SJC-13194

ROGER M. KLIGLER & another[1] vs. ATTORNEY GENERAL & another.[2]

Suffolk. March 9, 2022. - December 19, 2022.

Present: Budd, C.J., Gaziano, Lowy, Cypher, Wendlandt, & Georges, JJ.

Physician-Assisted Suicide. Doctor, Doctor-patient relationship, Prescription. Declaratory Relief. Injunction. Practice, Civil, Declaratory proceeding, Injunctive relief, Standing. Jurisdiction, Justiciable question, Declaratory relief, Injunction against criminal prosecution. Supreme Judicial Court, Justiciable question, Jurisdiction. Constitutional Law, Equal protection of laws, Freedom of speech and press, Standing. Due Process of Law. Homicide. Practice, Civil, Summary judgment.

Civil action commenced in the Superior Court Department on October 24, 2016.

The case was heard by Mary K. Ames, J., on motions for summary judgment.

The Supreme Judicial Court on its own initiative transferred the case from the Appeals Court.

[1] Alan Steinbach.

[2] District attorney for the Cape and Islands district.

John Kappos, of California (Meng Xu, of California, Kevin Díaz, of Oregon, & Jonathan M. Albano also present) for the plaintiffs.

Maria Granik, Assistant Attorney General (Julie E. Green & James A. Sweeney, Assistant Attorneys General, also present) for the defendants.

Christopher P. Schandevel, of Virginia, for Euthanasia Prevention Coalition USA.

The following submitted briefs for amici curiae:

Konstantin Tretyakov, pro se.

Dwight G. Duncan for Massachusetts Citizens for Life, Inc.

Michelle M. Uzeta, of California, for Disability Rights Education and Defense Fund & others.

Catherine Glenn Foster, Steven H. Aden, Katie Glenn, & Natalie M. Hejran, of the District of Columbia, Carolyn McDonnell, of Wisconsin, & Andrew Beckwith for Christian Medical & Dental Associations.

Kevin Yuill, pro se.

Brandon Jiha, of the District of Columbia, Robert A. Skinner, Thanithia Billings, & Douglas Hallward-Driemeier for Massachusetts Medical Society & another.

Andrés J. Gallegos, of Illinois, for National Council on Disability.

Michael J. Kerrigan for four Roman Catholic Bishops of the Dioceses of Massachusetts.

GAZIANO, J. In this case, we are faced with the solemn task of determining whether the Massachusetts Declaration of Rights provides a substantive due process right to physician-assisted suicide. The plaintiffs, a doctor who wishes to provide physician-assisted suicide and a patient who has been diagnosed with an incurable cancer, contend that terminally ill patients with six months or less to live have a constitutional right to receive a prescription for lethal medication in order to bring about death at a time and in a manner of their choosing.

Although we recognize the paramount importance and profound significance of all end-of-life decisions, after careful consideration, we conclude that the Massachusetts Declaration of Rights does not reach so far as to protect physician-assisted suicide.[3] We conclude as well that the law of manslaughter may prohibit physician-assisted suicide, and does so, without offending constitutional protections.

Background. We summarize the facts based on the summary judgment record on the parties' cross motions for summary judgment. "In a case like this one where both parties have moved for summary judgment, the evidence is viewed in the light most favorable to the party against whom judgment [has entered]." Boazova v. Safety Ins. Co., 462 Mass. 346, 350 (2012).

1. Physician-assisted suicide. Physician-assisted suicide, also known as medical aid in dying, is a term of art that refers to the practice of providing a terminally ill, competent patient who has a short time left to live with a

[3] We acknowledge the amicus briefs submitted by Konstantin Tretyakov; Massachusetts Citizens for Life, Inc.; Disability Rights Education and Defense Fund and eighteen other organizations; Christian Medical and Dental Associations; Euthanasia Prevention Coalition USA; Kevin Yuill; Massachusetts Medical Society and Hospice and Palliative Care Federation of Massachusetts; and four Roman Catholic Bishops of the Dioceses of Massachusetts; as well as the amicus letter submitted by the National Council on Disability.

prescription for medication that the patient may ingest to bring about a quick and painless death.[4] See Morris v. Brandenburg, 2016-NMSC-027, ¶ 5; Myers v. Schneiderman, 30 N.Y.3d 1, 10 (2017). See also Pope, Medical Aid in Dying: Key Variations Among U.S. State Laws, J. Health & Life Sci. L., vol. 14, Oct. 2020, at 32. The prescription generally is for barbiturates and includes instructions on the manner in which to administer the medication in a way that will cause death.

After obtaining the prescription, the patient may choose to self-administer the medication and die painlessly at a time and place of his or her choosing. For some terminally ill individuals, obtaining such a prescription may alleviate anxiety related to the process of dying by serving as reassurance that the individual will have the option to end his or her own suffering.

Physician-assisted suicide has been legalized in ten States and the District of Columbia.[5] Attempts to legalize the practice

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[4] While the plaintiffs use the term "medical aid in dying," in 2018, the American Medical Association's Council on Judicial and Ethical Affairs again asserted its belief that "ethical deliberation and debate is best served" by using the term "physician-assisted suicide" rather than the more ambiguous "aid in dying." The vast majority of cases and statutes to have addressed the issue to date in other jurisdictions also use the phrase "physician-assisted suicide."

[5] See Cal. Health & Safety Code §§ 443 et seq.; Colo. Rev. Stat. §§ 25-48-101 et seq.; D.C. Code §§ 7-661.01 et seq.; Haw. Rev. Stat. §§ 327L-1 et seq.; Me. Rev. Stat. tit. 22, § 2140;

in Massachusetts, however, have been unsuccessful. In 2012, voters rejected a proposed ballot initiative that would have allowed a physician to provide a competent, terminally ill patient with medication to end the patient's life. See Secretary of the Commonwealth, Statewide Ballot Questions -- Statistics by Year: 1919-2018.[6] See also Secretary of the Commonwealth, Massachusetts Information for Voters: 2012 Ballot Questions 7-8.[7] Additionally, although lawmakers have introduced over a dozen bills to legalize physician-assisted suicide in the Commonwealth, none has advanced to a vote.[8] To the contrary, the Legislature has adopted a stance against physician-assisted suicide. See G. L. c. 111, § 227 (c) (health care providers are

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N.J. Stat. Ann. §§ 26:16-1 et seq.; N.M. Stat. Ann. §§ 24-7c-1 et seq.; Or. Rev. Stat. §§ 127.800 et seq.; Vt. Stat. Ann. tit. 18, §§ 5281 et seq.; Wash. Rev. Code §§ 70.245.010 et seq.; Baxter v. State, 2009 MT 449, ¶¶ 49-50 (terminally ill patient's consent to physician-assisted suicide constitutes statutory defense to charge of homicide).

[6] Available at https://www.sec.state.ma.us/ele/elebalm/balmresults.html [https://perma.cc/ZE73-J2MF].

[7] Available at https://www.sec.state.ma.us/ele/elepdf/IFV-2012.pdf [https://perma.cc/J3X7-G32K].

[8] See House Bill No. 2381 (Feb. 8, 2021); Senate Bill No. 1384 (Feb. 8, 2021); House Bill No. 4782 (May 29, 2020); Senate Bill No. 2745 (May 29, 2020); House Bill No. 1926 (Jan. 8, 2019); Senate Bill No. 1208 (Jan. 14, 2019); Senate Bill No. 1225 (Jan. 18, 2017); House Bill No. 1194 (Jan. 18, 2017); House Bill No. 2233 (Jan. 21, 2011); House Bill No. 1468 (Jan. 14, 2009); House Bill No. 3195 (Jan. 2003); House Bill No. 1543 (Jan. 1997); House Bill No. 3173 (Jan. 1995).

not permitted to "offer to provide information about assisted suicide or the prescribing of medication to end life"); G. L. c. 201D, § 12 ("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 the permit the natural process of dying").

2. Parties. Plaintiff Roger Kligler is a retired physician who has been diagnosed with metastatic prostate cancer. His cancer is categorized as stage 4, which is the most advanced form of cancer. In May 2018, Kligler's treating physician estimated that there was a fifty percent chance that Kligler would die within five years.

Nonetheless, Kligler has not yet received a six-month prognosis; indeed, his cancer currently has been contained, and his physician asserts that it would not be surprising if Kligler were alive ten years from now. Kligler asserts, however, that if he were to receive a six-month prognosis, he would wish to pursue physician-assisted suicide. In Kligler's view, the possibility of physician-assisted suicide "would allow [him] to live out the rest of [his] days knowing that, if [his] suffering becomes too great, [he] would have the option of ending [his] suffering." Given the uncertain legal status of physician-

assisted suicide, Kligler has been unable to find a doctor in Massachusetts willing to provide such assistance.

Plaintiff Alan Steinbach is a licensed physician and currently practices as an urgent care provider in Falmouth. Although Steinbach is not Kligler's doctor, Steinbach treats other patients who are nearing the end of life and who wish to discuss various end-of-life options, including physician-assisted suicide. Steinbach asserts that he would like to provide physician-assisted suicide, but that he does not do so out of fear of prosecution.

The Attorney General and the district attorney for the Cape and Islands district (district attorney) are named as defendants in their official capacities. They are both elected officials empowered to prosecute those who violate State criminal laws. Although the defendants have not expressed an affirmative intention to prosecute Kligler or Steinbach, they have declined to commit not to prosecute those who engage in physician-assisted suicide based on their conclusion that such a practice is "not immune from prosecution in Massachusetts."

3. Prior proceedings. In October of 2016, the plaintiffs commenced a civil action in the Superior Court, seeking declaratory and injunctive relief. Specifically, they sought a declaration that "physicians do not violate the criminal laws of the Commonwealth of Massachusetts when they follow a medical

standard of care and prescribe Medical Aid in Dying medications for self-administration by the patient . . . or alternatively, that application of criminal laws of the Commonwealth of Massachusetts to physicians providing such care is unconstitutional under the Massachusetts [C]onstitution." The plaintiffs also sought an injunction to enjoin the defendants from "prosecuting physicians for . . . prescribing medication for Medical Aid in Dying to such patients upon request." The complaint asserted that such relief was warranted for several reasons. In the plaintiffs' view, physician-assisted suicide could not satisfy the required elements of manslaughter as a matter of law. To the extent that the law of manslaughter does apply to physician-assisted suicide, the complaint asserted that the law is unconstitutionally vague and, moreover, interferes with the plaintiffs' constitutional rights to equal protection and substantive due process. Finally, the complaint asserted that a physician's right to freedom of speech precludes the prosecution of doctors for discussing physician-assisted suicide with a terminally ill patient.

The defendants moved to dismiss on the ground that the complaint failed to state a claim for declaratory relief because the allegations did not give rise to an actual controversy. A Superior Court judge concluded that the plaintiffs had presented

an actual controversy and were eligible to seek declaratory relief. The judge therefore denied the motion to dismiss.

The plaintiffs subsequently moved for partial summary judgment on their equal protection and free speech claims, and the defendants filed a cross motion for summary judgment on all claims. The same Superior Court judge granted the plaintiffs' motion for partial summary judgment as to the free speech claim, but granted the defendants' motion for summary judgment on the other claims. The judge concluded that "providing advice and information about [medical aid in dying] is permitted in the Commonwealth," a determination from which the defendants did not appeal. The judge also concluded that physician-assisted suicide could constitute involuntary manslaughter and that the law of manslaughter was not unconstitutionally vague when applied in such a way. The judge determined that the criminalization of physician-assisted suicide did not offend the plaintiffs' rights to equal protection and due process. In so holding, the judge reasoned that the Massachusetts Declaration of Rights did not protect a fundamental right to physician-assisted suicide and that the criminalization of physician-assisted suicide is supported by a rational basis. The plaintiffs appealed from the order allowing the defendants' motion for summary judgment, and we transferred the case to this court on our own motion.

Discussion. We review a grant of summary judgment, including the judge's legal conclusions, de novo. Roman v. Trustees of Tufts College, 461 Mass. 707, 711 (2012).

The plaintiffs contend that the judge erred in allowing the defendants' motion for summary judgment for a number of reasons. They argue that the Massachusetts Declaration of Rights protects a fundamental right to physician-assisted suicide and that therefore the practice may not be criminalized; they assert that any prosecution for physician-assisted suicide would be unconstitutional. They also argue that physician-assisted suicide is not wanton or reckless, and is not the proximate cause of a patient's death, and therefore it cannot satisfy the required elements of involuntary manslaughter. The plaintiffs maintain that, in any event, physician-assisted suicide cannot be prosecuted because the law of manslaughter is unconstitutionally vague as applied. In addition, in their view, the criminalization of physician-assisted suicide violates their rights to equal protection under the law by differentiating between terminally ill individuals who wish to pursue physician-assisted suicide and those who wish to hasten death through other means.

We first consider whether we have jurisdiction over the matter, and we then proceed to the merits of the plaintiffs' claims.

1. Jurisdiction. The declaratory judgment act, G. L. c. 231A, § 1, authorizes courts to make "binding declarations of right, duty, status and other legal relations" where the parties present an "actual controversy." Such relief is appropriate only if a plaintiff can demonstrate the existence of an actual controversy, as well as "the requisite legal standing to secure its resolution" (citation omitted). Entergy Nuclear Generation Co. v. Department of Envtl. Protection, 459 Mass. 319, 326 (2011).

An actual controversy is

> "a real dispute caused by the assertion by one party of a legal relation, status or right in which he has a definite interest, and the denial of such assertion by another party also having a definite interest in the subject matter, where the circumstances attending the dispute plainly indicate that unless the matter is adjusted such antagonistic claims will almost immediately and inevitably lead to litigation."

Gay & Lesbian Advocates & Defenders v. Attorney Gen., 436 Mass. 132, 134-135 (2002) (GLAD), quoting Bunker Hill Distrib., Inc. v. District Attorney for the Suffolk Dist., 376 Mass. 142, 144 (1978). "A party has standing when it can allege an injury within the area of concern of the statute, regulatory scheme, or constitutional guarantee under which the injurious action has occurred." Doe No. 1 v. Secretary of Educ., 479 Mass. 375, 386 (2018).

"The purpose of both the actual controversy and the standing requirements is to ensure the effectuation of the statutory purpose of G. L. c. 231A, which is to enable a court 'to afford relief from . . . uncertainty and insecurity with respect to rights, duties, status and other legal relations'" (alteration in original). Massachusetts Ass'n of Indep. Ins. Agents & Brokers v. Commissioner of Ins., 373 Mass. 290, 292 (1977), quoting G. L. c. 231A, § 9. "In declaratory judgment actions, both requirements are liberally construed" so as to effectuate the statute's broad, remedial purpose. Doe No. 1, 479 Mass. at 384-385.

a. Actual controversy. Kligler's interest in and ability to pursue physician-assisted suicide under the fundamental right as he asserts it is contingent upon his receipt of a six-month prognosis. We previously have recognized that a plaintiff may present an actual controversy even if his or her exercise of a right is contingent upon the occurrence of some other event. See, e.g., Oxford v. Oxford Water Co., 391 Mass. 581, 584 (1984) ("It is not necessary that the parties be irrevocably bound to a course of action before a court can afford declaratory relief"); Southbridge v. Southbridge Water Supply Co., 371 Mass. 209, 213-214 (1976), S.C., 411 Mass. 675 (1992) (exercise of right at stake was contingent upon outcome of town meeting vote). See also American Mach. & Metals v. De Bothezat Impeller Co., 166

F.2d 535, 536 (2d. Cir. 1948) ("Where there is an actual controversy over contingent rights, a declaratory judgment may nevertheless be granted"). For example, in Southbridge Water Supply Co., supra at 212-214, we concluded that a town could receive a declaratory judgment regarding what it would have to pay to purchase a corporation, even though the town's ability to purchase the corporation was contingent upon a town vote. We recognized that the town could decide against purchasing the corporation and that, even if the town chose to attempt to complete the purchase, it might not receive the votes to do so. Id. at 214. Nonetheless, we granted declaratory relief in part because doing so would inform the town's decision whether to pursue the purchase of the corporation. Id. at 214-215.

This case, however, is distinguishable because Kligler does not currently possess the option of pursuing physician-assisted suicide, as the plaintiffs define the right, given that he has not yet received a six-month prognosis. Nor is it apparent that he will soon receive such a prognosis and therefore meet the stated qualifications for physician-assisted suicide. Kligler's doctor opined that "[Kligler's] cancer is under good control with the treatment that he has had," and that he has a "good prognosis." The doctor also noted that "[s]ome patients can live for many years" with Kligler's particular type of cancer. Should Kligler's cancer become more aggressive, the doctor

indicated there are at least five treatment options that might be able to control the cancer, and thus delay a six-month prognosis. Accordingly, Kligler's doctor stated that he would not "be surprised if [Kligler] is alive in ten years' time."

Because Kligler is not currently in the position that the plaintiffs assert is necessary to be entitled to pursue physician-assisted suicide, issuing a declaratory judgment would have no immediate impact on Kligler or his decision-making, and therefore would not fulfill the purposes of the declaratory judgment act. See Massachusetts Ass'n of Indep. Ins. Agents & Brokers, 373 Mass. at 292 ("the declaration issued is intended to have an immediate impact on the rights of the parties"). Accordingly, Kligler's complaint for declaratory relief should have been dismissed.

Steinbach's claims, on the other hand, present a different question. Steinbach asserts that he would engage in assisting patients who were seeking physician-assisted suicide were it not for the risk of prosecution for manslaughter. Thus, he argues, an actual controversy exists because he faces a credible threat of prosecution should he carry out his intention to provide physician-assisted suicide. "When contesting the constitutionality of a criminal statute, 'it is not necessary that [the plaintiff] first expose himself to actual arrest or prosecution'" in order to present an actual controversy.

Babbitt v. United Farm Workers Nat'l Union, 442 U.S. 289, 298 (1979), quoting Steffel v. Thompson, 415 U.S. 452, 459 (1974). See, e.g., Commonwealth v. Baird, 355 Mass. 746, 755 (1969), cert. denied, 396 U.S. 1029 (1970). Rather, "[a] plaintiff who challenges a statute must demonstrate a realistic danger of sustaining a direct injury as a result of the statute's operation or enforcement." Babbitt, supra, quoting O'Shea v. Littleton, 414 U.S. 488, 494 (1974). An actual controversy exists where the plaintiff demonstrates (1) "an intention to engage in a course of conduct arguably affected with a constitutional interest, but [arguably] proscribed by a statute," and (2) "a credible threat of prosecution thereunder." Babbitt, supra.

Here, Steinbach asserts that he intends to provide physician-assisted suicide for qualifying patients if he can do so lawfully. Thus, an actual controversy exists. Compare Sturgis v. Attorney Gen., 358 Mass. 37, 38 (1970) (actual controversy existed where doctors who challenged statute that prohibited unmarried persons from obtaining contraceptives stated that "[i]t has been, is, and will be [their] desire in the course of [their] medical practice . . . to administer to, and prescribe for, certain unmarried patients drugs or articles intended for the prevention of pregnancy").

Whether Steinbach has demonstrated "a credible threat of prosecution," however, presents a much closer question. See Babbitt, 442 U.S. at 298. The motion judge concluded that Steinbach faced a credible threat based on statements to the media made by the district attorney indicating his belief that physician-assisted suicide is a prosecutable offense under current law.

We occasionally have recognized the presence of an actual controversy where a prosecuting official expresses an opinion that a plaintiff's intended course of action violates the law. For example, in Essex Theatre Corp. v. Police Comm'r of Boston, 365 Mass. 183, 184 (1974), we held that a controversy existed where the plaintiff sought publicly to display a film admittedly depicting "explicit sexual congress," and the defendant "indicated that any film which showed explicit sexual congress was obscene and a showing of it would violate [the law]." Similarly, in Benefit v. Cambridge, 424 Mass. 918, 922 (1997), we concluded that the plaintiff faced "a continuing threat . . . of prosecution" where the district attorney, who previously had brought charges against the plaintiff for engaging in a form of speech prohibited by statute, refused to commit to "refrain[ing] from enforcing [the challenged statute] against the plaintiff."

The asserted threats in this case, however, are somewhat atypical. The statements were not addressed to Steinbach

specifically and were discussing conduct that Steinbach has yet to attempt. Compare Benefit, 424 Mass. at 919-920. Moreover, the defendants have never prosecuted anyone for physician-assisted suicide. Compare Essex Theatre Corp., 365 Mass. at 184. This calls into question whether Steinbach faces a threat of prosecution sufficient to support an actual controversy. The United States Supreme Court occasionally has concluded that a true threat, and therefore an actual controversy, existed even where no threat of prosecution was made by a prosecuting official. See, e.g., Steffel, 415 U.S. at 459 (actual controversy existed where plaintiff twice had been warned to stop "handbilling" at shopping center, which was prohibited by statute he argued was unconstitutional, and where plaintiff was told he likely would be prosecuted if he did so again). See also Holder v. Humanitarian Law Project, 561 U.S. 1, 8-13, 15 (2010) (actual controversy existed where plaintiffs wanted to violate statute prohibiting knowingly providing material support to foreign terrorist organization, of which plaintiffs had been members before it was designated as terrorist group, but did not do so out of fear of prosecution). In light of the current state of the law on manslaughter, which we review in some detail infra, we conclude that, even apart from any consideration of specific media reports concerning statements attributed to the district attorney, Steinbach does

face a true threat of prosecution, and thus an actual controversy exists.

i. Law of manslaughter. "Involuntary manslaughter is an unintentional, unlawful killing caused by wanton or reckless conduct." Commonwealth v. Earle, 458 Mass. 341, 347 (2010). To sustain a conviction of involuntary manslaughter, the Commonwealth bears the burden of proving "that the defendant's conduct (1) was intentional; (2) was wanton or reckless; and (3) caused the victim's death" (footnote omitted).[9] See Commonwealth v. Carter, 474 Mass. 624, 632 (2016) (Carter I), S.C., 481 Mass. 352 (2019) (Carter II), cert. denied, 140 S. Ct. 910 (2020).

To satisfy the first element, the Commonwealth need only establish general intent, that is, that a defendant intended to "perform the act that causes death." See Commonwealth v. Life Care Ctrs. of Am., Inc., 456 Mass. 826, 832 (2010). It is irrelevant whether the defendant intended the resulting harm. See Commonwealth v. Welansky, 316 Mass. 383, 398 (1944).

As to the second element, wanton or reckless conduct is that which a defendant knew or should have known created a substantial risk of death or serious bodily injury. See

[9] "There is no statutory definition of manslaughter in Massachusetts; its elements are derived from common law." Commonwealth v. Catalina, 407 Mass. 779, 783 (1990).

Commonwealth v. Carrillo, 483 Mass. 269, 275 (2019). See also Model Jury Instructions on Homicide 88-89 (2018). "The risk of harm must be more than a possible or unreasonable risk; it must reach a 'high degree of likelihood.'" Carrillo, supra at 276, quoting Welansky, 316 Mass. at 399. "[A] defendant's subjective awareness of the reckless nature of his conduct is sufficient, but not necessary, to convict him of involuntary manslaughter. Conduct which a reasonable person, in similar circumstances, would recognize as reckless will suffice as well." Commonwealth v. Catalina, 407 Mass. 779, 789 (1990).

With respect to the third element, to prove that a defendant caused the victim's death, the Commonwealth must demonstrate that the defendant's actions were the proximate cause of death. See Commonwealth v. Cunningham, 405 Mass. 646, 659 (1989). "[P]roximate cause is a cause which in the natural and continuous sequence produces death and without which the death would not have occurred" (citation omitted). Commonwealth v. Askew, 404 Mass. 532, 534 (1989). "If a series of events occur between the [wanton or reckless] conduct and the ultimate harm, the court must determine whether those intervening events have . . . extinguished the element of proximate cause and become a superseding cause of the harm." Kent v. Commonwealth, 437 Mass. 312, 321 (2002). Intervening conduct extinguishes

proximate cause only if it was not reasonably foreseeable. See Catalina, 407 Mass. at 791.

Steinbach argues that the law of involuntary manslaughter is per se inapplicable to physician-assisted suicide because a doctor's participation in physician-assisted suicide is not wanton, reckless, or the proximate cause of death. Steinbach maintains that the determination whether a doctor acted wantonly or recklessly turns on genuine issues of material fact regarding the doctor's decision-making process. In Steinbach's view, a doctor who follows general medical standards in prescribing lethal medication for the purpose of physician-assisted suicide is not acting wantonly or recklessly; rather, he or she is making an informed and deliberate medical judgment calculated "to help a terminally ill patient obtain peace of mind, rather than causing harm or death of the patient."

As Steinbach asserts, whether a doctor facing a charge of involuntary manslaughter acted wantonly or recklessly in prescribing medication that resulted in a patient's death ordinarily is a question of fact for a fact finder. See Commonwealth v. Levesque, 436 Mass. 443, 452 (2002) ("Whether certain behavior is properly categorized as reckless or negligent is ordinarily left for the jury"). But for purposes of Steinbach's motion for summary judgment, the question we must decide is whether he is entitled to a judgment declaring that

"manslaughter charges are not applicable to physicians who follow a medical standard of care" in providing physician-assisted suicide. Thus, we need only decide whether a charge of involuntary manslaughter would be foreclosed as a matter of law in any case of physician-assisted suicide, and we need not wade through a factual determination whether any particular exercise of physician-assisted suicide is wanton or reckless. See Piantedosi v. Bassett, 279 Mass. 337, 339 (1932) (determining that certain conduct cannot be considered negligent as matter of law).

As the motion judge concluded, physician-assisted suicide could constitute wanton or reckless conduct. Our case law demonstrates that knowingly providing someone who has expressed an interest in ending his or her life with the means to do so may be considered wanton or reckless behavior. See, e.g., Persampieri v. Commonwealth, 343 Mass. 19, 23 (1961) (husband acted recklessly or wantonly in providing his wife, who was emotionally distraught and threatening to commit suicide, with loaded weapon and instructions on how she could use it to kill herself). That a doctor's intent in providing the lethal medication was to alleviate a patient's suffering is irrelevant, as conduct may be wanton or reckless even where the actor "meant no harm to the victim." See Commonwealth v. Walker, 442 Mass. 185, 193 n.16 (2004), quoting Commonwealth v. Depradine, 42

Mass. App. Ct. 401, 407 (1997). See Commonwealth v. Pugh, 462 Mass. 482, 495 n.21 (2012) (motive is irrelevant to crime of manslaughter).

Steinbach further contends that a doctor who provides a lethal prescription pursuant to the practice of physician-assisted suicide cannot be considered the proximate cause of a patient's suicide under this court's reasoning in Carter I, 474 Mass. at 635-636, and Carter II, 481 Mass. at 368. In Carter I, supra, and Carter II, supra at 354, we concluded that a defendant who verbally pressured her boyfriend into committing suicide could be liable for involuntary manslaughter. The boyfriend had planned to kill himself by filling his truck with carbon monoxide, a plan which he previously had discussed with the defendant. Carter II, supra. The defendant and the victim remained in contact via telephone as the victim began to carry out his plan. Id. at 358. At some point, the victim suspended his suicide attempt by getting out of the truck and telling the defendant that he was afraid the carbon monoxide was working. Id. at 359. The defendant then instructed him to get back into the truck, knowing that it had become a toxic environment. Id. The victim complied, and eventually he succumbed to the carbon monoxide. Id. We concluded that, although the victim ultimately died by his own hand, the defendant nonetheless was the proximate cause of his death because she "overpowered" his

will to live by coercing and pressuring him to complete his suicide attempt, while aware that he was in a "weakened state." Id. at 363.

With respect to the third element of involuntary manslaughter, causation, Steinbach maintains that Carter I, 474 Mass. at 635-636, and Carter II, 481 Mass. at 368, stand for the proposition that a defendant is not the proximate cause of another's suicide unless the defendant uses coercion to "overpower[] that person's will to live." Carter II, supra. Because doctors who provide physician-assisted suicide in accordance with medical standards do not coerce or pressure victims to ingest the lethal medication, Steinbach asserts that they cannot be the proximate cause of a patient's suicide.

This argument misconstrues our reasoning in Carter I, 474 Mass. at 635-636, and Carter II, 481 Mass. at 361-362. Those cases did not create a new standard of causation where a victim dies by suicide, but, rather, they applied our ordinary standards of causation in a novel context. Although the coercion in those cases was sufficient to establish causation, it does not follow that coercion is always necessary to establish causation in cases of suicide. See Carter II, supra at 363 ("legal causation in the context of suicide is an incredibly complex inquiry" that depends on facts of each case). Indeed, we previously have concluded that a defendant caused a

victim's suicide even where the defendant's actions were not so coercive as to overpower the victim's will to live. See, e.g., Commonwealth v. Atencio, 345 Mass. 627, 629-630 (1963) (defendants who played game of "Russian roulette" with victim caused victim's self-inflicted death, even though they did not "force the deceased to play or suggest that he play").

Steinbach argues that, regardless, doctors who provide physician-assisted suicide cannot be the proximate cause of a patient's death because the patient's decision to ingest the medication is a superseding event that extinguishes proximate cause. We do not agree. It is entirely foreseeable that a terminally ill patient who requests medication intended to bring about death may use the medication for such a purpose. See Catalina, 407 Mass. at 791 ("Intervening conduct that is reasonably foreseeable will not relieve the defendant of criminal responsibility"). Indeed, the majority of patients who receive a prescription for lethal medication pursuant to physician-assisted suicide ultimately die by ingesting the medication.[10]

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[10] Based on data from reports of States where physician-assisted suicide is legal, approximately sixty-seven percent of patients who received a prescription for lethal medication died from ingesting the medication. See California Department of Public Health, California End of Life Option Act: 2020 Data Report (July 2021); District of Columbia Department of Health, District of Columbia Death with Dignity Act: 2018 Data Summary; Hawaii Department of Health, Report to the Thirty-first

Of course, as Steinbach notes, there is always a possibility that a patient ultimately will decide against ingesting the medication, as the outcomes suggest about one-third of patients do. See note 10, supra. But that conduct is not inevitable does not mean that it is not foreseeable. See, e.g., Catalina, 407 Mass. at 791 (defendant who provides heroin to another may be liable for user's death because "the act of the [user] in injecting [him- or her]self is not necessarily so unexpected, unforeseeable or remote as to insulate the [defendant] from criminal responsibility," even though user may decide against injecting provided heroin). The act of ingesting the lethal medication therefore is foreseeable and does not destroy proximate causation. See Askew, 404 Mass. at 534.

In sum, under our existing law, doctors who engage in physician-assisted suicide may risk liability for involuntary

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Legislature: 2021 (July 1, 2021); Hawaii Department of Health, Report to the Thirtieth Legislature: 2020 (July 1, 2020); Maine Department of Health and Human Services, Patient-Directed Care: 2020 Annual Report (Mar. 1, 2020); Maine Department of Health and Human Services, Patient-Directed Care at End of Life: Annual Report (Apr. 28, 2020); Oregon Health Authority, Oregon Death with Dignity Act: 2020 Data Summary (Feb. 26, 2021); Vermont Department of Health, Report to the Vermont Legislature: Report Concerning Patient Choice at the End of Life (Jan. 15, 2018); Washington Department of Health, 2020 Death with Dignity Act Report (Oct. 21, 2021); Washington Department of Health, 2019 Death with Dignity Act Report (Aug. 16, 2021); Washington Department of Health, 2018 Death with Dignity Act Report (July 2019); Washington Department of Health, Death with Dignity Act Report (Mar. 2018).

manslaughter. We turn to consider whether this potential risk is sufficient to demonstrate that Steinbach has established an actual controversy.

ii. Possibility that Steinbach will be prosecuted for manslaughter. The line between an abstract question and an actual controversy is not always clear cut, but, rather, "necessarily one of degree." See Maryland Cas. Co. v. Pacific Coal & Oil Co., 312 U.S. 270, 273 (1941). In borderline cases, such as this one, "[a] judge enjoys some discretion in deciding whether a case is appropriate for declaratory relief." Pazolt v. Director of the Div. of Marine Fisheries, 417 Mass. 565, 569 (1994). Although "[i]n different circumstances we might conclude that that some of the questions presented were not proper subjects for a declaratory decree," here we exercise our discretion in determining that Steinbach presents an actual controversy. See Southbridge Water Supply Co., 371 Mass. at 215, quoting Cohasset Water Co. v. Cohasset, 321 Mass. 137, 149 (1947).

Were we to decline to consider the merits today, "the rights of the parties may never be set to rest," as it seems unlikely that a more suitable case would arise. See Ciszewski v. Industrial Acc. Bd., 367 Mass. 135, 139 (1975). Given the current state of the law on manslaughter, and the significant penalties a conviction carries, it is doubtful that any doctor

would be willing openly to practice physician-assisted suicide. See G. L. c. 265, § 13 (manslaughter is punishable by up to twenty years in prison). It similarly is unlikely that a prosecutor definitively would commit to prosecuting any particular individual should he or she engage in physician-assisted suicide, because prosecutors "cannot be compelled to render advisory opinions, at the behest of private citizens." Bunker Hill Distrib., Inc., 376 Mass. at 147.

Moreover, the case at hand "involve[s] questions of pressing public importance" that reach far beyond Steinbach's immediate interest. See School Comm. of Boston v. Board of Educ., 352 Mass. 693, 697 (1967). Without resolution of the questions presented by this case, terminally ill patients will face uncertainty about their options, which may have an impact on their end-of-life decisions. See District Attorney for the Suffolk Dist. v. Watson, 381 Mass. 648, 660 (1980) (issuance of declaratory judgment on constitutionality of death penalty was warranted where it would afford "relief from present uncertainties which in turn, to say the least, will affect major decisions" in plaintiffs' ongoing criminal prosecutions).

Therefore, addressing the request for declaratory relief in the instant case would "remove, and . . . afford relief from, uncertainty and insecurity in the applicability of [laws]," and thus would serve the remedial purpose of the declaratory

judgment act. See Massachusetts Ass'n of Tobacco Distrib. v. State Tax Comm'n, 354 Mass. 85, 88-89 (1968). Accordingly, we "exercise[] our discretion very broadly in this case in favor of declaratory relief for the reason that a decision of all these matters seems important to enable parties to deal intelligently with the situation before them . . . and to reduce as much as possible the area of future litigation." See Southbridge Water Supply Co., 371 Mass. at 214-215, quoting Cohasset Water Co., 321 Mass. at 149.

b. Standing. We turn to the question whether Steinbach had standing to bring a claim for declaratory and injunctive relief. As a general rule, a plaintiff does not have standing "'to vindicate the constitutional rights of some third party,' because '[o]nly one whose rights are impaired by a statute can raise the question of its constitutionality, and he can object to the statute only as applied to him" (citation omitted). See McCarty's Case, 445 Mass. 361, 367 (2005), quoting Blixt v. Blixt, 437 Mass. 649, 661 (2002), cert. denied, 537 U.S. 1189 (2003). Nonetheless, a plaintiff may have standing to assert the rights of a third party under jus tertii standing. See Planned Parenthood League of Mass., Inc. v. Bell, 424 Mass. 573, 578 (Bell), cert. denied, 522 U.S. 819 (1997). Although "jus tertii standing is infrequently granted," it nonetheless is appropriate where (1) "the relationship of the litigant to the

third party whose right the litigant seeks to assert [is] such that 'the enjoyment of the right is inextricably bound up with the activity the litigant wishes to pursue'" and (2) there is "some genuine obstacle that renders the third party unable to assert the allegedly affected right on his or her own behalf." See id., quoting Singleton v. Wulff, 428 U.S. 106, 114-116 (1976). Relying on jus tertii standing, we previously have determined that physicians may assert their patients' constitutional right to choose to terminate a pregnancy. See Bell, supra at 579. See also Singleton, supra at 118 ("it generally is appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision").

Jus tertii standing is appropriate here for similar reasons. Physician-assisted suicide, much like abortion, necessarily requires the involvement of a medical provider. See Akron v. Akron Ctr. for Reproductive Health, Inc., 462 U.S. 416, 427 (1983) ("because abortion is a medical procedure, . . . the full vindication of the woman's fundamental right necessarily requires" physician's exercise of medical judgment). Moreover, a terminally ill patient claiming a constitutional right to physician-assisted suicide would face the significant obstacle of "imminent mootness," because, by definition, the patient would be likely to pass away within six months. See Singleton,

428 U.S. at 117 (women seeking abortion face obstacle of "imminent mootness," as their pregnancy likely would conclude prior to resolution of litigation). Thus, Steinbach has standing not only to challenge the application of the law of manslaughter to physicians who practice physician-assisted suicide, but also to litigate the constitutional rights of terminally ill patients seeking physician-assisted suicide.

2. Substantive due process. The Fourteenth Amendment to the United States Constitution and arts. 1, 10, and 12 of the Massachusetts Declaration of Rights guarantee individuals due process of law. See Klein v. Catalano, 386 Mass. 701, 707 n.6 (1982). This guarantee has two aspects, one procedural and one substantive. See Vasquez v. Commonwealth, 481 Mass. 747, 757 (2019). "[P]rocedural due process mandates that deprivations of life, liberty, or property be 'implemented in a fair manner.'" Commonwealth v. Preston P., 483 Mass. 759, 766-767 (2020), quoting Brangan v. Commonwealth, 477 Mass. 691, 703 (2017). Substantive due process, on the other hand, protects individual liberty against "certain government actions regardless of the fairness of the procedures used to implement them." Daniels v. Williams, 474 U.S. 327, 331 (1986). Substantive due process thus prohibits governmental actions that unduly interfere with rights that are deemed fundamental. See Commonwealth v. Simmons, 448 Mass. 687, 695 (2007).

"Fundamental rights are those rights that are 'explicitly or implicitly guaranteed by the Constitution.'" Chelsea Collaborative Inc. v. Secretary of the Commonwealth, 480 Mass. 27, 32 n.16 (2018), quoting Watson, 381 Mass. at 663. Statutes that have an impact on fundamental rights are subject to strict scrutiny, an exacting form of judicial review requiring that the statute be "narrowly tailored to further a compelling and legitimate government interest." See LeSage, petitioner, 488 Mass. 175, 181 (2021). Statutes that do not have an impact on fundamental rights, by contrast, are subject to rational basis review, "a less exacting standard of review whereby a challenged [law] will pass constitutional muster . . . if it 'bears a reasonable relation to a permissible legislative objective.'" See Aime v. Commonwealth, 414 Mass. 667, 673 (1993), quoting Rushworth v. Registrar of Motor Vehicles, 413 Mass. 265, 268 (1992). "For due process claims, rational basis analysis requires that statutes 'bear[] a real and substantial relation to the public health, safety, morals, or some other phase of the general welfare." Goodridge v. Department of Pub. Health, 440 Mass. 309, 330 (2003), quoting Coffee-Rich, Inc. v. Commissioner of Pub. Health, 348 Mass. 414, 422 (1965). The fit between the challenged statute and the asserted government interest need only be reasonable; the government is not required to tailor the statute precisely to further its interest, Murphy v. Department

of Correction, 429 Mass. 736, 742 (1999), nor is the government "bound to choose the best or gentlest of methods" to advance this interest, see Spence v. Gormley, 387 Mass. 258, 271 (1982).

"In determining which rights are fundamental, judges are not left at large to decide cases in light of their personal and private notions." Griswold v. Connecticut, 381 U.S. 479, 493 (1965) (Goldberg, J., concurring). To the contrary, because identifying a right as fundamental generally "place[s] the matter outside the arena of public debate and legislative action," courts must proceed with the "'utmost care' . . . lest the [rights] protected by [due process] be subtly transformed into the policy preferences" of the court. See Washington v. Glucksberg, 521 U.S. 702, 720 (1997), quoting Collins v. Harker Heights, 503 U.S. 115, 125 (1992). "This principle of judicial restraint includes recognition of the inability and undesirability of the judiciary substituting its notions of correct policy for that of a popularly elected Legislature." Zayre Corp. v. Attorney Gen., 372 Mass. 423, 433 (1977). Perhaps especially where such matters are hotly debated by those representatives, judges must not forget that "[o]ur obligation is to define the liberty of all, not to mandate our own moral code." Goodridge, 440 Mass. at 312, quoting Lawrence v. Texas, 539 U.S. 558, 571 (2003).

To discipline the substantive due process inquiry, the United States Supreme Court has articulated two standards for identifying fundamental rights under the Federal Constitution. As a matter of Federal law, a fundamental right may be determined either through a narrow view of this nation's history and traditions, see Glucksberg, 521 U.S. at 720-721, or through a more comprehensive approach, which uses "reasoned judgment" to determine whether a right is fundamental, even if it has not been recognized explicitly in the past, guided by history and precedent, see Obergefell v. Hodges, 576 U.S. 644, 664 (2015).

The narrow approach to identifying a fundamental right involves two discrete steps. First, the court "careful[ly] describ[es]" the fundamental liberty interest at issue (citation omitted). Glucksberg, 521 U.S. at 721. In so doing, the asserted right cannot be generalized to vague precepts, such as personal autonomy; rather, it must be phrased with narrow precision to reflect the specific activity at issue. See id. at 722-723. Second, the court considers whether the right is "deeply rooted in this [n]ation's history and tradition, and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed" (quotations and citations omitted). Id. at 720-721. Emphasis on the nation's history and legal traditions is essential, because "guideposts for responsible decisionmaking in [the area

of substantive due process] are scarce and open-ended." Collins, 503 U.S. at 125.

For example, in Glucksberg, 521 U.S. at 720-721, the United States Supreme Court considered whether a law prohibiting physician-assisted suicide unduly burdened an individual's fundamental rights. Rejecting the plaintiffs' framing of the liberty interest as the right to "choose how to die," or to "determin[e] the time and manner of one's death," the Court first defined the right at issue as the right to commit suicide with the assistance of another. Id. at 722-723. Then, the Court surveyed the common-law tradition, as revealed by contemporaneous legal treatises. See id. at 712, quoting 4 W. Blackstone, Commentaries *189 ("the law has . . . ranked [suicide] among the highest crimes" [alteration in original]); Glucksberg, supra at 714, quoting Blackwood v. Jones, 111 Fla. 528, 532 (1933) ("No sophistry is tolerated . . . which seek[s] to justify self-destruction as commendable or even a matter of personal right").

The Court also examined, citing judicial precedent and statutes, the historical condemnation of suicide from the time of the early American colonies to the modern era. Glucksberg, 521 U.S. at 712-718. The Court observed that "a consistent and almost universal tradition [exists] that has rejected the asserted right, and continues explicitly to reject it today,

even for terminally ill, mentally competent adults." Id. at 723. Accordingly, the Court concluded that there was no fundamental right to physician-assisted suicide and allowed the "earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide . . . to continue, as it should in a democratic society." Id. at 728, 735.

The Court also has articulated another, more comprehensive standard of substantive due process. This standard is based on its observation that identifying and protecting fundamental rights "is an enduring part . . . of the judicial duty to interpret the Constitution," which "requires courts to exercise reasoned judgment in identifying interests of the person so fundamental that the State must accord them its respect." See Obergefell, 576 U.S. at 663-664.

The exercise of reasoned judgment cannot be reduced to a mechanical formula. See Obergefell, 576 U.S. at 671. Reasoned judgment may counsel against an overly narrow description of a right, where such a framing would perpetuate or otherwise reflect invidious discrimination. See id. See also Goodridge, 440 Mass. at 328. Thus, the right at issue may be stated at a higher level of generalization where the asserted liberty interest converges with an equality interest. See Obergefell, supra. When phrased at a higher level of generalization, the right is stripped of the particulars of who is exercising it,

and how, in an effort to avoid invidious discrimination. For example, in Lawrence, 539 U.S. at 562-563, a challenge to a statute that prohibited sexual acts between two men, the right at issue was framed as the right to enter into consensual, intimate relationships, rather than as the right to engage in same-sex sodomy. After all, "[i]f rights were defined by who exercised them in the past, then received practices could serve as their own continued justification and new groups could not invoke rights once denied." Obergefell, supra. Using the proper framing, a reviewing court then may examine modern precedent -- in addition to history -- to determine whether the right is fundamental. See id. at 664-665. "History and tradition guide and discipline this inquiry but do not set its outer boundaries. . . . That method respects our history and learns from it without allowing the past alone to rule the present." Id. at 664, citing Lawrence, supra at 572.

> "The nature of injustice is that we may not always see it in our times. The generations that wrote and ratified the Bill of Rights and the Fourteenth Amendment did not presume to know the extent of freedom in all of its dimensions, and so they entrusted to future generations a charter protecting the right of all persons to enjoy liberty as we learn its meaning. When new insight reveals discord between the Constitution's central protections and a received legal stricture, a claim to liberty must be addressed."

Obergefell, supra. Reformulating the analysis in this way, constitutional tradition "gains content from the long sweep of

our history and from successive judicial precedents -- each looking to the last and each seeking to apply the Constitution's most fundamental commitments to new conditions." See Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2326 (2022) (Breyer, Sotomayor, & Kagan, JJ., dissenting).

For example, in Obergefell, 576 U.S. at 675, the Court considered whether same-sex couples had a fundamental right to marry. Rather than framing the asserted right as the "right to same-sex marriage," the Court explained that the true right at issue was the "right to marry," and concluded that this framing "capture[d] the essence of the right in a more accurate and comprehensive way." Id. at 670-672. The Court then undertook a survey of the ancient history of marriage, as well as modern judicial precedent recognizing the right to marry as a fundamental right. The Court began its analysis by emphasizing that "[f]rom their beginning to their most recent page, the annals of human history reveal the transcendent importance of marriage." Id. at 656. But the Court also carefully examined nearly fifty years of settled judicial precedent, which expressly recognized the "right to marry" as a fundamental right. Id. at 664, 671, citing Turner v. Safley, 482 U.S. 78, 95 (1987), Zablocki v. Redhail, 434 U.S. 374, 384 (1978), and Loving v. Virginia, 388 U.S. 1, 12 (1967). Deferring to judicial precedent, as well as to the long-standing veneration

of marriage, the Court held that same-sex couples had a fundamental right to marry. See Obergefell, supra at 675.

Although Obergefell, 576 U.S. at 675, and other cases applying the comprehensive approach remain good law, the United States Supreme Court appears to have abandoned the comprehensive approach and to have settled on the narrow approach as the definitive test for identifying fundamental rights protected by the Fourteenth Amendment. See Dobbs, 142 S. Ct. at 2242-2243.

"Fundamental to the vigor of our [F]ederal system of government is that '[S]tate courts are absolutely free to interpret [S]tate constitutional provisions to accord greater protection to individual rights than do similar provisions of the United States Constitution.'" Goodridge, 440 Mass. at 328, quoting Arizona v. Evans, 514 U.S. 1, 8 (1995). See Brennan, State Constitutions and the Protection of Individual Rights, 90 Harv. L. Rev. 489, 491 (1977) ("State constitutions, too, are a font of individual liberties, their protections often extending beyond those required by the Supreme Court's interpretation of [F]ederal law").

We previously have observed that "our treatment of due process challenges adheres to the same standards followed in Federal due process analysis." Gillespie v. Northampton, 460 Mass. 148, 153 n.12 (2011), quoting Goodridge, 440 Mass. at 353 (Spina, J., dissenting). See Commonwealth v. Ellis, 429 Mass.

362, 371 (1999). We also have recognized, however, that the Massachusetts Declaration of Rights "may demand broader protection for fundamental rights" than the Federal Constitution. See Goodridge, supra at 313. See also Gillespie, supra. Accordingly, we part ways with previously adopted Federal standards if they do not provide the degree of protection required by our State Constitution. See Commonwealth v. Clarke, 461 Mass. 336, 346 n.8 (2012) ("Where we have deemed Federal law inadequate to protect rights guaranteed under art. 12, we have not shied away from the promulgation of separate State law rules . . ."); Stornanti v. Commonwealth, 389 Mass. 518, 526 (1983) (Federal standards should only be applied if they are "consonant with our Constitution").

For the reasons that follow, we conclude that the narrow approach adopted by the United States Supreme Court in Glucksberg, 521 U.S. at 720-723, does not adequately protect the rights guaranteed by the Massachusetts Declaration of Rights. Accordingly, the proper analysis for identifying fundamental rights under the Massachusetts Declaration of Rights is the comprehensive approach.

By precluding this court from recognizing as fundamental those rights that may not have enjoyed legal protection throughout history, a rigid application of the narrow approach would "freeze for all time the original view of what

[constitutional] rights guarantee, [and] how they apply." See Dobbs, 142 S. Ct. at 2326 (Breyer, Sotomayor, & Kagan, JJ., dissenting). Such a result is incompatible with our State constitutional provisions, which "are, and must be, adaptable to changing circumstances and new societal phenomena." See Goodridge, 440 Mass. at 350 n.6 (Greaney, J., concurring). See also Commonwealth v. Horton, 365 Mass. 164, 177 (1974) ("Certainly constitutional interpretation must respond to social change . . ."). The comprehensive approach, unlike the narrow approach, allows us to interpret constitutional protections "in the light of our whole experience and not merely in that of what we said a hundred years ago," and therefore is more consonant with our State Constitution (citation omitted). See McDuffy v. Secretary of the Executive Office of Educ., 415 Mass. 545, 620 (1993). See, e.g., John Donnelly & Sons, Inc. v. Outdoor Advertising Bd., 369 Mass. 206, 218 (1975), quoting Euclid v. Ambler Realty Co., 272 U.S. 365, 387 (1926) ("'[W]hile the meaning of constitutional guaranties never varies, the scope of their application must expand or contract to meet the new and different conditions which are constantly coming within the field of their operation.' What was deemed unreasonable in the past may now be reasonable due to changing community values" [citation omitted]); Merit Oil Co. v. Director of the Div. on the Necessaries of Life, 319 Mass. 301, 305 (1946) (State's

constitutionally conferred regulatory authority adjusts "with the changing needs of society").

Moreover, the narrow approach risks perpetuating the discrimination and subordination of the past in a way that is odious to our Constitution. See Goodridge, 440 Mass. at 312 ("The Massachusetts Constitution affirms the dignity and equality of all individuals. It forbids the creation of second-class citizens"). By definition, marginalized groups have not possessed the full panoply of rights enjoyed by others throughout our nation's history and therefore, under the narrow approach, may be unable to prove that their rights are "deeply rooted." See id. at 339, quoting United States v. Virginia, 518 U.S. 515, 557 (1996) ("The history of constitutional law 'is the story of the extension of constitutional rights and protections to people once ignored or excluded'"). By phrasing the right more broadly, and considering modern precedent alongside history, we are able to cleanse our substantive due process analysis of the bigotry that too often haunts our history, and to ensure that those who were denied rights in the past due to outmoded prejudices are not denied those rights in the future. "The Massachusetts Constitution was never meant to create dogma that adopts inflexible views of one time to deny lawful rights to those who live in another." Goodridge, supra at 350 n.6 (Greaney, J., concurring).

In addition, the comprehensive approach is more consistent with our jurisprudence on substantive due process. For example, in our prior cases, we have not mechanically applied the precise framing required by the narrow approach, but, rather, occasionally have employed a more generalized framing of the right at issue. See, e.g., Commonwealth v. Weston W., 455 Mass. 24, 25, 32-33 (2009) (in case challenging ordinance that imposed curfew on minors, concluding that there is "[a] fundamental right to move freely within the Commonwealth"). Additionally, although we have viewed history as instructive, we have declined to treat it as determinative. See, e.g., Goodridge, 440 Mass. at 328 ("history must yield to a more fully developed understanding of the invidious quality of the discrimination"). Indeed, we regularly augment history with modern precedent, which may reveal new insights about the realm of liberty protected by substantive due process. See, e.g., id. at 339-340 (discussing modern precedent reflecting marriage as "an evolving paradigm"); Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 739 (1977) (basing right to refuse medical treatment in part on recent case law recognizing constitutional regard for privacy).

By parting ways with the recent Federal analysis of substantive due process, discussed supra, and instead adopting the comprehensive approach to substantive due process, we ensure

that the rights protected by the Massachusetts Declaration of Rights are not inappropriately limited by an unduly restrictive reading of history or tradition. In this way, we allow our State Constitution to respond effectively to our changing world, and to "define a liberty that remains urgent in our own era." See Obergefell, 576 U.S. at 672.

3. Application to Steinbach's assertion of a fundamental right. We turn to Steinbach's contention that the application of the law of manslaughter to physician-assisted suicide infringes upon fundamental rights protected by the Massachusetts Declaration of Rights.[11] As noted, an asserted right should be stated at a higher level of generality where the right intersects with an equality interest. Here, there is no allegation that the asserted right at issue is tainted by a history of invidious discrimination. Cf. Dobbs, 142 S. Ct. at 2324-2325 (Breyer, Sotomayor, & Kagan, JJ., dissenting) (discussing how colonial-era abortion restrictions reflected historical disregard for rights of women). Nor does Steinbach represent a class seeking equal access to a right presently

[11] Steinbach contends that the criminalization of physician-assisted suicide violates terminally ill patients' "privacy rights," as well as their rights to "personal autonomy and liberty." Nonetheless, as the motion judge observed, "[b]oth the Commonwealth and [Steinbach] appear to treat these [c]ounts as asserting substantive due process claims." Accordingly, we do not distinguish between the two claims.

enjoyed by others. Cf. Goodridge, 440 Mass. at 328 (considering whether same-sex couples enjoyed same right to marry as heterosexual couples). Because the right at stake does not implicate any equality concerns, it need not be generalized. Accordingly, the question we must consider is whether physician-assisted suicide ranks among those fundamental rights protected by the Massachusetts Declaration of Rights.

a. Historical treatment of suicide. There is little question that, throughout history, American society has not regarded suicide, in any form, as an individual right. To the contrary, both the Commonwealth and the nation at large have long treated suicide as a social problem to be prevented and remedied.

English common law ranked suicide as "among the highest crimes" one could commit, and punished it accordingly. See 4 W. Blackstone, Commentaries *189. The early colonies, including Massachusetts, appear to have adopted a similar view, universally condemning and punishing suicide as "self-murder." See generally Marzen, O'Dowd, Crone, & Balch, Suicide: A Constitutional Right?, 24 Duq. L. Rev. 1, 64-65 (1985) (Marzen). See, e.g., The General Laws and Liberties of the Massachusetts Colony (1672), reprinted in 2 The Laws and Liberties of Massachusetts 1641-1691, 363 (J.D. Cushing ed., 1976) (General Laws and Liberties); The Earliest Acts and Laws of the Colony of

Rhode Island and Providence Plantations 1647-1719, at 19 (J.D. Cushing ed., 1977); A.P. Scott, Criminal Law in Colonial Virginia 108 & n.193, 198 & n.15 (1930). For instance, in Massachusetts, the Colony Act provided that a person who committed suicide was to be "Buried in some Common High-way . . . [with] a Cart-load of Stones laid upon the Grave." General Laws and Liberties, supra.

States, including Massachusetts, eventually repealed laws intended to punish suicide, see, e.g., St. 1824, c. 143; Glucksberg, 521 U.S. at 713, "not because suicide itself was viewed as a lesser evil or as a human right, but because the penalties punished the innocent family of the suicide, without in any way reaching the real perpetrator of the act" (emphasis in original), Marzen, supra at 69. See Commonwealth v. Mink, 123 Mass. 422, 428-429 (1877) (repeal of State law punishing suicide "may well have had its origin in consideration for the feelings of innocent surviving relatives," but did not render suicide lawful). See also Glucksberg, supra ("the movement away from the common law's harsh sanctions did not represent an acceptance of suicide; rather . . . this change reflected the growing consensus that it was unfair to punish the suicide's family for his wrongdoing").

Even if suicide was not technically a crime, courts continued to consider it a "grave public wrong." See Hundert v.

Commercial Travelers' Mut. Acc. Ass'n of Am., 244 A.D. 459, 460 (N.Y. 1935). See also Glucksberg, 521 U.S. at 714. For example, in Mink, 123 Mass. at 426, we noted that suicide was "considered malum in se, and a felony," notwithstanding the repeal of the Colony Act. This view was not unique, but rather was shared by other State courts across the country. See State v. Willis, 255 N.C. 473, 475 (1961) ("Nearly all [State courts] agree that suicide is malum in se"). To this day, courts regard suicide as a serious social ill that the State has a strong interest in preventing. See Guardianship of Doe, 411 Mass. 512, 521, cert. denied, 503 U.S. 950 (1992) (recognizing "the prevention of suicide" as an "important State interest[]"). See, e.g., Krischer v. McIver, 697 So. 2d 97, 103 (Fla. 1997) (State "has a compelling interest in preventing suicide"); State v. Melchert-Dinkel, 844 N.W.2d 13, 22 & n.4 (Minn. 2014) (State has "compelling interest in preserving human life by preventing suicide"); McNabb v. Department of Corrections, 163 Wash. 2d 393, 403 (2008) (recognizing compelling State interest in "the prevention of suicide").

Perhaps for this reason, assisting another to commit suicide largely has been, and continues to be, regarded as a serious crime. See Carter I, 474 Mass. at 635-636 (defendant who pressured individual to commit suicide may be prosecuted for involuntary manslaughter); Commonwealth v. Bowen, 13 Mass. 356,

358 (1816) ("those who are counselling, hiring, and procuring the suicide to be committed are principal felons"). See also Glucksberg, 521 U.S. at 716 ("voters and legislators continue for the most part to reaffirm their States' prohibitions on assisting suicide"); Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 280 (1990) ("the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide"); Model Penal Code § 210.5 ("A person who purposely aids or solicits another to commit suicide is guilty of a felony in the second degree . . ."). Generally, it is no defense that the decedent may have requested the perpetrator's assistance. See Marzen, supra at 78 (Twentieth Century courts have "held that consent is no defense to a charge of homicide"); Model Penal Code § 210.5 comment 5 ("the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim"). But see Baxter v. State, 2009 MT 449, ¶¶ 40-42 (statutory consent defense may apply to physicians who provide physician-assisted suicide).

Nor is it legally relevant that the decedent was close to death. See Glucksberg, 521 U.S. at 714 ("the prohibitions against assisting suicide never contained exceptions for those

who were near death"). See also Blackburn v. State, 23 Ohio St. 146, 163 (1872) ("The life of those to whom life has become a burden -- of those who are hopelessly diseased or fatally wounded -- . . . are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live"). For example, in Bowen, 13 Mass. at 360, we upheld the conviction of a defendant who encouraged a fellow prisoner to commit suicide, even though the prisoner's execution was imminent. We stated that the defendant's offense was no less severe simply because only "a small portion of [the decedent's] earthly existence could, in any event, remain to him." Id.

While our nation's stance against suicide writ large is clear and virtually unanimous, physician-assisted suicide specifically has engendered more controversy. Far from being a contemporary dilemma, "[t]he question of whether severely ill suffering patients are entitled to a physician's help to end their suffering by ending their lives has been debated since antiquity." See Quill & Sussman, The Hastings Center, Physician-Assisted Death (Sept. 23, 2015).[12]

[12] Available at https://www.thehastingscenter.org /briefingbook/physician-assisted-death/ [https://perma.cc/43CN-BHSN].

Throughout history, physicians have assisted patients in hastening death, most often in secret. See Macleod, Wilson, & Malpas, Assisted or Hastened Death: The Healthcare Practitioner's Dilemma, 4 Global J. Health Sci. 87, 90 (2012). The practice, however, has never enjoyed broad social acceptance and has "remained a concept that the medical profession as a whole condemn[s]." See Ebbott, A "Good Death" Defined by Law: Comparing the Legality of Aid-in-Dying Around the World, 37 Wm. Mitchell L. Rev. 170, 177-178 & n.62 (2010). Indeed, no medical professional society in the United States has adopted an official stance in favor of physician-assisted suicide. See Barsness, Regnier, Hook, & Mueller, U.S. Medical and Surgical Society Position Statements on Physician-Assisted Suicide and Euthanasia: A Review, BMC Medical Ethics 4 (2020).[13]

Only recently has physician-assisted suicide come to enjoy any form of legal protection. See Dugdale, Lerner, & Callahan, Pros and Cons of Physician Aid in Dying, 92 Yale J. of Biology & Med. 747, 748 (2019). Ten States and the District of Columbia currently have statutory protections for physician-assisted suicide, but "[n]o appellate court has held that there is a

[13] Available at https://bmcmedethics.biomedcentral.com /track/pdf/10.1186/s12910-020-00556-5.pdf [https://perma.cc /HVA7-A9SG].

constitutional right to physician aid in dying." See Morris, 2016-NMSC-027, ¶ 5.

In sum, the history of suicide in general, and physician-assisted suicide in particular, provides no support for the conclusion that physician-assisted suicide is an individual right protected by the Massachusetts Declaration of Rights.

b. Modern precedent. Of course, that something may have been unprotected, or even prohibited, throughout history is not determinative, as our Constitution evolves alongside newly discovered insights about the nature of liberty. See McDuffy, 415 Mass. at 620 (constitutional protections "necessarily will evolve together with our society"). See, e.g., Loving, 388 U.S. at 12 (determining that there is fundamental right to interracial marriage, notwithstanding historical prohibitions against it). We therefore look to the arc of precedent to discern whether our tradition has evolved so as to encompass a right to physician-assisted suicide. See Goodridge, 440 Mass. at 327-328 (considering ways in which protections for marriage have evolved over time by evaluating recent precedent).

In Steinbach's view, the right to physician-assisted suicide is a natural outgrowth of the right to refuse medical treatment recognized in Saikewicz, 373 Mass. at 736, and Brophy v. New England Sinai Hosp., 398 Mass. 417, 419 (1986). In Saikewicz, supra, we considered the right of an individual to

decline potentially life-prolonging treatment, and ultimately concluded that there was a protected right to refuse medical treatment. Id. at 739-740. Such a right is derived from two related sources. Id. First, "a person has a strong interest in being free from nonconsensual invasion of his [or her] bodily integrity." Id. at 739. This interest is reflected in the common-law doctrine of informed consent, which protects "the inviolability of [an individual's] person" from unwanted intrusion (citation omitted). Id. See Feeley v. Baer, 424 Mass. 875, 880 (1997) (O'Connor, J., concurring) ("doctrine of informed consent has its foundation in the law of battery"). Second, we determined that the unwritten constitutional right to privacy "encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances." Saikewicz, supra.

Subsequently, in Brophy, 398 Mass. at 419, we again examined the right to refuse medical treatment in deciding whether to honor the previously expressed desire of a person, then in a persistent vegetative state, to discontinue life-sustaining nutrition and hydration. We once again concluded that a patient has a right to refuse medical treatment based on the common law of informed consent and "the unwritten and penumbral constitutional right to privacy." Id. at 430. "A significant aspect of this right of privacy is the right to be

free of nonconsensual invasion of one's bodily integrity," which reflects the historical regard for "self-determination and individual autonomy." Id. at 430-432.

The reasoning in Brophy, 398 Mass. at 430-432, and Saikewicz, 373 Mass. at 739-740, however, does not extend so far as to encompass physician-assisted suicide, which implicates neither the common-law right to be "free of nonconsensual invasion of one's bodily integrity" nor the right to privacy. With respect to the common-law tradition against unwanted physical intrusions, the patients in Brophy, supra, and Saikewicz, supra, were subjected to forced medical procedures. The same cannot be said of terminally ill patients who seek physician-assisted suicide. The common-law right to be free from unwanted bodily invasions therefore is not relevant to the analysis here.

As to the right to privacy, our prior cases have described the right as safeguarding an individual's ability to "mak[e] certain decisions that fundamentally affect his or her person 'free from unwarranted governmental intrusion.'" See Commonwealth v. Stowell, 389 Mass. 171, 173 (1983), quoting Eisenstadt v. Baird, 405 U.S. 438, 453 (1972). While the specific contours of this right elude precise definition, it is clear that the right does not extend to every ostensibly private activity or decision. See, e.g., Marcoux v. Attorney Gen., 375

Mass. 63, 66 (1978) (right to privacy does not encompass drug possession and use in one's home). See also Commonwealth v. Walter, 388 Mass. 460, 464 (1983) (right to privacy does not protect commercial sexual activity in private areas); Stowell, supra at 174 (right to privacy does not include right to engage in adulterous relationships).

Steinbach asserts that if the right to privacy includes the right to refuse unwanted medical care, it also necessarily must include the right to physician-assisted suicide, because there is no meaningful distinction between the two. We do not agree, but, rather, recognize an important distinction between the refusal of medical treatment and physician-assisted suicide, which lies in fundamental legal principles of cause and effect; whereas withdrawing or withholding medical care is not the primary cause of a patient's death, physician-assisted suicide is.

These principles are not new; to the contrary, they have been invoked explicitly in the very cases upon which Steinbach relies. For instance, in Saikewicz, 373 Mass. at 743 n.11, we noted that

> "[i]n the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death."

Indeed, we deemed the distinction between withholding life-prolonging treatment and suicide to be so obvious and incontrovertible that it "require[d] little if any discussion." Id.

Similarly, in Brophy, 398 Mass. at 439, we concluded that honoring the patient's desire to withdraw life-sustaining medical treatment did not implicate the State's interest in the prevention of suicide. In distinguishing between ceasing treatment and suicide, we observed that

> "[the patient] suffers an affliction which makes him incapable of swallowing. The discontinuance of [artificial nutrition and hydration] will not be the death producing agent set in motion with the intent of causing his own death. Prevention of suicide is an inapplicable consideration. A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient. Declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury." (Quotations, citations, alterations, and footnote omitted.)

Id. We relied on this distinction to state that "the law does not permit suicide" and therefore "does not permit unlimited self-determination, nor give unqualified free choice over life." Id. at 434 n.29.

The distinction between medical intervention that causes death and that which does not is not arbitrary, but, rather, is

"widely recognized and endorsed in the medical profession and in our legal traditions" (footnote omitted). See Vacco v. Quill, 521 U.S. 793, 800-801 (1997). In medical ethics, "the right of competent, informed patients to refuse life-prolonging interventions . . . is firmly established," whereas the right to physician-assisted suicide is a matter of "ethical . . . controversy." See, e.g., Quill, Lo, & Brock, Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia, 278 JAMA 2099, 2099-2100 (1997).

The American Medical Association has opined, for example, that although physicians should "honor patients' informed decisions to refuse life-sustaining treatment," physician-assisted suicide "is fundamentally incompatible with the physician's role as healer." See American Medical Association, Code of Medical Ethics c. 5, at 8-9.[14] See also Lagay, Physician-Assisted Suicide: The Law and Professional Ethics, 5 AMA J. Ethics 21, 21 (2003), quoting Scott, Assisted-Suicide Foes, AMA, Defeat Maine Ballot Initiative, Physician's Weekly, Dec. 4, 2000 ("physician-assisted suicide goes against 2,000 years of medical ethics"). Similarly, the American College of

[14] Available at https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf [https://perma.cc/V9SZ-PUQR].

Physicians "does not support the legalization of physician-assisted suicide," which it believes "raises ethical, clinical, and other concerns." See Sulmasy & Mueller, Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper, Annals of Internal Medicine 3 (Sept. 19, 2017).[15] The medical community's differing treatment is justified by the fact that the withdrawal of medical treatment does not cause death, whereas physician-assisted suicide does. See id. at 3-5; Glasson, Report of the Council on Ethical and Judicial Affairs, Physician-Assisted Suicide of the American Medical Association, 10 Issues L. & Med. 91, 93 (1994) ("When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease").

Courts likewise frequently have distinguished between actions that cause death and those that do not. See Vacco, 521 U.S. at 804 n.8, and cases cited. The United States Supreme Court, and State courts in every State, have relied on this distinction unanimously to conclude that broader protections for individual privacy do not extend so far as to include physician-assisted suicide. See, e.g., Glucksberg, 521 U.S. at 725 (right to end life-sustaining treatment does not support right to

[15] Available at https://www.acponline.org/system/files/documents/clinical_information/ethics-professionalism/ethics-and-the-legalization-of-physician-assisted-suicide-2017.pdf [https://perma.cc/P6ZR-MJ7T].

physician-assisted suicide); Sampson v. State, 31 P.3d 88, 94 (Alaska 2001) (rights to personal autonomy implicit in State Constitution do not "remotely hint[] at" right to physician-assisted suicide); Donorovich-Odonnell v. Harris, 241 Cal. App. 4th 1118, 1139 (2015) (rejecting argument that terminally ill patients have privacy interest in assisted suicide); People v. Kevorkian, 447 Mich. 436, 464 (1994), cert. denied, 514 U.S. 1083 (1995) (no fundamental right to assisted suicide "grounded in the notion of personal autonomy and springing from common-law concepts of bodily integrity and informed consent").

Accordingly, although courts in other jurisdictions widely protect the right to refuse medical treatment, none has concluded that physician-assisted suicide constitutes a fundamental right. See, e.g., Krischer, 697 So. 2d at 102-103 (discussing "significant difference" between protected privacy right to refuse medical treatment and physician-assisted suicide); Morris, 2016-NMSC-027, ¶ 52 (no part of protected State right to medical autonomy supports finding physician-assisted suicide to be fundamental right); Myers, 30 N.Y.3d at 14 (noting "well-established distinction between refusing life-sustaining treatment and assisted suicide").

In sum, given our long-standing opposition to suicide in all its forms, and the absence of modern precedent supporting an affirmative right to medical intervention that causes death, we

cannot conclude that physician-assisted suicide ranks among those fundamental rights protected by the Massachusetts Declaration of Rights. Thus, application of the law of manslaughter to physician-assisted suicide would not impinge on an individual's right to substantive due process.

4. Vagueness. Steinbach contends as well that the law of manslaughter is unconstitutionally vague as applied to physician-assisted suicide. He notes that we have not previously directly addressed whether physician-assisted suicide constitutes involuntary manslaughter, yet implied in Carter I, 474 Mass. at 636, that it did not.

"A law is unconstitutionally vague and denies due process of law if it fails to provide a reasonable opportunity for a person of ordinary intelligence to know what is prohibited or if it does not provide explicit standards for those who apply it." Commonwealth v. Jasmin, 396 Mass. 653, 655 (1986). "The . . . principle is that no man shall be held criminally responsible for conduct which he could not reasonably understand to be proscribed." Bouie v. Columbia, 378 U.S. 347, 351 (1964), quoting United States v. Harriss, 347 U.S. 612, 617 (1954).

Our previous cases make clear that someone who causes another's suicide through wanton or reckless behavior may be liable for involuntary manslaughter. See Carter II, 481 Mass. at 365; Atencio, 345 Mass. at 628-629; Persampieri, 343 Mass.

at 22-23. Although physician-assisted suicide is, in some ways, factually distinct from these cases, the distinctions are not legally significant. For example, it is irrelevant that the decedent may have been close to death. See Bowen, 13 Mass. at 360 (defendant who encouraged prisoner to commit suicide was liable for murder, even though prisoner was to be executed imminently). It similarly is not relevant that the physician acted out of care for the patient. See Pugh, 462 Mass. at 495 n.21 (motive is irrelevant in prosecution for manslaughter).

Because our prior cases indicate that physician-assisted suicide may constitute involuntary manslaughter, it is of not moment that we have not yet applied the law of manslaughter to physician-assisted suicide. See United States v. Lanier, 520 U.S. 259, 271 (1997) ("general statements of the law are not inherently incapable of giving fair and clear warning"). A law is not impermissibly vague simply because "the very action in question has [not] previously been held unlawful" (alteration in original). Krupien v. Ritcey, 94 Mass. App. Ct. 131, 135 (2018), quoting Lanier, supra. See Carter I, 474 Mass. at 631 n.11, 633 (concluding that law of manslaughter was not unconstitutionally vague as applied, even though court had never previously "had occasion to consider [an indictment for involuntary manslaughter] against a defendant on the basis of words alone").

Steinbach argues that Carter I, 474 Mass. at 636, nonetheless renders the law of manslaughter impermissibly vague as applied to physician-assisted suicide. In Carter I, supra, we stated that "a person offering support, comfort, and even assistance to a mature adult who, confronted with [terminal illness,] has decided to end his or her life" was "easily distinguishable" from the facts of that case.

Of course, the statement undoubtedly was dictum and therefore is not a controlling statement of law. See Crocker v. Justices of the Superior Court, 208 Mass. 162, 173 (1911) (although dicta "are entitled to respect, they are not of binding authority, and . . . not to be regarded as of controlling significance"). In any event, when viewed in context, the dictum did not imply that providing a terminally ill patient with a lethal prescription could not be considered involuntary manslaughter. Our decision in Carter I, 474 Mass. at 633, determined whether an indictment for involuntary manslaughter for assisting in a suicide could stand "on the basis of words alone." Our passing mention of a physician who offers "assistance" to a terminally ill patient did not address the issues we confront in this case. See id. at 636. This understanding was further emphasized in Carter II, 481 Mass. at 368. There, we stated that, "[a]s we explained in Carter I, [supra], and reemphasize today, this case does not involve the

prosecution of end-of-life discussions between a doctor . . . and a mature, terminally ill adult" (emphasis added). Carter II, supra. Thus, the application of the law of manslaughter to physician-assisted suicide is clearly foreshadowed by our precedent and is not rendered unconstitutionally vague by our passing mention in Carter I, supra.

5. Equal protection. Steinbach also argues that the application of common-law manslaughter to physician-assisted suicide violates the right to equal protection of the law by treating terminally ill adults who wish to pursue physician-assisted suicide differently from other terminally ill adults.

Articles 1 and 10 of the Massachusetts Declaration of Rights guarantee equal protection under the law. Commonwealth v. Long, 485 Mass. 711, 715 (2020). This guarantee "is essentially a direction that all persons similarly situated should be treated alike." Moore v. Executive Office of the Trial Court, 487 Mass. 839, 848 (2021), quoting Doe v. Acton-Boxborough Regional Sch. Dist., 468 Mass. 64, 75 (2014). Accordingly, in order to prove a violation of equal protection, plaintiffs must "identify and relate specific instances where persons situated similarly in all relevant aspects were treated differently" (quotation and citation omitted). Cote-Whitacre v. Department of Pub. Health, 446 Mass. 350, 376 (2006). See

Matter of Corliss, 424 Mass. 1005, 1006 (1997) ("One indispensable element of a valid equal protection claim is that individuals who are similarly situated have been treated differently").

Steinbach argues that, by criminalizing physician-assisted suicide, the Commonwealth treats terminally ill adults who wish to avail themselves of the practice differently from those who wish to hasten death through other means, such as voluntarily stopping eating or drinking, withdrawing life support, or palliative sedation.[16] This argument, however, cannot succeed because application of the law of manslaughter to physician-assisted suicide does not treat any person differently from any other. See Doe, 468 Mass. at 75 (differential treatment is "essential component[] of any equal protection claim"). Under

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[16] "With [voluntarily stopping eating and drinking], a patient who is otherwise physically capable of taking nourishment makes an active decision to discontinue all oral intake and then is gradually 'allowed to die,' primarily of dehydration or some intervening complication." See Quill, Lo, & Brock, Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia, 278 JAMA 2099, 2099 (1997). Palliative sedation is a "last-resort option" if a "patient finds severe physical symptoms intolerable despite state-of-the-art palliative care, and continuing consciousness under the circumstances is unacceptable." See Quill, Lo, Brock, & Meisel, Last-Resort Options for Palliative Sedation, 151 Annals Internal Med. 421, 422 (2009). In palliative sedation, "sedation is rapidly increased over minutes to a few hours until the patient is unresponsive," and medical treatments, including artificial nutrition and hydration, generally are withdrawn until death occurs. See id.

our current law, competent adults who are terminally ill may elect to stop eating or drinking, may agree to the withdrawal of life support, or may choose to pursue palliative sedation, but none is entitled to physician-assisted suicide. See Brophy, 398 Mass. at 430 & 434 n.29. Accordingly, because Steinbach has not identified any form of differential treatment, he does not state a violation of the equal protection of the laws.

Application of the law of manslaughter to physician-assisted suicide passes constitutional muster because the law is reasonably related to the State's legitimate interests in preserving life; preventing suicide; protecting the integrity of the medical profession; ensuring that all end-of-life decisions are informed, voluntary, and rational; and "protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives." Vacco, 521 U.S. at 808-809. See Glucksberg, 521 U.S. at 728-733; Myers, 30 N.Y.3d at 16. We respect the immense magnitude of all end-of-life decisions and acknowledge the overwhelming importance of the desire to conclude one's life in a way that is painless, peaceful, and consistent with one's values. Our decision today does not diminish the critical nature of these interests, but rather recognizes the limits of our Constitution, and the proper role of the judiciary in a functioning democracy. The desirability and practicality of physician-assisted suicide

raises not only weighty philosophical questions about the nature of life and death, but also difficult technical questions about the regulation of the medical field. These questions are best left to the democratic process, where their resolution can be informed by robust public debate and thoughtful research by experts in the field.

Conclusion. Because Kligler does not present an actual controversy, the case is remanded to the Superior Court for entry of an order dismissing Kligler as a party. We otherwise affirm the Superior Court judge's order on summary judgment as it pertains to Steinbach.

So ordered.

CYPHER, J. (concurring). In this appeal, the plaintiffs seek a declaration that the Massachusetts Constitution protects a fundamental right to physician-assisted suicide, thereby immunizing the practice from criminal prosecution. I agree with the court that the proposed right, as defined by the plaintiffs,[1] finds no support in the relevant provisions of our State Constitution. See Moe v. Secretary of Admin. & Fin., 382 Mass. 629, 633 n.4 (1981) ("We have historically taken the view that the principles of due process of law in our State Constitution are embodied in arts. 1, 10, and 12 of the Declaration of Rights and in Part II, c. 1, of the Constitution").

I write separately, however, to probe the court's position that, in every circumstance, the Commonwealth's interests

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[1] I.e., that a terminally ill patient, determined by appropriate medical professionals to be (1) mentally competent and (2) possessing six months or less to live, can receive a prescription for lethal medication, which they then can elect to self-administer at their chosen time and place. Sanctioning such a complex and ethically fraught medical protocol by judicial fiat, "with its implicit assessment of the effectiveness of alternative means, raises an unacceptable danger of this court's substituting its judgment for that of the Legislature," "absent a constitutional mandate to do so." Blue Hills Cemetery, Inc. v. Board of Registration in Embalming & Funeral Directing, 379 Mass. 368, 375 (1979). See Pope, Medical Aid in Dying: Key Variations Among U.S. State Laws, 14 J. Health & Life Sci. L. 25, 32 (2020) (detailing eligibility requirements and procedural safeguards in eleven United States jurisdictions that allow physician-assisted suicide). Indeed, such a decision likely would conflict with the separation of powers provision of our Constitution. See art. 30 of the Massachusetts Declaration of Rights.

outweigh those of terminally ill patients seeking physician-assisted suicide. In doing so, I call attention to those patients presently experiencing the objective limitations of late-stage palliative care, a group faced "not with the choice of whether to live, only of how to die." Washington v. Glucksberg, 521 U.S. 702, 746 (1997) (Stevens, J., concurring). For that group of patients, our case law addressing the right to refuse medical treatment -- in tandem with certain end-of-life practices already in use in the Commonwealth -- provides a constitutional zone of liberty and bodily autonomy that, while narrow, should not be subject to the State's reach.

It is undisputed that patients in Massachusetts have certain fundamental rights when it comes to accepting or rejecting medical treatment. See Lane v. Candura, 6 Mass. App. Ct. 377, 383 (1978) ("The law protects [a person's] right to make [his or her] own decision to accept or reject treatment, whether that decision is wise or unwise"). These rights "arise[] both from the common law and the unwritten and penumbral . . . right to privacy" afforded by the Massachusetts Constitution. Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 430 (1986). See Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 728, 738-739 (1977) ("There is implicit recognition in the law of the Commonwealth, as elsewhere, that a person has a strong interest in being free

from nonconsensual invasion of his bodily integrity"). See also Harnish v. Children's Hosp. Med. Ctr., 387 Mass. 152, 154 (1982); Matter of Spring, 380 Mass. 629, 634 (1980); Commissioner of Correction v. Myers, 379 Mass. 255, 261 (1979).

In Saikewicz, 373 Mass. at 729-730, 742, which concerned a patient's choice to decline life-prolonging chemotherapy for his leukemia, we first recognized a "substantial distinction" in the State's interests in the preservation of human life "where the affliction is curable, as opposed to" where "the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended." As such, we concluded that it was "not inconsistent" with the State's interest in promoting life "to recognize a right to decline medical treatment in a situation of incurable illness." Id. at 742 ("The constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life"). Equally as important as recognizing a patient's right to make certain end-of-life decisions, however, Saikewicz signaled a shift by reviewing courts "away from a paternalistic view of what is 'best' for a patient toward a reaffirmation that the basic question is what decision will comport with the will of the person involved." Brophy, 398 Mass. at 430-431.

This shift readily is apparent in Brophy, 398 Mass. at 423, decided a decade after Saikewicz, where we were asked to consider the previously expressed wishes of a patient in a vegetative state that he not be kept alive through artificial means. The patient in Brophy was situated in a qualitatively different position from the one in Saikewicz, however, as the former was neither "terminally ill nor in danger of imminent death" from an underlying illness. Id. at 434. Rather, the patient in Brophy relied on a noninvasive plastic tube for nourishment and hydration, but otherwise was stable in a medical sense. See id. at 425 & n.16 ("Brophy breathes on his own, without a respirator . . . . All of his other major organs function normally and without mechanical assistance"). Nevertheless, we reasoned that the "duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity." Id. at 434. We therefore concluded that it was "antithetical to our scheme of ordered liberty and to our respect for the autonomy of the individual for the State [rather than the patient] to make decisions regarding the individual's quality of life" and, as a practical consequence, ruled that the maintenance of the feeding tube "for [an indefinite] period of

several years" constituted "intrusive treatment as a matter of law." Id. at 434-435.

Two propositions can be derived from our reasoning in Saikewicz and Brophy. The first is that the paternalism of the State in matters involving health care must yield, on occasion, to the personal autonomy of patients facing outcomes that vary only in their respective degrees of bleakness. The second is that the State recognizes that certain medical scenarios permit the deeply personal decision to hasten death, sometimes drastically so. See Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 279 (1990) (due process clause of Fourteenth Amendment to United States Constitution grants competent persons constitutionally protected right to refuse both lifesaving and life-sustaining hydration and nutrition); Brophy, 398 Mass. at 434-435. In short, the State can, and has, conceived of a life that may no longer be worth living. See Brophy, supra. Contrast Cruzan, supra at 335 n.8 (Stevens, J., dissenting) (Missouri argued in Cruzan that all life is "worthy of preservation without regard to its quality").

As far as determining whether a patient has a right to physician-assisted suicide, I can find no meaningful distinction between a mentally competent adult in a semicomatose -- but otherwise painless -- state, see Brophy, 398 Mass. at 434-435, and a terminally ill patient, who faces certain, imminent, and

excruciating death effectuating his or her own death, see id. at 447 (Lynch, J., dissenting in part) ("If nutrition and hydration are terminated, it is not the illness which causes the death but the decision [and act in accordance therewith] that the illness makes life not worth living. There is no rational distinction between suicide by deprivation of hydration or nutrition in or out of a medical setting -- both are suicide" [footnote omitted]).[2]

To justify this incongruity, the court in this matter relies on (1) the well-established right of patients to be free from "forced medical procedures" (i.e., the doctrine of informed consent) as well as (2) a cause-and-effect analysis, in which the underlying affliction is presumed to "cause," in a legal sense, the medical death of the patient rather than the actions or omissions of the medical provider or patient. See ante at . Both lines of argument are unconvincing in a jurisdiction where Brophy remains good law.

The patient's feeding apparatus in Brophy was a tube that was powered by gravity. See Brophy, 398 Mass. at 425-426. It did not deliver unnatural medical interventions to the patient, such as chemotherapy or synthesized opioids. See id. Rather,

[2] I recognize that the consequences for the physician, however, are quite different.

the tube delivered to the patient only those essential units of life: water and calories. See id. at 426.

This mechanism does not appear to me to be what is meant by "forced medical intervention." To claim that the affirmative withdrawal of the tube was not the proximate cause of the patient's death ignores logic. See id. at 444 (Lynch, J., dissenting in part) ("the cause of death would not be some underlying physical disability like kidney failure or the withdrawal of some highly invasive medical treatment, but the unnatural cessation of feeding and hydration which, like breathing, are part of the responsibilities we assume toward our bodies routinely").

Moreover, the fact that this court cites to the court's opinion in Brophy -- which rationalized the patient's inability to swallow as the actual "death producing agent" that would "caus[e] his own death" -- should have some legal import for the thousands of Commonwealth families with loved ones suffering from advanced Alzheimer's disease, Parkinson's disease, amyotrophic lateral sclerosis, or other terminal illness that interferes with swallowing. Id. at 439. See Bolser, A Serious and Often Overlooked Issue for Patients with Brain Diseases: Swallowing, The Conversation (Mar. 16, 2017), https://theconversation.com/a-serious-and-often-overlooked-issue-for-patients-with-brain-diseases-swallowing-67042 [https://perma.cc

/G6NM-326B] (millions of Americans with brain diseases, including those with Alzheimer's, Parkinson's, amyotrophic lateral sclerosis disease, stroke, multiple sclerosis, and traumatic brain injury, suffer from some form of dysphagia).

I think that Saikewicz and Brophy were decided correctly. But, in keeping with the comprehensive approach we always have used to identify fundamental rights under the Massachusetts Constitution, I seek to highlight the degree to which our precedent has arced vitally close toward encompassing a right to physician-assisted suicide. See Goodridge v. Department of Pub. Health, 440 Mass. 309, 327-328 (2003) (invoking modern cases to reveal evolving insights about marriage in contemporary context).

By vindicating the interest of the patient in Brophy to refuse hydration and nourishment, this court already has "authorized affirmative conduct" that would not only hasten death but also would guarantee that outcome. Glucksberg, 521 U.S. at 743 (Stevens, J., concurring). If a constitutionally cognizable liberty interest outweighing the respective interests of the State were found for a patient who was neither terminally ill nor in obvious pain, then logic dictates that that same interest should be able to be invoked by patients suffering through late-stage palliative care -- patients straddling the periphery between life and death.

Of course, the removal of life-sustaining nourishment is just one of several ways medical personnel are (legally) able to hasten a patient's death in Massachusetts. Other deliberate efforts include the removal of breathing tubes, the turning off of ventilators, and the discontinuing of intravenous life-sustaining medications. Notably, none of "[t]hese measures are . . . passive." Myers v. Schneiderman, 30 N.Y.3d 1, 24 (2017) (Rivera, J., concurring).

Apart from these more traditional actions to hasten death for the terminally ill, the State also permits physicians to practice palliative sedation to unconsciousness,[3] commonly known as terminal sedation.[4] Terminal sedation is used when a

[3] In its Code of Medical Ethics, the American Medical Association sanctions the use of sedation to unconsciousness as "an intervention of last resort." American Medical Association, Code of Medical Ethics, c. 5.6, at 7, https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-5.pdf [https://perma.cc/V9SZ-PUQR]. Pursuant to the code, terminal sedation should be practiced only in those rare instances "[w]hen a terminally ill patient experiences severe pain or other distressing clinical symptoms that do not respond to aggressive, symptom-specific palliation." Id.

[4] For relevant statutes addressing palliative care, see G. L. c. 6D, § 14 (certification standards for patient-centered medical homes); G. L. c. 6D, § 15 (certification standards for accountable care organizations); G. L. c. 12C, § 20 (public information regarding palliative care); G. L. c. 94C, § 19D (exception to seven-day supply limitation on opioids for palliative care); G. L. c. 111, § 24K (pediatric palliative care program); G. L. c. 111, § 57D (hospice programs providing palliative care); G. L. c. 111, § 227 (disclosures regarding palliative care); G. L. c. 111, § 233 (palliative care and quality of life interdisciplinary advisory council); G. L.

terminally ill patient's pain cannot otherwise be relieved with medication and the patient's death clinically is imminent. See Quill, Lo, Brock, & Meisel, Last-Resort Options for Palliative Sedation, 151 Annals Internal Med. 421, 421 (2009) (Quill, Last-Resort Options); Quill, Lo, & Brock, Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia, 278 JAMA 2099, 2100 (1997) (Quill, Comparisons).

The goal of palliative sedation to unconsciousness is to make the patient unconscious to provide complete relief. See Quill, Last-Resort Options, supra at 421; Quill, Comparisons, supra at 2100. In this method, "sedation is rapidly increased over minutes to a few hours until the patient is unresponsive," artificial nutrition and hydration typically are not provided, and the patient remains in this state until death occurs. Quill, Last-Resort Options, supra at 422. See Quill, Comparisons, supra at 2100 ("Although death is inevitable, it usually does not take place for days or even weeks"). Palliative sedation to unconsciousness is the last-resort clinical response to spare terminally ill patients with no

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c. 111, § 234 (palliative care consumer and professional information and education program); G. L. c. 111O, § 4 (members of mobile integrated health advisory council to be drawn from fields including palliative care).

likely prospect of recovery from otherwise unrelievable physical suffering. Quill, Last-Resort Options, supra at 422. As with all forms of palliative care, palliative sedation to unconsciousness is undertaken only with the consent of the patient or a surrogate, with the patient's treatment goals and priorities in mind. See L. Forrow & H.S. Smith, Pain Management in End of Life: Palliative Care, in Principles and Practice of Pain Medicine 492, 494 (C.A. Warfield & Z.H. Bajwa, eds., 2d ed. 2004).

For this subgroup of terminally ill patients, the State recognizes palliative sedation to unconsciousness as a lawful means to end life. The difference, however, "between injecting a drug that sedates a patient while simultaneously quickening death and prescribing lethal medication is not meaningful in the constitutional sense." Myers, 30 N.Y.3d at 27 (Rivera, J., concurring). In undertaking both practices, "the purpose of the physician's act and the patient's goal . . . is to expedite the dying process and avoid the severe pain, suffering, and indignity associated with the last stage of a terminal illness." Id.

I would go so far as to argue that, from a legal standpoint, terminal sedation requires more direct action on the part of the attending physician to facilitate patient death than does physician-assisted suicide. See Quill, Last-Resort

Options, supra at 422 ("With [terminal sedation], sedation is rapidly increased over minutes to a few hours until the patient is unresponsive . . ."). See also Glucksberg, 521 U.S. at 736-737 (O'Connor, J., concurring) ("a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death"). In the former method, a doctor places the patient into a chemically induced torpor from which he or she loses all agency to struggle against death, at which point the anesthetizing drugs, the removal of supplemental hydration, and, of course, the underlying condition(s) each become the potential legal cause of expiration. See Orentlicher, The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia, 24 Hastings Const. L.Q. 947, 957 (1997). By contrast, with physician-assisted suicide, the doctor's involvement ends after prescribing lethal drugs to the competent patient. The decision whether to consume the drugs -- much less whether to fill the prescription -- remains at all times with the patient.[5]

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[5] As one amicus points out, data from these jurisdictions shows that, of the total number of patients who have requested and received the necessary prescription for lethal medication, between one-quarter and one-half of them never take the final step of self-administering the medication. The available data shows that, in California, 63.54 percent of patients who have

The court attempts to draw a bright line between those medical interventions "that cause death and those that do not." Ante at . See id. at (finding meaningful distinction between right to refuse unwanted medical care and practice of physician-assisted suicide vis-à-vis classic legal principles of cause and effect). What the State-sanctioned practice of terminal sedation makes clear, however, is that no one can really say just where that line is.[6]

Given that terminally ill patients in the Commonwealth, who are in severe pain resistant to palliation, may invoke their liberty interests and opt to be terminally sedated, the State appears to have no rational interest in denying patients

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received a prescription for lethal medication as part of physician-assisted suicide have taken it; in the District of Columbia, fifty percent; in Maine, 60.78 percent; and in Oregon, 65.8 percent. See California Department of Health, California End of Life Option Act: 2020 Data Report 3 (July 2021); District of Columbia Department of Health, District of Columbia Death with Dignity Act: 2018 Data Summary 2; Maine Department of Health and Human Services, Patient-Directed Care: Annual Report 5 (Mar. 1, 2021); Maine Department of Health and Human Services, Patient-Directed Care at End of Life: Annual Report 4 (Apr. 28, 2020); Oregon Health Authority, Oregon Death with Dignity Act: 2020 Data Summary 14 (Feb. 26, 2021).

[6] See Glucksberg, 521 U.S. at 751 (Stevens, J., concurring) ("The illusory character of any differences in intent or causation [between physician-assisted suicide and terminal sedation] is confirmed by the fact that the American Medical Association unequivocally endorses the practice of terminal sedation -- the administration of sufficient dosages of pain-killing medication to terminally ill patients to protect them from excruciating pain even when it is clear that the time of death will be advanced").

similarly situated the "choice of a less intrusive option . . . which may better comport with [that] patient's autonomy and dignity." Myers, 30 N.Y.3d at 29 (Rivera, J., concurring). Rather, this subgroup of patients possesses what the late Justice Stevens deemed a "constitutionally protected [liberty] interest" that "differs from, and is stronger than, both the common-law right to refuse medical treatment and the unbridled interest in deciding whether to live or die." Glucksberg, 521 U.S. at 745 (Stevens, J., concurring). The usual reasons used to deny these patients access to physician-assisted suicide (e.g., reverence for life, archaic proscriptions against suicide, incorrect prognoses) do not carry the same weight when the patient's choices are limited to either inadequate pain management or terminal sedation, a practice that differs from physician-assisted suicide in degree and not in kind.

"The duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity." Brophy, 398 Mass. at 434. This court authored those poignant words some three and one-half decades ago when it honored the previously expressed wishes of an adult patient not to be left to subsist in a vegetative state. In doing so, we broadened our conception of a patient's autonomy to encompass the liberty to forgo basic life-sustaining

care even if that patient were neither "terminally ill nor in danger of imminent death from any underlying physical illness." Id. Since that time, the United States Supreme Court has recognized the same individual liberty interest under the Federal Constitution and has concluded that competent adults in a persistent vegetative state have the "right to die." Cruzan, 497 U.S. at 277.

I concur with the court that the plaintiffs' proposed physician-assisted suicide schema is, as a matter of right, too procedurally complex for us to adopt whole cloth. See note 1, supra. In addition, I fully support the court's thoughtful and timely primer on substantive due process, which preserves the comprehensive approach as the proper test for identifying fundamental rights under our State Constitution. See ante at ("For the reasons that follow, we conclude that the narrow approach [for identifying fundamental rights protected by the Fourteenth Amendment] adopted by the Supreme Court [in Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2242-2243 (2022),] does not adequately protect the rights guaranteed by [arts. 1, 10, and 12] of the Massachusetts Declaration of Rights. Accordingly, the proper test for identifying fundamental rights

under the Massachusetts Declaration of Rights is the comprehensive approach").[7] I therefore concur in the judgment.

However, based on the strength of our existing case law concerning end-of-life patient autonomy, in conjunction with current palliative treatments that are commensurate with physician-assisted suicide, I do "not foreclose the possibility that some applications" of our criminal statutes "may impose an intolerable intrusion on" patient freedom. Glucksberg, 521 U.S. at 751-752 (Stevens, J., concurring). When that appropriate challenge (or challenger) does come forward, we must be ready to extend our State constitutional protections to terminally ill patients seeking to exercise what remains of their bodily autonomy.

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[7] See J.E. Fleming, Construing Basic Liberties: A Defense of Substantive Due Process 226 (2022) ("Instead of looking exclusively to the [F]ederal Constitution, [liberal reformers] should be looking primarily to [S]tate [C]onstitutions, especially for the next generation"); Kafker, State Constitutional Law Declares Its Independence: Double Protecting Rights During a Time of Federal Constitutional Upheaval, 49 Hastings Const. L.Q. 115, 116 (2022) ("there is nothing in the design of the [F]ederal Constitution, or its original understanding, requiring [S]tates to adopt the Supreme Court's interpretation of analogous provisions in the [F]ederal Constitution as the default or lockstep setting for interpreting parallel provisions in [S]tate [C]onstitutions. State courts are fully empowered and expected to interpret independently analogous provisions in their [S]tate [C]onstitutions and thereby provide greater protections of individual rights, if they so conclude . . .").

WENDLANDT, J. (concurring in part and dissenting in part, with whom Budd, C.J., joins with regard to parts 2 and 3). The plaintiff, Roger M. Kligler, a terminally ill, mentally competent patient with incurable stage 4 prostate cancer, has presented an "actual controversy" for purposes of the declaratory judgment act, G. L. c. 231A, § 1 (act). While Kligler's death is not looming, he, like the patients of the plaintiff, Alan Steinbach, presents more than a potential future conflict. Kligler need not spend the last six months of his life embroiled in a legal battle; he, no less than Steinbach, deserves his day in court. Accordingly, I dissent from the portion of the court's decision dismissing Kligler's claims.

Because I agree with the court that there is no fundamental right to prescribe, or to receive a prescription for, medication to assist a terminally ill, mentally competent patient's suicide (physician-assisted suicide), I concur in the judgment as it concerns Steinbach. I also agree with the court that application of the criminal laws to physician-assisted suicide generally survives rational basis review. I write separately because, when a terminally ill, mentally competent patient approaches the final stage of the dying process, the Commonwealth's interest in criminalizing physician-assisted suicide reduces to a nullity, such that even under rational basis review, the State Constitution protects the nonfundamental

right to physician-assisted suicide from application of the State's criminal laws.

1. Actual controversy requirement. Kligler is mentally competent and terminally ill. He has stage 4 prostate cancer, and his diagnosis includes his treating physicians' best estimates as to his remaining life span. When he commenced this litigation, he had a fifty percent chance of dying within the next five years. Thankfully, those estimates do not yet put Kligler at death's door; in my view, however, they provide sufficient interest in the sought declaration to hurdle the minimal bar for an "actual controversy" set by the act. See Massachusetts Ass'n of Indep. Ins. Agents & Brokers, Inc. v. Commissioner of Ins., 373 Mass. 290, 293 (1977) ("the 'actual controversy' . . . requirement[] should be liberally construed"). Contrary to the court's conclusion, he does not allege merely a "potential future conflict[]." Cf. Penal Instits. Comm'r for Suffolk County v. Commissioner of Correction, 382 Mass. 527, 531 (1981).

To be sure, the plaintiffs have pleaded a right to physician-assisted suicide that they assert is triggered at the point when a patient has received an estimate of a six-month remaining life span, which is designed apparently to cabin the sought right to follow the best practices of medicine in those States that permit it. The court uses this pleading to conclude

that Kligler does not present an actual controversy because Kligler's own estimated remaining life span does not yet fall within the six-month window.

However, anyone who has received, or has had a loved one receive, an estimate as to the patient's remaining life span knows that by necessity (indeed, by definition) such an estimate lacks mathematical precision even though it is based on the collective experiences of similarly situated patients. Indubitably, Steinbach's patients' estimates also lack the rigor of a precise mathematical formula, yet that imprecision does not dissuade the court from addressing his claim.

Given that litigation challenging the constitutionality of State action often (and nearly always) lasts more than six months, the court ought to exercise its discretion to reach the merits of Kligler's claim consistent with its treatment of Steinbach's claim;[1] it is, after all, Kligler (the terminally ill patient) who is the principal to whom the right at issue here is

[1] Under the court's view, to meet the "actual controversy" requirements of the act, Kligler must spend the last six months of his life embroiled in litigation the end to which he will not likely witness because he will die. Such a miserly view of the act is inconsistent with our charge to liberally construe it. Massachusetts Ass'n of Indep. Ins. Agents & Brokers, Inc., 373 Mass. at 293.

most critical.[2] Accordingly, I dissent from the court's dismissal of Kligler's claims -- a decision that does nothing to further our interests either in conserving judicial resources or in avoiding prematurely deciding constitutional issues in view of the court's decision to address the merits of Steinbach's claims.

2. No fundamental right to physician-assisted suicide. I agree with the court that there is no fundamental right to physician-assisted suicide; as the court reasons, such a right finds no support in our history, in our evolving traditions and understandings of equality and fairness, or in our judicial precedent.[3] It is worth emphasizing that this lack of consensus

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[2] Indeed, as the court recognizes, Steinbach's standing to bring this action relies on the standing of his patients, who, like Kligler, have received a diagnosis of a terminal illness.

[3] Society's evolving traditions and better-informed understandings of the liberty interests protected by substantive due process may or may not be reflected in judicial precedent. Thus, while I agree with the court that judicial precedent may reflect new insights about the realm of liberty protected by substantive due process, see ante at , the insights themselves are what guide our analysis of the evolving understanding whether an asserted right is implicit in the concept of ordered liberty. If our recognition of new insights and societal understandings was limited to those found in judicial precedents, we would risk either ossifying our understanding or transforming the rights protected by due process into the policy preferences of the majority of the court. See Goodridge v. Department of Pub. Health, 440 Mass. 309, 312 (2003), quoting Lawrence v. Texas, 539 U.S. 558, 571 (2003) ("Our obligation is to define the liberty of all, not to mandate our own moral code"). Cf. Zayre Corp. v. Attorney Gen., 372 Mass. 423, 433 (1977) ("This principle of judicial restraint

is particularly salient to our substantive due process analysis of the presently asserted right because physician-assisted suicide does not implicate principles of equality. See Goodridge v. Department of Pub. Health, 440 Mass. 309, 320-321 (2003), quoting Lawrence v. Texas, 539 U.S. 558, 575 (2003) ("Equality of treatment and the due process right to demand respect for conduct protected by the substantive guarantee of liberty are linked in important respects . . ."); Goodridge, supra at 328 n.17 (Federal and State Constitutions "prohibit[] a State from wielding its formidable power to regulate conduct in a manner that demeans basic human dignity, even though that statutory discrimination may enjoy broad public support").

In connection with physician-assisted suicide, we do not write against a backdrop of bias, invidious discrimination, or animus that made the affected group's ability to participate in the legislative process to advocate for a given right more difficult as a practical matter. Compare Obergefell v. Hodges, 576 U.S. 644, 664-665 (2015) (right to marry someone of same sex); Lawrence, 539 U.S. at 564 (right to engage in same-sex sexual conduct); Loving v. Virginia, 388 U.S. 1, 12 (1967) (right to marry persons of different race). The argument

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includes recognition of the inability and undesirability of the judiciary substituting its notions of correct policy for that of a popularly elected Legislature").

presented is not part of "the story of the extension of constitutional rights and protections to people once ignored or excluded." Goodridge, 440 Mass. at 339, quoting United States v. Virginia, 518 U.S. 515, 557 (1996).

To the contrary, dying is something we all will face in time; it is something nearly all of us will have our closest loved ones experience. There is no disenfranchised group that needs constitutional protection by this court, or who cannot advocate zealously and fairly for the ability to die as they please. Rather, every one of us is free to vote and encourage our legislators to enact laws, and to craft appropriate procedural safeguards, with respect to one of the only human experiences that will affect us all. As such, the asserted right ought to be left to the democratic process. See Glucksberg, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring) ("There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure").

"Because the controversy surrounding physician-assisted suicide is so firmly rooted in questions of social policy, rather than constitutional tradition, it is a quintessentially legislative matter." Sampson v. State, 31 P.3d 88, 98 (Alaska

2001). See Morris v. Brandenburg, 2016-NMSC-027, ¶ 2 ("It is not easy to define who would qualify to be a terminally ill patient, or what would be the criteria for assuring a patient is competent to make an end-of-life decision, or what medical practices are acceptable to aid a patient in dying, or what constitutes a safe medication").

3. Rational basis review. Because there is no fundamental right to physician-assisted suicide, we employ rational basis review to evaluate whether criminalization of physician-assisted suicide through application of our criminal laws comports with due process. See Doe, Sex Offender Registry Bd. No. 339940 v. Sex Offender Registry Bd., 488 Mass. 15, 20 (2021). As a general matter, I agree with the court that the Commonwealth has identified several public safety and welfare interests, each of which is reasonably related to applying criminal laws to physician-assisted suicide.

I write separately because the application of criminal laws to physician-assisted suicide will not always pass constitutional muster even under the relatively meager bar of rational basis review. In particular, when a terminally ill, mentally competent patient approaches the final stage of the dying process, accompanied by unbearable pain that cannot be alleviated by palliative care short of sedation to unconsciousness, the rational basis calculus necessarily

changes. In such a situation, the Commonwealth's interests reduce to a nullity,[4] as the individual's liberty interest in choosing a peaceful death that comports with the individual's values and dignity, specifically through physician-assisted suicide, strengthens to its zenith; death is looming and inevitable, and the question is no longer "whether to live, only of how to die." Glucksberg, 521 U.S. at 746 (Stevens, J., concurring). See Myers v. Schneiderman, 30 N.Y.3d 1, 18 (2017) (Rivera, J., concurring) (as patient's life draws to inevitable end, State's interests diminish and "do not outweigh either the individual's right to self-determination or the freedom to choose a death that comports with the individual's values and sense of dignity"). "For this subgroup of patients, healing, as understood as a restoration of bodily health, is no longer a possibility." Id. at 33.

At such a moment, there is no meaningful distinction between physician-assisted suicide and palliative sedation to unconsciousness followed by withdrawal of nutrients so as to cause dehydration and starvation. Where the State permits the latter procedure, it "has no compelling rationale, or even a

[4] Our decision in Bowen is not to the contrary. There, we upheld the conviction of a prisoner who encouraged a death row inmate to commit suicide on the basis that there was a public interest in the public execution of criminals. Commonwealth v. Bowen, 13 Mass. 356, 360 (1816). No comparable interest exists in the context contemplated here.

rational interest, in refusing a mentally-competent, terminally-ill patient who is in the final stage of life the choice of a less intrusive option -- access to [physician-assisted suicide] -- which may better comport with the patient's autonomy and dignity." Id. at 29. In this scenario, depriving the patient of a legal path to bring about a death in line with his or her wishes also injures surviving family members, who must watch helplessly as their loved one suffers through the final moments of his or her life. Id. at 30. Allowing this subset of patients to choose to die with dignity as their final act while death is looming and inevitable would not result in harm to the public welfare. In such a case, application of the criminal laws to the nonfundamental right to physician-assisted suicide would be irrational and thus proscribed by substantive due process.

4. Conclusion. For the foregoing reasons, I dissent in part and concur in part.