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MONTANA
FAMILY FOUNDATION

MEMO

Date: 4-10-10
Subject: Legal analysis of the Baxter decision
~The Baxter decision still allows physicians to be charged with homicide

The attached analysis of the Montana Supreme Court's decision in Baxter v. Montana was written by attorneys Greg Jackson and Matt Bowman, at the request of the Montana Family Foundation. The purpose of the analysis is to place the decision in perspective, and to dispel much of the misinformation surrounding the issue. Contrary to recent headlines, the Supreme Court did not legalize physician assisted suicide. Medical personnel and institutions must understand that if they participate in assisted suicide they expose themselves to potential civil and criminal liability, and may even be charged with homicide.

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Montana Family Foundation is a non-profit research and education organization dedicated to supporting, protecting and strengthening Montana's families.

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ANALYSIS OF IMPLICATIONS OF THE *BAXTER* CASE ON POTENTIAL CRIMINAL LIABILITY

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for

The Montana Family Foundation

The Montana Supreme Court's assisted suicide decision is remarkable for what it did *not* do. In *Baxter v. State of Montana*, 354 Mont. 234 (2009), the Court did not declare assisted suicide a constitutional right, and it imposed no duty on physicians or hospitals to assist suicides. In fact, the Court's narrow decision didn't even "legalize" assisted suicide. The Court merely allowed a possible consent defense if persons continue to be charged with murder for assisted suicide. Because the Court defined the practice of assisted suicide so benignly, it is an open question whether most assisted suicides would even qualify for the defense. And since Montana law already defines assisted suicide as murder, the legislature doesn't have to make it "illegal"—it can simply declare that a consent defense for assisted suicide is not consistent with Montana public policy. After *Baxter*, assisted suicide continues to carry both criminal and civil liability risks for any doctor, institution, or lay person involved.

Although the parties in *Baxter* focused their arguments on whether "physician aid in dying" is a right under the Montana Constitution, the Court declined to rule on the constitutional issue. Decision ¶ 10. By avoiding the constitution and focusing on mere

statutory interpretation, the Court left the door open for the legislature to correct or clarify any of the Court's holdings.

The Court specifically focused on Montana's statutes defining murder and defining when a victim's consent can be used as a defense by someone charged with murder. The Court recognized that under Mont. Code Ann. § 45-5-102(1), "a person commits the offense of deliberate homicide if 'the person purposely or knowingly causes the death of another human being.'" Decision ¶ 10. The Court then inquired whether a physician charged with murder for assisted suicide could use another statute, the consent of the victim under § 45-2-211(1), as a defense during his prosecution. The Court observed that the consent statute can be available when the action is a "statutory crime." Decision ¶ 43.

By this analysis, the Court conceded that assisted suicide is already defined as murder, and therefore is a crime under Montana law. The Court did not strike down or reinterpret the murder statute to exclude the activity of assisted suicide. Assisted suicide remains an act that "knowingly causes the death of another human being" under the homicide statute. The consent defense itself confirms that assisted suicide qualifies as murder. Montana's consent statute, § 45-2-211(1), says that only applies "to conduct charged to constitute an offense," that is, to conduct that already meets the definition of a crime, in this case the crime of murder. A consent defense is only raised by a defendant who has already been charged with a crime and whose actions are defined as a crime. Therefore, persons committing assisted suicide in Montana are still committing an act

defined by statute as homicide. They face being charged and prosecuted for murder, with only the hope that they can defeat the charge by raising and succeeding a consent defense.

But just because a defendant can raise a consent defense doesn't mean he will succeed. The Court only decided whether and when defendants "could" raise the defense, not whether it would actually work for them. Decision ¶ 11. The consent defense, like other statutory defenses, is dependent on the unique facts of each particular case. Thus, although consent may be a defense, it is not a definitive shield from criminal culpability. Indeed, by adopting the rhetoric of the pro-assisted-suicide Plaintiffs, the *Baxter* decision defines "aid in dying" so benignly that many if not most actual circumstances of assisted suicide might not even qualify to use the defense.

The Court gave itself the job of deciding whether Montana's undefined "public policy" would allow the consent defense for "aid in dying" criminal defendants. Decision ¶ 14. To qualify as "aid in dying" under this public policy analysis, the Court had to show that society is not offended by "aid in dying" or its "resulting harms." *Id.* This required the Court to describe many details about what "aid in dying" does and does not involve. In this process, however, the Court effectively narrowed the very definition of "aid in dying," leaving only the idealistic, peaceful dream envisioned by assisted suicide advocates. But this narrowed the holding of the entire case, because the consent defense is only available for "aid in dying" *as the Court described it*. If an act of assisted suicide

exceeds the Court's benign definition of "aid in dying," a criminal defendant will not even be able to use *Baxter* to raise the consent defense, much less succeed on it.

The Court's narrow definition of "aid in dying" illustrates the difficulty of predicting which, if any, *actual* assisted suicides can even qualify for much less succeed with a consent defense. The Court initially defined "aid in dying" as occurring when, "with the patient's consent," "the physicians provide aid in dying," "to terminally ill" "mentally competent" "adult patients." Decision ¶ 12. The Court went on to point out that under the consent statute, consent must be "given by a person who is legally competent to authorize the conduct," not by someone "who by reason of youth, mental disease or defect, intoxication is unable to make a reasonable judgment as to the nature or harmfulness of the conduct," and not by someone who is "induced by force, duress, or deception." Courts, and more importantly, juries, are "required" to examine, "case by case," whether these determinations "render[] consent ineffective." Decision ¶ 14.

The Court went even further to narrow the scope of what kind of "aid in dying" qualifies for a consent defense. The Court emphasized the minimalism of a physician's involvement, by declaring that the doctor merely "makes medication available," and that "the physician's involvement in aid in dying consists solely of making the instrument of the 'act' available to the terminally ill patient" Decision ¶ 26, 32. The patient has to "affirmatively seek[] a lethal dose of medicine," when he "himself seeks out a physician and asks the physician to provide him the means to end his own life . . . . [T]he

solicitation comes from the patient himself, *not* a third party physician." Decision ¶ 40, 44. "[A] physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act." Decision ¶ 23. The patient is to make a "intervening," "subsequent private" decision "whether to take the medication" "without any direct assistance." Decision ¶ 23, 24, 28, 32, 40. The Court stressed that it was only applying the public policy exception in cases "when the patient is conscious and able to vocalize and carry out the decision himself with self-administered medicine with no immediate or direct physician assistance." Decision ¶ 30.

The Court's holding therefore leaves most actual assisted suicides with little or no protection. Since a patient's "consent" is required, the consent defense might fail or be unavailable due to flaws or obstacle in the patient's full and informed consent. The statute itself thoroughly lists factors that can weaken consent, such as "mental defect, intoxication, force, duress, or deception." These and other factors are especially present in assisted suicide situations due to medications, the effects of disease, depression and other psychological disorders often untreated, and pressure from family members or even from the medical staff. The frequent occurrence of elder abuse also inherently weakens the case for a true act of patient consent.

The Court's other comments restrict the consent defense even further. If a doctor does anything at all more than making the medication available for the patient's later ("subsequent") use, his proactive involvement in the process would exceed what *Baxter*

said counted as "aid in dying" that can trigger the consent defense. If the idea of suicide itself is suggested to the patient first by the doctor or even by the family, instead of being on the patient's sole initiative, the situation exceeds "aid in dying" as conceived by the Court. If a particular suicide decision process is anything but "private, civil, and compassionate," Decision ¶ 23, the Court's decision wouldn't guarantee a consent defense. If the patient is less than "conscious," is unable to "vocalize" his decision, or gets help because he is unable to "self-administer," or the drug fails and someone helps complete the killing, *Baxter* would not apply. If the patient is not "terminally ill," which the Court left undefined, the act isn't "aid in dying."

All of these circumstances and more serve to threaten absolute autonomy and are frequent in real-life assisted suicide situations. No doctor can prevent these human contingencies from occurring in a given case, even without his knowledge, in order to make sure that he can later use the consent defense if he is charged with murder. All of these factual issues are open to the prosecutor's, judge's, and jury's interpretation in each given case, by which the consent defense might fail or not be available to the homicide defendant at all.

Nothing shields a physician from being investigated and prosecuted for homicide if he decides to commit "aid in dying. The mere availability of a consent defense is not even certain for him, much less is its success. And although the legislature shielded doctors from civil lawsuit liability for merely withdrawing medical treatment from

patients who desire it, Mont. Code Ann. § 50-9-204, nothing in *Baxter* shields doctors, institutions, or any suicide assistant from being civilly liable for death or injury resulting from assisted suicide actions, especially the circumstances of an attempted death that are less than perfect.

Because *Baxter* framed its decision as a pure issue of interpreting the consent defense, the Montana Legislature is free to change the result. The Legislature is not even bound by the Court's determination that "aid in dying" is not against Montana "public policy." This is because the Court's interpretation of "public policy" was derived wholly from the Legislature's own directive in the consent statute that the defense is available if not against public policy. Mont. Code Ann. § 45-2-211(2)(d). The Court was left to interpret the scope of "public policy" only because the Legislature had not spoken on assisted suicide and consent specifically, and the Court's guide for deciding what public policy is was the Legislature's other statutes. The Montana Legislature does not even need to make assisted suicide "illegal." The activity is already homicide. The Legislature can merely specify that the public policy of Montana, with respect to the already-illegal act of assisted suicide, precludes the consent defense. The autonomy-weakening dangers referenced above are ample reasons for the Legislature to find that the consent defense should not apply to this type of homicide.

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