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Give Me Liberty at My Death: Expanding End-of-Life Choice in Massachusetts

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Give Me Liberty at My Death: Expanding End-of-Life Choice in Massachusetts

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I. INTRODUCTION

Modern medicine can extend the dying process so long that a terminally ill patient may feel trapped in a torturous, inexorable, lingering decline.¹ Sometimes the process takes too long and the suffering is unbearable. Some patients want to achieve a swifter, gentler end by ingesting medications prescribed to bring about a peaceful death, an option known as “aid in dying.”² This refers to the practice of a physician prescribing medication to a mentally competent, terminally ill patient that the patient may ingest to bring about a peaceful death.³ Having such a prescription in and of itself has a palliative effect. Many patients who obtain a prescription experience elevated mood and enhanced quality of life, and therefore never choose to fill it or ingest the life-ending medication.⁴

Enacting legislation to create an affirmative permission for aid in dying is difficult and has been achieved to date in just three states: Oregon (1994), Washington (2008)—both via ballot measures—and, most recently, in Vermont (2013) via the legislative process.⁵ In Montana, the state supreme court recognized that its citizens may freely choose aid in dying without a statute specifically authorizing the practice.⁶ On the other hand, several states have passed legislation specifically outlawing aid in

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1. See, e.g., Atul Gawande, *Letting Go: What Should Medicine Do When It Can't Save Your Life?*, NEW YORKER (Aug. 2, 2010), http://www.newyorker.com/reporting/2010/08/02/100802fa_fact_gawande (“For all but our most recent history, dying was typically a brief process. . . . These days, swift catastrophic illness is the exception; for most people, death comes only after long medical struggle with an incurable condition.”).
 2. This term is becoming widely accepted by organizations, including the American Medical Women’s Association, the American Medical Students’ Association, and the American Public Health Association, among others. In the past, this option was sometimes referred to as “physician assisted suicide,” but that term has since been rejected as inaccurate and pejorative. See Kathryn L. Tucker, *At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations*, 10 HARV. HEALTH POL’Y REV. 45, 46 n.6 (2009). Opponents continue to use the inaccurate term “assisted suicide,” knowing it evokes a negative response. Such tactics on the battlefield of terminology are engaged in virtually every socially evolving arena. See generally Hendrik Hertzberg, *Senses of Entitlement*, NEW YORKER (Apr. 8, 2013), http://www.newyorker.com/talk/comment/2013/04/08/130408taco_talk_hertzberg (“Call it what you will—enhanced interrogation or torture, collateral damage or civilian deaths, pro-life or anti-reproductive rights, global warming or climate change, homosexual marriage or marriage equality, assault rifles or ‘semi-automatic small-calibre sporting rifles with plastic accessories’—it’s all the same, and (excepting torture and warming) it’s all, to some degree, propaganda.”).
 3. See AM. MED. WOMEN’S ASS’N, POSITION PAPER ON AID IN DYING (2007), available at http://www.amwa-doc.org/cms_files/original/Aid_in_Dying1.pdf (“[T]he physician . . . may provide a terminally ill patient with, but not administer, a lethal dose of medication and/or medical knowledge, so that the patient can, without further assistance, hasten his/her death. This practice is known as Aid in Dying.”).
 4. Patients request aid-in-dying medication to address current anxiety about losing control, dying in a hospital, or suffering unbearable pain and other symptoms in the future. Physicians prescribe the medication, in part, to palliate those anxieties. Linda Ganzini et al., *Oregonians’ Reasons for Requesting Physician Aid in Dying*, 169 ARCHIVES INTERNAL MED. 489, 490 (2009).
 5. OR. REV. STAT. ANN. §§ 127.800–127.897 (West 2013); Wash. Rev. Code Ann. §§ 70.245.010–70.254.904 (West 2013); Vt. Stat. Ann. tit. 18, §§ 5281–92 (West 2013).
 6. See *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

dying.⁷ In other states, it is unclear whether providing aid in dying exposes physicians to prosecution under criminal laws.⁸ Some states have neither a permissive nor a prohibitory statute and are silent on the issue of aid in dying (hereinafter referred to as “silent states”). Hawaii is an example of a silent state; physicians there began an open practice of aid in dying in 2011, governed by professional practice standards. Hawaii provides a model for other silent states.⁹ Most medical care is not governed by statute or court decision, but instead by professional practice standards, also referred to as best practices or the standard of care.¹⁰ Massachusetts is another silent state. This article examines the pertinent law in Massachusetts and concludes that it is a jurisdiction where aid in dying can be provided, consistent with best practices, without exposing physicians to viable criminal prosecution.¹¹

In 2012, Massachusetts nearly became the third state—after Oregon in 1994 and Washington in 2008—to pass a law that would have established a statutory permission to choose aid in dying.¹² The measure, referred to as “Question 2,” enjoyed strong support early in the campaign.¹³ However, opponents of the measure outspent proponents in the final weeks of the campaign, spending \$4.8 million to

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7. See, e.g., ARK. CODE ANN. § 5-10-106(b) (West 2013); GA. CODE ANN. §§ 16-5-5(a)–(c) (West 2013); IDAHO CODE ANN. § 18-4017(1) (2013). See *infra* Part II.B.1.
 8. As discussed below, some states have a broad vague prohibition against “assisted suicide.” See, e.g., IND. CODE ANN. § 35-42-1-2.5 (West 2013); N.J. STAT. ANN. § 2C:11-6 (West 2013); N.M. STAT. ANN. § 30-2-4 (LexisNexis 2013); N.D. CENT. CODE ANN. § 12.1-16-04 (West 2013); 18 PA. CONS. STAT. ANN. § 2505 (West 2013). The reach of such statutes to aid in dying is unclear. A test case seeking to clarify that a vague prohibition on “assisting suicide” does not reach the conduct of a physician providing aid in dying is currently pending in New Mexico. See First Amended Complaint for Declaratory and Injunctive Relief, *Morris v. Brandenburg*, No. D-202-CV-2012-02909 (Dist. Ct. May 9, 2012).
 9. See *infra* Part IV.C; see generally Kathryn L. Tucker, *Aid in Dying: An End of Life Option Governed by Best Practices*, 8 J. HEALTH & BIOMED. L. 9, 11–12 (2012) (discussing the emergence of aid in dying as a practice governed by best practices in Hawaii).
 10. See 61 AM. JUR. 2d *Physicians, Surgeons, and Other Healers* § 189 (2013).
 11. It is, of course, possible that an aggressive prosecutor might initiate a prosecution; however, my conclusion is that such a prosecution would not have a serious possibility of a conviction. A prosecutor could opt to prosecute a physician for any of a variety of other life-ending options, including, for example, palliative sedation. Defense of such a prosecution would be similar to defending a prosecution for aid in dying, focusing on whether the physician’s conduct comported with professional practice standards.
 12. An attempt to enact a permissive measure reflects the assumption that aid in dying is not currently an option that patients can choose and physicians can provide. The assumption has been that providing aid in dying would subject physicians to criminal exposure. That assumption, this article asserts, is unfounded and erroneous.
 13. See Robert Rizzuto, *Massachusetts Voters Support Medical Marijuana and ‘Death with Dignity’ Ballot Initiatives*, MASSLIVE.COM (June 4, 2012), http://www.masslive.com/politics/index.ssf/2012/06/massachusetts_voters_support_m.html; see also Chris Camire, *Voter Support Withered for Assisted-Suicide Ballot Question*, SENTINELANDENTERPRISE.COM (Dec. 10, 2012), http://www.sentinelandenterprise.com/local/ci_22160837/voter-support-withered-assisted-suicide-ballot-question.

the \$1.1 million spent by Question 2 proponents.¹⁴ A barrage of advertisements hostile to Question 2 culminated in its defeat at the ballot box.¹⁵

Efforts to enact an affirmative statute permitting aid in dying are politically and emotionally charged. This is due, in part, to misinformation promoted by a well-organized opposition, as evident in the recent consideration of Question 2. Opponents of Question 2 misrepresented what the law would have allowed and campaigned to generate fear that a law permitting aid in dying would lead to involuntary euthanasia and create a culture in which there is a “duty to die.”¹⁶ Swayed by this well-financed, fear-based campaign, voters declined to adopt the measure.¹⁷ In late September 2013, polls showed 68% of voters supported allowing mentally competent, terminally ill patients to obtain a prescription for life-ending medication; however, the ballot measure failed by a 51% to 49% margin.¹⁸ Efforts to pass a law permitting aid in dying through the traditional legislative process in Massachusetts have also, to date, been unsuccessful.¹⁹

Even though opponents have defeated measures to specifically permit aid in dying by employing inflammatory language and conjuring frightening images, they have not defeated broad public support for it among citizens, including those of Massachusetts, where an overwhelming majority supports access to aid in dying.²⁰ Interestingly, it appears that no change in law is necessary for the practice to be accepted among the range of end-of-life options available to dying patients in Massachusetts.

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14. Camire, *supra* note 13; *see also* Chelsea Sheasley & Monique Scott, *Ballot Questions Raise Barely a Peep Ahead of Election*, SUN CHRONICLE (Attleboro, Mass.) (Nov. 2, 2012), http://www.thesunchronicle.com/news/local_news/ballot-questions-raise-barely-a-peep-ahead-of-election/article_78917d0e-c769-5bed-b143-a8e40281aec6.html.
 15. *See* Paula Span, *How the ‘Death With Dignity’ Law Failed in Massachusetts*, N.Y. TIMES (Feb. 6, 2012), <http://newoldage.blogs.nytimes.com/2012/12/06/how-the-death-with-dignity-law-died-in-massachusetts/>.
 16. *See* Wendy Kaminer, *How the Catholic Church Misunderstands Death With Dignity*, THE ATLANTIC (Sept. 17, 2012), <http://www.theatlantic.com/health/archive/2012/09/how-the-catholic-church-misunderstands-death-with-dignity/262347/>.
 17. *See* Valerie Richardson, *Inclusion Key in Anti-Suicide Drive*, WASH. TIMES (Nov. 15, 2012), <http://www.washingtontimes.com/news/2012/nov/14/inclusion-key-in-anti-suicide-drive/?page=all>.
 18. Camire, *supra* note 13.
 19. *See* H.B. 1468, 186th Gen. Ct. (Mass. 2009) (discussing the Act Relative to Death with Dignity, which failed in the Judiciary Committee) (statement of the bill’s sponsor) (“It was a tough bill and it didn’t go anywhere because it’s election season.”). This statement reflects the legislative concern that passing a law permitting aid in dying would result in a public backlash. *See also* H.B. 2233, 187th Gen. Ct. (Mass. 2012) (discussing the Joint Committee hearing completed on March 6, 2012). The last day for the legislative committee to report on this bill was July 31, 2012. *See id.*
 20. *See* Press Release, Public Policy Polling, Obama Holds Modest Lead in Massachusetts (Aug. 22, 2012), http://www.publicpolicypolling.com/pdf/2011/PPP_Release_MA_082212.pdf (showing results that 58% of those polled in Massachusetts would vote “yes” on Question 2); *see also* Press Release, Pew Research Center, *More Americans Discussing—and Planning—End-of-Life Treatment: Strong Public Support for Right to Die 8* (Jan. 5, 2006), <http://peoplepress.org/reports/pdf/266.pdf> (“A solid majority of Americans (60%) believe a person has a moral right to end their life if they are suffering great pain and have no hope of improvement.”).

Medical care is typically governed by professional practice standards, not by statutes or court decisions that either prohibit or provide affirmative permission for specific types of care.²¹ The development of best practices—also referred to as the standard of care—in medicine is left to physicians and regulated by the states.²² The existing statutory framework in Massachusetts already empowers patients to make autonomous decisions regarding their end-of-life care.²³ Medical practice already embraces a variety of life-ending practices, such as withdrawing life-prolonging treatment, sedating a patient and withdrawing a ventilator, stopping all food and fluids while providing palliative care, and palliative sedation (a practice in which a suffering, dying patient is sedated to unconsciousness with nutrition and hydration withheld until death arrives).²⁴ These all became integrated into end-of-life care—not through specific statutory authority, but rather through emerging professional practice standards. In addition to these expressions of affirmative respect for patient autonomy, Massachusetts does not have a criminal prohibition against aid in dying.²⁵ Accordingly, it is reasonable to conclude that Massachusetts is a jurisdiction in which physicians may provide aid in dying subject to best practices.²⁶

Part II.A provides an overview of the pertinent law in Massachusetts that vests citizens with the power to make autonomous medical decisions. Part II.B then examines Massachusetts's criminal law provisions that might have bearing on the practice of aid in dying, and concludes that Massachusetts law vests citizens with autonomy over end-of-life medical decisions, and has no law that could reasonably be seen to outlaw the practice. Part III argues that aid in dying can emerge in Massachusetts, subject to governance by professional practice standards. Part IV discusses how Massachusetts, as it begins to embrace the option of aid in dying within available end-of-life care options, can learn from the practices that have developed in states where aid in dying is openly practiced. Finally, Section V concludes by urging that aid in dying can emerge in Massachusetts without the need for change in state law, subject to governance by professional practice standards.

21. See 61 AM. JUR. 2d *Physicians, Surgeons and Other Healers* § 189 (2013).

22. See *Gonzales v. Oregon*, 546 U.S. 243, 271 (2006) (quoting *Hillsborough Cnty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985)).

23. See *infra* Part II.A.

24. The U.S. Supreme Court recognized that a suffering, dying patient has no legal barriers to access palliative sedation as a matter of federal law in *Washington v. Glucksberg*, 521 U.S. 702, 736–37 (1997) (O'Connor, J., concurring) (“[A] patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death.”). Authoritative medical literature also recognizes this option. See, e.g., Paul Rousseau, *Palliative Sedation in the Management of Refractory Symptoms*, 2 J. SUPPORTIVE ONCOLOGY 181 (2004); Susan D. Bruce et al., *Palliative Sedation in End-of-Life Care: The Process of Palliative Sedation*, 8 J. HOSPICE & PALLIATIVE NURSING 320 (2006); Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. PALLIATIVE CARE 31 (1994).

25. See *infra* Part II.B.

26. See Tucker, *supra* note 9 (discussing similar circumstances in the emergence of aid in dying subject to best practices in the state of Hawaii).

II. MASSACHUSETTS LAW GOVERNING END-OF-LIFE CARE

A. *Massachusetts Law Empowers Patients to Make Autonomous End-of-Life Treatment Decisions*

Massachusetts's statutory framework recognizes and respects the autonomy of patients in their decisions over end-of-life care. Massachusetts's Health Care Proxies Law empowers patients to make decisions about their health care through an appointed proxy if they become mentally incapacitated.²⁷ Under the law, a patient has the right to appoint a health care proxy to make decisions about the patient's health care in accordance with the patient's wishes, including decisions to withdraw or withhold life-sustaining treatment—even when doing so will cause death.²⁸

The Health Care Proxies Law contains a provision stating that the statute does not authorize or condone “suicide or mercy killing, or . . . permit any affirmative or deliberate act to end one's own life other than to permit the natural process of dying.”²⁹ It could be argued that this provision reflects a policy against aid in dying. Yet this language is common to many similar state statutes, including those in Oregon and Washington, and at least one court has held that the term “mercy killing” does not encompass aid in dying.³⁰ Moreover, it is critical to recognize that a failure to explicitly authorize an act does not constitute a prohibition of the act. Legislators know how to prohibit aid in dying when it is their intention to do so, as discussed *infra* in Part II.B.1.

In 2009, the Supreme Court of Montana concluded that a physician's provision of a prescription for medication—which the patient could ingest to achieve a peaceful death—is neither mercy killing nor euthanasia.³¹ The court found the provision of aid in dying to be supported by the public policy of the state, as reflected in the Rights of the Terminally Ill Act—a Montana statute that empowers terminally ill patients to make autonomous end-of-life decisions.³² *Baxter* suggests that Massachusetts's Health Care Proxies Law should be seen as reflecting that the policy of the Commonwealth of Massachusetts is to support autonomy in medical decisionmaking, and such policy would reasonably extend to the choice of a mentally competent, terminally ill patient to request medication that could be ingested to bring about a peaceful death.

While *Baxter* provides insight into the use of the term “mercy killing” in the Massachusetts Health Care Proxies Law, the law contains an additional provision that is not found within Montana's Right of the Terminally Ill Act and thus, was not analyzed by the Montana court in *Baxter*. The Massachusetts Health Care Proxies Law also states that the statute should not be construed “to permit any affirmative or deliberate act to end one's own life other than to permit the natural process of

27. See MASS. GEN. LAWS ANN. ch. 201D, § 1 (West 2013).

28. See *id.* § 5.

29. *Id.* § 12.

30. See *Baxter v. State*, 224 P.3d 1211, 1219 (Mont. 2009).

31. See *id.*

32. See *id.*; see also *infra* Part IV.B.

dying.”³³ Although this provision does not serve as a criminal prohibition, it could be argued that it serves as an implicit prohibition against aid in dying.³⁴

Massachusetts’s common law has long recognized and supported a patient’s right of self-determination over his or her course of treatment.³⁵ This reasonably extends to aid in dying. Patients choosing aid in dying do not intend self-destruction, but instead seek comfort by both empowering themselves with control over the time and manner of their inevitable, impending death and shaping their death in a manner they consider coherent with their life.³⁶ Many individuals who obtain a prescription never ingest the medication, but experience the palliative effect of comfort from knowing that they are able to exercise control over their death. In Oregon, about one-third of patients who obtain a prescription under the Death with Dignity Act choose not to ingest the

33. MASS. GEN. LAWS ANN. ch. 201D, § 12.

34. Similarly, a Massachusetts statute enacted in 2012 to ensure that terminally ill patients receive comprehensive counseling about end-of-life options states: “Nothing in this section shall be construed to permit a healthcare professional to offer to provide information about assisted suicide or the prescribing of medication to end life.” MASS. GEN. LAWS ANN. ch. 111, § 227. A statute that says it shall not be construed to permit an action does not, without more, erect a prohibition.

35. See *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 633 (Mass. 1986); see also *Guardianship of Doe*, 583 N.E.2d 1263, 1270 (Mass. 1992) (“It is well settled that withdrawing or refusing life-sustaining medical treatment is not equivalent to attempting suicide. Absent an intent to die, there can be no suicide. As we have previously held, a ‘death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient.’” (citations omitted)). Justice O’Connor, joined by Justice Lynch, dissented in *Doe*, arguing that the majority therein did not simply reaffirm the right to refuse medical treatment, but instead that “a competent individual has a legal right in this Commonwealth to commit suicide, and that others have a right to assist him or her in that effort.” *Doe*, 583 N.E.2d at 1275 (O’Connor, J., dissenting). Justice O’Connor continued:

I would agree that the law should recognize a competent person’s right to refuse or withdraw medical treatment when that choice is not motivated by a desire to die but, instead, is reasonably motivated by a desire to avoid procedures that are in themselves, and not simply because they prolong life, physically or emotionally painful. Suicide, however, is a different matter A humane society provides support of every kind, including moral support, to those who are burdened in order that they may live, not “go,” as the Probate Court judge, with this court’s approval, would have it, in “peace.” No “legal system” is worthy of that appellation unless its primary function is to protect the most vulnerable members of society. It follows that, in the absence of otherwise compelling legislation, no court should recognize a legal right to commit suicide, whether by action (e.g., lethal injection) or by inaction (e.g., withdrawal of nutrition and hydration, or withdrawal of antibiotic medication to treat pneumonia). Nor should any court recognize a corresponding right to assist in suicide or to engage in the closely related practice of voluntary euthanasia.

Id. (citations omitted). Justice O’Connor, joined by Justices Nolan and Lynch, similarly dissented in *Munoz*, which he described as endorsing “a right to assisted suicide.” *Norwood Hosp. v. Munoz*, 564 N.E.2d 1017, 1026 (Mass. 1971) (O’Connor, J., dissenting).

36. See RONALD DWORKIN, *LIFE’S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* 199 (1993) (“[W]e live our whole lives in the shadow of death [W]e die in the shadow of our whole lives. . . . We worry about the effect of life’s last stage on the character of life as a whole, as we might worry about the effect of a play’s last scene or a poem’s last stanza on the entire creative work.”).

medication and die of their underlying disease.³⁷ The experience in Oregon suggests that aid-in-dying patients seek comfort and empowerment, not self-destruction.³⁸ Furthermore, the mental health community recognizes a clear difference between the act of “suicide” and the choice of a terminally ill patient to bring about a peaceful death.³⁹ Accordingly, a dying patient’s act of ingesting medication to achieve a peaceful death is not—and ought not be—construed as suicide.⁴⁰

It is reasonable to conclude that physicians in Massachusetts may engage in the practice of aid in dying, subject to best practices, without risk of a viable criminal prosecution. Both the Massachusetts legislature and courts have recognized the right of an individual to make autonomous decisions about end-of-life care, even when death is the foreseeable result.⁴¹ As will be explored *infra* in Part II.B, the state has no statute or case law that could reasonably prohibit a physician’s conduct in providing aid in dying.⁴² Without an explicit prohibition of the practice, physicians should feel safe providing aid in dying subject to professional practice standards.⁴³

37. See *Oregon’s Death with Dignity Act—2012*, OR. PUB. HEALTH (Jan. 16, 2013), <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>; see also Ganzini et al., *supra* note 4, at 2.

38. The experience in Oregon is not unique to that state. In Massachusetts, at a hearing on a proposed death with dignity bill, Massachusetts resident Eileen Lipkind spoke of her husband, who had passed away after suffering from terminal cancer. She said, “Since he had absolutely no choice about dying, he wanted to choose when to go. He wanted his dignity.” Margery Eagan, *Memory of Suffering Helps Right-to-Die Bill Live*, BOS. HERALD (Feb. 23, 2010), http://bostonherald.com/news_opinion/columnists/2010/02/memory_suffering_helps_right_to_die_bill_live.

39. Mental health professionals recognize a distinct difference between “suicide” and the choice of aid in dying. The American Psychological Association advises: “It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide.” See, e.g., Rhea K. Farberman, *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28 PROF. PSYCHOL. RES. & PRAC. 544 (1997); David M. Smith & David Pollack, *A Psychiatric Defense of Aid in Dying*, 34 CMTY. MENTAL HEALTH J. 547 (1998); see also Tucker, *supra* note 2, at 46 (discussing medical and health policy organizations’ policies recognizing this distinction).

40. In the states with statutory permission for aid in dying, the act is expressly not to be considered suicide as a matter of law and is not to be referred to as such. See OR. REV. STAT. ANN. § 127.570(2) (West 2013); VT. STAT. ANN. tit. 18, § 5292 (West 2013); WASH. REV. CODE ANN. § 70.245.040(2) (West 2013).

41. See *supra* notes 27–29, 33–35, 38–40, and accompanying text.

42. Others analyzing Massachusetts’s statutory framework have also concluded that the state has no explicit or implicit prohibition against aid in dying. See Katherine Ann Wingfield & Carl S. Hacker, *Physician-Assisted Suicide: An Assessment and Comparison of Statutory Approaches Among the States*, 32 SETON HALL LEGIS. J. 14, 56 (2007) (analyzing Massachusetts’s statutory framework and concluding that the state has no explicit or implicit prohibition against aid in dying).

43. Physicians are notoriously cautious and, therefore, a statutory safe harbor would likely increase physicians’ willingness to provide aid in dying. A “safe harbor only” approach is embraced in Vermont’s recently enacted law permitting aid in dying. After a three-year period when Oregon-style mandates govern practice, those mandates expire and leave governance to professional practice standards—leaving in place criminal, civil, and disciplinary immunities creating a safe harbor for physicians. See VT. STAT. ANN. tit. 18, §§ 5289–90 (West 2013).

B. An Analysis of Criminal Prohibitions Governing End-of-Life Care in Massachusetts

This section analyzes Massachusetts law to determine whether it prohibits a physician from providing aid in dying, asking (1) whether Massachusetts law contains an express prohibition on physician aid in dying; (2) whether Massachusetts law could be interpreted as containing an implied prohibition on physician aid in dying; and (3) whether Massachusetts common law prohibits physician aid in dying. Each analysis is addressed in turn, leading to the conclusion that Massachusetts law does not prohibit a physician from providing aid in dying.⁴⁴

1. Massachusetts Has No Explicit Prohibition of Aid in Dying

If a legislature desires to criminalize aid in dying, it may do so. Such legislation must set forth with specificity the conduct that is proscribed.⁴⁵ A number of states have enacted statutes sufficiently specific to outlaw aid in dying: For example, Arkansas specifically makes “physician-assisted suicide” a crime.⁴⁶ This statute applies to a “physician . . . willfully prescribing any drug, compound, or substance for the express purpose of assisting a patient to intentionally end the patient’s life.” Idaho is another example of a state that has enacted a statute sufficiently specific to reach the conduct of a physician providing a prescription for aid in dying.⁴⁷

44. See Wingfield & Hacker, *supra* note 42 (“Massachusetts [law contains] no statutory prohibition of physician-assisted suicide or assisted suicide generally.”). Nor would there be grounds for a federal prosecution under the only possibly pertinent federal statute, the Controlled Substances Act (CSA), Pub. L. No. 91-513, 84 Stat. 1242 (1970) (codified at 21 U.S.C. § 801 (2013)). The CSA is intended to combat drug abuse and control trafficking in controlled substances. See *Gonzales v. Oregon*, 546 U.S. 243, 272 (2006). It is clear that there is no basis under the CSA for prosecution of a physician prescribing controlled substances for aid in dying. See *id.* at 274–75. In *Gonzales*, a case considering the possibility of CSA prosecution of a physician providing aid in dying in Oregon, the court held that the intention of the CSA would not support such action:

Viewed in its context, the prescription requirement is better understood as a provision that ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse. As a corollary, the provision also bars doctors from peddling to patients who crave the drugs for those prohibited uses. To read prescriptions for assisted suicide as constituting “drug abuse” under the CSA is discordant with the phrase’s consistent use throughout the statute, not to mention its ordinary meaning.

Id. at 275 (citation omitted).

45. See *Commonwealth v. Alexander*, 185 Mass. 551, 554 (1904) (“Criminal statutes are to be construed strictly. The court cannot extend or enlarge a statute to create an offense which is not created by the language of the enactment.”); see also Henry Campbell Black, Book Note, *Handbook on the Construction and Interpretation of the Laws*, 21 YALE L.J. 172 (1911). Penal statutes must define the criminal offense with sufficient clarity so ordinary people can understand what conduct is prohibited. See *Kolender v. Lawson*, 461 U.S. 352, 353, 357 (1983); *United States v. Harriss*, 347 U.S. 612, 617 (1954).

46. ARK. CODE ANN. § 5-10-106 (West 2013).

47. IDAHO CODE ANN. § 18-4017(5) (West 2013) (providing immunity to physicians for treating pain or symptoms but making clear that if a prescription is for the purpose of causing death, the immunity would not apply and the physician would be subject to criminal exposure).

Massachusetts may choose to outlaw aid in dying, as these states have chosen to do, but has not done so to date. If Massachusetts does prohibit the practice, the law must be sufficiently specific. Criminal statutes are construed strictly, not expansively, and are not extended or enlarged by implication to embrace conduct not included in the express terms of the text.⁴⁸

2. *Massachusetts, Unlike Many States, Does Not Have a Broad Vague Prohibition Against “Assisted Suicide”*

Not only is there no explicit prohibition of aid in dying in Massachusetts; there is not even a broad vague prohibition against “assisted suicide,”⁴⁹ as seen in many other states, that could arguably provide a basis for a prosecution for aid in dying.⁵⁰ Of course, aid in dying may—and ought to—fall outside the scope of these statutes.⁵¹ Physicians may nevertheless fear that they might be prosecuted for “assisting suicide” if they provide aid in dying. That fear, however, is groundless in Massachusetts because there is no statute prohibiting “assisted suicide” that could even arguably support such a prosecution. Specifically, the Massachusetts manslaughter statute does not prohibit the act of “assisting or aiding suicide.”⁵²

3. *Massachusetts Common Law Does Not Address the Act of a Physician Providing Aid in Dying*

Looking to Massachusetts case law for any reported cases that may be relevant to aid in dying, one looks largely in vain. The Massachusetts manslaughter statute has in one case been applied to reach “aiding self-murder.”⁵³ But application of the manslaughter statute to aid in dying would not be tenable under this case law. First, a dying patient ingesting medication to achieve a peaceful death and avoid further suffering in the final stage of terminal illness is not engaging in “self-murder.”⁵⁴ To the contrary, such a patient seeks to preserve the integrity and coherence of the self

48. See *supra* note 45.

49. See Wingfield & Hacker, *supra* note 42.

50. See, e.g., GA. CODE ANN. § 16-5-5 (West 2013); IND. CODE ANN. § 35-42-1-2.5 (West 2013); N.J. STAT. ANN. § 2C:11-6 (West 2013); N.M. STAT. ANN. § 30-2-4 (West 2013); N.D. CENT. CODE ANN. § 12.1-16-04 (West 2013); OR. REV. STAT. ANN. § 163.117 (West 2013); 18 PA. CONS. STAT. ANN. § 2505 (West 2013).

51. The choice of a dying patient for a peaceful death is recognized to be fundamentally different from “suicide” by mental health, medical, and health policy professionals. See, e.g., Farberman, *supra* note 39; Smith & Pollack, *supra* note 39; see also Tucker, *supra* note 2, at 45 (discussing medical and health policy organizations’ policies recognizing this distinction). Whether an “assisted suicide” statute reaches aid in dying is the subject of litigation in New Mexico. See First Amended Complaint for Declaratory and Injunctive Relief, *Morris v. New Mexico*, D-202-CV-2012-02909 (N.M. 2d Jud. Dist. Ct. May 9, 2012).

52. Massachusetts’s manslaughter statute does not prohibit the act of “assisting or aiding suicide.” See MASS. GEN. LAWS ANN. ch. 265, § 13 (West 2013).

53. See *Persampieri v. Commonwealth*, 175 N.E.2d 387, 389 (Mass. 1961).

54. See *supra* notes 27–29, 33–35, 38–40, and accompanying text.

in the face of inexorable deterioration as illness progresses. Second, it is hard to imagine that the facts of this bizarre “self-murder” case would be deemed to have any bearing on aid in dying. In *Persampieri v. Commonwealth*, a husband was found guilty of manslaughter for aiding and abetting his wife’s suicide.⁵⁵ Upon telling his wife that he wanted a divorce, the wife responded by threatening to kill herself.⁵⁶ After the husband taunted her and helped her to load and position the gun, his wife shot herself.⁵⁷ It is unlikely that the court’s holding on these starkly distinguishable and horrific facts would have any bearing upon a physician’s conduct in providing aid in dying to a mentally competent, terminally ill patient.

Other than this case, there is no case law that may apply to aid in dying in Massachusetts. Given that Massachusetts law empowers patients to make autonomous decisions about end-of-life care—and absent a criminal prohibition that could reasonably be construed to reach aid in dying—it is reasonable to conclude that physicians may provide this end-of-life option, subject to standards of professional practice, without significant risk of a viable criminal prosecution. This would place Massachusetts alongside Hawaii, as a “silent” state, in the governance of this practice.⁵⁸

III. AID IN DYING: GOVERNED BY PROFESSIONAL PRACTICE STANDARDS

Most medical care is not governed by statute or court decision, but instead by professional practice standards, also referred to as “best practices” or the “standard of care.”⁵⁹ In Massachusetts, the standard of care for a general practitioner is defined as the degree of care and skill of the average practitioner while taking into account advances in the profession.⁶⁰ A specialist, likewise, is held to the standard of care and

55. See *Persampieri*, 175 N.E.2d at 389–90.

56. *Id.* at 389.

57. *Id.*

58. See *infra* Part IV.C.

59. 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 189 (2013).

60. See *Palandjian v. Foster*, 842 N.E.2d 916, 920 (Mass. 2006); see also *Commonwealth v. Pierce*, 138 Mass. 165 (1884) (upholding the conviction of a physician where the physician ordered that patient-decedent be soaked in kerosene). The *Pierce* opinion stated:

If a person publicly practising as a physician, on being called upon to attend a sick woman, prescribes, with foolhardy presumption or gross recklessness, a course of treatment which causes her death, he may be found guilty of manslaughter, although he acted with her consent, and with no evil intent. . . .

Injurious acts resulting from gross carelessness or foolhardy presumption, without intent to injure, may constitute an assault. . . . The same general principle applies to medical treatment. The government must show, not merely the absence of ordinary care, but gross carelessness amounting to recklessness. A man is not to be convicted of manslaughter merely because of his ignorance. His ignorance is only important as bearing upon the question whether his conduct in the care and treatment of the patient was marked by foolhardy presumption or gross and reckless carelessness. The defendant in this case is to be tried by no other or higher standard of skill or learning than that which he necessarily assumed in treating her; that is, that he was able to do so, without gross recklessness or foolhardy presumption in undertaking it. It is not necessary to

skill of the average member of the profession practicing his or her specialty, while taking into account advances in the profession.⁶¹ Some jurisdictions have adopted the “respectable minority” standard in analyzing claims of medical negligence.⁶² This doctrine recognizes that a physician may legitimately engage in one of several recognized treatments and that the chosen treatment will not be deemed outside the standard of care merely because it has been adopted by only a minority of physicians.⁶³ Massachusetts has not considered the “respectable minority” rule, neither embracing nor rejecting it. Aid in dying is a “recognized course of treatment” as the practice has become increasingly accepted among medical and health policy organizations.⁶⁴ Surely a “respectable minority” of Massachusetts physicians who provide end-of-life care would provide aid in dying to eligible patients requesting it, if they felt safe doing so.⁶⁵

show an evil intent; if, by gross and reckless negligence, he caused the death, he is guilty of culpable homicide.

Id. at 171.

61. See *Palandjian*, 842 N.E.2d at 916.
62. See *Chumbler v. McClure*, 505 F.2d 489, 492 (6th Cir. 1974) (finding that nine physicians constituted a respectable minority so as to insulate the defendant-physician from liability for medical negligence); *Hood v. Phillips*, 537 S.W.2d 291, 294 (Tex. Civ. App. 1976), *aff’d*, 554 S.W.2d 160 (Tex. 1977); *Borja v. Phoenix Gen. Hosp., Inc.*, 727 P.2d 355, 355 (Ariz. Ct. App. 1986); *Schwab v. Tolley*, 345 So. 2d 747, 753 (Fla. Dist. Ct. App. 1977). See generally Meghan C. O’Connor, *The Physician-Patient Relationship and the Professional Standard of Care: Reevaluating Medical Negligence Principles to Achieve the Goals of Tort Reform*, 46 TORT TRIAL & INS. PRAC. L.J. 109, 126–27 (2010).
63. See *Chumbler*, 505 F.2d at 492.
64. See Tucker, *supra* note 2. Organizations with policies supportive of aid in dying include the American Medical Women’s Association (AMWA), http://www.amwa-doc.org/cms_files/original/Aid_in_Dying1.Pdf (last visited Dec. 28, 2013); the American Medical Students’ Association (AMSA), http://www.amsa.org/AMSA/Libraries/Exec_Docs/2013_PPP.sflb.ashx, at 76 (last visited Dec. 28, 2013); the American College of Legal Medicine (ACLM), http://www.aclm.org/resources/amicus_briefs/ACLM%20Aid%20in%20Dying%20Policy.pdf (last visited Dec. 28, 2013); the American Public Health Association (APHA), <http://www.apha.org/advocacy/policy/policysearch/> (last visited Dec. 28, 2013). The U.S. Supreme Court has recognized aid in dying as a legitimate medical practice. See *Gonzales v. Oregon*, 546 U.S. 243 (2006); see also Kathryn L. Tucker, *U.S. Supreme Court Ruling Preserves Oregon’s Landmark Death with Dignity Law*, 2:2 NAT’L ACAD. ELDER LAW ATT’YS J. 291–301 (2006). Clinical Practice Guidelines for aid in dying have been promulgated and were recently endorsed by AMWA. *AMWA Advocacy History & Timeline*, AMWA-DOC.ORG, <http://www.amwa-doc.org/advocacy/history-timeline> (last visited Dec. 28, 2013).
65. Physicians, including members of the Harvard Medical School faculty, were leading spokespersons for—and supporters of—Question 2. Dr. Marcia Angell, a physician, professor at Harvard Medical School, and the first woman editor of the nation’s most distinguished medical journal, the *New England Journal of Medicine*, was among them. See Marcia Angell, *May Doctors Help You to Die?*, N.Y. REV. BOOKS (Oct. 11, 2012), available at <http://www.nybooks.com/articles/archives/2012/oct/11/may-doctors-help-you-die/> (“I have long favored legalizing physician-assisted dying for terminally ill patients whose suffering cannot be relieved in any other way, and I was the first of the original fourteen petitioners to put the Massachusetts Death with Dignity Act on the ballot in November. In 1997, as executive editor of the *New England Journal of Medicine* . . . I wrote an editorial favoring it, and told the story of my father, who shot himself rather than endure a protracted death from metastatic cancer of the prostate.”).

As discussed above, Massachusetts law empowers patients to make autonomous decisions regarding their end-of-life care. Under this framework, a standard of care has already emerged in which physicians, respecting patient autonomy, engage in life-ending practices in caring for terminally ill patients. For example, physicians discontinue a variety of life-prolonging treatments, including cardiac devices, ventilators, dialysis, feeding tubes, and medication—aware that doing so will certainly or likely precipitate death. They also provide palliative support to patients who choose to stop eating and drinking. Physicians may receive requests from mentally competent, terminally ill patients for a prescription for medication that would provide peace of mind and, if ingested, enable the patient to achieve a peaceful death. For physicians who believe such care is medically appropriate and are willing to provide it, best practices for aid in dying in Massachusetts will evolve and likely be informed by other jurisdictions that have more experience with an open practice of aid in dying. These jurisdictions, and the experiences in each, are discussed below.

IV. AID-IN-DYING PRACTICE IN OTHER STATES WILL INFORM PROFESSIONAL PRACTICES IN MASSACHUSETTS

A. States with Statutory Permission

1. Aid in Dying in Oregon

Oregon enacted statutory permission for aid in dying in 1994 when voters approved passage of the Oregon Death with Dignity Act.⁶⁶ Opponents delayed implementation of the act for three years through an ultimately unsuccessful lawsuit.⁶⁷ Consequently, in 1998, aid in dying became an open and transparent practice in Oregon with the dismissal of that suit.⁶⁸ Oregon's statutory permission for aid in dying allows a mentally competent, terminally ill patient to request a prescription for medication that he or she may ingest to bring about a peaceful death.⁶⁹ Oregon's law requires the collection and reporting of a tremendous amount of data about patients who choose aid in dying and their reasons for doing so. This data has shown that when aid in dying is an available option, none of the harms opponents had speculated about came to pass.⁷⁰ In the face of this evidence, opponents increasingly recognize

66. OR. REV. STAT. ANN. §§ 127.800–897 (West 2013).

67. See *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997).

68. See Death with Dignity Act, OR. HEALTH AUTH., <http://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx> (last visited Dec. 28, 2013).

69. See OR. REV. STAT. ANN. § 127.805.

70. See Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. MED. ETHICS 591 (Oct. 2007); Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, 138 ANNALS INTERNAL MED. 208 (Feb. 4, 2003); Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285:18 JAMA 2363 (May 2001), available at <http://jama.jamanetwork.com/article.aspx?articleid=193817&resultClick=3> (reviewing Oregon's experience with its Death with Dignity Act and concluding that no harm occurred to vulnerable populations); Melinda A. Lee &

that opposition to aid in dying can be justified only on personal moral or religious grounds.⁷¹ Medical and health policy groups, including the American Public Health Association, have adopted policies supportive of the practice after taking a careful look at the experience in Oregon with aid in dying.⁷²

2. *Aid in Dying in Washington*

In 2008, Washington voters, undoubtedly influenced by the positive experience in Oregon, adopted a statutory permission for aid in dying nearly identical to that in Oregon, also through the initiative process.⁷³ Washington began implementing its law in March 2009.⁷⁴ As in Oregon, the Washington statute requires the state to gather and publish data regarding aid in dying as reported by health care providers.⁷⁵ The data shows that most of those choosing aid in dying in Washington are Caucasian, well educated, and dying of cancer.⁷⁶

3. *Aid in Dying in Vermont*

In the 2013 legislative session, Vermont took the historic step of becoming the first state to enact a law to permit aid in dying through the traditional legislative process, doing so with a “next generation” approach to the issue.⁷⁷ Vermont embraces the statutory mandates governing the practice as in Oregon and Washington, but only for a period of three years.⁷⁸ After three years, the statutory mandates expire and the practice

Susan W. Tolle, *Oregon's Assisted Suicide Vote: The Silver Lining*, 124 ANNALS INTERNAL MED. 267 (1996); Joseph B. Straton, *Physician Assistance with Dying: Reframing the Debate; Restricting Access*, 15 TEMP. POL. & CIV. RTS. L. REV. 475, 479–82 (2006).

71. See Daniel E. Lee, *Physician-Assisted Suicide: A Conservative Critique of Intervention*, 33 HASTINGS CTR. REP. 1, 17 (2003).
72. See Tucker, *supra* note 2.
73. See WASH. REV. CODE ANN. §§ 70.245.010–904 (West 2013).
74. See WASH. STATE DEP'T OF HEALTH, 2009 DEATH WITH DIGNITY ACT REPORT (2009), available at <http://www.doh.wa.gov/portals/1/Documents/5300/DWDA2009.pdf>.
75. See OR. REV. STAT. ANN. § 127.855 (West 2013); WASH. REV. CODE ANN. § 70.245.150.
76. WASH. STATE DEP'T OF HEALTH, 2011 DEATH WITH DIGNITY ACT REPORT (2011), available at <http://www.doh.wa.gov/portals/1/Documents/5300/DWDA2011.pdf>.
77. Vermont Senate Bill 77 was passed by the Senate on February 14, 2013, and the House on May 13, 2013. It was signed into law by the Governor on May 20, 2013. See Kevin Liptak, *Vermont Moves to Pass End-of-Life Choice Law*, CNN (May 14, 2013, 8:13 AM), <http://politicalticker.blogs.cnn.com/2013/05/14/vermont-moves-to-pass-end-of-life-choice-law/>; *The Vermont Legislative Bill Tracking System*, VT. STATE LEGISLATURE, <http://www.leg.state.vt.us/database/status/summary.cfm?Bill=S.0077> (last visited Dec. 28, 2013). The Vermont law reflects an interesting new experiment in the “laboratory of the States,” as invited by the U.S. Supreme Court. See *Washington v. Glucksberg*, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring) (quoting *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 292 (1990)).
78. See VT. STAT. ANN. tit. 18, § 5283 (West 2013) (to be repealed July 1, 2016) (immunity for prescription and documentation); VT. STAT. ANN. tit 18, §§ 5289–90 (West 2013) (effective July 1, 2016) (protecting patient choice at end of life and immunity for physicians). The remaining sections of this act shall take effect on passage.

will be governed by professional practice standards.⁷⁹ Physicians will continue to be protected from criminal, civil, and professional liability for providing aid in dying.⁸⁰

B. Aid in Dying Absent an Explicit Statutory Permission: The Montana Supreme Court Speaks

The Montana Supreme Court recognizes the right of its citizens to freely choose aid in dying, even where no statute specifically authorizes the practice.⁸¹ In *Baxter v. State*, Robert Baxter, a seventy-five-year-old patient dying of cancer, sued the State of Montana to establish his right to choose aid in dying.⁸² Baxter argued that (1) Montanans have a right to aid in dying that is protected by the Montana state constitutional guarantees of privacy and individual dignity;⁸³ and (2) alternatively, physicians who provide aid in dying could not be subject to prosecution for homicide because of the state's "consent as a defense" doctrine under the Montana homicide statute.⁸⁴

The Montana Supreme Court declined to reach the state constitutional issues, resolving the case on statutory grounds.⁸⁵ The court held that Montana's advance directive statute, the Rights of the Terminally Ill Act, reflects a policy of the state to vest patients with broad autonomy over medical decisionmaking and to leave these decisions to the individual.⁸⁶ Aid in dying was therefore recognized as a choice left to the individual as a matter of patient autonomy.⁸⁷ Accordingly, the court held that no prosecution of a physician providing aid in dying would be proper.⁸⁸ Physicians need

79. See VT. STAT. ANN. tit. 18, §§ 5283, 5289–90.

80. See VT. STAT. ANN. tit. 18, §§ 5283, 5289–90. For a detailed discussion of the Vermont law permitting aid in dying, see Kathryn L. Tucker, *Vermont's Patient Choice at End of Life Act: A Historic "Next Generation" Law Governing Aid in Dying* (forthcoming 2014) (on file with the Vermont Law Review).

81. See *Baxter v. State*, 224 P.3d 1211, 1215 (Mont. 2009).

82. See *id.* at 1214. Additional plaintiffs included four Montana physicians who treat terminal illnesses, as well as Compassion & Choices, the national nonprofit organization which advocates to protect and expand the rights of the terminally ill.

83. *Id.*

84. See MONT. CODE ANN. § 45-2-211(1) (West 2013) (providing that the "consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense").

85. See *Baxter*, 224 P.3d at 1215–16.

86. See *id.* at 1215.

87. See *id.*

88. See *id.* Opponents of aid in dying in Montana, including a group called Montanans Against Assisted Suicide, assert that *Baxter* did nothing more than recognize a potential defense to a physician providing aid in dying. See Greg Jackson & Matt Bowman, *Baxter Case Analysis: Analysis of Implications of the Baxter Case on Potential Criminal Liability*, MONTANANS AGAINST ASSISTED SUICIDE, <http://www.montanansagainstassistedsuicide.org/p/baxter-case-analysis.html> (last visited Dec. 28, 2013). This plainly misrepresents the decision and its impact. Prosecuting attorneys are public servants and licensed members of the Bar. Filing a criminal charge against a physician who acted within the bounds recognized in *Baxter* would be frivolous, or possibly malicious, and potentially expose that prosecutor to sanctions for violating the state's rules of professional responsibility, so long as the patient was terminally ill and gave effective consent to the treatment. See generally MONT. R. PROF'L CONDUCT 3.8 (2004).

not fear disciplinary action either—at least, no more so than when providing any other medical procedure or engaging in any other medical practice. The Montana Board of Medical Examiners adopted a position statement on aid in dying in 2011 stating this position. This seemingly small and modest statement is actually enormously significant because it reflects the normalization of aid in dying within the practice of medicine.⁸⁹

Montana physicians are not subject to the statutes that govern the practice of aid in dying in Oregon, Washington, and, for a three-year period, Vermont. However, the Montana Supreme Court recognized certain boundaries which are codified in those other states' statutory schemes: a patient must be both terminally ill and mentally competent, and the physician's role is limited to providing a prescription for medication that would, if ingested, precipitate a peaceful death.⁹⁰ Beyond these bright lines established in *Baxter*, the practice of aid in dying in Montana is developing in end-of-life medical practice, subject to best practices.⁹¹ Because the practice is not governed by statute in Montana, there is no required reporting by physicians about patients choosing aid in dying.⁹²

C. Aid in Dying in “Silent” States: Hawaii Leads the Way

An open practice of aid in dying began in Hawaii in 2011, subject to the best practices approach outlined in this article.⁹³ A conference held in Hawaii in October 2011 explored the views of leading experts in law, medicine, civil rights, and health policy, on the law and policy landscape governing end-of-life care in Hawaii. These experts concluded that an open practice of aid in dying could emerge under existing law, subject to best practices.⁹⁴ A Physicians' Advisory Council for Aid in Dying

89. See MONT. BD. OF MED. EXAMINERS, PHYSICIAN AID IN DYING (Mar. 16, 2012).

90. See *Baxter*, 224 P.3d at 1215; OR. REV. STAT. ANN. § 127.05 (West 2013); VT. STAT. ANN. tit 18, § 5283 (West 2013); WASH. REV. CODE ANN. § 70.245.010 (West 2013).

91. Montana physicians have openly provided aid in dying since *Baxter*, and support their patients having access to this option. See, e.g., Span, *supra* note 15 (reporting the experience of Montana hospice and palliative care physician Dr. Eric Kress, who testified against a proposed legislative prohibition of aid in dying in the 2013 legislative session and who has responded to ten patient requests for aid in dying in the first three years following *Baxter* and provided prescriptions to three of the ten patients, including one who was in the terminal stage of Amyotrophic Lateral Sclerosis (ALS) and two who were dying of cancer).

92. Attempts to enact statutory regulations or a prohibition of aid in dying have failed in two successive sessions of the Montana legislature. Most recently, the Montana Senate defeated H.B. 505, which would have mandated prison sentences and fines for physicians who provide aid in dying to terminally ill patients. See Dylan Scott, *Physician-Assisted Suicide Bills Die in Montana*, GOVERNING (Apr. 8, 2013), <http://www.governing.com/blogs/view/gov-montana-experiences-two-extremes-of-aid-in-dying-debate.html>.

93. For a full discussion of the law and policy pertinent to aid in dying in Hawaii, see Tucker, *supra* note 9, at 9 (discussing the emergence of aid in dying as a practice that is governed by best practices in Hawaii).

94. See, e.g., Scott Foster, *Expert Panel Concur: Hawaii Physicians Can Provide Aid in Dying*, HAW. REP. (Oct. 5, 2011), available at <http://www.hawaiiireporter.com/expert-panel-concur-hawaii-physicians-can-provide-aid-in-dying/123>; Barbara Coombs Lee, *Hawaii: The Latest State Where Doctors Can Provide Aid in Dying*, HUFFINGTON POST (Oct. 6, 2011, 3:04 PM), http://www.huffingtonpost.com/barbara-coombs-lee/hawaii-aid-in-dying_b_995217.html.

formed, and physicians began evaluating requests for aid in dying and prescribing medication to mentally competent, terminally ill adults who met eligibility criteria and would derive a palliative benefit from the option.⁹⁵ There have been no investigations or prosecutions of Hawaii physicians providing aid in dying—despite open discussion in the media of the fact that physicians are engaging in this practice.⁹⁶

Key similarities exist in Hawaii and Massachusetts with regard to the practice of aid in dying, including the fact that both states have statutes empowering patients with autonomy over medical and end-of-life decisionmaking and the absence of any statute that can reasonably be read to address and outlaw the practice. In such situations, it is reasonable to conclude that the practice can be governed by professional practice standards.

V. CONCLUSION: AID IN DYING CAN EMERGE AS AN END-OF-LIFE OPTION IN MASSACHUSETTS GOVERNED BY PROFESSIONAL PRACTICE STANDARDS

Massachusetts voters considered—but did not adopt—an initiative permitting aid in dying in the November 2012 election. Yet it appears that the practice can nevertheless emerge without the need for a change in state law. Physicians who believe their patients should have this option should step forward and begin providing this treatment.

End-of-life medical practice openly includes aid in dying in Oregon, Washington, Montana, Hawaii, and, most recently, Vermont. Furthermore, a growing number of medical and health policy organizations have adopted policies supportive of aid in dying.⁹⁷ These facts demonstrate that this option is increasingly accepted.⁹⁸ The practice in Oregon, Washington, Montana, and Hawaii, as well as policies adopted by influential medical and health policy organizations, and emerging authoritative literature⁹⁹—will influence practice in other states, including Massachusetts.

Against this backdrop, it is timely for aid in dying to emerge in Massachusetts as an end-of-life option governed by professional practice standards. The law of the state recognizes that patients are empowered with autonomy in end-of-life decisionmaking.

95. See HAW. PHYSICIAN ADVISORY COUNSEL FOR AID IN DYING, ANNUAL REPORT: OCTOBER 5, 2011–OCTOBER 4, 2012, available at <http://community.compassionandchoices.org/document.doc?id=1242&erid=265611> (last visited Dec. 28, 2013).

96. Opponents of aid in dying sought and obtained an opinion from the Hawaii Attorney General, dated December 8, 2011, that takes the position that a criminal prosecution could be brought. Hawaii Law on Assistance with Dying, Op. Haw. Att’y Gen. (Dec. 8, 2011), available at http://choiceisanillusion.files.wordpress.com/2011/12/ag_opinion_as_not_legal.pdf. The reasoning in this opinion is unpersuasive for a number of reasons, including the failure to recognize the constellation of Hawaii laws that reflect it is the policy of the state to vest its citizens with broad autonomy over end-of-life decisions.

97. See Tucker, *supra* note 2, at 45; *AMWA Advocacy History & Timeline*, *supra* note 64.

98. See Tucker, *supra* note 2, at 45; *AMWA Advocacy History & Timeline*, *supra* note 64.

99. See Kathryn L. Tucker, *Aid in Dying: Guidance for an Emerging End-of-Life Practice*, 142 CHEST 218, 218–24 (2012) (arguing that it is timely for clinical practice guidelines for aid in dying to emerge and that these guidelines will inform the practice and standards of care); see also *AMWA Advocacy History & Timeline*, *supra* note 64.

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In addition, no Massachusetts law prohibits the practice with sufficient specificity. Accordingly, aid in dying can emerge within end-of-life medical practices governed by best practices. This would extend an important additional choice to mentally competent, terminally ill Massachusetts residents who confront a dying process that they may find unbearable.

