life support. RAIII/212-213 at ¶ 10.

The Superior Court further noted that palliative sedation differs from MAID because it does not necessarily involve an intent to shorten life nor does it necessarily cause or hasten death. Summary Judgement Order at 22. But the same can be said of MAID—the intent of the physician is to alleviate suffering, not that his patient die. Statistics show that in over 30% of MAID prescriptions the medication does not hasten death because the patient does not take the medication. Simply having the prescription on hand provides peace of mind that the patient will not suffer. And where the patient elects to ingest the MAID medication there still is no real distinction from palliative sedation because in both cases the physician understands that the patient's death would be hastened. Patients choose to refuse life support and undergo palliative sedation with the specific intent of bringing about their death. RAIII/159 at ¶ 18; RAIII/212-213 at ¶ 10. And "[t]here is broad agreement that physicians must respect such refusals, even when the patient's intention is to die." RAIII/212-213 at ¶18. Doctors and their staff take specific

actions to facilitate the resulting death. "Continuous sedation usually requires a subcutaneous or intravenous infusion and intensive involvement by the health care team for observation, monitoring, and support." RAIII/158at ¶ 16. An impartial lawmaker would well understand that doctors engaged in palliative sedation understand that their actions are intended to hasten their patients' death. RAIII/212-213 at ¶ 10. Thus, there is no logical distinction between the intents and purposes behind end-of-life palliative sedation and MAID.

The Superior Court further noted that palliative sedation may be conducted in such a fashion as to ensure that the underlying disease, not the sedation causes death. This is not true. Sedation is used in other contexts, such as trauma, burn, postsurgical, and intensive care. RAIII/157 at ¶ 13. In those contexts, ventilation, hydration, and nutrition are maintained and obviously death is not intended. RAIII211-212 at ¶ 9. But in the end-of-life context—which is what this action is all about—hydration and nutrition are withheld during the administration of palliative sedation. *Id.* It is "implausible" in those circumstances to claim that death is unintended, or that the continuous administration of sedation would not alter the timing or mechanism of death. RAIII/159-160 at ¶ 19. Rather, death is certain, and in most cases caused by a mechanism (e.g., dehydration) different from the underlying disease (e.g., cancer). *Id.*

Thus, there is no logical distinction between palliative sedation and MAID

because both involves actions taken by a medical professional that likely alter the timing and mechanism of a terminally ill patient's death. Even if a statutory prohibition existed it would be irrational and illogical for an impartial legislator to refuse to offer MAID on the grounds that some people who undergo palliative sedation (in a different context) do not die. RAIII/211-212 at ¶¶ 9-10.

The Superior Court further held that other end of life alternatives differ from MAID because they occur in hospitals or other institutions devoted to medical treatment so they potentially involve less risk than MAID. But this assertion is factually incorrect because most hospice care is administered at home. Moreover, the Commonwealth offered no evidence that the legalization of MAID in other jurisdictions has caused more risks than other end of life alternatives. The fact that MAID does not occur in hospitals does not make it rational for the Court to ignore the equal protection violation suffered by Plaintiffs.

Therefore, the trial court erred in determining that the Commonwealth's prohibition on MAID meets the rational basis test for both due process and equal protection.

VI. Conclusion

For the foregoing reasons, this Court should reverse the judgment of the Superior Court.

DR. ROGER M. KLIGLER AND DR. ALAN STEINBACH

By their attorneys,

Date: May 10, 2021

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RULE 16(K) CERTIFICATION

The undersigned hereby certifies that this brief complies with the rules of court that pertain to the filing of briefs, including but not limited to Mass. R. App. P. 16(a)(6)(pertinent findings or memorandum of decision); Mass. R. App. P. 16(e) (references in briefs to the record); Mass. R. App. P. 16(f) (reproduction of statutes, rules and regulations), Mass. R. App. P. 16(h) (length of briefs); Mass. R. App. P. 18 (appendix to the briefs); and Mass. R. App. P. 20 (forms of briefs, appendices, and other papers).

This brief complies with Mass. R. App. P. 20(a)(2)(A) because it has been produced in proportionally spaced typeface using Times New Roman 14-point font and, excluding the parts of the document exempt by Mass. R. App. P. 20(a)(2)(D), contains 8,386 words.

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COMMONWEALTH OF MASSACHUSETTS

APPEALS COURT

No. 2021-P-0156

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

Appellants (Plaintiffs Below),

v.

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

Appellees (Defendants Below),

CERTIFICATE OF SERVICE

I, Jonathan M. Albano, hereby certify that on May 10, 2021, I caused the foregoing Brief of Appellant to be served electronically by means provided by the clerk, and by e-mail, to counsel of record for appellees:

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ADDENDUM

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NOTIFY

COMMONWEALTH OF MASSACHUSETTS

SUFOLK, ss.

SUPERIOR COURT
CIVIL ACTION
NO. 2016-03254-F

ROGER KLIGLER & another[1]

vs.

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

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

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

[1] Dr. Alan Steinbach.

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

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

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

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

BACKGROUND

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

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

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

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

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

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

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

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

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

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

DISCUSSION

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Vagueness (Count II)

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

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

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

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

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

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

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

C. Freedom of Speech (Count V)

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

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

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

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

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

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

1. *Standard of Review*

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

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

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

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

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

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

> First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication. . . . Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them. . . . The same is true when a doctor provides aggressive palliative care; in some cases, pain killing drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, must, necessarily and indubitably, intend primarily that the patient be made dead. . . . Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not. . . . The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. . . . Put differently, the law distinguishes actions taken because of a given end from actions taken in spite of their unintended but foreseen consequences.

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

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

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

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

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

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

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

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

> In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death. . . . Furthermore, the underlying State interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.

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

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

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

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

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

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

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

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

2. *Rational Basis Analysis*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Conclusion

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

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

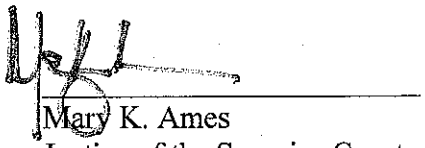
plaintiffs have presented several strong arguments for making MAID a legal option for those suffering from terminal illness, there are equally strong arguments for prohibiting MAID or ensuring that MAID occurs in an environment in which clear, thoughtful, and mandatory standards are in place to protect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

ORDER

For the forgoing reasons:

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

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



Mary K. Ames
Justice of the Superior Court

Dated: December 31, 2019

West's Oregon Revised Statutes Annotated
Title 13. Protective Proceedings; Powers of Attorney; Trusts
Chapter 127. Powers of Attorney; Advance Directives for Health Care; Physicians Orders for Life-Sustaining Treatment Registry; Declarations for Mental Health Treatment; Death with Dignity
the Oregon Death with Dignity Act
(General Provisions) (Section 1)

O.R.S. T. 13, Ch. 127, Refs & Annos
Currentness

O. R. S. T. 13, Ch. 127, Refs & Annos, OR ST T. 13, Ch. 127, Refs & Annos
Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

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the Oregon Death with Dignity Act (Refs & Annos)
(General Provisions) (Section 1) (Refs & Annos)

O.R.S. § 127.800

127.800. § 1.01. Definitions [1]

Currentness

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

(1) “Adult” means an individual who is 18 years of age or older.

(2) “Attending physician” means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) “Capable” means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

(4) “Consulting physician” means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(5) “Counseling” means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor licensed to practice medicine under ORS 677.100 to 677.228.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

Credits

Laws 1995, c. 3, § 1.01; Laws 1999, c. 423, § 1; Laws 2017, c. 409, § 3, eff. Jan. 1, 2018.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.800, OR ST § 127.800

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

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the Oregon Death with Dignity Act (Refs & Annos)
(Written Request for Medication to End One's Life in a Humane and Dignified Manner) (Section 2)

O.R.S. § 127.805

127.805. § 2.01. Who may initiate a written request for medication [1]

Currentness

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability.

Credits

Laws 1995, c. 3, § 2.01; Laws 1999, c. 423, § 2.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.805, OR ST § 127.805

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th

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O.R.S. § 127.810

127.810. § 2.02. Form of the written request [1]

Currentness

(1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services by rule.

Credits

Laws 1995, c. 3, § 2.02.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.810, OR ST § 127.810

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

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(Safeguards) (Section 3)

O.R.S. § 127.815

127.815. § 3.01. Attending physician responsibilities [1]

Effective: January 1, 2020
Currentness

(1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the time the patient makes the patient's second oral request pursuant to ORS 127.840;

(i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of ORS 127.855;

(k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(L)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Oregon Medical Board, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or

(B) With the patient's written consent:

(i) Contact a pharmacist and inform the pharmacist of the prescription; and

(ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's report of death.

Credits

Added by Laws 1995, c. 3, § 3.01. Amended by Laws 1999, c. 423, § 3; Laws 2013, c. 366, § 62, eff. June 13, 2013, operative Jan. 1, 2014; Laws 2019, c. 624, § 1, eff. Jan. 1, 2020.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.815, OR ST § 127.815

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the Oregon Death with Dignity Act (Refs & Annos)
(Safeguards) (Section 3)

O.R.S. § 127.820

127.820. § 3.02. Consulting physician confirmation [1]

Currentness

Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.

Credits

Laws 1995, c. 3, § 3.02.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.820, OR ST § 127.820

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127.820. § 3.02. Consulting physician confirmation [FN 1], OR ST § 127.820

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(Safeguards) (Section 3)

O.R.S. § 127.825

127.825. § 3.03. Counseling referral [1]

Currentness

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

Credits

Laws 1995, c. 3, § 3.03; Laws 1999, c. 423, § 4.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.825, OR ST § 127.825

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die

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(Safeguards) (Section 3)

O.R.S. § 127.830

127.830. § 3.04. Informed decision [1]

Currentness

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision.

Credits
Laws 1995, c. 3, § 3.04.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.830, OR ST § 127.830
Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

127.830. § 3.04. Informed decision [FN 1], OR ST § 127.830

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(Safeguards) (Section 3)

O.R.S. § 127.835

127.835. § 3.05. Family notification [1]

Currentness

The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

Credits

Laws 1995, c. 3, § 3.05; Laws 1999, c. 423, § 6.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.835, OR ST § 127.835

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127.835. § 3.05. Family notification [FN 1], OR ST § 127.835

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(Safeguards) (Section 3)

O.R.S. § 127.840

127.840. § 3.06. Written and oral requests [1]

Effective: January 1, 2020
Currentness

(1) In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than 15 days after making the initial oral request.

(2) Notwithstanding subsection (1) of this section, if the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to his or her attending physician at any time after making the initial oral request.

(3) At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

Credits
Added by Laws 1995, c. 3, § 3.06. Amended by Laws 2019, c. 624, § 2, eff. Jan. 1, 2020.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.840, OR ST § 127.840

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

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(Safeguards) (Section 3)

O.R.S. § 127.845

127.845. § 3.07. Right to rescind request [1]

Currentness

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

Credits
Laws 1995, c. 3, § 3.07.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.845, OR ST § 127.845
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127.845. § 3.07. Right to rescind request [FN 1], OR ST § 127.845

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(Safeguards) (Section 3)

O.R.S. § 127.850

127.850. § 3.08. Waiting periods [1]

Effective: January 1, 2020
Currentness

(1) No less than 15 days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897.

(2) Notwithstanding subsection (1) of this section, if the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die before the expiration of at least one of the waiting periods described in subsection (1) of this section, the prescription for medication under ORS 127.800 to 127.897 may be written at any time following the later of the qualified patient's written request or second oral request under ORS 127.840.

Credits
Added by Laws 1995, c. 3, § 3.08. Amended by Laws 2019, c. 624, § 3, eff. Jan. 1, 2020.

Footnotes

1 Section title supplied by initiative petition.
O. R. S. § 127.850, OR ST § 127.850

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(Safeguards) (Section 3)

O.R.S. § 127.855

127.855. § 3.09. Medical record documentation requirements [1]

Effective: January 1, 2020
Currentness

The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) Any medically confirmed certification of the imminence of the patient's death;

(7) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and

(8) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

Credits

Added by Laws 1995, c. 3, § 3.09. Amended by Laws 2019, c. 624, § 4, eff. Jan. 1, 2020.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.855, OR ST § 127.855

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O.R.S. § 127.860

127.860. § 3.10. Residency requirement [1]

Currentness

Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:

(1) Possession of an Oregon driver license;

(2) Registration to vote in Oregon;

(3) Evidence that the person owns or leases property in Oregon; or

(4) Filing of an Oregon tax return for the most recent tax year.

Credits
Laws 1995, c. 3, § 3.10; Laws 1999, c. 423, § 8.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.860, OR ST § 127.860

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(Safeguards) (Section 3)

O.R.S. § 127.865

127.865. § 3.11. Reporting requirements [1]

Currentness

(1)(a) The Oregon Health Authority shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The authority shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the authority.

(2) The authority shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The authority shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section.

Credits

Laws 1995, c. 3, § 3.11; Laws 1999, c. 423, § 9; Laws 2001, c. 104, § 40; Laws 2009, c. 595, § 89, eff. June 26, 2009.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.865, OR ST § 127.865

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

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the Oregon Death with Dignity Act (Refs & Annos)
(Safeguards) (Section 3)

O.R.S. § 127.870

127.870. § 3.12. Effect on construction of wills, contracts and statutes [1]

Currentness

(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner.

Credits
Laws 1995, c. 3, § 3.12.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.870, OR ST § 127.870
Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020;

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(Safeguards) (Section 3)

O.R.S. § 127.875

127.875. § 3.13. Insurance or annuity policies [1]

Currentness

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.

Credits

Laws 1995, c. 3, § 3.13.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.875, OR ST § 127.875

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die

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the Oregon Death with Dignity Act (Refs & Annos)
(Safeguards) (Section 3)

O.R.S. § 127.880

127.880. § 3.14. Construction of Act [1]

Currentness

Nothing in ORS 127.800 to 127.897 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. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.

Credits
Laws 1995, c. 3, § 3.14.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.880, OR ST § 127.880
Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

127.880. § 3.14. Construction of Act [FN 1], OR ST § 127.880

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the Oregon Death with Dignity Act (Refs & Annos)
(Immunities and Liabilities) (Section 4)

O.R.S. § 127.885

127.885. § 4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions [1]

Currentness

Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a

new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS 127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (3), (4), (5) or (6).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community.

Credits

Laws 1995, c. 3, § 4.01; Laws 1999, c. 423, § 10; Laws 2003, c. 554, § 3.

Footnotes

1 Section title editorially revised by Legislative Counsel in 2019.

O. R. S. § 127.885, OR ST § 127.885

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

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(Immunities and Liabilities) (Section 4)

O.R.S. § 127.890

127.890. § 4.02. Liabilities [1]

Currentness

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897.

Credits
Laws 1995, c. 3, § 4.02.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.890, OR ST § 127.890

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

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(Immunities and Liabilities) (Section 4)

O.R.S. § 127.892

127.892. Claims by governmental entity for costs incurred

Currentness

Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to the provisions of ORS 127.800 to 127.897 in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim.

Credits
Laws 1999, c. 423, § 5a.

O. R. S. § 127.892, OR ST § 127.892
Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

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(Severability) (Section 5)

O.R.S. § 127.895

127.895. § 5.01. Severability [1]

Currentness

Any section of ORS 127.800 to 127.897 being held invalid as to any person or circumstance shall not affect the application of any other section of ORS 127.800 to 127.897 which can be given full effect without the invalid section or application.

Credits
Laws 1995, c. 3, § 5.01.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.895, OR ST § 127.895
Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

127.895. § 5.01. Severability [FN 1], OR ST § 127.895

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the Oregon Death with Dignity Act (Refs & Annos)
(Form of the Request) (Section 6)

O.R.S. § 127.897

127.897. § 6.01. Form of the request [1]

Currentness

A request for a medication as authorized by ORS 127.800 to 127.897 shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from , which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.....

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Is not a patient for whom either of us is attending physician.

_____ Witness 1/Date

_____ Witness 2/Date

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

Credits

Laws 1995, c. 3, § 6.01; Laws 1999, c. 423, § 11.

Footnotes

1 Section title supplied by initiative petition.

O. R. S. § 127.897, OR ST § 127.897

Current through laws enacted in the 2020 Regular Session of the 80th Legislative Assembly, which adjourned sine die March 3, 2020; laws enacted in the First Special Session of the 80th Legislative Assembly, which adjourned sine die June 26, 2020; laws enacted during the Second Special Session of the 80th Legislative Assembly, which adjourned sine die August 10, 2020; ballot measures approved by the electorate in the November 3, 2020 General Election; and laws enacted in the Third Special Session of the 80th Legislative Assembly, which adjourned sine die December 21, pending classification of undesignated material and text revision by the Oregon Reviser. See ORS 173.160.

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