SENATE JUDICIARY
EXHIBIT NO. 9
DATE 2/9/11
BILL NO. SB116

MEMORANDUM

To: Senate Judiciary Committee

From: Senator Greg Hinkle

Re: The Urgent Need to Now Enact SB 116, "An Act to Prohibit Aid in Dying."

Date: February 2, 2011

I. SUMMARY

SB 116 is needed now because Compassion & Choices, the former Hemlock Society, is openly encouraging doctors and the public to engage in assisted suicide. Someone is going to get hurt if they haven't been already. Indeed, Compassion & Choices is publicly claiming that Montana citizens are dying now.

This can be stopped with the passage of a simple, four sentence bill, SB 116.

II. DISCUSSION

A. *Baxter* Overlooks Montana Public Policy

"Aid in dying" means assisted suicide and euthanasia.[1] In the context of assisted suicide, *Baxter* held that a patient's consent to "aid in dying" is a defense to a charge of homicide

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[1] *See e.g.*, Craig A. Brandt *et. al.*, Model Aid-in-Dying Act, 75 IOWA L. REV. 125 (1989), available at http://www.uiowa.edu/~sfklaw/euthan.html (notice the letters "euthan" in the link). *See also* video transcript of Barbara Wagner, http://www.katu.com/news/26119539.html?video=YHI&t=a (last visited Nov. 4, 2010) ("'physician aid in dying' [is] better known as assisted suicide").

against an aiding physician.[2]

When making this ruling, the Montana Supreme Court overlooked its own precedent imposing civil liability against doctors and others who cause another person to commit suicide, typically in a hospital or jail setting.[3] The Court also overlooked elder abuse by heirs and others who will benefit from the patient's death.[4] Preventing elder abuse is official Montana State policy under at least two statutes.[5] Preventing suicide for persons "of all ages" is an official state policy under another statute.[6] *Baxter* nonetheless found that there was "nothing" in Montana statutes or precedent indicating that assisted suicide is against public policy.[7]

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[2] *Baxter v. State*, 354 Mont. 234, 251, ¶ 50 (2009) states: "We . . . hold that under § 45-2-211, MCA, "a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply."

[3] *Baxter* does not mention *Krieg v. Massey*, 239 Mont. 469, 471-3, 781 P.2d 277 (1989), which allows civil liability for a suicide in two circumstances: (1) causing another to commit suicide; and (2) in a custodial situation where suicide is foreseeable, typically involving a hospital or prison.

[4] *Baxter* states that the only person "who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication." *Baxter*, 354 Mont. at 239, ¶ 11. *Baxter* thereby overlooked criminal behavior by family members and others who benefit from an older person's death, for example, due to an inheritance.

[5] *See e.g.*, "Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act," 52-3-801, MCA; and "Protective Services Act for Aged Persons or Disabled Adults," 52-3-201, MCA.

[6] 53-21-1101, MCA (regarding a required suicide reduction plan, which is to address reducing suicides by Montanans "of all ages").

[7] *Baxter*, 354 Mont. at 250, ¶49 ("we find nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy").

B. Compassion & Choices is Telling Doctors and the Public that Assisted Suicide is Legal and "Safe"

Compassion & Choices has been telling doctors and the public that assisted suicide is legal and that it's "safe" for a doctor to cause a patient's suicide. For example, Compassion & Choices' media package contains the following statement:

> [T]he Montana Supreme Court ruled that terminally ill Montanans have the right to choose aid in dying under state law.[8]

Compassion & Choices also has this handout on its website: "Willing Providers in Montana are Safe to Practice Aid in Dying in Montana."[9]

C. Enticing the Public to Suicide

In 2010, the *Missoulian* ran an article featuring a Compassion & Choices' spokesman who claimed that assisted suicide prevents murder-suicide. He said: "We believe these tragic and violent deaths are 100 percent preventable."[10] The article printed Compassion & Choices' toll free number, 1-800-247-7421, and indicated that callers would be able to prevent violent

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[8] Copy attached hereto at A-1.

[9] Copy attached hereto at A-2 . *See also* http://community.compassionandchoices.org/document.doc?id=454

[10] Michael Jamison, "Libby shooting, arson tragedy puts focus on 'aid in dying,'" *The Missoulian*, September 4, 2010. (Copy attached at A-3). Also available at http://missoulian.com/news/local/article_14e5e9b6-b7db-11df-aa1c-001cc4c03286.html

deaths, apparently by signing up for the lethal dose.[11] The spokesperson stated: "Call us; we'll help you understand what's available, so you can make choices."[12]

In Oregon, where assisted-suicide has been legal since 1997, murder-suicide has not been eliminated.[13] Indeed, murder-suicide follows "the national pattern."[14] The claim that legal assisted suicide prevents murder-suicide is without factual support.

D. Compassion & Choices Claims That Montanans are Already Dying

On January 16, 2011, an AP article reported that physician-assisted suicide is occurring in Montana. The article states:

> [M]ore than one terminally ill patient has died of a lethal ingestion of drugs, said Jessica Grennan, spokeswoman for the advocacy

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11 *Id.*

12 *Id.*

13 *See* Don Colburn, "Recent murder-suicides follow the national pattern," *The Oregonian*, November 17, 2009("In the span of one week this month in the Portland area, three murder-suicides resulted in the deaths of six adults and two children") (Copy attached at A-5 and available at http://www.oregonlive.com/health/index.ssf/2009/11/recent_murder-suicides_follow.html); "Murder-suicide suspected in deaths of Grants Pass [Oregon] couple," *Mail Tribune News*, July 2, 2000 (regarding husband, age 77, and wife, age 76) at http://archive.mailtribune.com/archive/2000/july/070200n6.htm; and Colleen Stewart, "Hillsboro [Oregon] police investigating couple's homicide and suicide," *The Oregonian*, July 23, 2010 ("Wayne Eugene Coghill, 67, shot and killed his wife, Nyla Jean Coghill, 65, before taking his own life in their apartment"), at http://www.oregonlive.com/hillsboro/index.ssf/2010/07/hillsboro_police_investigating_homicide_and_suicide.html

14 *Id.*

group Compassion & Choices.[15]

The article also states:

> The actual number of physician-assisted suicides is unclear because there are no state reporting requirements to the state. Compassion & Choices does not release statistics about its end-of-life consultation service.[16]

E. Enforcement Against Compassion & Choices is Not Guaranteed

With the above activities, Compassion & Choices would appear to be soliciting or causing suicide in violation of Montana state law.[17] As a non-doctor, Compassion & Choices is ineligible for *Baxter's* defense.[18] Compassion & Choices would also be subject to a wrongful death action by a complaining family member upset about the suicide.[19] On the other hand, *Baxter's* erroneous

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[15] Matt Volz, "Legislature to take up assisted suicide bills," *The Associated Press*, January 16, 2011 (attached at A-8). Also available at http://www.mtstandard.com/news/local/article_ccdb7ca2-21e9-11e0-a8c9-001cc4c03286.html

[16] *Id.*

[17] *See e.g.* 45-5-105(1), MCA ("A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide"). When the suicide occurs, the charge is deliberate homicide under 45-5-102, MCA.

[18] *See Baxter supra* at note 2. *See also* Greg Jackson & Matt Bowman, *Analysis of Implications of the Baxter Case on Potential Criminal Liability* (April 2010), available at http://www.montanafamily.org/portfolio/pdfs/Baxter_Decision_Analysis_v2.pdf (last visited October 22, 2010).

[19] *See Krieg supra* at note 3 (allowing civil liability for a suicide in two circumstances: (1) causing another to commit suicide; and (2) in a custodial situation where suicide is foreseeable, typically involving a hospital or prison).

public policy determination is apparently giving Compassion & Choices comfort. In a recent bar article, Compassion & Choices' legal director featured these *Baxter* quotes:

> [*Baxter* found:] no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy. . . .
>
> Each stage of the physician-patient interaction is private, civil, and compassionate. . . .[20]

With this language, will enforcement against Compassion & Choices, a "non-profit charity," be successful, especially, if there is no objecting family member available?.[21] Or what if the family members have been recruited by Compassion & Choices for an opposing media blitz? The outcome of any appeal would also seem uncertain. Would the Supreme Court really admit it was wrong? The taxpayers, regardless, will be picking up the cost to process the litigation.

Enacting SB 116 now, to overrule *Baxter* and clearly prohibit "aid in dying," will eliminate these problems. With *Baxter* gone, enforcement will be straight-forward: "Aid in dying" is prohibited. They can't do it.

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[20] Kathryn Tucker & Christine Salmi, "Aid in Dying: Law, Geography and Standard of Care in Idaho," *The Advocate: Official Publication of the Idaho State Bar* No. 8, 42, at 44 (August 2010)(quotes attached at A-12; entire article attached at A-10 to A-13). Also available at http://www.isb.idaho.gov/pdf/advocate/issues/adv10aug.pdf

[21] An excerpt from a Compassion & Choices brochure is attached at A-14.

F. How SB 116 Works

SB 116 is a four sentence bill that overrules *Baxter* and explicitly prohibits "aid in dying" (assisted suicide and euthanasia). The bill works by amending two existing statutes (amending or adding two sentences to each statute).[22]

III. CONCLUSION

If SB 116 is not passed, we will soon be facing the issues of Washington and Oregon.[23] Our citizens will be at increased risk of abuse and worse at the hands of their relatives.[24] Our citizens will be steered to suicide.[25] There will be multiple other problems.[26]

We must enact SB 116 now to overrule *Baxter* and clearly prohibit "aid in dying." Otherwise, we will lose our only chance.

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22 A copy of SB 116 is attached at A-23.

23 *See* Margaret K. Dore, "'Death with Dignity': What Do We Advise Our Clients?," King County Bar Association, *Bar Bulletin*, May 2009 (attached at A-15); Charles Bentz, MD, Letter to the Editor, "Don't follow Oregon's lead," *The Advocate*, November/December 2010 (attached at A-18); William Toffler, MD, Letter to the Editor, "Oregon's law doesn't work," Chris Carlson, Letter to the Editor, "Doctors not always right," Kenneth Stevens, MD, "Oregon mistake cost lives," *The Advocate*, September 2010 (attached at A-19); and Statement for the BBC from William Toffler, MD (attached at A-21).

24 *Id.*

25 *Id.*

26 *Id.*

Dated this 1st day of February 2011

Senator Greg Hinkle

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This memo was prepared by Margaret Dore, an elder law/appellate attorney in Washington state, where assisted suicide is legal. She has been licensed to practice law since 1986. She is a former Law Clerk to the Washington State Supreme Court for then Chief Justice Vernon Pearson. She is a former Law Clerk to the Washington State Court of Appeals to Judge John A. Petrich. She is a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. She is admitted to practice in the United States Supreme Court, the Ninth Circuit Court of Appeals, the United States District Court of Western Washington and the State of Washington. For more information, see www.margaretdore.com.

Montana Aid in Dying – *Baxter v. Montana*

Background - Robert Baxter, a marine veteran, outdoorsman and career long haul truck driver was suffering from lymphocytic leukemia when he, along with four Montana doctors and Compassion & Choices, filed a case seeking recognition that the right to choose aid in dying is protected by the Montana Constitution's guarantees of privacy, dignity and equal protection.

On October 17th, 2007, Mr. Baxter asked the court to affirm his legal right to be able to hasten his inevitable death and die in a peaceful and dignified manner by taking medication prescribed by his doctor for that purpose. Physician plaintiffs who wanted to know that they could assist a patient with aid in dying and not be subject to criminal prosecution joined Mr. Baxter in this suit.

District Court Judgment and Appeal - On December 5 2008, Montana State District Court Judge Dorothy McCarter issued summary judgment to plaintiffs, holding that the state constitution's individual dignity clause and the constitution's "stringent" right of privacy are "intertwined insofar as they apply to plaintiffs' assertion that competent terminal patients have the constitutional right to determine the timing of their death and to obtain physician assistance in doing so."

The State filed a notice of appeal. It also sought a stay of the lower court ruling pending the appeal. Judge McCarter denied the request for a stay in January 2009, meaning her ruling was fully effective and remained so unless and until the Montana Supreme Court ruled differently.

Montana Supreme Court Decision - On December 31, 2009, in a 5 – 2 decision, the Montana Supreme Court ruled that terminally ill Montanans have the right to choose aid in dying under state law. The court ruled that public policy of Montana does not criminalize, and much in current public policy affirmatively supports, aid in dying. The court did not reach the question of whether the Montana constitution specifically protects aid in dying.

In a detailed review of Montana law on the "Rights of the Terminally Ill," the Court concluded that the legislature specifically defers to a patient's own decisions and affords patients the right to control their own bodies at the end of life. The decision to self-administer life-ending medication receives the same treatment as a decision to discontinue life sustaining therapies such as mechanical ventilation.

Learn more about *Baxter v. Montana* and Aid in Dying in Montana online at http://www.compassionandchoices.org/montana.

compassion & choices

Support. Educate. Advocate. Choice & Care at the End of Life

Printed 1/31/11

Willing Providers in Montana Are Safe to Practice Aid in Dying

In December, a Montana District judge ruled that mentally competent, terminally ill Montanans have a fundamental right to a dignified death as protected by their state constitution. Yet four months into this ruling, two terminally ill Montana residents who wish to access this constitutional right cannot find a willing physician to help them. This is emotionally devastating for them both, as they had hoped to access the comfort and peace of mind the law would bring.

Janet Murdock, 67, of Missoula, has terminal ovarian cancer. "I was so hopeful when the court recognized my right to die with dignity," she said. "I feel as though my doctors do not feel able to respect my decision to choose aid in dying. Access to physician aid in dying would restore my hope for a peaceful, dignified death in keeping with my values and beliefs."

Doctors need not leave patients like her out in the cold.

Montana Physicians Are Free to Practice Aid in Dying without Fear of Prosecution

A physician prescribing life-ending medications to an eligible patient runs no risk of prosecution under Montana statutes.

"Physicians either have not heard about the decision or do not understand its implications for practice," said Compassion & Choices Legal Director Kathryn Tucker, who argued the case with Montana litigator Mark Connell. "We must remedy this. Surely in this context 'justice delayed is justice denied,' as patients who are currently confronting end-stage terminal illness will not live to see the Montana Supreme Court rule."

Professional Medical Groups Support Aid in Dying

Professional medical associations are increasingly adopting policies in support of aid in dying, reflecting a trend among major medical groups.

In 2008, the APHA, the nation's largest public health association, adopted policy supporting aid in dying. The policy supports "allowing a mentally competent, terminally ill adult to obtain a prescription for medication that the person could self-administer to control the time, place, and manner of his or her impending death ...'"

The American Medical Women's Association adopted a position in March 2008 supporting the practice. According to the group's position statement, "The American Medical Women's Association supports patient autonomy and the right of terminally ill patients to hasten death."

MT
9/4/10

Missoulian

Libby shooting, arson tragedy puts focus on 'aid in dying'

By MICHAEL JAMISON of the Missoulian | Posted: Saturday, September 4, 2010 6:00 am

LIBBY - It was an act of love, Darryl Anderson said, an act of compassion and caring and bullets and arson and it didn't have to be that way.

"Basically," Anderson said, "it was a mercy killing, to end the pain. They were good people, but there was terrible pain."

William "Ted" Hardgrove used to visit Anderson - Lincoln County's sheriff - at work, showing off his inventions or detailing his own detective work on the latest unsolved case. He'd stay and chat and sometimes harangue, Anderson said, "and I thought he was just a super old guy."

Hardgrove was 81, just like his wife Swanie. She was known for her baking, and her gardening and her lace-making, and for the fact that she had cerebral palsy as well as other crippling medical problems. In recent weeks, the increasing pain had completely overwhelmed her medication.

On the last Saturday in August, Ted Hardgrove stopped the pain. He moved their valuables out of the Libby-area house and into the garage, then left a note explaining this final, desperate act of love.

He took the household chemicals from the home, took the hunting ammunition and anything else that might explode or burn too hot. Anderson figures Hardgrove was protecting the firemen he knew would come.

Then Hardgrove went back inside, shot his wife, set their home afire and shot himself.

"It was a very carefully planned thing," Anderson said. "He left that note, said he was tired of seeing her suffer so badly, and there was a better place."

But there was also, perhaps, a better way.

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"What we want people to know," said Steve Hopcraft, "is there is help and information out there."

Hopcraft works with a nonprofit called Compassion and Choices, a group that offers free end-of-life planning, counseling and options.

"We believe that these tragic and violent deaths are 100 percent preventable," Hopcraft said. "It's a matter, really, of getting the information out."

Information such as the fact that Montana is among three states - Oregon and Washington are the other two - where doctors are allowed to provide what's known as "aid in dying." They can prescribe lethal drugs to terminally ill patients, who can then choose whether and when to use the pills.

Voters in Oregon and Washington approved such measures, which come with safeguards and careful case reporting. In Montana, no such structure exists. Instead, the state Supreme Court ruled last New Year's Eve that no public policy here prohibits aid in dying, so it's legal but largely unregulated.

It's also largely unknown, which is what Hopcraft hopes to change.

"Talking about death can't kill you," he said, "but it can help you have the peaceful death that everyone wants."

His group provides counseling, and help with wills and advance directives. They lay out options, such as hospice, and involve entire families. And they do it for free.

"It's just a phone call," Hopcraft said. A toll-free call to 1-800-247-7421. "You can call any time, at each step along the way. Most of us are total amateurs when it comes to approaching death. We don't know what the options are, or where to get information. Call us; we'll help you understand what's available, so you can make choices."

Most of all, he said, Compassion and Choices helps people communicate. Doctors and patients, patients and family, family and physicians. "Because too often," he said, "failure to communicate ends in less than optimal care."

Or, more tragically, in an anguished couple choosing the only option they think is available.

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"No one, no matter what their condition, should feel they have to resort to violence when confronting advanced illness," said Stephen Speckart, retired Missoula oncologist. "Patients need to feel safe talking with their doctors about unbearable symptoms and their feelings of desperation and desire for a peaceful death."

Sheriff Anderson understands, in an abstract kind of way, why his friends chose their end. He does not, however, understand why they chose that end.

"Why the fire?" he wonders. "I don't know. Maybe it was to wipe out everything and leave it clean. We'll never know."

And that, Hopcraft said, is precisely the problem. The friends and family will never know, because no one knew to sit down and consider all the options.

"We all want the same thing," Hopcraft said. "We want to die peacefully, at home, surrounded by the people we love. We want the chance to tell people goodbye."

Ted and Swanie Hardgrove didn't have that chance. Her body was found in an upstairs bathroom, his in the basement. A gun was at his side, the home still smoldering.

"It didn't have to be that way," Anderson said. "I think a lot of people wish it had been different."

Reporter Michael Jamison can be reached at 1-800-366-7186 or at mjamison@missoulian.com.

OregonLive.com
Everything Oregon

Recent murder-suicides follow the national pattern

Published: Tuesday, November 17, 2009, 10:04 PM

By **Don Colburn, The Oregonian**

In a span of one week this month in the Portland area, three murder-suicides resulted in the deaths of six adults and two children.

While the three cases appear to have nothing to do with one another, they do match the national pattern for such lethal outbursts. In each case, the killer or suspect was a man -- either a husband, former husband or boyfriend -- and used a gun.

Experts caution against calling three separate incidents a "cluster" or trend.

"These are very difficult cases to understand, and each one is unique," said Mark S. Kaplan, professor of community health at Portland State University and an expert on suicide. "One needs to be very careful about generalizing."

But patterns do show up in large studies, he said. Murder-suicide is carried out predominantly by white males and almost always with a firearm.

"Distressingly simple"

"The pattern to murder-suicide is distressingly simple: a male offender, a female victim and a gun -- but literally anyone can be caught in its wake," concludes a 2002 report called "American Roulette: The Untold Story of Murder-Suicide in the United States," by the Violence Policy Center, an advocacy group in Washington, D.C.

"Unlike homicides, murder-suicides are far more likely to involve family or intimate acquaintances, and have different demographics than the typical homicide or suicide," the report states.

Nationwide, between 1,000 and 1,500 people a year die in murder-suicides, the Violence Policy Center estimates.

There were eight murder-suicides in Oregon in 2007, resulting in 16 deaths, said Lisa Millet, manager of the state Public Health Division's injury and violence prevention program.

Over the past five years, Oregon recorded 42 murder-suicides, totaling 88 deaths. Most of the murder victims were women; nearly all killers were men. A firearm was involved in 86 percent of the cases.

A-5

A study by the Centers for Disease Control and Prevention found that 88 percent of murder-suicides involve firearms and more than half the murders involved the killing of a former intimate partner.

Four common threads

The National Institute of Justice studied 591 murder-suicides and found four common threads: a prior history of domestic violence; access to a gun; repeated and increasingly specific threats; and a prior history of mental health problems and drug or alcohol abuse.

Of those murder-suicides, 92 percent involved use of a firearm.

The role of the economy is less clear.

"The very low number of murder-suicide incidents makes it hard for researchers to understand exactly what role the economy plays in these cases," the National Institute of Justice concluded. "What is known is that economic distress is a factor, but it is only one of several factors that trigger a man to murder his family. In most cases, the couple have a history of disagreement over many issues, most commonly money, sex and child-rearing."

Depression plays role

And depression can be a precipitating factor, as it is in most suicides.

"One of the untold stories about depression," Millet said, "is that it doesn't look the same in men as in women."

Depressed men are less likely than depressed women to get help for their emotional health, and they are more likely to try to control external factors. In extreme cases and under the effect of other stressors, that can lead to violent outbursts, she said.

She urged any woman threatened with domestic violence to seek help right away. The most dangerous time, when relationships are most likely to turn violent, is immediately after a breakup.

The Portland Women's Crisis Line is a private nonprofit that helps women who are in a violent or potentially violent relationship, referring them to a shelter if necessary. The Crisis Line takes calls 24 hours a day, seven days a week. Most of the roughly 26,000 calls to the Crisis Line last year were prompted by fear, threats or attacks of domestic violence.

To reach the Crisis Line: call 503-235-5333. Or check **online**.

By the numbers

Murder-suicides in Oregon, 2003 through 2007

42 murder-suicides (average: eight per year)

88 deaths

78 killed by a firearm

46 homicides (31 females, 15 males; 41 adults, five children)

42 homicide suspects (38 men, four women)

Source: Oregon Violent Death Reporting System, Public Health Division

Risk factors

The top five risk factors that tend to make domestic violence escalate into homicide. Experts say they are especially insidious because they don't leave any visible mark that could be noticed by another.

1. Has the abuser ever used, or threatened to use, a gun, knife or other weapon against the victim? (If yes, the victim is 20 times more likely to be killed than others who experience domestic violence.)
2. Has the abuser ever threatened to kill or injure the victim? (15 times more likely)
3. Has the abuser ever tried to strangle or choke the victim? (10 times more likely)
4. Is the abuser violently or constantly jealous? (Nine times more likely)
5. Has the abuser ever forced the victim to have sex? (Eight times more likely)

Source: U.S. Department of Justice

Don Colburn

mtstandard.com

Legislature taking up assisted suicide bills

By Matt Volz / Associated Press | Posted: Monday, January 17, 2011 12:15 am

HELENA - The Legislature had been out of session in the year since the Montana Supreme Court ruled that nothing in state law prevents physician-assisted suicide, leaving doctors and terminally ill patients to operate without regulations or oversight.

Now that lawmakers have convened in Helena, they are being asked to consider two competing measures: one that would create rules for doctors who are asked to write a prescription for a lethal dose of medication and another that would ban assisted suicide altogether.

The Dec. 31, 2009, Supreme Court ruling in the case Baxter v. Montana effectively made Montana the third state to allow physician-assisted suicide, along with Oregon and Washington.

Advocates, while applauding the Supreme Court decision, say many physicians still fear prosecution because of the lack of standards and regulations.

"Unless there is detail spelled out by the Legislature, I think a great number of physicians will be hesitant to follow through," said Steve Johnson, a brain tumor patient from Helena.

One measure, Senate Bill 167, aims to protect patients from being coerced, sets out specific steps for physicians to follow and would require a patient to receive two doctor opinions before they could be prescribed the lethal medication.

"This ensures that doctors can follow the will of their patients without fear of prosecution," said Sen. Anders Blewett, D-Great Falls, the bill's sponsor. "I don't think government has any role in telling patients how to make their medical decisions."

The other measure, Senate Bill 116 sponsored by Sen. Greg Hinkle, R-Thompson Falls, would flatly prohibit assisted suicide.

"The potential for an elder person to be abused for monetary reasons is huge," Hinkle said. "There is no real way to protect that."

Since the Supreme Court decision, more than one terminally ill patient has died of a lethal ingestion of drugs, said Jessica Grennan, spokeswoman for the advocacy group Compassion & Choices.

The actual number of physician-assisted suicides is unclear because there are no state reporting requirements to the state. Compassion & Choices does not release statistics about its end-of-life consultation service.

Blewett's bill would not create such a reporting requirement. What it would do is define what terminally ill means, require a patient to meet that definition to qualify and ensure that the patient is mentally competent to make the decision.

Once the doctor diagnoses a patient as being terminally ill, that patient must make voluntary oral and written requests for a lethal prescription of medication. The request must be signed by two witnesses, one of whom must be a person who is not related by blood, marriage or adoption.

The doctor must then refer the patient to a second physician to confirm the first doctor's diagnosis and that the patient is competent and acting voluntarily. That second opinion requirement can be waived if an appointment can't be made in a reasonable amount of time, if the doctor is too far away, or else if the illness has advanced to the point where confirmation is not necessary.

If a patient is diagnosed as depressed, the doctor must refer that patient to counseling, and the medication may not be prescribed until the counselor determines that a disorder or depression is not impairing the patient's judgment.

The doctor would not be allowed to help the patient administer the drugs.

The Montana Supreme Court ruling came in the case filed on behalf of Robert Baxter of Billings and four physicians. Baxter died of lymphoma Dec. 5, 2008 - the day a district judge ruled that Baxter had a protected right to end his suffering and bring about a peaceful death by ingesting medication.

A-8

Westlaw

MT ST 45-5-105
MCA 45-5-105

West's Montana Code Annotated Currentness
Title 45. Crimes
Chapter 5. Offenses Against the Person
Part 1. Homicide

45-5-105. Aiding or soliciting suicide

(1) A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide.

(2) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed $50,000, or both.

CREDIT(S)

Enacted 94-5-106 by Laws 1973, ch. 513, § 1; Revised Code of Montana 1947, 94-5-106. Amended by Laws 1981, ch. 198, § 7.

CRIMINAL LAW COMMISSION COMMENTS

Source: New.

If the conduct of the offender made him the agent of the death, the offense is criminal homicide notwithstanding the consent or even the solicitations of the victim. See sections 94-5-101 through 94-5-105 [now MCA, 45-5-102 through 45-5-104].

Rather than relying on aiding or soliciting an attempted homicide, this section sets forth the specific formula to make such acts punishable. The rationale behind the felony sentence for the substantive offense of aiding or soliciting suicide is that the act typifies a very low regard for human life.

MCA 45-5-105, MT ST 45-5-105

Current through all 2009 legislation

END OF DOCUMENT

Baxter blew off commission comments that a victim could not consent. See Baxter, 942

Aid in Dying: Law, Geography and Standard of Care in Idaho

Kathryn L. Tucker
Compassion & Choices
Christine Salmi
Perkins Coie, LLP

MERIDIAN -- An elderly couple is dead after shots were fired in a Meridian home Sunday evening. . .

Ada County Coroner . . . says 87-year-old Robert Emerson shot and killed his wife, 90-year-old Olive Emerson, and then turned the gun on himself.

Meridian Police . . . say investigators were told by family members that Robert and Olive were both suffering from terminal cancer . . .[1]

Introduction

The news report above reflects a tragedy that arises when terminally ill patients feel trapped in a dying process they find unbearable, yet don't feel they can turn to their physician to obtain a prescription for medication that can be consumed to bring about a peaceful death. Idaho law empowers citizens with broad autonomy over medical decisions, including specifically decisions relating to end of life care. However, Idaho has no legislation either permitting or prohibiting the end of life option known as "aid in dying." Aid in dying refers to the practice of a physician prescribing medication that a mentally competent, terminally-ill patient can ingest to bring about a peaceful death if the dying process becomes unbearable.[2] A fraction of terminally-ill patients – including those who have excellent pain and symptom management – confront a dying process so prolonged, and marked by such extreme suffering and deterioration, that they decide aid in dying is preferable to the alternatives. This practice has become increasingly accepted among medical and health policy organizations, including the American Public Health Association.[3] Having the option of aid in dying provides comfort to terminally ill patients even if they do not consume the medication to bring about death. The experience in Oregon, where aid in dying has been affirmatively legal for a dozen years, reflects this: roughly one-third of the patients who obtain the medication each year do not go on to ingest it. They are comforted by this option, but die of their underlying disease. Oregon's data also tells us much about why patients choose aid in dying: loss of autonomy, loss of dignity, and decreasing ability to participate in activities that made life enjoyable are the most frequently mentioned reasons.


Kathryn L. Tucker


Christine Salmi

Idaho has no legislation either permitting or prohibiting the end of life option known as "aid in dying."

This article reviews the law in Idaho governing end-of-life care, the law and practice in the surrounding states, and the possible implications for Idaho of being situated among states that affirmatively permit aid in dying. It is time for Idaho to join the surrounding states by including aid in dying among end-of-life options available for patients with terminal illnesses. This article posits that Idaho can do so under the current state of the law by incorporating this intervention into medical practice subject to the standard of care.

Idaho law governing end of life care

Idaho statutes include The Medical Consent and Natural Death Act (MCNDA), I.C. §§ 39-4501 to -4515. This statute empowers citizens to refuse or direct withdrawal of life-prolonging medical treatment. In enacting this statute, the Idaho Legislature set forth the following policy statements:

> (1) The legislature recognizes the established common law and *the fundamental right of adult persons to control the decisions relating to the rendering of their medical care*, including the decision to have life-sustaining procedures withheld or withdrawn. . . .
>
> (2) *In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of this state shall recognize the right of a competent person to have his or her wishes for medical treatment* and for the withdrawal of artificial life-sustaining procedures carried out even though

that person is no longer able to communicate with the physician.[4]

The MCNDA includes a provision stating that this Act "does not make legal, and in no way condones, euthanasia, mercy killing, or assisted suicide or permits an affirmative or deliberate act or omission to end life, other than to allow the natural process of dying."[5]

This raises the question whether aid in dying could fall within this exclusion. Those who consider the act of allowing a dying patient to ingest medication to achieve a peaceful death a form of suicide would argue that it does. Others who recognize that the choice of a dying patient for a peaceful death is something fundamentally different from suicide would argue that this exclusion does not apply to aid in dying.[6] In any event, the statute does not contain a prohibition against aid in dying.

A critical analysis of the law in Idaho supports the contention that Idaho patients should be able to access aid in dying because there is no logical distinction between a terminally-ill patient's right to refuse life-sustaining treatment and such patient's right to have access to medication which the patient could ingest to bring about a peaceful death.

One might argue that aid in dying could be prosecuted under Idaho's criminal statute, I.C. § 18-4014, which provides, in part:

> Every person who, with intent to kill, administers or causes or procures to be administered, to another, any poison or other noxious or destructive substance or liquid, but by which death is not caused, is punishable by imprisonment in the state prison not less than ten (10) years, and the imprisonment may be extended to life.[7]

However, this statute only applies if the patient does not die. A patient who ingests medication prescribed by their physician for aid in dying will almost certainly achieve the desired death.[8] If the patient does achieve the desired death, an aggressive prosecutor might argue that the physician could be prosecuted for homicide. This situation was recently addressed in Montana, and the Montana Supreme Court squarely rejected the possibility of a homicide charge being brought against a physician who provided aid in dying.[9]

Based on this landscape, Idaho physicians should feel safe to provide aid in dying to their competent, terminally-ill patients, free of fear of criminal prosecution.[10] The matter has not been discussed in the medical or legal literature in Idaho. Yet, there is growing support for aid in dying, reflected in the fact that three neighboring states now affirmatively permit the practice, and in the growing support for the practice in the medical and health policy communities.

The Montana Supreme Court squarely rejected the possibility of a homicide charge being brought against a physician who provided aid in dying.

Aid in dying in surrounding states

Oregon

Oregonians approved the passage of the Oregon Death with Dignity Act (Dignity Act) in 1994.[11] The Dignity Act allows a mentally-competent, terminally-ill patient to obtain medication from his or her physician, which the patient can consume to bring about a peaceful death.[12] The experience in Oregon demonstrates that when this option is available, it does not place patients at risk, as those who oppose aid in dying have advocated.[13] Oregon's experience has caused even staunch opponents to admit that continued opposition to such a law can only be based on moral or religious grounds.[14]

The option of aid in dying has not been unwillingly forced upon those who are poor, uneducated, uninsured, or otherwise disadvantaged.[15] In fact, those with a baccalaureate degree or higher were 7.9 times more likely than those without a high school diploma to choose aid in dying.[16] One hundred percent of patients opting for aid in dying had private health insurance, Medicare, or Medicaid, and were overwhelmingly enrolled in hospice care.[17] Furthermore, during the first 12 years in which it was a legal option, only 460 Oregonians chose it.[18] Terminally ill adults who chose this option in 2009 represented 19 deaths for every 10,000 Oregonians who died that year. Roughly one-third of those patients who complete the process of seeking medications under the Dignity Act do not go on to consume the medications.[19]

Simultaneously, Oregon doctors increased efforts to improve their ability to provide adequate end-of-life care, including increasing their knowledge of pain medication usage for the terminally ill, becoming more informed at recognizing depression and other conditions that could impair decision making, and referring their patients to hospice programs with greater frequency.[20] The option of aid in dying also has psychological benefits for terminally ill patients. The availability of the option gives a terminally-ill patient autonomy, control, and choice, which physicians in Oregon have identified as the predominant motivational factors behind the decision to request assistance in dying.[21]

Washington

Washington passed a Dignity Act virtually identical to Oregon's in November 2008.[22] The Washington Department of Health publishes information about the types and quantities of forms received under the Dignity Act on its website[23] and updates this information weekly.[24] The Department of Health also publishes an annual report that includes information on how many prescriptions are written under the Act, and how many people ingest the prescribed medication. The first annual report includes data from March 2009 through December 31, 2009.[25] Statistical reports will be completed annually thereafter.

Montana

Montana recognizes the right of its citizens to choose aid in dying through a decision of the Montana Supreme Court. In *Baxter v. State*, Robert Baxter, a 75-year-old U.S. Marine veteran and long-haul truck driver dying of lymphocytic leukemia, sued the State to establish his right to choose aid in dying.[26] Baxter was married, with four grown children, and was fiercely independent; he wanted the option for a peaceful death on his own terms if his suffering became unbearable.[27] Additional plaintiffs included four Montana physicians who treat patients with termi-

nal illnesses and Compassion & Choices, the national non-profit organization that advocates on behalf of terminally ill persons.[28]

The plaintiffs challenged the application of Montana's homicide statute to a physician providing a prescription to a terminally-ill, mentally-competent patient for medication that the patient could consume to bring about a peaceful death if he found his dying process unbearable.[29] The case invoked the Montana State Constitution's guarantees of privacy and dignity.[30] Commentators speculated that constitutional claims of this nature had a good chance of success given the state constitution's text and the body of law construing these provisions, which was robustly protective of individual decision-making.[31]

Plaintiffs asserted an alternative argument that under the consent as a defense doctrine, a doctor who provided aid in dying could not be subject to prosecution for homicide.[32] The patient would have consented to the physician's assistance in precipitating the patient's death and there was no public policy reason to deny the consent defense under these circumstances.[33] The plaintiffs in *Baxter* had the advantage of being able to point to many years of data from Oregon's implementation of its statute affirmatively making aid in dying legal, which made clear that risks to patients do not arise when patients have the option to choose aid in dying.[34] The argument— that risks will still be present if aid in dying is an option— had been central to the states' efforts to prevent courts from finding a right to choose this intervention.[35]

On December 5, 2008, the Montana State District Court issued summary judgment in favor of the Plaintiffs, holding that the state constitution's Individual Dignity Clause and the stringent right of privacy are "intertwined insofar as they apply to Plaintiffs' assertion that competent terminal patients have the constitutional right to determine the timing of their death and to obtain physician assistance in doing so."[36] The district court further concluded that "[t]he decision as to whether to continue life for a few additional months when death is imminent certainly is one of personal autonomy and privacy."[37] In an odd synchronicity, Plaintiff Bob Baxter died the same day the lower court ruling was issued. The State appealed.

The Supreme Court held 5-2 that terminally ill Montanans have the right to choose aid in dying under state law.[38] The court declined to reach the constitutional issues.[39] Instead, it resolved the case on the alternative ground under the consent defense to the homicide statute, finding:

> "no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy."[40]
>
> . . . [A] physician who aids a terminally ill patient in dying is not directly involved in the final decision *or* the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician-patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient's subsequent private decision whether to take the medicine does not breach public peace or endanger others.
>
> . . .
>
> . . . There is thus no indication in the homicide statutes that physician aid in dying—in which a terminally ill patient elects and consents to taking possession of a quantity of medicine from a physician that, if he chooses to take it, will cause his own death—is against public policy.
>
> . . .
>
> The Rights of the Terminally Ill Act very clearly provides that terminally ill patients are entitled to autonomous, end-of-life decisions, even if enforcement of those decisions involves direct acts by a physician. Furthermore, there is no indication in the Rights of the Terminally Ill Act that an additional means of giving effect to a patient's decision—in which the patient, without any direct assistance, chooses the time of his own death—is against public policy.[41]

Montana has not enacted statutes with specific requirements governing provision of aid in dying.[42] Accordingly, the limitations of the laws in Oregon and Washington do not apply in Montana, although certain boundaries recognized by the Court are similar to the Oregon and Washington requirements; all three states require that the patient be terminally ill, mentally competent, and that the physician involvement be limited to providing a prescription that the patient can self-administer.

Most medical care is not governed by statute or court decision, but is instead governed by the standard of care.

Aid in dying in Idaho should be governed by the standard of care

Most medical care is not governed by statute or court decision, but is instead governed by the standard of care.[43] In determining the standard of care, Idaho courts apply an objective community standard test that looks at what a similarly situated practitioner in the local community would do, taking into account his or her training, experience, and fields of medical specialization.[44]

Oregon's, Washington's and Montana's practices of affirmatively permitting mentally competent, terminally ill patients to choose aid in dying will appropriately influence the standard of care in Idaho. Idaho is particularly well situated to be the first state that adopts this approach, given that it has no legislation specifically addressing the matter and is surrounded by states where the practice is now an established option available to patients dying of terminal illnesses.

Conclusion

Most Americans "believe a person has a moral right to end their life if they are suffering great pain and have no hope of improvement."[45] It is critically important that patients can turn to their physician for aid in dying. When a patient does not feel able to discuss the desire for aid in dying with his or her physician or cannot find a physician willing to provide it, the patient may seek assistance in precipitating death from a family member or loved one. Tragically, these incidents often involve a violent means to death, such as gunshot.

Cases of this nature appear with disturbing frequency in the newspapers, as noted at the outset of this article.[46] However, should aid in dying emerge as an end-of-life option in Idaho, it is hopeful that such tragedies can be avoided in the future.

About the Authors

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Christine Salmi *practices commercial litigation with the Boise office of Perkins Coie, LLP. Ms. Salmi provided research and editing support for this article.*

Endnotes

[1] KTVB & Associated Press, *Coroner: Meridian couple planned murder-suicide*, KTVB.COM, April 5, 2010, *available at* http://www.ktvb.com/news/Meridian-police-involved-death-investigation-89888732.html.

[2] "Aid in dying" is a recognized term of medical art. *See, e.g.*, Kathryn Tucker, *At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations*, 10 HARV. HEALTH POL'Y REV. 45, 45 (2009), *available at* http://www.compassionandchoices.org/documents/Harvard_Health_Policy_Rvw_Tucker.pdf.

[3] *See id.*

[4] IDAHO CODE ANN. § 39-4509(1), (2) (2005) (emphasis added).

[5] IDAHO CODE ANN. § 39-4514(2) (2005).

[6] Mental health professionals recognize a distinct difference between "suicide" and the choice of a dying patient for a peaceful death. *See Gonzales v. Oregon*, 126 S. Ct. 904 (2006).

[7] IDAHO CODE ANN. § 18-4014 (1972).

[8] OR. DEP'T OF HUMAN SERVS., TWELFTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT tbl.1 at 2 (2010), *available at* http://www.oregon.gov/DHS/ph/pas/docs/yr12-tbl-1.pdf.

[9] *Baxter v. State*, 224 P.3d 1211, 1215 (Mont. 2009).

[10] Concerns about possible criminal prosecution are the primary reason physicians fear providing aid in dying. Another concern is that professional disciplinary action can be taken against a physician for providing such care.

[11] OR. REV. STAT. § 127.800–.995 (2005); *see Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *vacated*, 107 F.3d 1382 (9th Cir. 1997).

[12] OR. REV. STAT. § 127.865 (2009). The Dignity Act requires that Oregon collect extensive data about who uses the Dignity Act each year and publish the findings in annual reports. *See* OR. DEP'T OF HUMAN SERVS., DEATH WITH DIGNITY ACT ANNUAL REPORTS [hereinafter ANNUAL REPORTS], *available at* http://oregon.gov/dhs/ph/pas/ar-index.shtml.

[13] Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. MED. ETHICS 591 (2007).

[14] *See* Daniel E. Lee, *Physician-Assisted Suicide: A Conservative Critique of Intervention*, 33 Hastings Center Rep.17, (Jan.–Feb. 2003).

[15] *E.g.*, CTR. FOR DISEASE PREVENTION & EPIDEMIOLOGY, OR. HEALTH DIV., DEP'T OF HUMAN RES., OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE, 7 (1999), *available at* http://oregon.gov/dhs/ph/pas/docs/year1.pdf.

[16] OFFICE OF DISEASE PREVENTION & EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., EIGHTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT, 12 (2006), *available at* http://oregon.gov/dhs/ph/pas/docs/year8.pdf .

[17] *Id.* at 23.

[18] ANNUAL REPORTS, *supra* note 12, YEAR 12 – 2009 SUMMARY (2010).

[19] *Id.*

[20] *See* Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide*, 347 NEW ENG. J. MED. 582, 584-85 (2002); Lawrence J. Schneiderman, *Physician-Assisted Dying*, 293 JAMA 501, 501 (2005).

[21] *See* Kathy L. Cerminara & Alina Perez, *Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 512–13 (2000); *See also* Ganzini, *supra* note 20.

[22] Washington Death with Dignity Act, WASH. REV. CODE § 70.245 (2008).

[23] WASH. STATE DEP'T OF HEALTH, CENTER FOR HEALTH STATISTICS, DEATH WITH DIGNITY ACT, http://www.doh.wa.gov/dwda (last visited July 1, 2009).

[24] *Id.*, FORMS RECEIVED, http://www.doh.wa.gov/dwda/formsreceived.htm (last visited Apr. 6, 2010).

[25] *Id.*, 2009 DEATH WITH DIGNITY ACT REPORT, http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf (last visited July 1, 2009).

[26] 224 P.3d at 1214.

[27] *Id.* at 1224.

[28] *Id.* at 1214.

[29] *Id.*

[30] MONT. CONST. art. II, §§ 4, 10.

[31] Kathryn L. Tucker, *Privacy and Dignity at the End of Life: Protecting the Right of Montanans to Choose Aid in Dying*, 68 MONT. L. REV. 317 (2007); James E. Dallner & D. Scott Manning, *Death with Dignity in Montana*, 65 MONT. L. REV. 309 (2004); Scott A. Fisk, *The Last Best Place to Die: Physician-Assisted Suicide and Montana's Constitutional Right to Personal Autonomy Privacy*, 59 MONT. L. REV. 301 (1998).

[32] MONT. CODE ANN. § 45-2-211(2)(d) (2009).

[33] *Id.*

[34] OR. REV. STAT. §§ 127.800-897 (2003). *See also* ANNUAL REPORTS, *supra* note 14.

[35] *See, e.g.*, Kathryn L. Tucker, *The Chicken and the Egg: The Pursuit of Choice for a Humane Hastened-Death as a Catalyst for Improved End-of-Life Care; Improved End-of-Life Care as a Precondition for Legalization of Assisted Dying*, 60 N.Y.U. ANN. SURV. AM. L. 355 (2004) .

[36] *Baxter v. Montana*, No. 2007-787 (Mont. 1st Dist. Dec. 5, 2008).

[37] *Id.*

[38] *Baxter*, 224 P.3d at 1222.

[39] *Id.* at 1216.

[40] *Id.* at 1215.

[41] *Id.* at 1217-18.

[42] Sen. Greg Hinkle, R-Thompson Falls, quickly responded to the decision by filing a draft request for a bill with the short title "Prohibit physician-assisted suicide." *See* Dan Person, *Political notes*, BOZEMAN DAILY CHRONICLE, Feb. 14, 2010, *available at* http://www.bozemandailychronicle.com/news/article_90d2cbd4-966d-5901-9405-d10e053-b983c.htm.

[43] *See* 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 189 (2002).

[44] IDAHO .CODE ANN. § 6-1012 (1976); *see also Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 164, 45 P.3d 816, 820 (2002).

[45] News Release, Pew Research Center: For The People & The Press, More Americans Discussing — and Planning — End-of-Life Treatment: Strong Public Support for Right to Die 1 (Jan. 5, 2006), http://people-press.org/reports/pdf/266.pdf.

[46] *See* also, Carla Rubinski, *Spotlight on Assisted Suicide in Connecticut, available at* http://www.neilrogers.com/news/articles/2005030818.html (last visited July 1, 2010).

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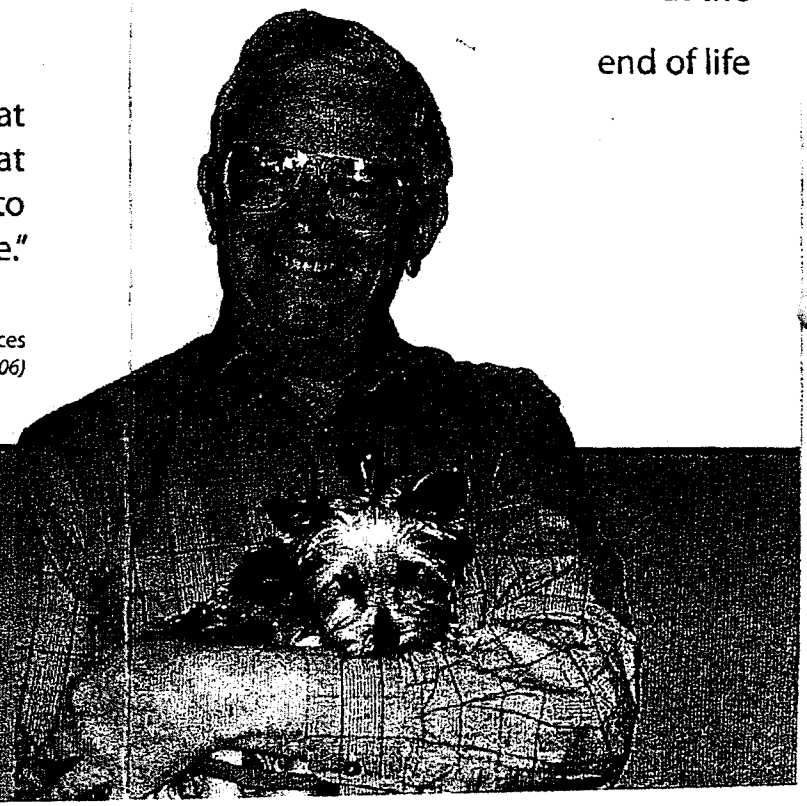

May 2009 Bar Bulletin

'Death with Dignity':

What Do We Advise Our Clients?

By Margaret Dore

Recently Washington's law

A client wants to know about the new Death with Dignity Act, which legalizes physician-assisted suicide in Washington.[1] Do you take the politically correct path and agree that it's the best thing since sliced bread? Or do you do your job as a lawyer and tell him that the Act has problems and that he may want to take steps to protect himself?

Patient "Control" is an Illusion

The new act was passed by the voters as Initiative 1000 and has now been codified as Chapter 70.245 RCW.

During the election, proponents touted it as providing "choice" for end-of-life decisions. A glossy brochure declared, "Only the patient — and no one else — may administer the [lethal dose]."[2] The Act, however, does not say this — anywhere. The Act also contains coercive provisions. For example, it allows an heir who will benefit from the patient's death to help the patient sign up for the lethal dose.

How the Act Works

The Act requires an application process to obtain the lethal dose, which includes a written request form with two required witnesses.[3] The Act allows one of these witnesses to be the patient's heir.[4] The Act also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient's heir.[5] This does not promote patient choice; it invites coercion.

Interested witness

By comparison, when a will is signed, having an heir as one of witnesses creates a presumption of undue influence. The probate statute provides that when one of the two required witnesses is a taker under the will, there is a

rebuttable presumption that the taker/witness "procured the gift by duress, menace, fraud, or undue influence."[6]

Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons. Indeed, no one is required to be present. The Act does not state that "only" the patient may administer the lethal dose; it provides that the patient "self-administer" the dose.

"Self-administer"

In an Orwellian twist, the term "self-administer" does not mean that administration will necessarily be by the patient. "Self-administer" is instead defined as the act of ingesting. The Act states, "'Self-administer' means a qualified patient's act of ingesting medication to end his or her life."[7]

In other words, someone else putting the lethal dose in the patient's mouth qualifies as "self-administration." Someone else putting the lethal dose in a feeding tube or IV nutrition bag also would qualify. "Self-administer" means that someone else can administer the lethal dose to the patient.

No witnesses at the death

If, for the purpose of argument, "self-administer" means that only the patient can administer the lethal dose himself, the patient still is vulnerable to the actions of other people, due to the lack of required witnesses at the death.

With no witnesses present, someone else can administer the lethal dose without the patient's consent. Indeed, someone could use an alternate method, such as suffocation. Even if the patient struggled, who would know? The lethal dose request would provide an alibi.

This situation is especially significant for patients with money. A California case states, "Financial reasons [are] an all too common motivation for killing someone."[8] Without disinterested witnesses, the patient's control over the "time, place and manner" of his death, is not guaranteed.

If one of your clients is considering a "Death with Dignity" decision, it is prudent to be sure that they are aware of the Act's gaps.

What to Tell Clients

1. Signing the form will lead to a loss of control

By signing the form, the client is taking an official position that if he dies suddenly, no questions should be asked. The client will be unprotected against others in the event he changes his mind after the lethal prescription is filled and decides that he wants to live. This would seem especially important for clients with money. There is, regardless, a loss of control.

2. Reality check

The Act applies to adults determined by an "attending physician" and a "consulting physician" to have a disease expected to produce death within six months.[9] But what if the doctors are wrong? This is the point of a recent article in The Seattle Weekly: Even patients with cancer can live years beyond expectations[10]. The article states:

> Since the day [the patient] was given two to four months to live, [she] has gone with her children on a series of vacations . . . .

"We almost lost her because she was having too much fun, not from cancer," [her son chuckles].[11]

Conclusion

As lawyers, we often advise our clients of worst-case scenarios. This is our obligation regardless of whether it is politically correct to do so. The Death with Dignity Act is not necessarily about dignity or choice. It also can enable people to pressure others to an early death or even cause it. The Act also may encourage patients with years to live to give up hope. We should advise our clients accordingly.

Margaret Dore is a Seattle attorney admitted to practice in 1986. She is the immediate past chair of the Elder Law Committee of the ABA Family Law Section. She is a former chair of what is now the King County Bar Association Guardianship and Elder Law Section. For more information, visit her website at www.margaretdore.com.

1 The Act was passed by the voters in November as Initiative 1000 and has now been codified as RCW chapter 70.245.

2 I-1000 color pamphlet, "Paid for by Yes! on 1000."

3 RCW §§ 70.245.030 and .220 state that one of two required witnesses to the lethal-dose request form cannot be the patient's heir or other person who will benefit from the patient's death; the other may be.

4 id.

5 RCW § 70.245.010(3) allows someone else to talk for the patient during the lethal-dose request process; for example, there is no prohibition against this person being the patient's heir or other person who will benefit from the patient's death. The only requirement is that the person doing the talking be "familiar with the patient's manner of communicating."

6 RCW § 11.88.160(2).

7 RCW § 70.245.010(12).

8 People v. Stuart, 67 Cal. Rptr. 3rd 129, 143 (2007).

9 RCW § 70.245.010(11) & (13).

10 Nina Shapiro, "Terminal Uncertainty," Washington's new "Death with Dignity" law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong? The Seattle Weekly, January 14, 2009. http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty.

11 id.

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LETTERS TO THE EDITOR

Don't follow Oregon's lead: Say no to assisted suicide

Dear Editor:

I am an internal medicine doctor, practicing in Oregon where assisted suicide is legal. I write in support of Margaret Dore's article, Aid in Dying: Not Legal in Idaho; Not About Choice. I would also like to share a story about one of my patients.

I was caring for a 76 year-old man who came in with a sore on his arm. The sore was ultimately diagnosed as a malignant melanoma, and I referred him to two cancer specialists for evaluation and therapy. I had known this patient and his wife for over a decade. He was an avid hiker, a popular hobby here in Oregon. As he went through his therapy, he became less able to do this activity, becoming depressed, which was documented in his chart.

During this time, my patient expressed a wish for doctor-assisted suicide to one of the cancer specialists. Rather than taking the time and effort to address the question of depression, or ask me to talk with him as his primary care physician and as someone who knew him, the specialist called me and asked me to be the "second opinion" for his suicide. She told me that barbiturate overdoses "work very well" for patients like this, and that she had done this many times before.

I told her that assisted-suicide was not appropriate for this patient and that I did NOT concur. I was very concerned about my patient's mental state, and I told her that addressing his underlying issues would be better than simply giving him a lethal prescription. Unfortunately, my concerns were ignored, and approximately two weeks later my patient was dead from an overdose prescribed by this doctor. His death certificate, filled out by this doctor, listed the cause of death as melanoma.

The public record is not accurate. My patient did not die from his cancer, but at the hands of a once-trusted colleague. This experience has affected me, my practice, and my understanding of what it means to be a physician.

What happened to this patient, who was weak and vulnerable, raises several important questions that I have had to answer, and that the citizens of Idaho should also consider:

- If assisted suicide is made legal in Idaho, will you be able to trust your doctors, insurers and HMOs to give you and your family members the best care? I referred my patient to specialty care, to a doctor I trusted, and the outcome turned out to be fatal.
- How will financial issues affect your choices? In Oregon, patients under the Oregon Health Plan have been denied coverage for treatment and offered coverage for suicide instead. See e.g. KATU TV story and video at http://www.katu.com/home/video/26119539.html (about Barbara Wagner). Do you want this to be your choice?
- If your doctor and/or HMO favors assisted suicide, will they let you know about all possible options or will they simply encourage you to kill yourself? The latter option will often involve often less actual work for the doctor and save the HMO money.

In most states, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient received was a lethal prescription, intended to kill him.

Is this where you want to go? Please learn the real lesson from Oregon.

Despite all of the so-called safeguards in our assisted suicide law, numerous instances of coercion, inappropriate selection, botched attempts, and active euthanasia have been documented in the public record.

Protect yourselves and your families. Don't let legalized assisted suicide come to Idaho.

Charles J. Bentz MD
Oregon Health & Sciences University
Portland, OR

quest to legalize assisted suicide in Idaho, the particular doctor used by those authors to make their point may feel betrayed if an Idaho court fails to find the legal analysis contained in their article applicable to the Idaho doctor's conduct. And, whatever the court ultimately decides about the legality of the doctor's conduct will come too late for the doctor's former "patient" by now likely buried in Idaho.

Richard A. Hearn, M.D.
Racine Olson Nye Budge & Bailey, Chtd.

Wrong article for *The Advocate*

Dear Editor:

I was appalled to read the article "Aid in Dying: Law, Geography and Standard of Care in Idaho" in the last issue of *The Advocate*. What was your rationale for publishing such malarkey? Was this a vain attempt on your part to increase readership, or do you have a more sinister political motive?

According to your website:

"*The Advocate* features articles written by attorneys on topics of interest to members of the legal community."

Kathryn L. Tucker is not an Idaho attorney. She is an extremely well-paid political activist stirring up controversy through her erroneous rhetoric. I find it extremely difficult to believe that this subject matter would be of interest to the majority of your readers. Which leads me to ask why publish such an article? Are you using your position as editor to help promote your own political agenda?

Robin Sipe
Eagle, ID

Oregon's law doesn't work

Dear Editor:

I am a doctor in Portland Oregon where assisted suicide is legal. I disagree with Kathryn Tucker's rosy description of our assisted suicide law, which she terms "aid in dying."

In Oregon, the so-called safeguards in our law have proved to be a sieve. Although we are reassured that "only the patient" is supposed to take the lethal dose, there are documented cases of family members administering it.

Family members often have their own agendas and also financial interests that dovetail with a patient's death. Yet the true extent of such cases is not known as the only data published comes from second-and even third-hand reports (often from doctors who themselves who were not present at the death and who are active suicide promoters). What we do know about assisted suicide in Oregon is essentially shrouded in secrecy.

The scant information provided by the "official" Oregon statistics report that the majority of patients who have died via Oregon's law have been "well educated" with private health insurance. See official statistics at http://www.oregon.gov/DHS/ph/pas/docs/year12.pdf.

In other words, they were likely people with money. Was it really their "choice?"

Preserve choice in Idaho. Reject assisted suicide.

William L. Toffler MD
Professor of Family Medicine
OHSU--FM
Portland, OR

Doctors not always right

Dear Editor:

I live in Idaho, but formerly lived in Washington state where assisted suicide is legal. I was appalled to see Kathryn Tucker's article promoting "aid in dying," which is not only a euphemism for assisted suicide, but euthanasia. Indeed, in 1991, an "aid in dying" law was proposed in Washington State, which would have legalized direct euthanasia "performed in person by a physician." Legalizing these practices is bad public policy for many reasons. One personal to me is that doctors are not always right.

In 2005, I was diagnosed with a rare form of terminal endocrine cancer. This, along with having contracted Parkinson's disease, has made for a challenging life. Like most people, I sought a second opinion from the premier hospital in the nation that treats this form of cancer, M.D. Anderson, in Houston. But they refused to even see me, indicating they thought it was hopeless. Now five years later, it's obvious they were wrong.

Tucker's article refers to "aid in dying" is an "option." A patient hearing this "option" from a doctor, who he views as an authority figure, may just hear he has an obligation to end his life. A patient, hearing of this "option" from his children, may feel that he has an obligation to kill himself, or in the case of euthanasia, be killed. As for me, I would have missed some of the best years of my life. These are but some of the tragedies of legalized "aid in dying."

I can only hope that the people of Idaho will rise up to chase this ugly issue out of town.

Chris Carlson
Medimont, ID

Article's lousy legal analysis

Dear Editor:

I read with some dismay the article on aid in dying in the August *Advocate*. While I realize that Ms. Tucker and Ms. Salmi have strong opinions on the subject, that is no excuse for *The Advocate* to publish a diatribe so lacking in rational analysis.

The authors first address an Idaho statute dealing with "euthanasia, mercy killing, ... or... an affirmative or deliberate act or omission to end life" and, in conclusory fashion, state that this passage does not include "aid in dying." Worse, they go on to cite the Montana Supreme Court case on the application of homicide statutes in support of the conclusion that Idaho physicians "should feel safe" in helping their patients to kill themselves. I wonder what percentage of the Idaho Bar would be willing to give this advice to a physician client when that client faces loss of liberty and/or their license to practice medicine should the attorney prove to be wrong? This article is editorial comment masquerading as legal analysis and, at the very least, should have been accompanied by someone making a counter-argument.

Robert Moody
Boise, ID

Oregon mistake cost lives

Dear Editor:

I was disturbed to see that the suicide lobby group, Compassion & Choices, is beginning an attempted indoctrination of your state, to accept assisted suicide as somehow promoting individual rights and "choice." I have been a cancer doctor in Oregon for more than 40 years. The combination of assisted-suicide legalization and prioritized medical care based on prognosis has created a danger for my

patients on the Oregon Health Plan (Medicaid).

The Plan limits medical care and treatment for patients with a likelihood of 5% or less 5-year survival. My patients in that category who have a good chance of living another three years and who want to live, cannot receive surgery, chemotherapy or radiation therapy to obtain that goal. The Plan guidelines state that the Plan will not cover "chemotherapy or surgical interventions with the primary intent to prolong life or alter disease progression." The Plan WILL cover the cost of the patient's suicide.

Under our law, a patient is not supposed to be eligible for voluntary suicide until they are deemed to have six months or less to live. In the cases of Barbara Wagner and Randy Stroup, neither of them had such diagnoses, nor had they asked for suicide. The Plan, nonetheless, offered them suicide. Neither Wagner nor Stroup saw this event as a celebration of their "choice." Wagner said: "I'm not ready, I'm not ready to die," They were, regardless, steered to suicide.

In Oregon, the mere presence of legal assisted-suicide steers patients to suicide even when there is not an issue of coverage. One of my patients was adamant she would use the law. I convinced her to be treated. Ten years later she is thrilled to be alive. Don't make Oregon's mistake.

Kenneth Stevens, MD
Sherwood, OR

Physicians for Compassionate Care Education Foundation

JANUARY 31, 2011

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MEMBER VIEW POINTS

Statement for the BBC from Dr. William Toffler – PCCEF's National Director

There has been a profound shift in attitude in my state since the voters of Oregon narrowly embraced assisted suicide 11 years ago. A shift that, I believe, has been detrimental to our patients, degraded the quality of medical care, and compromised the integrity of my profession.

Since assisted suicide has become an option, I have had at least a dozen patients discuss this option with me in my practice. Most of the patients who have broached this issue weren't even terminal.

One of my first encounters with this kind of request came from a patient with a progressive form of multiple sclerosis. He was in a wheelchair yet lived a very active life. In fact, he was a general contractor and quite productive. While I was seeing him, I asked him about how it affected his life. He acknowledged that multiple sclerosis was a major challenge and told me that if he got too much worse, he might want to "just end it." " It sounds like you are telling me this because you might ultimately want assistance with your own assisted suicide- if things got a worse," I said. He nodded affirmatively, and seemed relieved that I seemed to really understand.

I told him that I could readily understand his fear and his frustration and even his belief that assisted suicide might be a good option for him. At the same time, I told him that should he become sicker or weaker, I would work to give him the best care and support available. I told him that no matter how debilitated he might become, that, at least to me, his life was, and would always be, inherently valuable. As such, I would not recommend, nor could I participate in his assisted-suicide. He simply said, "Thank you."

The truth is that we are not islands. How physicians respond to the patient's request has a profound effect, not only on a patient's choices, but also on their view of themselves and their inherent worth.

When a patient says, "I want to die"; it may simply mean, "I feel useless."

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When a patient says, "I don't want to be a burden"; it may really be a question, "Am I a burden?"

When a patient says, "I've lived a long life already"; they may really be saying, "I'm tired. I'm afraid I can't keep going."

And, finally, when a patient says, "I might as well be dead"; they may really be saying, "No one cares about me."

Many studies show that assisted suicide requests are almost always for psychological or social reasons. In Oregon there has never been any documented case of assisted suicide used because there was actual untreatable pain.[6] As such, assisted suicide has been totally unnecessary in Oregon.

Sadly, the legislation passed in Oregon does not require that the patient have unbearable suffering, or any suffering for that matter. The actual Oregon experience has been a far cry from the televised images and advertisements that seduced the public to embrace assisted suicide. In statewide television ads in 1994, a woman named Patty Rosen claimed to have killed her daughter with an overdose of barbiturates because of intractable cancer pain.[7] This claim was later challenged and shown to be false. Yet, even if it had been true, it would be an indication of inadequate medical care- not an indication for assisted suicide.

Astonishingly, there is not even inquiry about the potential gain to family members of the so-called "suicide" of a "loved one." This could be in the form of an inheritance, a life insurance policy, or, perhaps even simple freedom from previous care responsibilities.

Most problematic for me has been the change in attitude within the healthcare system itself. People with serious illnesses are sometimes fearful of the motives of doctors or consultants. Last year, a patient with bladder cancer contacted me. She was concerned that an oncologist might be one of the "death doctors." She questioned his motives—particularly when she obtained a second opinion from another oncologist which was more sanguine about her prognosis and treatment options. Whether one or the other consultant is correct or not, such fears were never an issue before assisted suicide was legalized.

In Oregon, I regularly receive notices that many important services and drugs for my patients-even some pain medications-won't be paid for by the State health plan. At the same time, assisted suicide is fully covered and sanctioned by the State of Oregon and by our collective tax dollars.12]

I urge UK leaders to reject the seductive siren of assisted suicide. Oregon has tasted the bitter pill of barbiturate overdoses and many now know that our legislation is hopelessly flawed. I believe Great Britain, the birthplace of Dame Cicely Saunders, and the Hospice movement, and a model to the rest of the world, deserves better.

On May 12, 2006 the Physicians-Assisted Suicide Bill was defeated in the United Kingdom (UK) Parliament House of Lords 148 – 100 vote.

2011 Montana Legislature

Additional Bill Links PDF (with line numbers)

SENATE BILL NO. 116

INTRODUCED BY G. HINKLE

A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING AID IN DYING; AMENDING SECTIONS 45-2-211 AND 50-9-205, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

WHEREAS, the phrase "aid in dying" is commonly used to describe assisted suicide and euthanasia; and

WHEREAS, the vast majority of states to consider legalizing such practices have rejected them; and

WHEREAS, in the context of assisted suicide, Baxter v. State, 354 Mont. 234, 224 P.3d 1211 (2009), holds that a patient's consent to aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician;

WHEREAS, Baxter overlooked elder abuse, which is often difficult to detect because of the unwillingness of victims to report the abuse; and

WHEREAS, with the difficulty of detecting and proving homicide generally and the difficulties in preventing and detecting abuse specifically, it is against public policy to allow a victim to consent to the victim's own homicide; and

WHEREAS, aid in dying is otherwise against Montana public policy.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 45-2-211, MCA, is amended to read:

"45-2-211. Consent as ~~a~~ defense. (1) The consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense.

(2) Consent is ineffective if:

(a) it is given by a person who is legally incompetent to authorize the conduct charged to constitute the offense;

(b) it is given by a person who by reason of youth, mental disease or defect, or intoxication is unable to make a reasonable judgment as to the nature or harmfulness of the conduct charged to constitute the offense;

(c) it is induced by force, duress, or deception; or

(d) it is against public policy to permit the conduct or the resulting harm, even though consented to.

(3) It is against public policy for a victim to consent to the victim's own homicide, and consent is ineffective if a victim consents to the victim's own homicide in the context of being provided with aid in dying. This consent includes the victim's agreement to being provided with an agent capable of causing death by any means for the intended purpose of causing

the victim's death or for mercy killing, euthanasia, or assisted suicide."

Section 2. Section 50-9-205, MCA, is amended to read:

"50-9-205. Effect on insurance -- patient's decision. (1) Death resulting from the withholding or withdrawal of life-sustaining treatment in accordance with this chapter does not constitute, for any purpose, a suicide or homicide.

(2) The making of a declaration pursuant to 50-9-103 does not affect the sale, procurement, or issuance of any policy of life insurance or annuity, nor does it affect, impair, or modify the terms of an existing policy of life insurance. A policy of life insurance is not legally impaired or invalidated by the withholding or withdrawal of life-sustaining treatment from an insured, notwithstanding any term of the policy to the contrary.

(3) A person may not prohibit or require the execution of a declaration as a condition for being insured for or receiving health care services.

(4) This chapter does not create a presumption concerning the intention of an individual who has revoked or has not executed a declaration with respect to the use, withholding, or withdrawal of life-sustaining treatment in the event of a terminal condition.

(5) This chapter does not affect the right of a patient to make decisions regarding use of life-sustaining treatment, ~~so~~ as long as the patient is able to do so, or impair or supersede a right or responsibility that any person has to effect the withholding or withdrawal of medical care.

(6) This chapter does not require a health care provider to take action contrary to reasonable medical standards.

(7) This chapter does not condone, authorize, or approve mercy killing, ~~or~~ euthanasia, assisted suicide, or aid in dying as provided in 45-2-211(3). These practices are against public policy and are prohibited."

NEW SECTION. **Section 3. Effective date.** [This act] is effective on passage and approval.

- END -

Latest Version of SB 116 *(SB0116.01)*

Processed for the Web on January 6, 2011 (6:21pm)

New language in a bill appears underlined, deleted material appears stricken.

Sponsor names are handwritten on introduced bills, hence do not appear on the bill until it is reprinted.

See the status of this bill for the bill's primary sponsor.

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All versions of all bills (PDF format)

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