Review of Massachusetts House Bill H.2381 and Senate Bill S. 1384

***Overview*:**

Neither the Massachusetts constitution nor the U.S. Constitution contains a right to assisted suicide; therefore, no individual has the right to authorize another to kill him or her in violation of federal and state criminal laws. *Washington v. Glucksberg*, 521 U.S.702, 735 (1997). Instead, Massachusetts has an "unqualified interest in the preservation of human life." *Id.* at 728. Under Massachusetts common law, assisting a suicide is a form of homicide, and the criminalization of the practice "both reflects and advances [a] commitment to [preserving and protecting human life]." *Id.* at 735.

Importantly, suicide, including physician-assisted suicide, is not a typical reaction to an acute problem or life circumstance, and many individuals who contemplate suicide, including the terminally ill, suffer from clinical depression or other treatable emotional or mental issues, which frequently go undiagnosed and untreated by physicians. *See, e.g.*, New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide And Euthanasia In The Medical Context 77-82 (May 1994). For this reason and many others, the medical profession as a whole opposes physician-assisted suicide because it is contrary to the medical profession's role as healer and undermines the physician-patient relationship. *Washington v. Glucksberg*, 521 U.S. at 731.

Massachusetts House Bill H. 2381 and Senate Bill S. 1384 seek to obliterate the state's "unqualified interest" in protecting and preserving human life, including the lives of the vulnerable, sick, and disabled. Instead, the bill erroneously accepts a "sliding-scale approach" that claims certain "qualities of life" are not worthy of equal legal protection. *Id.* at 729.

Rather than legalizing physician-assisted suicide, Massachusetts should consider legislation to statutorily define assisting a suicide as a crime, building upon existing common law and better protecting vulnerable citizens.

Specific Concerns with S. 1384 and H. 2381:

The bills purport to provide a legal mechanism under which certain patients are able to request assistance from a physician in committing suicide. This usually involves the prescription of lethal medications that patients will "self-administer." There are many, significant problems with the bills' language that endanger the vulnerable, sick, and disabled.

• Dangerous Policy Decision to Decriminalize Physician-Assisted Suicide: Recognizing its "unqualified interest" in preserving and protecting all human life, Massachusetts common law[1] prohibits assisted suicide. In Massachusetts, assisting suicide is considered a form of involuntary manslaughter.[2]

H. 2381 and S. 1384 decriminalize physician-assisted suicide, deceptively reclassifying it as accepted medical treatment. Rather than permitting physician-assisted suicide, Massachusetts should enact a specific criminal statute prohibiting the practice.

• Broad Definition of "Terminal Condition": To qualify for physician-assisted suicide under H. 2381 and S. 1384, a patient must have a "terminal condition." However, the bills' definition of "terminal condition" is incredibly broad. For example, the bills specifically provide that a "terminal condition" covers both situations where death will occur within 6 months even with treatment and situations where death would not likely occur if the patient sought and received treatment. This means that someone who has a treatable disease or condition

1 Common law, also known as case law, is a body law based on legal precedents established by the courts. Common law typically draws from opinions and interpretations from judicial authorities and public juries.

2 Involuntary manslaughter involves "intentional conduct, either by way 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." *See Commonwealth v. Catalina*, 407 Mass. 779, 789 (1990). Writing a prescription for a lethal medication "is an intentional act that, given its very purpose, is highly likely to result in death." *Kligler v. Healey*, No. 2016-03254-F (Sufolk Sup. Ct. Dec. 31, 2019) (refusing to declare a legal right to physician-assisted suicide and reaffirming that a physician assisting a suicide is subject to involuntary manslaughter charges), available at https://d279m997dpfwglcloudfront.net/wp/2020/01/Superior-Court-Decision-Order%5E12-31-19.pdf.

(e.g., diabetes) who refuses treatment or who is denied insurance coverage for certain treatments is eligible to request and receive lethal drugs.

• Lack of Meaningful Mental Health Evaluation: Under H. 2381 and S. 1384, a physician must refer a patient to "counseling to determine that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment." A licensed mental health professional is required to review the medical history of the patient relevant to the patient's current mental health … and [to] … submit a final written report" to the referring physician. There is no statutory requirement that the mental health professional actually meet with the patient or that the requisite "counseling" take place in person.

The bills do not contain an affirmative requirement that a patient requesting physician-assisted suicide undergo a complete mental health evaluation or be treated for any diagnosed psychiatric or psychological disorder. Instead, the purpose of the counseling is simply to determine if the patient is suffering from "impaired judgment" or is being subject to "coercion." Neither "impaired judgment" or "coercion" is defined by the bills, rendering these purported limitations on receiving lethal medications suspect.

Evidence suggests that many patients whose mental health concerns are properly diagnosed and treated change their minds about suicide. For example, in one study of assisted suicide in Oregon, 46% of patients seeking assisted suicide changed their minds when their physicians intervened and appropriately addressed suicidal ideations by treating their pain, depression, and/or other medical problems. Linda Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act," 342 New Eng. J. Med. 557, 557 (2000).

Concerns with Process for Requesting Lethal Medication:

• *No Requirement for In-Person Consultations*: The bills do not require that the oral or written requests for assisted suicide, any medical consultations, or even the mental health counseling take place during in-person meetings or consultations. The bills require a patient to make a written request for lethal medication, witnessed by two others. But there is no explicit requirement that the written request be presented in-person to the prescribing physician. This opens the door to the inappropriate use of "telemedicine" for these requests and consultations, increasing opportunities for coercion of the patient and for abuse of the process.

• *Bills Do Not Protect Against Coercion and Undue Influence*: The bills' provisions do not adequately protect patients from coercion or undue influence, using the terms but failing to define them and prescribing inadequate screening for them. This dangerous oversight allows coercion or undue influence to occur unchecked to the detriment of the vulnerable patients.

• *Witnesses to Written Request Can Have Conflicts of Interest*: The bills require that the patient's written request for physician-assisted suicide be witnessed by two persons. One of the witnesses can be a relative, heir, or someone with a claim to the patient's estate. There are also no requirements that the second witness (who is not a relative or heir) be completely independent and unrelated to either the patient or the other witness. This could easily result in abuses. For example, the second witness could be a friend of a person who stands to benefit financially from the patient's death.

• No Oversight of Lethal Drug Administration: H. 2381 and S. 1384 do not require that the prescribing physician be present when the lethal medication is ingested to ensure the patient's voluntary decision/action or to deal with possible complications. In fact, there is no requirement that any witness attest to the patient's physical or mental capacity when the drugs are ingested, to confirm that the drugs were actually self-administered (as required), or to confirm that the patient's decision was voluntary.

• H. 2381 and S.1384 Repeatedly Perpetuate and Engage in Dangerous Falsehoods: Attempting to maintain the fiction that physician-assisted suicide is legitimate medical treatment, the bills assert that "[a] qualified patient's act of self-administering medication obtained pursuant [the bills] shall not constitute suicide." The also decree that "state regulations, documents and reports shall not refer to the practice of aid in dying under this chapter as 'suicide' or 'assisted suicide.'"

The bills also specifically provide that, despite the patient ending his/her life by suicide, "the patient's death certificate … shall list the underlying terminal disease as the cause of death."

• The Bills Compromise Constitutional and Conscience Rights: Section 15(b) provides that a healthcare "professional organization or association may not subject an individual to … loss of membership … for participating … in providing [lethal] medication." A "professional organization or association" will not be able to limit its membership to those who do not support or participate in assisted suicide or require that its members affirm its opposition to the practice. Under this provision, for example, a Catholic medical association that publicly holds to the Church's teaching on the sanctity of life cannot exclude from membership physicians who actively participate in assisted suicides. This provision violates both the First Amendment right to free association and medical conscience rights.

While H. 2381 and S. 1384 purport to affirm the right of healthcare providers to decline to participate in assisted suicide, they require an objecting healthcare provider to furnish patients with certain "consumer disclosures"—an impermissible form of compelled speech. These disclosures include describing "the mechanism the provider will use to provide patients a referral to another provider who is willing to" provide lethal medication" and describing "the provider's policies and procedures relating to transferring patients to other providers who will implement" the prescribed process for providing lethal medication. Such disclosures and referrals may violate the consciences of some healthcare providers and should not be mandated.

1 Common law, also known as case law, is a body law based on legal precedents established by the courts. Common law typically draws from opinions and interpretations from judicial authorities and public juries. • **2** Involuntary manslaughter involves "intentional conduct, either by way 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." See Commonwealth v. Catalina, 407 Mass. 779, 789 (1990). Writing a prescription for a lethal medication "is an intentional act that, given its very purpose, is highly likely to result in death." Kligler v. Healey, No. 2016-03254-F (Sufolk Sup. Ct. Dec. 31, 2019) (refusing to declare a legal right to physician-assisted suicide and reaffirming that a physician assisting a suicide is subject to involuntary manslaughter charges), available at https://d279m-997dpfwglcloudfront.net/wp/2020/01/Superior-Court-Decision-Order%5E12-31-19.pdf.