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.”

I. INTRODUCTION

Under early common law, many states punished assisted suicide as murder. In 1994, however, the Supreme Court of Michigan drew a legal distinction between the concepts of murder and assisted suicide. Despite this distinction, forty-seven states still prohibit physicians from assisting in a patient’s death. 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. 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.

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

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

11. See infra Part III.
12. See infra Part III.
13. See infra Part III.
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.
Active euthanasia is the process by which a health care practitioner causes the patient’s death through an affirmative act. 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. Presently, no state allows a doctor to practice active euthanasia.

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. For example, in People v. Roberts, the defendant’s wife suffered from multiple sclerosis. Upon his wife’s request, the defendant poured a lethal mixture and placed it next to her bed. The defendant’s wife drank the deadly cocktail and died. 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. The case gained significant attention throughout the country and around the world.


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.).


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


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.

Roberts remained uncontested for seventy-four years until the case of People v. Kevorkian. In Kevorkian, a doctor was found guilty of murder after providing lethal dosages of medicine to two patients, Sherry Miller and Marjorie Wantz. 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. The court reasoned that Dr. Kevorkian’s actions did not meet the necessary elements of murder. Specifically, the State lacked evidence that Dr. Kevorkian acted as the direct and natural cause of the patient’s death. While reversing the murder charges, the court held that nothing in the United States Constitution prohibited Michigan from passing a statute prohibiting assisted suicide.

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. The majority of states, however, have passed statutes specifically criminalizing the act of assisting in another’s suicide. A handful of states, including

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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. 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. STAT. ANN.
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


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/NEJM199002133220506 (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

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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).


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.


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. 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. 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.

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. In 2000, Maine nearly legalized P.A.S. Without requiring patient consent at the time the drug is administered. 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.


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

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

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). The ODDA was the first successful attempt to legalize P.A.S., and it did not come without controversy.


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 Dependant 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.


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

In the first year of availability, twenty-three patients requested and received lethal prescriptions. Fifteen died from the prescription; six died from their underlying illness; two were alive at the end of the year. 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.

In the second year, thirty-three patients received lethal prescriptions. Twenty-six patients died from the dosage, while five died from their underlying illness. Two patients were still alive at the conclusion of the study. The patients’ primary reasons for choosing P.A.S. included loss of autonomy (81%); decreased ability to participate in enjoyable activities (81%); desire for
control over the manner and time of death (74%); loss of control of bodily functions (68%); and physical suffering (53%).

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. 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. 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. Finally, despite concerns that the Act targeted the disabled, the highest usage came from cancer and ALS patients.

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


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/amytrophiclateralarsclerosis.html (last updated Jan. 30, 2013).


Washington’s bill, the state has experienced results similar to the early results in Oregon. The Montana Supreme Court implicitly legalized P.A.S. by recognizing physician-aided death as a valid defense to a charge of homicide. The court limited its holding, however, by declining to rule on whether individuals have a constitutional right to assisted suicide. Montana’s legislature has not reacted to the court’s decision, thus allowing the holding to stand as present state law.

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.
P.A.S. allows patients to choose a pain-free alternative to end-of-life care. 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. Finally, proponents argue that the risk of abuse is misguided. 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.

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. The Supreme Judicial Court consistently held that Massachusetts citizens do not have an absolute right to choose the time and manner of their death. 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.

78. See Velleman, supra note 43, at 673 (discussing Oregon patients’ top concerns about end of life).
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.
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).
In 2011, the Dignity 2012 Coalition proposed the DWDA. Like Washington, the Massachusetts proposed bill was based heavily on Oregon’s Death with Dignity Bill. Opponents sharply criticized the bill as destroying the medical community and creating a slippery slope towards involuntary euthanasia. Supporters of the bill claimed that the DWDA would provide patients with merciful end-of-life options.

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

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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.


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. On November 6, 2012, Massachusetts voters voiced their opinion. Voters defeated the bill, fifty-one percent to forty-nine percent.

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. 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. 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. If a patient fears she is a burden on her family, she can legally seek palliative care or refuse medical treatment altogether.

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. 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


93. See BALLOT PEDIA, 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.abc.umn.edu/img/assets/26104/End_of_Life.pdf (discussing effects of overutilization and undertreatment of pain relievers during end-of-life care).
unappealing end-of-life decisions. Rather than a painful end to life, Massachusetts citizens could end their lives peacefully, surrounded by friends and family for a final farewell.

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. However, the Nazi concept of “euthanasia” differs dramatically from the DWDA. 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. Inflammatory predictions that the DWDA will lead to a government-run death program do nothing to address legitimate questions about expanding medical technology.

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

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).
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/hx/ (last visited Jan. 31, 2013) (listing number of homosexual Holocaust victims).
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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{109}

\section*{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{112}

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

\begin{itemize}
\item \textsuperscript{107} See supra note 40 and accompanying text (discussing difficulty in determining mental competency).
\item \textsuperscript{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).
\item \textsuperscript{110} See supra notes 44-46 and accompanying text (discussing Hippocratic Oath and role of physicians).
\item \textsuperscript{111} See Tyson, supra note 45 (noting rejection of original Hippocratic Oath in modern medical schools).
\item \textsuperscript{112} 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. Dept’ 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).
\item \textsuperscript{113} 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.
\end{itemize}
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. Historically, controversial legal outcomes have often resulted in widespread social change regarding previously taboo subjects. Already, advancements in medical technology have significantly altered the way Americans think about and prepare for death. 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.

The shift in American perceptions towards end-of-life care began years ago and continues to take shape. A 2010 Gallup poll shows that forty-six percent of American citizens found P.A.S. morally acceptable. 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.

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. In theory, every


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.


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).


A child facing a terminal disease is already facing more "adult" choices than many people ever will. 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.

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

On the other hand, euthanasia is a significantly more radical approach to end-of-life care than P.A.S. By legalizing euthanasia, doctors would have the legal authority to cause death directly, a power the American legal system rarely grants. While P.A.S. limits this power to the patient, legalizing active
euthanasia would allow a private actor to intentionally and deliberately end another’s life based on consent. 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.

Another issue of active euthanasia is the idea of consent by proxy. If a state allowing health care proxies legalized euthanasia, a proxy could presumably authorize doctors to affirmatively end a patient’s life. Arguably, this power is no different from a proxy’s present legal power to remove life-sustaining treatment. 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. At that point, the line between consensual and nonconsensual euthanasia becomes dangerously unclear.

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’Y, 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).


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).