The Doctor Will See You for the Last Time Now: Physician-Assisted Suicide in Massachusetts

"No one knows whether death may not be the greatest of all blessings for a man, yet men fear it as if they knew that it is the greatest of evils."[1]

I. INTRODUCTION

Under early common law, many states punished assisted suicide as murder.[2] In 1994, however, the Supreme Court of Michigan drew a legal distinction between the concepts of murder and assisted suicide.[3] Despite this distinction, forty-seven states still prohibit physicians from assisting in a patient's death.[4] The justifications for this restriction include avoiding the possibility of abuse, preventing the risk of a slippery slope to involuntary euthanasia, or preserving the integrity of the medical profession.[5] The three states that allow the practice view physician-assisted suicide (P.A.S.) as a means of promoting patient autonomy and providing a merciful end-of-life option for terminally ill patients.[6]

Presently, Massachusetts is in line with the majority of states in prohibiting P.A.S.[7] In September 2011, Attorney General Martha Coakley certified an initiative petition to legalize physician-assisted suicide.[8] The bill, known as the

1. Plato, *Apology of Socrates*, WASH. & LEE U., http://home.wlu.edu/~mahonj/Ancient_Philosophers/Apology2.htm (last visited Jan. 31, 2013).

2. *See* Stephenson v. State, 179 N.E. 633, 654-55 (Ind. 1932) (ignoring "much-mooted question" of criminal liability for one who assists suicide); People v. Roberts, 178 N.W. 690, 693 (Mich. 1920), *overruled by* People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994).

3. *See* People v. Kevorkian, 527 N.W.2d 714, 716 (Mich. 1994) (holding State could not charge physician with murder for prescribing life-ending medication to patients).

4. *See* Cyndi Bollman, Comments, *A Dignified Death? Don't Forget About the Physically Disabled and Those Not Terminally Ill: An Analysis of Physician-Assisted Suicide Laws*, 34 S. ILL. U. L.J. 395, 400 (2010) (describing state measures to prohibit physician assisted suicide).

5. *See infra* Part II.C (discussing state rationale for banning P.A.S.).

6. *See infra* Part II.D (discussing states' rationale for legalizing P.A.S.).

7. *See* MASS. GEN. LAWS ANN. ch. 201D, § 12 (2012) (declaring nothing in Massachusetts General Laws permits assisted suicide).

8. *See* Scot Lehigh, Op-Ed., *Death with Dignity in Mass.*, BOS. GLOBE, Sept. 23, 2011, http://articles.boston.com/2011-09-23/bostonglobe/30194758_1_terminally-human-life-ballot-question.

Massachusetts Death with Dignity Act (DWDA), would have allowed terminally ill patients to request and receive lethal dosages of medication to end their own lives.[9] Voters narrowly rejected the bill during the 2012 general election.[10]

This Note will focus on the effects that a bill like the proposed DWDA might have on patient care in Massachusetts.[11] Specifically, this Note focuses on the effect of legalized physician-assisted suicide on patient autonomy, elder care, and the dignity of the medical profession.[12] This Note also discusses the potential future of end-of-life care, including active euthanasia and the availability of physician-assisted suicide to minors.[13]

II. HISTORY

A. Definitions

Regarding end-of-life care, there are three possible means of hastening death: passive euthanasia, physician-assisted suicide, and active euthanasia.[14] Passive euthanasia involves a health care practitioner allowing a terminally ill patient to die by withholding or withdrawing life support.[15] Passive euthanasia is the only death-hastening measure currently protected by the United States Constitution.[16] It differs from physician-assisted suicide and active euthanasia because the cause of death is an underlying disease rather than an affirmative action by the patient or physician.[17]

P.A.S., the procedure discussed in this Note, occurs when a health care practitioner intentionally provides a patient with the medical means or knowledge needed to end his or her life.[18] A typical example of P.A.S. involves a physician purposefully prescribing a lethal dose of medication for a patient, who then ingests it to end his or her life.[19]

9. *See* H.R. 3884, 187th Gen. Ct. (Mass. 2011).

10. *See Massachusetts "Death With Dignity" Initiative, Question 2 (2012)*, BALLOTPEDIA, http://ballotpedia.org/wiki/index.php/Massachusetts_%22Death_with_Dignity%22_Initiative,_Question_2_(2012) (last visited Dec. 20, 2012) [hereinafter BALLOTPEDIA] (discussing voting results).

11. *See infra* Part III.

12. *See infra* Part III.

13. *See infra* Part III.

14. *See Forms of Euthanasia*, BBC, http://www.bbc.co.uk/ethics/euthanasia/overview/forms.shtml (last visited Jan. 31, 2013).

15. *See* BLACK'S LAW DICTIONARY 634 (9th ed. 2009) (defining passive euthanasia). Life support usually involves a feeding tube or respirator that artificially sustains life. *Id.*

16. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (holding competent patients have constitutionally protected liberty interest in refusing unwanted medical treatment).

17. *See* Barber v. Superior Court, 195 Cal. Rptr. 484, 498-92 (Cal. Ct. App. 1983) (holding physician not criminally liable for withdrawing life support absent affirmative duty to act).

18. *See* BLACK'S LAW DICTIONARY 1571 (9th ed. 2009) (defining P.A.S.).

19. *See* People v. Kevorkian, 527 N.W.2d 714, 733 (Mich. 1994) (explaining Kevorkian's process of providing patients with means to self inject lethal dosage).

Active euthanasia is the process by which a health care practitioner causes the patient's death through an affirmative act.[20] While a physician engaging in P.A.S. only provides the patient with the dosage of medicine, a practitioner engaged in active euthanasia injects the dosage directly into the patient's body.[21] Presently, no state allows a doctor to practice active euthanasia.[22]

B. From Murder to Medicine: The Development of P.A.S. in the United States

Under early common law, many states considered assisting suicide tantamount to murder.[23] For example, in *People v. Roberts*, the defendant's wife suffered from multiple sclerosis.[24] Upon his wife's request, the defendant poured a lethal mixture and placed it next to her bed.[25] The defendant's wife drank the deadly cocktail and died.[26] The Michigan Supreme Court upheld the defendant's first-degree murder conviction, reasoning that his conduct amounted to a deliberate, premeditated act done with the purpose of ending another person's life.[27] The case gained significant attention throughout the country and around the world.[28]

20. *See* BLACK'S LAW DICTIONARY 634 (9th ed. 2009) (defining active euthanasia).

21. *See Chronology of Dr. Jack Kevorkian's Life and Assisted Suicide Campaign*, FRONTLINE, http://www.pbs.org/wgbh/pages/frontline/kevorkian/chronology.html (last visited Jan. 31, 2013) (describing legal consequences of Dr. Kevorkian's conduct). While Dr. Kevorkian successfully appealed his first murder conviction for providing patients with lethal medication, he was found guilty in his second trial after directly injecting medication into the patient. *Id.*

22. *See* WEST'S ENCYCLOPEDIA OF AMERICAN LAW 236-41 (Shirelle Phelps & Jeffrey Lehman eds., 2d ed. 2005) (explaining legal status of active euthanasia). An intentional killing is considered a homicide even if the patient expresses a desire to die. *Id.* If the medical community begins to recognize P.A.S. as a valid medical procedure, the potential for legalizing active euthanasia becomes more likely. *See infra* Part III.D (analyzing potential implications of legalizing P.A.S.).

23. *See, e.g.*, Commonwealth v. Bowen, 13 Mass. 356, 356 (1816) (holding defendant potentially guilty for providing rope to help prisoner hang himself); People v. Roberts, 178 N.W. 690, 691 (Mich. 1920), *overruled by* People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994) (prosecuting husband who provided poison to terminally ill wife upon request); Blackburn v. State, 23 Ohio St. 146, 160 (1872), *overruled in part by* State v. Staten, 18 Ohio St. 2d 13 (1969) (upholding murder conviction where defendant provided poison to encourage suicide). This categorization was usually based on the theory that suicide was self-murder, so assisting in a suicide was like assisting in a murder. *See* Washington v. Glucksberg, 521 U.S. 702, 706-07 (1997) (discussing Washington's criminalization of "assisting . . . self-murder"); Commonwealth v. Mink, 123 Mass. 422, 428 (1877) (comparing aiding suicide to aiding and abetting murder).

24. *See Roberts*, 178 N.W. at 691 (discussing terminal nature of wife's medical condition).

25. *See id.* (describing mixture of paris green and water). Paris green is a highly toxic powder used as a pesticide. *See Hazardous Substance Fact Sheet*, N.J. DEP'T OF HEALTH & SENIOR SERVS., http://nj.gov/health/eoh/rtkweb/documents/fs/0529.pdf (last visited Jan. 31, 2013). It is also used to create the color blue in fireworks. *See* Lee Partin, *Copper as a Colorant*, SKYLIGHTER.COM, http://www.skylighter.com/fireworks/how-to-make/blue-copper-fireworks-stars.asp (last visited Jan. 31, 2013).

26. *See Roberts*, 178 N.W. at 691 (repeating coroner's testimony from lower court).

27. *See id.* at 693 (refusing to acknowledge wife's consent as defense). The court looked at a number of different definitions of murder and found that Roberts's action fit each one. *Id.* In reaching its final holding, the court pointed out that Roberts deliberately placed the poison within his wife's reach and that there was no other way she could have ended her life. *Id.* His motive for aiding in his wife's death was irrelevant. *Id.* Roberts was sentenced to life imprisonment for his crime. *Id.*

28. *See* ENCYCLOPEDIA OF DOMESTIC VIOLENCE 186 (Nicky Ali Jackson ed., 2007). The case spurred a

Roberts remained uncontested for seventy-four years until the case of *People v. Kevorkian*.[29] In *Kevorkian*, a doctor was found guilty of murder after providing lethal dosages of medicine to two patients, Sherry Miller and Marjorie Wantz.[30] On appeal, the Michigan Supreme Court explicitly overruled *People v. Roberts* and held that the state could not charge Dr. Kevorkian with murder merely for assisting in the patients' suicides.[31] The court reasoned that Dr. Kevorkian's actions did not meet the necessary elements of murder.[32] Specifically, the State lacked evidence that Dr. Kevorkian acted as the direct and natural cause of the patient's death.[33] While reversing the murder charges, the court held that nothing in the United States Constitution prohibited Michigan from passing a statute prohibiting assisted suicide.[34]

C. Do Fear the Reaper: States Banning P.A.S.

A number of states have avoided the issue faced by the Michigan Supreme Court by passing statutes classifying assisted suicide as manslaughter.[35] The majority of states, however, have passed statutes specifically criminalizing the act of assisting in another's suicide.[36] A handful of states, including

1941 German film entitled "Ich klage an" ("I Accuse") dramatizing the trial. *Id.* The film received international acclaim and won a gold medal at the Venice Film Festival. *Id.* Despite denials by the director, many experts consider the piece a sophisticated Nazi propaganda film, used to promote the "mercy killings" that eventually grew into the Holocaust. *Id.*

29. 527 N.W.2d 714, 716 (Mich. 1994) (overruling *Roberts* after seventy-four years).

30. *See id.* at 723 (describing Dr. Kevorkian's "suicide machine"). Dr. Kevorkian's process involved strapping a board to the patient's arm to prevent movement, then inserting a needle attached to an IV tube into the patient's blood vessel. *Id.* The tube contained lethal chemicals that the patient could release by raising his or her hand in the air. *Id.*

31. *See id.* at 716 (explicitly overruling *Roberts*).

32. *See id.* (holding Dr. Kevorkian's conduct did not satisfy causation element).

33. *See Kevorkian*, 527 N.W.2d at 716 (explaining court's reasoning). The court pointed out that the State could have prosecuted Dr. Kevorkian for assisting suicide as a common-law felony under the savings clause of the Michigan Penal Code. *Id.*

34. *See id.* While the constitutionality of these statutes is not discussed in this Note, the United States Supreme Court has generally held that such prohibitions are permissible. *See* Vacco v. Quill, 521 U.S. 793, 807-08 (1997) (holding New York's prohibition on assisting suicide did not violate Equal Protection Clause); Washington v. Glucksberg, 521 U.S. 702, 728 (1997) (holding Washington's ban on assisted suicide served legitimate government interest in preserving life). Additionally, the Court has never recognized a constitutionally protected interest in assisted suicide. *See Glucksberg*, 521 U.S. at 723 (analyzing historical views of suicide and assisted suicide).

35. *See* ALASKA STAT. § 11.41.120(a)(2) (2012); ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (2012); ARK. CODE ANN. § 5-10-104(a)(2) (2012); COLO. REV. STAT. § 18-3-104(1)(b) (2012); CONN. GEN. STAT. ANN. § 53a-56 (West 2012); FLA. STAT. ANN. § 782.08 (West 2012); HAW. REV. STAT. ANN. § 707-702(1)(b) (LexisNexis 2012); MO. ANN. STAT. § 565.023(1) (West 2012); N.Y. PENAL LAW § 125.15 (McKinney 2012); OR. REV. STAT. ANN. § 163.125(1)(b) (West 2012).

36. *See* CAL. PENAL CODE § 401 (West 2012); DEL. CODE ANN. tit. 11, § 645 (2012); GA. CODE ANN. § 16-5-5(b)-(c) (2012); IDAHO CODE ANN. § 18-4017 (2012); 720 ILL. COMP. STAT. ANN. 5/12-34.5 (2012); IND. CODE ANN. § 35-42-1-2.5 (West 2012); IOWA CODE ANN. § 707A.2 (West 2012); KAN. STAT. ANN. § 21-5407 (West 2012); KY. REV. STAT. ANN. § 216.302 (West 2012); LA. REV. STAT. ANN. § 14:32.12 (2012); ME. REV.

Massachusetts, have simply ignored this issue and continue to punish assisted suicide under common law.[37] Nevada, Utah, and Wyoming have declined to punish assisted suicide under common law or through a statute, but none have affirmatively legalized the practice.[38]

The first rationale for prohibiting physician-assisted suicide is the fear that a terminally ill patient is incapable of making a rational, informed decision about ending his or her life.[39] Opponents of P.A.S. argue that it is extremely difficult, if not impossible, to determine whether a terminally ill patient is choosing death rationally or as a result of pain or financial pressure.[40] Studies revealing significant under-diagnosis of depression in terminally ill patients support the concern that many seemingly competent patients are actually too emotionally unstable to make an informed decision.[41] Additionally, many patients may

STAT. ANN. tit. 17A, § 204 (2011); MD. CODE ANN., CRIM. LAW § 3-102 (LexisNexis 2013); MICH. COMP. LAWS ANN. § 750.329a (1), (3) (West 2012); MINN. STAT. ANN. § 609.215 (West 2012); MISS. CODE ANN. § 97-3-49 (2012); MONT. CODE ANN. § 45-5-105 (2011); NEB. REV. STAT. ANN. § 28-307 (LexisNexis 2012); N.H. REV. STAT. ANN. § 630:4 (2012); N.J. STAT. ANN. § 2C:11-6 (2013); N.M. STAT. ANN. § 30-2-4 (West 2012); N.D. CENT. CODE § 12.1-16-04 (2011); OHIO REV. CODE ANN. § 3795.02 (LexisNexis 2012); OKLA. STAT. tit. 21, §§ 813, 818 (2012); OKLA. STAT. tit. 63, § 3141.1; 18 PA. CONS. STAT. ANN. § 2505 (West 2012) (unless force, duress, or deception used, in which case appropriately charge murder); P.R. LAWS ANN. tit. 33, § 4738 (2009); R.I. GEN. LAWS § 11-60-3 (2012); S.C. CODE ANN. § 16-3-1090(B), (E), (F), (G)(1) (2012); S.D. CODIFIED LAWS § 22-16-37 (2012); TENN. CODE ANN. § 39-13-216(a), (e), (f), (g) (2012); TEX. PENAL CODE ANN. § 22.08 (West 2011); V.I. CODE ANN. tit. 14, § 2141 (2012); VA. CODE ANN. § 8.01-622.1 (2012); WASH. REV. CODE ANN. § 9A.36.060 (West 2012) (although permissible if performed by physician); WIS. STAT. ANN. § 940.12 (West 2012). Montana punishes assisted suicide as homicide if the attempt results in death, but provides a defense if performed by a physician. MONT. CODE ANN. § 45-5-105 (West 2011). New York became the first state to explicitly outlaw assisted suicide by statute in 1828. *Glucksberg*, 521 U.S. at 706 (discussing history of assisted suicide laws).

37. *See Assisted Suicide Laws in the United States,* PATIENTS RIGHTS COUNCIL, http://www.patientsrightscouncil.org/site/assisted-suicide-state-laws (last visited Jan. 30, 2013). Alabama, North Carolina, Vermont, Washington D.C., and West Virginia also treat assisted suicide under common law. *Id.*

38. *See id.* Nevada's statute permitting withdrawal of life support explicitly states that the statute does not "condone, authorize or approve mercy-killing." NEV. REV. STAT. ANN. § 449.670(2) (LexisNexis 2012). Similarly, Utah's Advance Health Care Directive Act "does not authorize mercy killing, assisted suicide or euthanasia." UTAH CODE ANN. § 75-2a-122(2) (LexisNexis 2012).

39. *See* Susan M. Wolf, *Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate*, 82 MINN. L. REV. 1063, 1074 (1998) (noting difficulty of determining whether patients competent during end-stages of terminal diseases). Opponents argue that linking P.A.S. and patient autonomy is a false, idealistic presumption that ignores the reality of actual patient care. *Id.* They argue that in most cases, if a patient has to make end-of-life choices, he or she has already lost the physiological capacity to do so. *Id.*; *see also* Nicholas G. Smedira et al., *Withholding and Withdrawal of Life Support from the Critically Ill*, 322 NEW ENG. J. MED. 309, 313 (1990), *available at* http://www.nejm.org/doi/full/10.1056/NEJM199002013220506 (studying patient competency during end-of-life decisions). A study of 115 patients at San Francisco General Hospital found that only four percent were competent at the time the physician removed life support. Smedira et al., *supra*.

40. *See* Wolf, *supra* note 39, at 1076-77 (discussing end-of-life choices from patient's perspective). Opponents note that patients depend almost entirely on health professionals in the end-stages of life, suffer from depression, or experience too much pain and discomfort to make independent and truly voluntary decisions. *Id.* Many patients do not even realize that depression or pain can be treated without suicide. *Id.*

41. *See* Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153

make the decision to end their lives based on fears about mounting medical bills.[42] Rather than promoting patient autonomy, P.A.S. would force patients to make decisions that they are mentally unable to handle.[43]

A second reason for banning P.A.S. is the idea that the procedure violates the integrity of the medical profession.[44] Opponents argue that legalizing P.A.S. transforms doctors from healers into killers, perverting the role of medicine and violating the Hippocratic Oath.[45] Some states have begun to address this concern by proposing legislation that would allow a physician to refuse to perform medical procedures that contradict his or her fundamental beliefs or conscience.[46] Critics of this argument point out that much of the original language of the Hippocratic Oath is outdated and no longer applicable to current medical practices.[47]

The third argument for banning P.A.S. is preventing a slippery slope towards involuntary euthanasia.[48] The concern is that by legalizing P.A.S., the right to

AM. J. PSYCHIATRY 1469, 1474 (1996) (finding many Oregon psychiatrists had difficulty determining whether patients seeking assisted suicide depressed).

42. *See* Leslie Joan Harris, *Semantics and Policy in Physician-Assisted Death: Piercing the Verbal Veil*, 5 ELDER L.J. 251, 289-90 (1997) (discussing patients' financial pressures). Facing increasing expenses, patients might feel compelled to choose P.A.S. in order to avoid imposing a financial burden on their loved ones after death. *Id.*; *see also* Washington v. Glucksberg, 521 U.S. 702, 730 (1997) (worrying patients might resort to P.A.S. to spare families from severe financial burden). Some proponents of P.A.S., however, argue that this concern is not a danger at all. *See* Harris, *supra*, at 290. Rather, they assert that it is logical for a patient to want to avoid passing excessive medical bills onto his or her family just to live out the last few days of his or her life battling a terminal illness. *See id.*; *see also* Jeffrey A. Johnson, *Denial: The American Way of Death*, ORTHODOXY TODAY (Nov. 16, 2004), http://www.orthodoxytoday.org/articles4/JohnsonDeath.php (discussing overwhelming negative perception of death by Americans).

43. *See* J. David Velleman, *Against the Right to Die*, 17 J. MED. & PHIL. 665, 668 (1992) (discussing negative impact of increasing end-of-life options).

44. *See* Kurt Darr, *Physician-Assisted Suicide: Legal and Ethical Considerations*, 40 J. HEALTH L. 29, 60 (2007) (predicting impact of legalizing P.A.S. on medical community). Opponents argue that legalizing P.A.S. would undermine the physician's role as a healer. *Id.* A patient's awareness of this change in the physician's role would arguably undercut the trust necessary in the physician-patient relationship. *See id.*

45. *See* Peter Tyson, *The Hippocratic Oath Today*, PBS (Mar. 27, 2001), http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html (setting forth traditional oath sworn by medical students at graduation). The relevant portion of the original Oath states, "I swear . . . I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect." *Id.* Around the 1920s, many American medical schools abandoned the original Oath in graduation ceremonies, instead using modified versions reflecting modern developments in medicine. *See id.*

46. *See* S.B. 46, 2011 Reg. Sess. (Ala. 2011) (defining conscience as either religious or ethical beliefs). In a 2010 poll of approximately 10,000 physicians, forty-five percent believed P.A.S. should be allowed in some cases, while forty percent believed in a blanket prohibition. *See* Leslie Kane, *Exclusive Ethics Survey Results: Doctors Struggle With Tougher-Than-Ever Dilemmas*, Medscape (Nov. 11, 2010), http://www.medscape.com/viewarticle/731485_2.

47. *See* Tyson, *supra* note 45 (reviewing use of Oath). According to a 1993 survey of 150 U.S. and Canadian medical schools, only fourteen percent of modern oaths prohibit euthanasia. *Id.* Eight percent of modern oaths continue to forbid abortion, and only three percent of modern oaths prohibit sexual conduct with patients, despite the classical Oath forbidding such relationships. *Id.* Other outdated portions of the Oath require medical students to teach medicine to the sons of professors free of charge and forbid use of a knife during surgery. *Id.*

48. *See* Margaret K. Dore, *"Death with Dignity": A Recipe for Elder Abuse and Homicide (Albeit Not by*

die would quickly become an obligation to die.[49] Opponents of P.A.S. point out that this fear is particularly alarming with regard to elderly and disabled patients, whose lives may be viewed as less valuable and potentially "disposable" even against the wishes of the patient.[50] In support of this position, a 2010 poll revealed that sixteen percent of physicians would halt life-sustaining treatment of a patient at the request of the patient's family, even if the physician believed it was premature.[51]

D. Swing and Miss: Failed Attempts to Legalize P.A.S. in the United States

Despite the underlying concerns leading to a ban on assisted suicide by most of the country, twenty-five states presented legislative proposals to legalize P.A.S. between 1994 and 2011.[52] In 2000, Maine nearly legalized P.A.S.[53]

Name), 11 MARQ. ELDER'S ADVISOR 387, 400-01 (2010) (discussing low safeguards of Oregon's and Washington's P.A.S. laws). Opponents of P.A.S. point out that both Oregon and Washington allow P.A.S. without requiring patient consent at the time the drug is administered. *Id.* at 391-92; *see also* OR. REV. STAT. ANN. §§ 127.800-.995 (West 2012) (lacking consent requirement at time of administration); WASH. REV. CODE ANN. §§ 70.245.010-.904 (West 2012) (wanting of consent requirement for administration). Opponents also highlight that both statutes allow another person to request lethal medication on behalf of the patient. Dore, *supra*, at 389. The Washington Act requires that "a patient has the ability to make and communicate an informed decision . . . including communication through persons familiar with the patient's manner of communicating." WASH. REV. CODE ANN. § 70.245.010(3). The Oregon Act uses similar language, defining a patient as "capable" if "a patient has the ability to make and communicate health care decisions . . . including communication through persons familiar with the patient's manner of communicating." OR. REV. STAT. ANN. § 127.800, § 1.01(3). Opponents warning of a slippery slope often point to the practice of euthanasia by the Nazis. *See* Ron Panzer, *Are We Becoming a Nazi-Like Nation?*, HOSPICE PATIENTS ALLIANCE (Apr. 25, 2005), http://www.hospicepatients.org/are-we-a-nazi-society.html. Before the Holocaust, the Nazis implemented a program called T-4, which was designed to exterminate members of the population physicians determined to be "unfit." *See generally* ROBERT JAY LIFTON, THE NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE (1986) (discussing historical origins for Nazi genocide). Some experts believe T-4 originated from several trials in 1938, where Adolf Hitler permitted the "mercy killing" of several developmentally disabled infants at the request of the children's guardians. *Id.* at 50–51. The Nazi regime used "mercy killing" to establish a program of murdering disabled children without guardian consent. *Id.* Eventually, this practice turned into the mass extermination of adults. *Id.*

49. *See* Dore, *supra* note 48, at 400.

50. *See* Marilyn Golden, *Why Assisted Suicide Must Not Be Legalized*, DISABILITY RIGHTS EDUC. & DEF. FUND, http://www.dredf.org/assisted_suicide/assistedsuicide.html (last visited Jan. 31, 2013) (focusing on societal view of disabled people as less fit to live than those without disabilities). After Oregon approved the Death with Dignity Act, lobbyists for the elderly pushed to pass Measure No. 51, an amendment that would have repealed the new law. Lori Long, *Basics on . . . Ballot Measure 51*, OR. LEGIS. POL'Y & RES. OFFICE (Oct. 1997), http://www.leg.state.or.us/comm/commsrvs/51final.pdf. The argument for passing the amendment relied heavily on the concern that legalizing P.A.S. would eventually lead to involuntary euthanasia of the elderly. *Id.*

51. *See* Kane, *supra* note 46 (examining physicians on various ethical issues regarding end-of-life treatment).

52. *See Attempts to Legalize*, PATIENTS RIGHTS COUNCIL, http://www.patientsrightscouncil.org/site/failed-attempts-usa (last visited Dec. 27, 2012) (summarizing legislative measures to legalize P.A.S.). Between January 1994 and March 2011, state legislatures presented 122 different proposals to legalize P.A.S. *Id.* Voters formally rejected proposals in Washington (1991), California (1992), Michigan (1998), and Maine (2000), while bills in twenty-one other states simply faded out at some point in the legislative process. *Id.* Hawaii has made the most attempts to legalize the practice, with ten undecided ballot proposals since 1998. *Id.*

Voters rejected the proposal by a vote of fifty-one percent to forty-nine percent.[54] Strong opposition by both the Maine Medical Association and religious groups contributed to the bill's defeat.[55]

E. States Legalizing P.A.S.

In 1994, voters made Oregon the first state to legalize P.A.S. by passing the Oregon Death with Dignity Act (ODDA).[56] The ODDA was the first successful attempt to legalize P.A.S., and it did not come without controversy.[57]

53. *See Maine Physician-Assisted Deaths, Question 1 (2000)*, BALLOTPEDIA (June 5, 2012), http://ballotpedia.org/wiki/index.php/Maine_Physician-Assisted_Deaths,_Question_1_(2000). Patterned after the Oregon Death with Dignity Act, the initiative would have legalized P.A.S. in Maine. *See Attempts to Legalize*, *supra* note 52.

54. *See Attempts to Legalize*, supra note 52. The final vote was 332,280 to 315,031. *Referendum Election Tabulations: November 7, 2000*, MAINE.GOV, http://www.maine.gov/sos/cec/elec/2000g/gen00r-s.htm (last visited Jan. 31, 2013). Nearly seventy percent of Maine's registered voters weighed in on the proposal. *Compare id.*, *with Enrolled and Registered Voters as of the November 7, 2000 General Election*, MAINE.GOV, http://www.maine.gov/sos/cec/elec/enr/enr00.htm (last visited Jan. 31, 2013) (numbering Maine's registered voters at 947,189 in 2000).

55. *See Voters Reject Assisted Suicide in Maine*, EUTHANASIA.COM, http://www.euthanasia.com/mainevote.html (last visited Jan. 31, 2013). National Right to Life, along with the National Legal Center for the Medically Dependent and Disabled, mailed detailed information about the flaws and faults of the assisted suicide proposal to every household in Maine. *Id.* After the ballot's defeat, the president of the American Medical Association commended the Maine Medical Association for "upholding the notion that terminally-ill patients should not be abandoned." *Id.*

56. *See* OR. REV. STAT. ANN. § 127.805 (West 2012) (making Oregon first state to legalize physician-assisted dying). Voters approved the measure in the November 1994 general election. *See* Or. Sec'y of State, *Initiative, Referendum and Recall: 1988-1995*, OR. BLUE BOOK, *available at* http://bluebook.state.or.us/state/elections/elections21.htm (last visited Jan. 31, 2013). Voters supported the bill by a vote of 627,980 voters (51.3%) to 596,018 voters (48.7%). *Id.*

57. *See* Ann Jackson, *The Inevitable—Death: Oregon's End-of-Life Choices*, 45 WILLAMETTE L. REV. 137, 139-40 (2008) (discussing lengthy legalization process). Voters passed the bill in 1994, but opponents filed an injunction that remained in place until 1997. *Id.* The Ninth Circuit lifted the injunction on October 27, 1997, and physician-assisted suicide became a legal option for terminally ill patients in Oregon. Arthur Euguene Chin et. al., OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE 1 (1999) [hereinafter OREGON YEAR ONE STUDY], *available at* http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year1.pdf. Eight days after the ban was lifted, Oregon held a special election to vote on Measure 51, which would have repealed the Death with Dignity Act. *Id.* Voters rejected Measure 51, with 666,275 (60%) opposing the bill and 445,830 (40%) supporting it. *Id.* The U.S. Drug Enforcement Agency (DEA) then issued an opinion threatening to suspend physicians who wrote prescriptions under the Act. *See* Jackson, *supra*, at 140 (describing DEA response to Act). U.S. Attorney General Janet Reno reversed the opinion in April 1998, but, three years later, U.S. Attorney General John Ashcroft wrote an opinion claiming the Controlled Substances Act (CSA) granted the federal government authority to sanction physicians who prescribed controlled substances under ODDA. *Id.* Oregon's district court issued a restraining order against Ashcroft, prohibiting him from punishing physicians for prescribing medication under the ODDA. *See* Gonzales v. Oregon, 546 U.S. 243, 254 (2006) (reasoning CSA did not permit federal government to restrict state medical policies). The United States Supreme Court eventually upheld the restraining order, reasoning that the CSA did not authorize the Attorney General to prohibit doctors from prescribing medication under Acts like ODDA. *Id.* at 274-75. Seven months after *Gonzales*, Senator Sam Brownback sponsored an amendment that would have allowed the federal government to prohibit assisted suicide under the CSA. Assisted Suicide Prevention Act of 2006, S. 3788, 109th Cong. (2006) (proposing to allow federal government to restrict controlled substances used for assisted suicide). The

The ODDA includes a number of restrictions and limitations designed to address concerns about patient abuse and duress.[58] The ODDA does not mandate P.A.S. and allows any physician or hospital to refrain from engaging in the practice.[59]

In the first year of availability, twenty-three patients requested and received lethal prescriptions.[60] Fifteen died from the prescription; six died from their underlying illness; two were alive at the end of the year.[61] Patients from the first year primarily cited a fear of losing autonomy or control over bodily functions as the reasons for their decision to request medication.[62]

In the second year, thirty-three patients received lethal prescriptions.[63] Twenty-six patients died from the dosage, while five died from their underlying illness.[64] Two patients were still alive at the conclusion of the study.[65] The patients' primary reasons for choosing P.A.S. included loss of autonomy (81%); decreased ability to participate in enjoyable activities (81%); desire for

bill never gained any significant momentum or support. *See S. 3788 (109th): Assisted Suicide Prevention Act of 2006*, GOVTRACK.US, http://www.govtrack.us/congress/bills/109/s3788 (last visited Jan. 31, 2013) (explaining bill referred to committee and never passed).

58. *See, e.g.*, OR. REV. STAT. ANN. § 127.805(2) (West 2012) (precluding qualification solely on age or disability); *id.* § 127.810 (requiring two witnesses to attest to patient capability and voluntariness); *id.* § 127.815(1)(c) (outlining doctor responsibilities to ensure informed patient decision). The ODDA is only applicable to capable Oregon residents eighteen or older who have been diagnosed with a terminal illness that will lead to death within six months. *Id.* § 127.800(1),(12). A patient is "capable" if the patient is able to make and communicate health-care decisions. *Id.* (noting both prescribing physician and consulting physician make determination). The patient must make an initial written and oral statement to his or her attending physician, and then repeat the request at least fifteen days later. *Id.* § 127.840. If the attending or consulting physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, or that the patient is depressed, the patient must be referred for counseling. *Id.* § 127.825. The attending physician must inform the patient of viable alternatives to assisted suicide, including comfort care, hospice care, and pain control. *See id.* § 127.815(1)(c)(E). The prescribing physician must request, but may not require, the patient to notify his or her next of kin of the prescription request. *See id.* § 127.835.

59. *See id.* § 127.885(4).

60. *See* OREGON YEAR ONE STUDY, *supra* note 57, at 4. The average patient age was sixty-nine. *Id.* Every patient was white. *Id.* Of the patients who died, eleven were male and ten were female. *Id.* Every patient underwent a psychological analysis to determine capability. *Id.* at 5.

61. *See id.* at 1. Although Oregon voters passed the ballot in 1994, the first medications were distributed in 1998, after the Ninth Circuit lifted the district court's injunction. *Id.* One of the two living patients ingested the lethal medication shortly after the conclusion of the first year study. Amy D. Sullivan et al., OREGON'S DEATH WITH DIGNITY ACT: THE SECOND YEAR'S EXPERIENCE 9 (2000) [hereinafter OREGON YEAR TWO STUDY], *available at* http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year2.pdf (discussing patients from year one study).

62. *See* OREGON YEAR ONE STUDY, *supra* note 57, at 8. The study showed that patients who chose P.A.S. were not disproportionately poor (as measured by Medicaid status), less educated, lacking in insurance coverage, or lacking in access to hospice care. *Id.* Concern about the financial impact of illnesses was not disproportionately associated with the decision to choose P.A.S. *Id.* Nevertheless, this study acknowledged that its data was limited by the small sample size and a lack of information about unreported lethal prescriptions. *Id.* at 9.

63. *See* OREGON YEAR TWO STUDY, *supra* note 61, at 3.

64. *See id.*

65. *See id.*

control over the manner and time of death (74%); loss of control of bodily functions (68%); and physical suffering (53%).[66]

Despite initial concerns that the ODDA would open up floodgates to patient suicide, utilization of the procedure remained relatively low during the first ten years of availability.[67] Fears that Oregon's Act targeted the poor and uneducated appear to have been misguided, as studies revealed that a majority of patients choosing P.A.S. were well educated and financially stable.[68] Although divorced and single adults request P.A.S. more than married patients, data suggests that lack of social support was actually a low concern for patients considering whether to utilize ODDA.[69] Finally, despite concerns that the Act targeted the disabled, the highest usage came from cancer and ALS patients.[70]

In 2008, Washington became the second state to legalize P.A.S.[71] Voters passed the ballot initiative, which closely models ODDA, by a vote of fifty-eight percent to forty-two percent.[72] In the brief time since voters passed

66. *See id.* (listing patient concerns and considerations). Like the patients in the first year study, the patients in the second year did not cite poverty, lack of education or insurance, or poor end-of-life care as important factors influencing their decisions to utilize P.A.S. *See id.* at 10 (indicating factors cited as contributors). In 2011, Oregon conducted another study and found that 93.8% of patients cited loss of autonomy as their primary concern when deciding whether to order a lethal prescription. Eileen McNamara, *Death With Dignity?*, BOS. MAG. (Dec. 2011), http://www.bostonmagazine.com/articles/2011/11/death-with-dignity/.

67. *See* Jackson, *supra* note 57, at 144-45 (listing utilization rates). During public debates in 1994 and 1997, opponents of ODDA predicted that the utilization rate could be as high as ten percent of all deaths. *Id.* at 145. In the first ten years of ODDA, P.A.S. accounted for 341 of approximately 300,000 deaths in Oregon, a rate of about 0.1%. *Id.* In 2011, however, 114 patients requested lethal medication, with seventy-one dying as a result. *See* Tom Strode, *Oregon Breaks Its Assisted Suicide Record*, BAPTIST PRESS NEWS, Mar. 13, 2012, http://www.bpnews.net/BPnews.asp?ID=37385. Both numbers were a record high for the state. *See id.*

68. *See* Or. Health Auth., *Oregon's Death with Dignity Act—2007*, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year10.pdf (last visited Jan. 31, 2013) [hereinafter OREGON YEAR TEN STUDY]; *see also* Jackson, *supra* note 57, at 144-45 (discussing demographic most often choosing to undergo P.A.S.). Patients who request lethal prescriptions tend to have significantly more education than those in the cohort with the same diseases. Jackson, *supra* note 57, at 146. In 2003, more than ninety-six percent of patients choosing P.A.S. had health insurance, with sixty percent of the insurance privately funded, rather than provided by Medicare or Medicaid. McNamara, *supra* note 66.

69. *See* OREGON YEAR TEN STUDY, *supra* note 68 (noting divorced and single patients request P.A.S. more than married patients); Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide*, 347 NEW ENG. J. MED. 582, 584 & tbl.2 (2002), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMsa020562 (noting patients cited lack of social support as twentieth of twenty-one reasons for P.A.S.).

70. *See* Jackson, *supra* note 57. Most patients who actually used the prescription suffered from malignant or nonmalignant tumors. *See id.* Lung cancer represented the diagnosis with the highest number of ODDA users. *See id.* Most other patients suffered from ALS or HIV/AIDS. *See id.* ALS, also known as Lou Gehrig's disease, is a fatal, neurodegenerative disease that predominately affects motor neurons. *Amyotrophic Lateral Sclerosis*, MEDLINE PLUS, http://www.nlm.nih.gov/medlineplus/amyotrophiclateralsclerosis.html (last updated Jan. 30, 2013).

71. *See* WASH. REV. CODE ANN. § 70.245.903 (West 2012). Voters approved Washington's Death with Dignity Act on November 4, 2008. *Death with Dignity Act*, WASH. STATE DEP'T OF HEALTH, http://www.doh.wa.gov/dwda/default.htm (last visited Feb. 7, 2013).

72. *See November 04, 2008 General Election Results*, WASH. SEC'Y OF STATE, http://vote.wa.gov/results/20081104/Initiative-Measure-1000-concerns-allowing-certain-terminally-ill-competent-adults-to-obtain-

Washington's bill, the state has experienced results similar to the early results in Oregon.[73]

On December 31, 2009, the Montana Supreme Court implicitly legalized P.A.S. by recognizing physician-aided death as a valid defense to a charge of homicide.[74] The court limited its holding, however, by declining to rule on whether individuals have a constitutional right to assisted suicide.[75] Montana's legislature has not reacted to the court's decision, thus allowing the holding to stand as present state law.[76]

Proponents of P.A.S. argue that the procedure increases patient autonomy by providing a wider range of end-of-life choices to terminally ill patients.[77]

lethal-prescriptions.html (last updated Nov. 26, 2008). This measure passed by a vote of 1,715,219 supporting the bill, while 1,251,255 opposed. *Id.* Over eighty-four percent of registered voters appeared to weigh in on the initiative. *November 04, 2008 General Election Results*, WASH. SEC'Y OF STATE, http://vote.wa.gov/results/20081104/Turnout.html (last updated Nov. 26, 2008). In the same year, only sixty-two percent of registered voters voted in the presidential election. *See* GEORGE PILLSBURY ET AL., NONPROFIT VOTER ENGAGEMENT NETWORK, AMERICA GOES TO THE POLLS: A REPORT ON VOTER TURNOUT IN THE 2008 ELECTION 2 (2008), *available at* http://www.nonprofitvote.org/voter-turnout.html (follow "America Goes to the Polls 2008: Full Report" hyperlink under "Voter Turnout Reports for Past Elections") (recognizing sixty-two-percent turnout highest in forty years).

73. *See* WASH. STATE DEP'T OF HEALTH, WASHINGTON STATE DEPARTMENT OF HEALTH 2010 DEATH WITH DIGNITY ACT REPORT 1 (2010), *available at* http://www.doh.wa.gov/portals/1/Documents/5300/DWDA2010.pdf (describing data in response to act). In 2010, eighty-seven individuals received medication under the Act. *Id.* Fifty-one died from ingesting the medication. *Id.* Fifteen died from natural causes. *Id.* For six individuals, the cause of death was unknown. *Id.* Seventy-eight percent of the individuals had cancer. *Id.* Eighty-eight percent had some type of public or private health insurance, or a combination of both. *Id.* Ninety-five percent of the individuals were white, and sixty-two percent were college educated. *Id.* Only ten percent had less than a high school education. *Id.* at 5. The primary concerns behind choosing P.A.S. were loss of autonomy (90%), loss of dignity (64%), and loss of the ability to participate in activities that made life enjoyable (87%). *Id.* at 1. Only four percent of patients considered the financial implications of treatment in their decision. *Id.* at 5. Nevertheless, twenty-eight percent of individuals cited burdening family or friends as a concern. *Id.* at 7.

74. *See* Baxter v. State, 224 P.3d 1211, 1222 (Mont. 2009) (holding P.A.S. did not violate public policy). In *Baxter*, a patient suffering from terminal leukemia wanted his physician to prescribe a lethal dosage of medication. *Id.* at 1214. The patient challenged the constitutionality of Montana's homicide statute as applied to physicians aiding in the death of competent, terminally ill patients. *Id.* The court looked to Montana's consent statute, which provides that the defense of consent is available in a criminal case unless "'it is against public policy to permit the conduct or the resulting harm, even though consented to.'" *Id.* at 1215 (quoting MONT. CODE ANN. § 45-2-211 (West 2011)). The court held that physician-assisted death is a valid form of consent that does not violate public policy. *Id.* at 1222.

75. *See id.* at 1214 (declining to rule on constitutionality of statute).

76. *See* Kevin B. O'Reilly, *Physician-Assisted Suicide Legal in Montana, Court Rules*, AM. MED. NEWS, Jan. 18, 2010, http://www.ama-assn.org/amednews/2010/01/18/prsb0118.htm. Montana State Representative Dick Barrett plans to propose an Oregon-style physician-assisted-suicide law to protect doctors from civil liability and to institute waiting periods, public reporting, and other patient protections for P.A.S. *See id.* Opponents of the procedure have pledged to push through legislation explicitly prohibiting P.A.S. *Id.*

77. *See* Jackson, *supra* note 57, at 155 (citing burdening loved ones as low concern and "loss of autonomy" as high concern); Rachel D. Kleinberg & Toshiro M. Mochizuki, Recent Development, *The Final Freedom: Maintaining Autonomy and Valuing Life in Physician-Assisted Suicide Cases*, 32 HARV. C.R.-C.L. L. REV. 197, 205 (1997) (discussing "liberty interest" in choosing means of death); Hugh M. Lee & Jo Alison Taylor, *Physician-Assisted Suicide; Involuntary Euthanasia—Arguments For and Against Physician-Assisted Suicide*, *in* ALABAMA ELDER LAW § 7:58 (2004).

P.A.S. allows patients to choose a pain-free alternative to end-of-life care.[78] Additionally, proponents contend that concerns about violating the Hippocratic Oath and the sanctity of the medical profession fall flat when viewed in light of modern medical developments.[79] Finally, proponents argue that the risk of abuse is misguided.[80] In support, they cite the already legal use of "palliative care," a method of treating terminally ill patients by intentionally providing excessive levels of pain medication.[81]

F. So Close and Yet So Far: The Attempt to Legalize P.A.S. in Massachusetts

Before the 2012 election, Massachusetts prohibited P.A.S.[82] The Supreme Judicial Court consistently held that Massachusetts citizens do not have an absolute right to choose the time and manner of their death.[83] At the same time, however, the court recognized that an individual possesses at least some degree of privacy and liberty in controlling his or her final moments of life.[84] In the rare instances when the court has been presented with the issue of assisted suicide, it has consistently forbidden the practice.[85]

78. *See* Velleman, *supra* note 43, at 673 (discussing Oregon patients' top concerns about end of life).

79. *See* S.B. 46, 2011 Reg. Sess. (Ala. 2011) (introducing bill allowing physicians to refuse to perform procedures in violation of religious or ethical beliefs); Margaret P. Battin, *Is a Physician Ever Obligated to Help a Patient Die?*, *in* REGULATING HOW WE DIE: THE ETHICAL, MEDICAL, AND LEGAL ISSUES SURROUNDING PHYSICIAN-ASSISTED SUICIDE 21, 21-22 (Linda L. Emanuel ed., 1998) (discussing physician discretion in most severe medical practices); Marcia Angell, *Give Terminally Ill a Choice*, WORCESTER TELEGRAM & GAZETTE, Sept. 30, 2011, http://www.telegram.com/article/20110930/NEWS/109309785/1020 (discussing ability of physicians to choose not to participate in P.A.S. under proposed law).

80. *See* Darr, *supra* note 44, at 42 (recognizing no Oregon physician has ever been disciplined for improper prescription); Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 895, 904 (1998); Brett Kingsbury, Note, *A Line Already Drawn: The Case for Voluntary Euthanasia After the Withdrawal of Life-Sustaining Hydration and Nutrition*, 38 COLUM. J.L. & SOC. PROBS. 201, 237-38 (2004) (arguing patient has greatest interest of all in ending life during final stages of disease); Lehigh, *supra* note 8 (discussing lack of abuse in Oregon, but acknowledging abuse in Netherlands).

81. *See generally* Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844 (1989) (discussing palliative care). Proponents argue that legalizing P.A.S. would only allow doctors to openly acknowledge that they are acting to hasten a terminally ill patient's death. *See* Harris, *supra* note 42, at 265-66 (describing lethal medication as physician's "last act in a continuum of care" for terminal patients).

82. *See* MASS. GEN. LAWS ANN. ch. 201D § 12 (2012). Massachusetts law provides, "Nothing in this chapter shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one's own life other than to permit the natural process of dying." *Id.*

83. *See, e.g.*, Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 634 (Mass. 1986) (holding right to refuse medical treatment in life-threatening situations not absolute); Comm'r of Corr. v. Myers, 399 N.E.2d 452, 458 (Mass. 1979) (holding Department of Correction Commissioner could authorize prisoner's life-sustaining treatment despite prisoner's objection); Custody of a Minor, 379 N.E.2d 1053, 1056 (Mass. 1978) (allowing state intervention where parents refused to treat child's leukemia).

84. *See Myers*, 399 N.E.2d at 457 (recognizing state's interest in preserving life does not invariably control right to refuse medical treatment); *see also Brophy*, 497 N.E.2d at 633 (recognizing historical protection of self-determination and individual autonomy in medical decisions).

85. *See* Commonwealth v. Mink, 123 Mass. 422, 425 (1877) (refusing to acknowledge consent as justification for homicide); Commonwealth v. Bowen, 13 Mass. 356, 357-58 (1816) (upholding murder conviction for advising and assisting suicide).

In 2011, the Dignity 2012 Coalition proposed the DWDA.[86] If passed, the bill would have made Massachusetts the fourth state to legalize P.A.S.[87] Like Washington, the Massachusetts proposed bill was based heavily on Oregon's Death with Dignity Bill.[88] Opponents sharply criticized the bill as destroying the medical community and creating a slippery slope towards involuntary euthanasia.[89] Supporters of the bill claimed that the DWDA would provide patients with merciful end-of-life options.[90]

In December 2011, the Dignity 2012 Coalition met the signature requirement needed to put the question of P.A.S. on the 2012 ballot.[91] In March 2012, a Public Policy Poll showed that forty-three percent of

86. *See Group: Mass. Patient Suicide Measure Clears Hurdle*, BOSTON.COM, Dec. 7, 2011, http://articles.boston.com/2011-12-07/news/30486645_1_ballot-question-hurdle-patient [hereinafter *Suicide Measure Clears Hurdle*].

87. *But see* Kim Severson, *Georgia Court Rejects Law Aimed at Assisted Suicide*, N.Y. TIMES, Feb. 6, 2012, http://www.nytimes.com/2012/02/07/us/assisted-suicide-law-is-overturned-by-georgia-supreme-court.html. Georgia's supreme court recently struck down a law prohibiting advertisements that offered assisted suicide. *See id.* The court did not hold, however, that P.A.S. was otherwise legal in the state. *See id.* Critics of P.A.S. fear that the court's lack of clarity has turned Georgia into the "wild, wild West for those who are promoting doctor-assisted suicide." *Id.*

88. *See* McNamara, *supra* note 66 (describing proposed procedure for P.A.S. in Massachusetts); *supra* note 58 (describing Oregon provisions). Under the bill, a mentally competent adult could request a prescription for a fatal dose of medication. *See* McNamara, *supra* note 66. Two doctors would have to certify that the patient is within six months of death and is making the request voluntarily. *Id.* The patient would be required to ask two separate times, at least fifteen days apart. *Id.* One request would need to be in writing and witnessed by two people. *Id.* Before any prescription could be written, the doctor would have to wait forty-eight hours after the second request and would have to inform the patient about alternative courses of action, including pain management and hospice care. *Id.* Physicians would be prohibited from directly administering the lethal dose, and no doctor who objected to the law would be required to write such a prescription. *Id.*

89. *See* Kathy McCabe, *Cardinal Rips Suicide Ballot Effort*, BOSTON.COM, Sept. 19, 2011, http://www.boston.com/news/local/massachusetts/articles/2011/09/19/cardinal_urges_opposition_to_assisted_suicide_ballot_petition/ (summarizing Catholic Church's disapproval of bill). Cardinal O'Malley expressed concern that "[b]y rescinding the legal protection for the lives of a category of people, the government sends a message that some persons are better off dead." McNamara, *supra* note 66; *see also* Christine M. Williams, *Medically Vulnerable Need Compassion, Not Death, Speaker Says*, BOS. PILOT, Feb. 3, 2012, http://www.thebostonpilot.com/article.asp?ID=14277 (referring to P.A.S. as "medical abandonment" of vulnerable patients). Opponents also note that despite a lack of any involuntary euthanasia cases in Oregon, Oregon's Medicaid program refuses to pay for some cancer treatment but offers to pay for P.A.S. Mark J. Rollo, *Doctor-Assisted Suicide: An Undignified Death*, SENTINEL & ENTERPRISE, Nov. 22, 2011, http://www.sentinelandenterprise.com/local/ci_19389622. Opponents contend that this choice shows a movement towards pressuring the terminally ill to die rather than to seek expensive treatment. *See id.* To support this position, opponents point out that while advocates for abortion argued that it would be limited to cases where the woman was raped, the procedure was soon offered for almost any reason. *See id.*

90. *See* Catherine L. Bjorck, Comment, *Physician-Assisted Suicide: Whose Life Is It Anyway?*, 47 SMU L. REV. 371, 371 (1994) (discussing 1992 poll showing fifty-three percent of respondents approving P.A.S.); *Americans Still Split on Doctor-Assisted Suicide*, MSNBC, May 29, 2007, http://www.msnbc.msn.com/id/18923323/. Several notable organizations that previously opposed P.A.S., including the Massachusetts Medical Society, have recently manifested support for legalization. McNamara, *supra* note 66 (discussing ethics committee's reassessment of P.A.S.).

91. *See Suicide Measure Clears Hurdle*, *supra* note 86 (discussing signatures). Although only 69,000 signatures were required, over 86,000 supporters provided a certified signature supporting the bill. *Id.*

Massachusetts citizens supported the legislation and twenty percent were undecided.[92] On November 6, 2012, Massachusetts voters voiced their opinion.[93] Voters defeated the bill, fifty-one percent to forty-nine percent.[94]

III. ANALYSIS

A. Under Pressure: Would P.A.S. Impose an Obligation on Patients to Die?

Like in Oregon and Washington, opponents of P.A.S. in Massachusetts argued that the procedure will impose an obligation on the terminally ill to end their lives to avoid burdening loved ones.[95] However, this fear is undercut by the results in Oregon, where burdening loved ones is a relatively low concern in relation to other reasons for choosing P.A.S.[96] Furthermore, if there actually is a risk that patients will feel an "obligation to die," the means for doing so already exist in the current medical profession.[97] If a patient fears she is a burden on her family, she can legally seek palliative care or refuse medical treatment altogether.[98]

Rather than imposing an obligation to die, P.A.S. offers a solution to the problems inherent in the end-of-life choices presently legalized in Massachusetts.[99] P.A.S. gives patients the power to control the time and place of their death, allowing them to avoid the choice between two equally

92. *See* Press Release, Public Policy Polling, *Massachusetts Voters Happy with Gay Marriage* (Mar. 22, 2012), http://www.publicpolicypolling.com/pdf/2011/PPP_Release_MA_322121.pdf. Among voters age sixty-five and older, forty percent opposed legalization. *Id.* The forty-six to sixty-five age range gave the highest approval, with forty-nine percent supporting legalization. *Id.*

93. *See* BALLOTPEDIA, *supra* note 10 (discussing voting results).

94. *See id.* Nearly three million voters weighed in on the initiative, with a disparity of 63,000 votes. *Id*. As of one month before the election, two separate polls showed strong support for legalizing P.A.S. *Id.*

95. *See* McCabe, *supra* note 89 (discussing Catholic Church's concern that P.A.S. will devalue human life).

96. *See supra* notes 60-66 and accompanying text (listing patients' reasons for choosing P.A.S.).

97. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (upholding competent patient's right to refuse medical treatment, even if resulting in death); Howard Brody, *Physician-Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice*, 82 MINN. L. REV. 939, 947 (1998) (recognizing legal palliative care often indistinguishable from euthanasia). Some experts see no distinction between intentionally ending a patient's life, which is illegal, and slowly increasing morphine to an amount likely to cause the patient's death, which is permissible as "palliative care." *See* Brody, *supra*, at 942-44; *see also* Wanzer et al., *supra* note 81 (pointing out physicians already prescribe medically dangerous dosages of medicine to relieve pain).

98. *See Cruzan*, 497 U.S. at 278 (allowing refusal of life support); Brody, *supra* note 97, at 947 (discussing practice of palliative care).

99. *See* OREGON YEAR ONE STUDY, *supra* note 57, at 8 (listing loss of autonomy and desire for control as reasons for choosing P.A.S.). Without P.A.S., terminally ill patients have two choices: They can either spend their last days of life sedated by painkillers, barely cognizant of their final days as they drift in and out of consciousness, or they can refuse medical treatment altogether, living out their last days suffering from their disease. *See* CTR. FOR BIOETHICS, UNIV. OF MINN., END OF LIFE CARE: AN ETHICAL OVERVIEW 17 (2005), *available at* http://www.ahc.umn.edu/img/assets/26104/End_of_Life.pdf (discussing effects of overutilization and underutilization of pain relievers during end-of-life care).

unappealing end-of-life decisions.[100] Rather than a painful end to life, Massachusetts citizens could end their lives peacefully, surrounded by friends and family for a final farewell.[101]

B. How to Succeed at Death Without Really Trying: The Risk of Abusing P.A.S.

Another concern with legalizing P.A.S. is that it will turn Massachusetts into the Fourth Reich.[102] However, the Nazi concept of "euthanasia" differs dramatically from the DWDA.[103] While the purpose of the DWDA is to provide a merciful end-of-life option to terminally ill patients, the purpose of the Nazi euthanasia movement was to exterminate undesired ethnicities for the sake of promoting the Aryan race.[104] Inflammatory predictions that the DWDA will lead to a government-run death program do nothing to address legitimate questions about expanding medical technology.[105]

Legalization of P.A.S. raises legitimate issues about patient consent.[106] The first problem is determining whether a patient is mentally competent to make

100. *See* Peter Rogatz, *The Virtues of Physician-Assisted Suicide*, HUMANIST, Nov./Dec. 2001, *available at* http://www.thehumanist.org/humanist/articles/rogatz.htm (arguing P.A.S. provides dignified alternative to other end-of-life choices).

101. *See id.*

102. *See supra* note 49 (discussing concerns about involuntary euthanasia). The Fourth Reich is a theoretical future successor of Nazi Germany that would promote extermination of "inferior" demographics. *See generally* MICHAEL SCHMIDT, THE NEW REICH—VIOLENT EXTREMISM IN UNIFIED GERMANY AND BEYOND (1993). Critics of P.A.S. often cite that the Nazis resorted to state-approved assisted suicide as a precursor to the Holocaust. *See supra* note 49 (discussing Nazi use of P.A.S. before Holocaust).

103. *See* SIMONE GIGLIOTTI & BEREL LANG, THE HOLOCAUST: A READER 14 (2005) (discussing Nazis' use of mass extermination to destroy various ethnic groups and political parties).

104. *See Massachusetts Death With Dignity Initiative*, MASS. ATT'Y GEN. (Aug. 22, 2011), http://www.mass.gov/ago/docs/government/2011-petitions/11-12.pdf. The language prefacing the Massachusetts initiative states that the bill is intended to provide "a defined and safeguarded process by which . . . [a] patient may . . . end his or her life in a humane and dignified manner." *Id.* The preface goes on to require "such a process be entirely voluntary on the part of all participants, including the patient, his or her physicians, and any other health care provider or facility providing services or care to the patient." *Id.* On the other hand, Nazi Germany justified euthanasia as a way of promoting social Darwinism by killing off the weaker members of the human species. Michael Burleigh, *The Legacy of Nazi Medicine in Context*, *in* MEDICINE AND MEDICAL ETHICS IN NAZI GERMANY: ORIGINS, PRACTICES, LEGACIES 112, 120 (Francis R. Nicosia & Jonathan Huener eds., 2002). To maintain the purity of the Aryan race, the Nazis tried to exterminate any "degenerate" groups, including Jews, homosexuals, the disabled, and political opponents. *Id.* The absurdity of the comparison between Nazi Germany and Massachusetts is exemplified by the fact that while Nazis attempted to wipe out homosexuality as an abomination to Aryan culture, Massachusetts recently became the first state to legalize same-sex marriage. *Compare* Goodridge v. Dep't of Pub. Health, 798 N.E.2d 941, 948 (Mass. 2003) (upholding right of homosexuals to marry in Massachusetts), *with Nazi Persecution of Homosexuals 1933-1945,* U.S. HOLOCAUST MEM'L MUSEUM, http://www.ushmm.org/museum/exhibit/online/hsx/ (last visited Jan. 31, 2013) (listing number of homosexual Holocaust victims).

105. *See* Jane St. Clair, *Hitler, the Nazis, and Assisted Suicide*, COMPASSIONATE CHOICE, http://www.thecompassionatechoice.com/articles/hitler-the-nazis-and-assisted-suicide-2/ (last visited Jan. 31, 2013) (discussing harmful effect of outrageous rhetoric in discussing P.A.S.).

106. *See supra* note 40 and accompanying text (discussing problems with obtaining patient consent); *supra* note 49 (discussing concerns about allowing family to consent on behalf of patient).

medical decisions near the end stage of a terminal disease.[107] Massachusetts physicians will face a paradox: They must decide whether a patient is emotionally stable to give informed consent while the patient is requesting drugs to end his or her life, which in most cases indicates emotional instability.[108] Another issue is determining when a family member, particularly a family member with financial interests, should be able to give consent on the patient's behalf.[109]

C. They Cannot Look Any Worse Than Lawyers: Whether P.A.S. Will Compromise the Integrity of the Medical Profession

One other concern with legalizing P.A.S. in Massachusetts is that it will degrade the integrity of the medical profession.[110] However, in a modern society, where technology allows medical professionals to extend human life further than ever, the role of the physician becomes more complex.[111] In this setting, P.A.S. does not undermine the integrity of the medical profession, but rather sparks discussion about the changing role of the physician in the expanding universe of medical care.[112]

The American Medical Association continues to discourage P.A.S. as an end-of-life treatment option.[113] Similarly, the National Hospice and Palliative Care Organization disapproves of assisted suicide.[114] However, individual physicians' attitudes about P.A.S. as a medical option remain fairly evenly divided.[115]

107. *See supra* note 40 and accompanying text (discussing difficulty in determining mental competency).

108. *See* DAVID H. BARLOW & V. MARK DURAND, ABNORMAL PSYCHOLOGY: AN INTEGRATIVE APPROACH 2, 48-49 (5th ed. 2005) (reporting connection between depression and suicide).

109. *See supra* note 49 (discussing risk of creating obligation to die). Massachusetts law already permits family members to make life and death decisions about loved ones, regardless of any financial interest. MASS. GEN. LAWS ANN. ch. 201D, § 5 (2012) (allowing designation of health-care proxy to make end-of-life choices).

110. *See supra* notes 44-46 and accompanying text (discussing Hippocratic Oath and role of physicians).

111. *See* Tyson, *supra* note 45 (noting rejection of original Hippocratic Oath in modern medical schools). Despite the traditional notion that a physician only practices medicine for the purpose of healing, the United States Supreme Court has acknowledged a constitutionally protected interest in passive euthanasia and abortion, two procedures that arguably work against the promotion of life and health. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (acknowledging right to refuse medical treatment); Roe v. Wade, 410 U.S. 113, 153 (1973) (acknowledging woman's privacy interest in abortion decision).

112. *See* Harris, *supra* note 42, at 265-66 (describing some physicians' view of P.A.S. as final treatment of patient); Wanzer et al., *supra* note 81 (arguing legalizing P.A.S. would only allow what physicians already practice illegally). Some studies suggest that around forty-five percent of physicians support the practice of P.A.S. in some cases. Kane, *supra* note 46.

113. *See Opinion 2.211 – Physician-Assisted Suicide*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page (last updated June 1996) ("Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life.").

114. *See Commentary and Resolution on Physician Assisted Suicide*, NAT'L HOSPICE & PALLIATIVE CARE ORG., http://www.nhpco.org/sites/default/files/public/PAS_Resolution_Commentary.pdf (last visited Jan. 31, 2013) (focusing policy on improving end-of-care treatment, not hastening death).

115. *See generally* Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among*

D. Blazing the Trail: A Shifting Society

As more states begin to address legalization of P.A.S., questions arise as to the effect of the procedure on American views towards death and dying.[116] Historically, controversial legal outcomes have often resulted in widespread social change regarding previously taboo subjects.[117] Already, advancements in medical technology have significantly altered the way Americans think about and prepare for death.[118] The ability to control the time and manner of dying may further reshape this perception by removing much of the mystery and fear surrounding the final moments of life.[119]

The shift in American perceptions towards end-of-life care began years ago and continues to take shape.[120] A 2010 Gallup poll shows that forty-six percent of American citizens found P.A.S. morally acceptable.[121] In a 2005 poll, sixty-nine percent of participants stated a doctor should be allowed to end a patient's life when the patient's condition is incurable.[122]

E. What Lies Beneath: Looking at the (Possible) Future of End-of-Life Care

The effort towards legalization of P.A.S. foreshadows two controversial medical issues: P.A.S. for minors and active euthanasia.[123] In theory, every

Physicians in Washington State, 331 New Eng. J. Med. 89 (1994), *available at* http://www.nejm.org/doi/full/10.1056/NEJM199407143310206.

116. *See* Johnson, *supra* note 42 (discussing current American perception of death). In modern society, death is hidden from view, left in the hands of a medical professional behind the door of a morgue. *Id.*

117. *See generally* Roe v. Wade, 410 U.S. 113 (1973) (strengthening feminist movement by recognizing woman's privacy interest in bodily decisions); Loving v. Virginia, 388 U.S. 1 (1967) (sparking acceptance of interracial marriage by striking down prohibition); Brown v. Bd. of Educ., 347 U.S. 483 (1954) (promoting racial integration by rejecting concept of "separate but equal").

118. *See* Johnson, *supra* note 42 (discussing historical perception of death). In the 1800s, people traditionally died at home in the presence and care of families. *Id.* Families became less fearful of death as they helped loved ones pass on. *See id.* As medical technology advanced, hospitals became the traditional place to end one's life, and death became a hidden, frightening mystery. *Id.*

119. *See id.* While sanitation concerns likely prevent a shift back to dying in the home, P.A.S. arguably will force patients and families to once again acknowledge the inevitability of death instead of hiding and fighting until the bitter end. *See id.*

120. *See generally* Charles O. Jackson, *American Attitudes to Death*, 11 J. AM. STUD. 297 (1977) (discussing increasing American interest in death and dying).

121. *See* Lydia Saad, *Four Moral Issues Sharply Divide Americans*, GALLUP (May 26, 2010), http://www.gallup.com/poll/137357/Four-Moral-Issues-Sharply-Divide-Americans.aspx.

122. *See* Lydia Saad, *Americans Choose Death over Vegetative State*, GALLUP (Mar. 29, 2005), http://www.gallup.com/poll/15448/Americans-Choose-Death-Over-Vegetative-State.aspx.

123. *See* GERALD DWORKIN ET AL., EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE 35 (1998) (debating whether any actual distinction exists between passive euthanasia and active euthanasia); André Janssen, *The New Regulation of Voluntary Euthanasia and Medically Assisted Suicide in the Netherlands*, 16 INT'L J.L. POL'Y & FAM. 260, 265 (2002) (discussing law in Netherlands allowing active euthanasia for patients as young as twelve years old); Susan M. Wolf, *Facing Assisted Suicide and Euthanasia in Children and Adolescents*, *in* REGULATING HOW WE DIE: THE ETHICAL, MEDICAL, AND LEGAL ISSUES SURROUNDING PHYSICIAN-ASSISTED SUICIDE 92, 92 (Linda L. Emanuel ed., 1998) (noting P.A.S. advocates largely ignore teenagers and children); Rita L. Marker, *Assisted Suicide: Not for Adults Only?*, PATIENTS RIGHTS COUNCIL,

patient, regardless of age, should have the same right to end-of-life options.[124] A child facing a terminal disease is already facing more "adult" choices than many people ever will.[125] Nevertheless, the legal system has historically maintained a strict distinction between adults and minors in determining a patient's ability to consent to medical procedures.[126]

Active euthanasia raises significant questions about patient consent and physician abuse.[127] Nevertheless, many have argued that euthanasia is a logical step after physician-assisted suicide.[128] Often, patients who desire to hasten death are physically unable to ingest drugs without assistance.[129] Active euthanasia gives those patients an opportunity to end life in a merciful and dignified manner, regardless of their physical capabilities.[130]

On the other hand, euthanasia is a significantly more radical approach to end-of-life care than P.A.S.[131] By legalizing euthanasia, doctors would have the legal authority to cause death directly, a power the American legal system rarely grants.[132] While P.A.S. limits this power to the patient, legalizing active

http://www.patientsrightscouncil.org/site/not-for-adults-only/ (last visited Jan. 13, 2013) (discussing possibility of extending P.A.S. to terminally ill children).

124. *See* DWORKIN ET AL., *supra* note 123, at 22-23 (noting active euthanasia involves physician injecting medication); Marker, *supra* note 123 (discussing attempts to extend P.A.S. to children). P.A.S. for minors would eliminate the present age barrier that requires a patient to be at least eighteen years old to receive a lethal prescription. Marker, *supra* note 123; *see also End-of-Life Care for Children with Terminal Illness*, KIDSHEALTH, http://kidshealth.org/parent/system/ill/bfs_hospice_care.html (last visited Jan. 31, 2013) (discussing present hospice options for terminally ill children).

125. *See* Amanda Carey, *Brave Boy, 12, Calls Halt to Cancer Treatment*, ABC NEWS, Feb. 23, 2012 8:31 AM, http://abcnews.go.com/blogs/headlines/2012/02/brave-boy-12-calls-halt-to-cancer-treatment/ (describing twelve-year-old boy who decided to stop futile cancer treatment).

126. *See* Zoski v. Gaines, 260 N.W. 99, 99 (Mich. 1935); Perry v. Hodgson, 148 S.E. 659, 659 (Ga. 1929) (requiring parent's informed consent for leg operation on child); Moss v. Rishworth, 222 S.W. 225, 225 (Tex. Comm'n App. 1920) (requiring parental consent for tonsillectomy). *But see* J.B.G., Annotation, *Consent as Condition of Right to Perform Surgical Operation*, 139 A.L.R. 1370, 1372 (1942) (noting parental consent relaxed where child has reached maturity).

127. *See* DWORKIN ET AL., *supra* note 123, at 120 (discussing patient's inability to change decision once physician injects medication). At least in theory, every P.A.S. patient is required to ingest the lethal medication on his or her own. *See* OR. REV. STAT. ANN. §§ 127.800–.995 (West 2012); WASH. REV. CODE ANN. § 70.245.010–.904 (West 2012) (describing permissible means of ingestion). Active euthanasia, however, allows a physician to cause the patient's death without any affirmative conduct by the patient, giving the physician substantially more power to end a patient's life without legal consequences. DWORKIN ET AL., *supra* note 123, at 120. Active euthanasia would allow physically disabled patients to receive lethal medication even if they cannot physically ingest the medication on their own. *Id.* at 124.

128. *See* Kingsbury, *supra* note 80, at 236 (discussing rationale for allowing active euthanasia).

129. *See* Bollman, *supra* note 4, at 396 (describing terminally ill patient's inability to ingest medication on own).

130. *See id.* (describing hypothetical chain of suffering for terminally ill patient). In addition to active euthanasia, some advocates seek looser requirements for P.A.S. that would allow patients who are not terminally ill, yet suffer immense chronic pain, to pursue P.A.S. *Id.*

131. *See* T. Howard Stone & William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States*, 16 J. LEGAL MED. 481, 484-85 (1995) (discussing United States' history and state developments regarding P.A.S. and euthanasia).

132. *See* Bollman, *supra* note 4, at 399-400. Physicians committing active euthanasia may be criminally

euthanasia would allow a private actor to intentionally and deliberately end another's life based on consent.[133] Legalizing active euthanasia removes the safety net of P.A.S. by eliminating the requirement that the patient take the final step to end his or her life.[134]

Another issue of active euthanasia is the idea of consent by proxy.[135] If a state allowing health care proxies legalized euthanasia, a proxy could presumably authorize doctors to affirmatively end a patient's life.[136] Arguably, this power is no different from a proxy's present legal power to remove life-sustaining treatment.[137] On the other hand, this power would allow a private individual other than the actual patient to demand that doctors intentionally take the patient's life.[138] At that point, the line between consensual and nonconsensual euthanasia becomes dangerously unclear.[139]

IV. CONCLUSION

Although voters narrowly rejected the DWDA, the proposal will likely have a substantial impact on future health policy in Massachusetts and throughout the country. Not only will P.A.S. reshape the way physicians care for terminally ill patients, it will change the way people look at death in the end-stages of a disease. Instead of fighting death to the bitter end, people will be able to control and regulate the final moments of life.

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charged for a patient's homicide because their actions purposely and directly caused the patient's death. *See id.*

133. *See id.*

134. *See generally id.* (discussing conflicting views between disability advocate groups). Some disability groups argue that active euthanasia essentially opens the door for extermination of the disabled without consent. *See* Pamela Fadem et al., *Attitudes of People with Disabilities Toward Physician-Assisted Suicide Legislation: Broadening the Dialogue*, 28 J. HEALTH POL. POL'Y & L. 977, 978 (2003). Others see it as a way of providing care and compassion to the disabled. *Id.*

135. *See supra* note 126 (discussing proxy decision-making by parents in surgical procedures for minors).

136. *See* 40 AM. JUR. 3D *Proof of Facts* § 11.5 (1997) (discussing parent's right to terminate child's life support in certain conditions). *But see* Montalvo v. Borkovec, 647 N.W.2d 413, 419 (Wis. Ct. App. 2002) (declining right of parent to withhold life-sustaining treatment without persistent vegetative state).

137. *See* MASS. GEN. LAWS ANN. ch. 201D § 5 (2012) (allowing health care proxies in Massachusetts).

138. *See supra* note 132 (discussing concerns about actively ending patients' lives).

139. *See* Wolf, *supra* note 39, at 1074 (discussing present difficulty of obtaining consent from patient).