COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

SJC-13194

DR. ROGER M. KLIGLER AND DR. ALAN STEINBACH
Appellants (Plaintiffs Below),

v.

MAURA T. HEALEY, IN HER OFFICIAL CAPACITY AS THE ATTORNEY GENERAL OF THE COMMONWEALTH OF MASSACHUSETTS, AND MICHAEL O'KEEFE, IN HIS OFFICIAL CAPACITY AS DISTRICT ATTORNEY OF CAPE & ISLANDS DISTRICT
Appellees (Defendants Below)

On Appeal from the Suffolk County Superior Court
Civil Action No. 16-3254F

BRIEF FOR AMICI CURIAE MASSACHUSETTS MEDICAL SOCIETY AND HOSPICE & PALLIATIVE CARE FEDERATION OF MASSACHUSETTS IN SUPPORT OF NEITHER PARTY

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Supreme Judicial Court Rule 1:21, the Massachusetts Medical Society (MMS) states it is a 501(c)(6) corporation organized under the laws of the Commonwealth of Massachusetts. The MMS does not issue stock or have parent corporations, and no publicly held corporations own stock in the MMS.

Similarly, the Hospice & Palliative Care Federation of Massachusetts (HPCFM) states it is a 501(c)(3) corporation organized under the laws of the Commonwealth of Massachusetts. The HPCFM does not issue stock or have parent corporations, and no publicly held corporations own stock in the HPCFM.

PREPARATION OF AMICUS BRIEF

Pursuant to Mass. R. App. P. 17(c)(5), amici curiae and their counsel declare that:

(a) no party or party's counsel authored this brief in whole or in part;

(b) no party or party's counsel contributed money to fund preparing or submitting this brief;

(c) no person or entity, including amici curiae, contributed money that was intended to fund preparing or submitting this brief; and

(d) counsel has not represented any party in this case or in proceedings involving similar issues, or any party in a case or legal transaction at issue in the present appeal.

STATEMENT OF INTEREST OF AMICI CURIAE

The Massachusetts Medical Society (MMS) is the largest professional association for physicians and medical students in Massachusetts, with over 25,000 members. The MMS contributes physician and patient perspectives to help inform health-related legislation at the state and federal levels, works in support of public health, and addresses issues of physician well-being.

The Hospice & Palliative Care Federation of Massachusetts (HPCFM) is a non-profit organization serving hospice and palliative care professionals who have provided end-of-life care to thousands of terminally ill patients in the Commonwealth. The HPCFM provides relevant public policy insights to the Massachusetts legislature and regulatory agencies, sponsors hospice and palliative care educational programs, and informs the public by disseminating information as well as research regarding end-of-life care.

PRELIMINARY STATEMENT

Amici curiae the MMS[1] and the HPCFM take no position on the question whether the Commonwealth ought to legalize the practice referred to as "medical aid in dying" (MAID). The MMS's 25,000 physician members represent a broad cross-section of the Commonwealth's medical community, and those members hold a range of views on whether MAID should be legal in Massachusetts. The HPCFM's membership is dedicated to advancing and promoting

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[1] The MMS defines medical aid-in-dying as the act of providing care — palliative, hospice, compassionate — to patients at the end of life. The act of a physician writing a prescription for a lethal dose of medication to be used by an adult with a terminal illness at such time as the patient sees fit will, if legalized, be recognized as an additional option in the care of the
terminally ill.

The MMS adopts the position of neutral engagement, serving as a medical and scientific resource to inform legislative efforts that will support patient and physician shared decision making regarding medical aid-in-dying, provided that physicians shall not be required to provide medical aid-in-dying that involves prescribing lethal doses of medication if it violates personally held ethical principles.

The MMS asserts that medical aid-in-dying that involves prescribing lethal doses of medication should be practiced only by a duly licensed physician in conformance with standards of good medical practice and statutory authority.

The MMS will support its members regarding clinical, ethical, and legal considerations of medical aid-in-dying, through education, advocacy, and/or the provision of other resources, whether or not members choose to practice it.

The MMS supports effective palliative care, especially at the end of life.

excellence in end-of-life care and thus are directly impacted by whether MAID is legalized in Massachusetts. Both amici curiae have adhered to a principle of neutrality regarding the ultimate question of legalization, while remaining engaged in the public debate about these topics to ensure that any decisions are made on the basis of accurate information.[2]

Amici curiae respectfully submit this brief to draw the Court's attention to crucial practical considerations that would need to be addressed if MAID were legalized. As demonstrated by the extensive experience and expertise of amici curiae's members, the question whether and on what terms Massachusetts might permit MAID raises numerous complicated and multi-faceted issues – including issues that are not before the Court and that implicate the interests of stakeholders who are not parties to the present litigation. A survey of applicable laws in the several United States jurisdictions that have legalized MAID illustrates the types of nuanced legal choices regarding the complex issues arising from MAID that Massachusetts would need to resolve if

[2] Amici curiae take no position regarding the appropriate terminology to be used for this practice, acknowledging that Appellee proposes the use of term "physician-assisted suicide" (PAS) rather than MAID. To avoid confusion, amici curiae use the phrase – MAID – employed by the Superior Court in rendering its opinion.

the practice were to be legalized in the Commonwealth. Authorization of MAID without such legal standards or safeguards would raise many concerns, including the possibility of abuse.

ARGUMENT

I. LEGALIZING MAID RAISES COMPLICATED, MULTIFACETED ISSUES THAT PRECLUDE ANY SIMPLE JUDICIAL RESOLUTION.

Decisions relating to end-of-life care – including the physician's role in those decisions – are profoundly complicated, necessarily implicating many issues not presented in this appeal or any litigated setting. By its nature, MAID as an end-of-life clinical option introduces unique complexities into the physician-patient relationship, and any consideration of legalizing MAID must carefully address these issues.

Amici curiae's own experiences reflect the complexity of the issues posed by end-of-life medical decisions. Their members practice in a range of specialties regularly involving care of terminally ill patients. Even under the current legal regime, the decisions faced by terminally ill patients, their families, and medical providers – including, for example, the extent to which potentially invasive life-extending measures will be taken, whether to pursue experimental treatments to extend life, when to transition to hospice care – are difficult and

nuanced. In collaboration with patients and their families, amici's members approach these decisions with careful consideration of the ethical and medical implications of each decision, as well as the patients' values and goals.

The legalization of MAID would introduce an additional set of complex questions, many of which are not addressed by current standards for end-of-life care. As described in the parties' submissions to the Court, MAID would involve physicians writing prescriptions to terminally ill, competent adults who request such aid intending to self-ingest a lethal dose of medication to end their lives. Each element of this definition raises issues as to which physicians and other medical providers would benefit from substantive guidance and standards before they could engage in the practice of MAID knowing that they were acting within the boundaries of the law and appropriate medical care. These questions, in situations where a patient has requested MAID, include:

- How is the concept of "terminal" illness defined in determining patient eligibility?
- How is the "competence" of a patient to be ensured, and can consent be provided on behalf of an incapacitated patient via a duly authorized surrogate decision-maker?

- What are the relevant procedural considerations to ensure that a patient's request is voluntary and not the result of coercion?
- Are there exceptional procedural considerations to ensure that patients are making an informed decision, and are aware of the full range of options for end-of-life care, including comfort care, hospice care and pain control?

Other courts considering the issue have recognized these complexities. For instance, in *Morris v. Brandenburg*, the Supreme Court of New Mexico noted in considering legalization of MAID: "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 safe medication." 376 P.3d 836, 838 (N.M. 2016).

The following discussion provides by way of example some illustrations of the practical difficulties physicians and others providing end-of-life care would face addressing these questions if MAID were legalized without the adoption of guidelines and standards to govern implementation of the practice. Some of these issues are almost uniformly addressed (albeit sometimes in different ways) by legislation in states where MAID is legal. Other issues may not be addressed by existing legislation but represent the kinds of guidance (informed by

policy choices) that would benefit physicians and others providing end-of-life care before they enter into this new arena.

A. Patient Eligibility

There is presently no standard definition in the medical profession of when a patient is terminally ill. If physicians were authorized to prescribe lethal doses of medication upon request by terminally ill patients, uniform guidance on how "terminal" illness is to be defined would be helpful – for example, how *soon* the illness might be expected to cause the patient's death (*e.g.*, within a month, six months or year), and how *certain* that prognosis is (*e.g.*, possible, probable, or high likelihood). These definitional boundaries would have a large impact on which patients were eligible for MAID. There is a significant difference between the population of patients who are nearly certain to die within six months and those who are reasonably likely to die within a year or more.

Moreover, in practice, there are significant limitations in a physician's ability to predict patient outcomes; this is true even for end-of-life physician specialists. For example, in a study of 364 doctors who provided survival estimates for 468 terminally ill patients, only

20% of predictions were accurate.[3] Patients can substantially outlive prognoses offered by even the most skilled and experienced physicians. Accordingly, any decision-making as to patient eligibility for MAID must recognize the inherent limits in any physician's ability to predict patient outcomes and balance these realities against other values.

Many states that have legalized MAID through legislation include a residence requirement for the patient. This may be a policy choice made to prevent those states from becoming magnets for individuals from other locations where MAID is not legal; it may alternatively reflect a desire to ensure an appropriate, existing physician-patient relationship, which can help the physician assess and address the other issues that arise in connection with MAID. Should Massachusetts legalize MAID, the Commonwealth would need to decide how to provide legal guidance in the context of a state with many nationally recognized health providers, which attract seriously ill patients from across the nation and world.

These considerations strongly counsel that any legalization of MAID be accompanied by guidelines and standards regarding which

[3] Nicholas A. Christakis, *Extent and Determinants of Error in Doctors' Prognoses in Terminally Ill Patients: Prospective Cohort Study*, 7233 THE BMJ 469, 469-73 (2000).

health care professionals are authorized to evaluate the remaining lifespan of individuals contemplating MAID and how they should go about doing so. Such guidance might, for example, identify the required standard of confidence, impose evidentiary requirements, or address the use of second opinions.

B. Patient Competence

Patient competence is universally recognized as an essential element of a legal framework in states that permit MAID. When initiating the MAID process, physicians must ensure that patients are sufficiently competent to make an informed medical decision. Making this determination requires considerable clinical judgment on the part of the physician, even absent any self-evident mental health problems. Guidance can address what, if any, special qualifications and/or standards may be relevant to determining competence in this context. Such guidance also traditionally details whether a duly authorized surrogate decision-maker can consent to MAID on behalf of an incapacitated patient who otherwise qualifies for MAID.

All jurisdictions that have legalized MAID in the United States have limited decision-making authority to the patient who has capacity, creating an exceptional approach to the usual decision-making

construct in medicine. Ensuring a patient's capacity in the context of MAID is particularly important when they may be suffering from a mental health disorder, such as depression.

Under the legal structures in several jurisdictions that have legalized MAID, a patient seeking MAID that presents with depression, a physician first evaluates and seeks to understand the source of the depression, which can be particularly difficult in the context of any serious illness and especially in the case of a terminal illness. In addition to physical distress, a patient's suffering may include a range of psychosocial, spiritual, and existential factors, each of which should be addressed. Physicians assess whether interventions can improve a patient's depression. Such interventions may be biological, pharmacologic, or psychotherapeutic.[4] Clarifying the availability of and ensuring referral to hospice care, should the patient so desire, can also help alleviate some of the concerns of a depressed patient.

[4] *See* Anthony L. Back et al., *Clinician-Patient Interactions About Requests for Physician-Assisted Suicide*, 11 ARCH. INTERN MED. 1257, 1258-60 (explaining that when a patient asks for MAID, "[e]xperts agree that an initial clinical response should include the following: the clinician should ask why the patient is interested in [MAID], explore the meanings underlying the request, assess whether palliative care is adequate (especially in addressing depression), and revise the care plan to respond to the patient's concerns").

A related concern is ensuring that the patient is not experiencing undue pressures from other sources, such as concerns over family members or the availability of financial resources. To protect against this, most laws require a witness to a patient's request, often including a witness with no interest in the patient's estate.

When approaching MAID, important considerations include the qualifications and standards for helping to assess and improve the mental health of patients considering MAID, as well as for ensuring that the patient is fully competent and not unduly influenced by treatable mental health disorders or other external factors.

II. A SURVEY OF MEDICAL AID-IN-DYING LEGISLATION ILLUSTRATES THE NATURE OF THE NUANCED POLICY DECISIONS.

Several U.S. jurisdictions have authorized MAID through legislative action, enacting statutes that provide detailed guidance on who is eligible to receive aid-in-dying, who is qualified to provide it, and what appropriate safeguards patients and physicians must observe.[5]

[5] Montana is the one state that has legalized MAID through judicial decision. *Baxter v. State*, 354 Mont. 234 (2009). Given the small and dispersed population of Montana, there is little academic analysis of how this decision has been implemented in practice in the State. In 2015, the Journal of Palliative Medicine published *Clinical Criteria for Physician Aid in Dying* as proposed guidance for physicians to use in states like Montana, where requirements are not detailed in a statute.

While there are similarities across jurisdictions as to what categories of policy issues must be addressed in a legal framework for MAID, there are also notable differences in how policy-makers in the various states chose to address these questions.

A. Patient Eligibility

Legislative frameworks all provide carefully crafted definitions of which patients are eligible to request MAID. In a typical definition, a qualified individual is a terminally ill adult who is a resident of the relevant jurisdiction, has the requisite mental capacity to make medical decisions, and has satisfied the enumerated statutory requirements to obtain a prescription for MAID medication.

All states that have adopted MAID through legislation specify definitions of terminal illness for purposes of MAID eligibility, although there is some variation among those states' definitions. In Vermont, for example, a terminally ill patient is one suffering from "an incurable and irreversible disease which would, within reasonable

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See David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, JOURNAL OF PALLIATIVE MEDICINE, https://www.ncbi.nlm.nih.gov/pmc /articles/PMC4779271/. The non-authoritative guidance addresses many of the same issues addressed by other states' legislation, while also providing broader recommendations like what specific prescriptions physicians should write and the steps that patients should take in preparing their medication for ingestion.

medical judgment, result in death within six months." Vt. Stat. Ann. tit. 18, § 5281. California's definition of "terminal disease" means "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months," incorporating a medical confirmation requirement. Cal. Health & Safety Code § 443.1. In Colorado, by contrast, the definition of terminal illness does not include a six-month lifespan requirement. Colo. Rev. Stat. § 25-48-102.

Various states have additional statutory requirements for patient eligibility. In Vermont, a patient seeking MAID medication must make two oral requests for MAID medication at least 15 days apart before making a third request in writing, which must be witnessed by two disinterested people. *See* Vt. Stat. Ann. tit. 18, § 5283. *But see* Or. Rev. Stat. Ann. § 127.850 (allowing patient to bypass 15-day waiting period if attending physician medically confirms that patient will, within reasonable medical judgment, die before the expiration of required period). In Washington DC, there is a standardized form that every patient seeking MAID medications must complete. DC Code § 7-661.02.

B. Patient Competence

States also take somewhat different approaches to defining the mental competence necessary for patients to request MAID, as well as who is qualified to make the determination. In California, for example, a patient must, "in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, [be able] to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers. Cal. Health & Safety Code § 443.1 (2015). Vermont similarly requires that the patient "has the ability to make and communicate health care decisions to a physician." Vt. Stat. Ann. tit. 18, § 5281. Some jurisdictions like Washington, DC and Washington state also allow such determination to be made by a court. *See* Wash. Rev. Code Ann. § 70.245.010; DC Code § 7-661.01.

In addition to requiring an affirmative determination of a defined level of decision-making competence, several jurisdictions build in additional safeguards that seek to ensure that patients fully understand the process and their full range of treatment options. In California, for instance, before prescribing MAID medication, a physician must

determine if there are indications of a mental disorder; if so, the statute requires the physician to refer the patient to a mental health specialist. The mental health specialist would then make the capability determination by ensuring that the patient is not suffering from impaired judgment due to a mental disorder. After such determination is made, the physician is required to discuss feasible alternatives or additional treatment options such as comfort care, hospice care, palliative care, and pain control. Cal. Health & Safety Code § 443.5.

The physician then must counsel the patient of the importance of (1) having another person present when he or she ingests the MAID medication; (2) notifying the next of kin of his or her request for MAID medication; (3) participating in a hospice program; (4) not ingesting the MAID medication in a public place, and (5) maintaining the MAID medication in a secure location before ingesting it. The physician must also confirm that the patient's request was not the result of coercion or undue influence. Last, the physician is required to inform the patient that he or she is allowed to withdraw or rescind the request for MAID medication and offer him or her the opportunity to do so. *Id.*

Many jurisdictions where MAID is legal also seek to safeguard patients against coercion and undue influence by, for example,

disallowing provisions within contracts, wills, and other agreements that are conditioned on a patient's request for MAID. Colo. Rev. Stat. § 25-48-114 ("A provision in a contract, will, or other agreement, whether written or oral, that would affect whether an individual may make or rescind a request for medical aid in dying pursuant to this article is invalid."); Wash. Rev. Code Ann. § 70.245.160 ("Any obligation owing under any currently existing contract shall not be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner"). Similarly, in Colorado, the statute states that "[t]he sale, procurement, or issuance of, or the rate charged for, any life, health, or accident insurance or annuity policy must not be conditioned upon, or affected by, an individual's act of making or rescinding a request for medical aid-in-dying medication." Colo. Rev. Stat. § 25-48-115. And in California, "the attending physician, consulting physician, or mental health specialist cannot be related to the patient by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual's estate upon death." Cal. Health & Safety Code § 443.17.

C. Physicians' Practices

Another legal consideration relative to MAID is procedural guidance for medical care providers prescribing MAID medications. As with patient eligibility definitions, these physician requirements reflect the judgments of policymakers in the various jurisdictions who must balance many competing interests – typically after extensive data-gathering and study. For instance, all jurisdictions where MAID is legal require that a physician document the patient's written request, the patient's diagnosis, and any use of a consultant or medical health professional.[6] However, only California requires a physician to document a final affirmation as to the capacity of the patient. Such policy similarities and differences are seen throughout the entire MAID legal framework.

MAID legal frameworks universally address those steps that physicians are required to take to confirm a terminal patient's medical diagnosis and to verify the patient's capacity to make medical decisions before prescribing MAID medications. In many jurisdictions, this

[6] Jean T. Abbot et al., *Accepting Professional Accountability: A Call For Uniform National Data Collection On Medical Aid-In-Dying*, Health Affairs Blog, November 20, 2017, https://www.healthaffairs.org/do/10.1377/forefront.20171109.33370/full/.

involves some type of "second opinion." In California, for example, a diagnosis is "medically confirmed" when "the medical diagnosis and prognosis of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual's relevant medical records." Cal. Health & Safety Code § 443.1; *accord* Colo. Rev. Stat. § 25-48-102 ("'Medically confirmed' means that a consulting physician who has examined the terminally ill individual and the individual's relevant medical records has confirmed the medical opinion of the attending physician"). New Mexico, by contrast, does not require a second opinion to confirm medical diagnosis or verify capacity. In that State, the same physician who prescribes the MAID medicine may confirm the patient's diagnosis and verify the patient's capability. N.M. Stat. Ann. § 24-7C-3.

Although jurisdictions where MAID is legal do not, at least currently, specify particular medications that can be used for MAID, MAID legal frameworks regularly set forth how medications are to be dispensed and disposed of, again with variations across jurisdictions. For instance, whereas some jurisdictions allow for the dispensing of MAID medications directly from the prescribing physician, others only allow a pharmacist to dispense medications. *Compare* Vt. Stat. Ann.

tit. 18, § 5283 (noting that a physician may dispense the medication directly) *with* Or. Rev. Stat. Ann. § 127.815 (explaining that only physicians registered as dispensing physicians with the Oregon Medical Board or pharmacists may dispense lethal medications).

In Hawaii, the prescribing physician has the choice of either dispensing medications directly – provided that the physician is authorized to dispense controlled substances, has a current Drug Enforcement Administration certificate, and complies with any applicable administrative rules – or send a prescription to be fulfilled by a pharmacist. A pharmacist must then dispense the medication to either the qualified patient, the attending provider, or an expressly identified agent of the qualified patient. Haw. Rev. Stat. § 327L-15.

In the District of Columbia, the attending physician must offer the patient an opportunity to rescind his or her request for the medication immediately before prescribing or dispensing the medicine. DC Code § 7-661.05. Like in Hawaii, the attending doctor can choose either to distribute the medicine or to send a prescription to a pharmacist. In Washington DC, however, the pharmacist must "immediately notify" the attending physician when the medication is dispensed. *Id*.

Jurisdictions take different approaches in specifying what is to be done with any remaining medications following the patient's death. For instance, Colorado explicitly notes that a person in possession of unused medical aid-in-dying medication must dispose of the medication by returning the unused medicine to the attending physician or "by lawful means." Colo. Rev. Stat. § 25-48-120. New Jersey requires that the qualified patient designate a responsible person for the lawful disposal of the medication. N.J. Rev. Stat. § 26:16-12. Hawaii requires that any unused medication be "disposed of by lawful means." Haw. Rev. Stat. § 327L-15. New Mexico and Washington, DC provide no guidance for the handling of remaining medication. *See* N.M. Stat. Ann. § 24-7C-5; DC Code § 7-661.05.

D. Additional Safeguards and Provisions

Many jurisdictions where MAID is legal criminalize particular behavior related to the aid-in-dying drug administration to ensure compliance with the statutes and protect the best interests of the patients. For instance, crimes associated with MAID under Washington state law focus on a patient's autonomy in deciding to partake in MAID. A person commits a class A felony when he or she (1) willfully alters or forges a request for medication or conceals or

destroys a rescission of that request with the intent or effect of causing the patient's death without authorization of the patient, or (2) coerces or exerts undue influence on a patient to request medication to end the patient's life, or to destroy a rescission of a request. Such actions are explicitly criminalized in all jurisdictions where MAID is legal, except for New Mexico and Vermont. New Jersey further explicitly notes that theft of medication prescribed to a qualified terminally ill patient shall constitute an offense involving theft of a controlled dangerous substance. N.J. Rev. Stat. § 26:16-18.

Under Vermont's statute, "[n]othing [] shall be construed to limit liability for civil damages resulting from negligent conduct or intentional misconduct by any person" and that the statute "shall not be construed to limit civil or criminal liability for gross negligence, recklessness, or intentional misconduct." Vt. Stat. Ann. tit. 18, § 5283. Washington DC's statute provides that "[n]othing in this act shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist, psychologist, or other health care provider participating in this act." DC Code § 7-661.11.

Rather than criminalizing specified acts, the New Mexico legislation focuses on carefully circumscribing the scope of what is

authorized, and how its practice interacts with other legal provisions. The statute first specifies what is not authorized: "Nothing in the Elizabeth Whitefield End-of-Life Options Act shall be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing or euthanasia." N.M. Stat. Ann. § 24-7C-8. The statute then clarifies how the practice is characterized, which can be important for its interaction with other statutes or legal documents: "Actions taken in accordance with the Elizabeth Whitefield End-of-Life Options Act shall not be construed, for any purpose, to constitute suicide, assisted suicide, euthanasia, mercy killing, homicide or adult abuse under the law." *Id.*

If MAID were legalized in Massachusetts, consideration should be given whether similar provisions are appropriate in light of the interaction between such legalization and other laws within the Commonwealth.

CONCLUSION

Legalization of MAID in Massachusetts without a legal framework in place to address the complex issues discussed above would lead to considerable confusion and create at least some risk for abuse in the provision of end-of-life health care in the Commonwealth.

Amici curiae respectfully submit that any legalization of MAID in the Commonwealth should be accompanied by guidance and standards akin to those implemented in other U.S. jurisdictions that have legalized MAID. Such guidance, in any manner carrying the weight of law, is critical if MAID is to be safely implemented in keeping with patients' best interests and physicians' professional obligations.

Respectfully submitted,
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Dated: February 21, 2022

CERTIFICATE OF COMPLIANCE

I, Robert A. Skinner, hereby certify that the foregoing brief complies with all of the rules of the court that pertain to the filing of briefs, including but not limited to, the requirements imposed by Rules 16 and 20 of the Massachusetts Rules of Appellate Procedure. The brief complies with the applicable length limit in Rule 20 because it contains 5,370 words in 14-point Times New Roman font (not including the portions of the brief excluded under Rule 20), as counted in Microsoft Word (version: Word 2016).

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CERTIFICATE OF SERVICE

I hereby certify that, on February 21, 2022, the Brief for Amici Curiae Massachusetts Medical Society and Hospice & Palliative Care Federation of Massachusetts was served upon counsel for the parties as listed below. Service was made through the electronic filing system for all parties registered for electronic service.

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