

IN THE SUPREME COURT OF THE STATE OF MONTANA

No. DA 09-0051

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ROBERT BAXTER, et. al

Plaintiffs-Appellees,

v.

STATE OF MONTANA AND  
STEVE BULLOCK,

Defendants-Appellants

---

AMICUS BRIEF OF MARGARET DORE  
SUPPORTING THE APPELLANTS

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On Appeal from the First Judicial District Court of  
Lewis and Clark County, Judge Dorothy McCarter

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- Exhibit 3: Nina Shapiro, "Terminal Uncertainty,"  
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allows doctors to help people commit suicide  
- once they've determined that the patient  
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- Exhibit 9: Death with Dignity Act (PAS) Forms;
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- Exhibit 13: Consulting Physician Form;
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## **A. INTRODUCTION**

### **1. Parties**

This amicus brief supports the appellants, Montana and its Attorney General, Steve Bullock. The amicus is Margaret Dore, a Washington State attorney. She has studied the Oregon Death with Dignity Act and has expertise regarding its provisions.

### **2. Legal Overview**

This is an appeal from a decision and order on summary judgment, which legalizes physician assisted suicide. The decision is based on a finding that abuses of assisted suicide (involuntary deaths), can be controlled by state law. The district court supported this finding by referring to provisions in the Oregon Death with Dignity Act. The court thus implicitly found that the Oregon law controls abuses.

These findings are clearly erroneous because the structure and provisions of the Oregon law, instead, promote undue influence and worse.

## **B. ISSUES**

1. Whether the district court should be reversed on summary judgment because its decision is premised on a finding that abuses can be controlled by state law, specifically the Oregon Death with Dignity Act, which finding is clearly erroneous and/or speculative?

2. Whether the district court should be reversed because

its decision is based on the premise that legal assisted suicide will assure a patient "control" over the circumstances of his or her death, which premise is speculative?

3. Whether the district court should be reversed and remanded for trial because there are material issues of fact regarding the above referenced matters?

### C. STATEMENT OF THE CASE

#### 1. The Decision

##### a. "Self-administration" and Choice

On December 8, 2008, the district court granted summary judgment based on a constitutional right to die with dignity. (Exhibit 2, Decision, p.19, lines 10-11). The court defined this right as the ability to commit legal physician assisted suicide. (*Id.*, lines 12-15). The decision also provides that the lethal dose be "self-administered" if and when the patient chooses. (*Id.*, p. 6, lines 9-10).

##### b. Preventing involuntary death is a "compelling state interest"

The decision states that the right to assisted suicide is fundamental, so that it cannot be prohibited unless there is a compelling state interest to do so. (Exhibit 2, Decision, p. 20, line 19). The court conceded that preventing abuses identified by Justice O'Connor in Washington v. Glucksberg, would be a compelling state interest. (*Id.* at lines 13-16). The district

court stated:

Certainly the state has a compelling interest in preventing abuses stated by Justice O'Connor.

Exhibit 2, Decision and Order, p. 20, lines 22-23.

The abuses identified by Justice O'Connor include the following:

[T]he risk that a dying patient's request for assistance in ending his or her life might not be truly voluntary . . .

Id., lines 13-16.

c. The court's conclusion: abuses can be controlled by state law, specifically Oregon's law

The district court concluded that the identified abuses can be controlled by state law, specifically via provisions in Oregon's law. The court stated:

[T]hose abuses can be controlled by state law, such as requiring the written opinion of one or more physicians as to the medical status of the patient, his or her terminal state, and the patient's competence to make the decision as to the time and manner to end his or her life [a rough summary of provisions in Oregon's law].

The State of Oregon's Death with Dignity Act contains numerous requirements to avoid such potential abuses:

[The court then listed more provisions from Oregon's law and cited OR. Rev. Stat. 127.800 §897].

Exhibit 2, Decision, p. 20, lines 23-25; p. 21, lines 1-18.

The court also determined that the Oregon law is valid in

light of the Montana Constitution. *Id.*, p. 23, lines 9-14.

The court did not address the issue of when doctor predictions of life expectancy are wrong.<sup>1</sup> The patients at issue here are not necessarily dying.<sup>2</sup>

## 2. How Oregon's Law Works

Oregon's law has an application process, which includes a lethal dose request form. (*Infra* at Exhibit 10). During this process, the patient is not required to have legal capacity. (*Infra* at §§ E.3.a, E.3.c & E.4). The patient's heir, who will benefit from his death, is allowed to participate in the lethal dose request.<sup>3</sup>

Once the lethal dose is issued by the pharmacy, there is no oversight. Patient competency and consent are not required when the lethal dose is administered. (*Infra* at §§ E.3.a, E.3.c & E.4). Administration of the lethal dose by the patient himself is also not required. (*Infra* at §E.3.b). Indeed, Oregon's law allows involuntary killing. (*Infra* at §§ E.3.c & E.4-6).

## D. SUMMARY OF ARGUMENT

The finding that abuses such as involuntary killings can be

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<sup>1</sup> Cf. 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?," *Seattle Weekly*, January 14, 2009. (*Infra* at Exhibit 3).

<sup>2</sup> *Id.*

<sup>3</sup> Per ORS 127.810 §2.02, one of two required witnesses on the lethal dose request form is allowed to be the patient's heir. (*Infra* at Exhibit 1, p.3).

controlled by state law, specifically Oregon's law, is clearly erroneous because Oregon's law allows involuntary killing. The finding is also clearly erroneous due to a lack of required witnesses at the death. (*Infra* at §E.7). This is because without disinterested witnesses, the opportunity is created for someone else to administer the lethal dose to the patient without the patient's consent. (*Id.*).

The court's conclusion that the state's compelling interest in preventing involuntary killings is satisfied, is without factual basis and/or speculative.

In the alternative, there are material issues of fact as to whether Oregon's law or state law generally is capable of controlling abuses. Reversal and remand for trial is required.

## **E. ARGUMENT**

### **1. Standard of Review**

The Supreme Court reviews a district court's grant of summary judgment, *de novo*, applying the same criteria applied by the district court under M.R. Civ. P. 56. Hopkins v. Superior Mental, 349 Mont. 292, ¶ 5, 203 P.3d 803, 804 (2009). "All reasonable inferences that may be drawn from the evidence must be drawn in favor of the party opposing summary judgment." (*Id.*)

"[S]ummary judgment is never to be a substitute for trial if there is an issue of material fact." McDonald v. Anderson, 261 Mont. 268, 272, 862 P.2d 402 (1993). Summary judgment is proper

only when no genuine issues of material fact exist and the moving party is entitled to judgment as a matter of law. *Id.*

Findings of fact must be upheld unless they are clearly erroneous. Estate of Bradshaw, 305 Mont. 178, 181 (2001).

## 2. The Big Picture

Physician assisted-suicide is legal in just three states: Oregon, Washington and now Montana via the decision and order on appeal.

Oregon's law was passed via an initiative and went into effect in 1997. Washington's law was passed via an initiative in 2008 and went into effect last month. (*Infra* at Exhibit 4).

Washington's law is modeled on Oregon's law. Both laws are deceptively written in that they seem to provide patient protections, but then they don't. Both laws utilize circular definitions to mask what they are really about.

## 3. The Trial Court's Finding That Oregon's Law Prevents Abuses is Clearly Erroneous

### a. Oregon's law does not require legal capacity; no mental standard or patient consent is required at the time of administration

Under Oregon's law, the "attending physician" and a "consulting physician" are required to determine that the patient is "capable" at the time of the lethal dose request. The Oregon law states:

"Capable" means . . . a patient has the

ability to make and communicate health care decisions to health care providers . . .

ORS 127.800 § 1.01(3), *infra* at Exhibit 1, p.1.

The law also requires that patients make an "informed decision" about the lethal dose request, which means that the patient has "an appreciation" of relevant facts. See: ORS 127.800 §1.01 (7).

There is no requirement that the patient have the ability to make "responsible" or "rational" decisions, which is the definition of legal capacity in Montana.<sup>4</sup> More importantly, there is no requirement that the patient be competent, capable or even aware when the lethal dose is administered.<sup>5</sup> There is no requirement that the patient give consent when the lethal dose is administered.<sup>6</sup>

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<sup>4</sup> Cf. Entire Oregon law, *infra* at Exhibit 1; and 72-5-101(1), MCA, (defining an "incapacitated person" for the purpose of a guardianship or conservator, as one who lacks sufficient understanding or capacity to make or communicate "responsible decisions" concerning his person or which cause has so impaired the person's judgment that he is incapable of realizing and making a "rational decision" with respect to his need for treatment).

<sup>5</sup> Oregon's law requires that a determination of "capable" be made in conjunction with the lethal dose request. See: ORS 127.800 § 1.01 (3); ORS 127.800 §1.01(5); ORS 127.800 §1.01(11); ORS 127.805 §2.01; ORS 127.800 §2.02; ORS 127.815 §3.01(1)(a); ORS 127.815 §3.01(1)(d); ORS 127.820 §3.02; ORS 127.855 §3.09(3); and ORS 127.855 §3.09(4). There is no requirement that the patient be capable, competent or even aware at the time of administration. See: Entire Oregon Act, *infra* at Exhibit 1.

<sup>6</sup> Oregon's law requires that a determination of "voluntariness" be made in conjunction with the lethal dose request, not later. See: ORS 127.805 §2.01(1); ORS 127.810 §2.02(1); ORS 127.815 §3.01(1)(a); ORS 127.815 §3.01(1)(d); ORS 127.820 §3.02; ORS 127.855 §3.09(3); ORS 127.855 §3.09(4); and ORS 127.897 §6.01. There is no requirement that the patient be acting on a voluntary basis at the time of administration. See: Entire Oregon Act, *infra* at Exhibit 1.

Without strict competency requirements during the lethal dose request process, the stage is set for undue influence. § 28-2-407(2) MCA, defines undue influence as: "[T]aking an unfair advantage of another's weakness of mind."

Without a requirement of competency, consent or even awareness when the lethal dose is administered, the stage is set for undue influence and worse.

b. "Self-administer" does not necessarily mean that a patient administers the lethal dose to himself

Oregon's law implies that patients administer the lethal dose to themselves.<sup>7</sup> The law does not, however, require this. Oregon's law does not state that "only" the patient can administer the lethal dose.<sup>8</sup>

Oregon's law instead refers to patient administration as the "act of ingesting medication to end his or her life."<sup>9</sup> Oregon's official forms also refer to administration as "ingestion," "ingesting" and other forms of the word "ingest." (*Infra* at

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<sup>7</sup> The suggested lethal dose request form in ORS 127.897 §6.01 states: "I expect to die when I take the [lethal dose]."

<sup>8</sup> See: Entire Oregon Act, *infra* at Exhibit 1.

<sup>9</sup> Oregon's law states:

Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health or accident insurance or an annuity policy. (Emphasis added.)

ORS 127.875 §3.13, *Infra* at Exhibit 1, p. 7.

Exhibit 16, pp. 1-4).

With administration described as the "act of ingesting medication to end his or her life," someone else putting the lethal dose in the patient's mouth qualifies as proper administration; someone else putting the lethal dose in a feeding tube or IV nutrition bag would also qualify.

In Washington's law, the phrase "act of ingesting medication to end his or her life" is the statutory definition for "self-administer." Washington's law states:

"Self-administer" means a qualified patient's act of ingesting medication to end his or her life . . .

RCW 70.245.010(12), *infra* at Exhibit 4.

Self-administer means the act of ingesting. In an Orwellian twist, "self-administer" does not require that the patient administer the lethal dose to himself.

**c. Oregon's law allows involuntary killing**

In summary, Oregon's law contains no requirement that the patient be competent, capable or even aware when the lethal dose is administered. There is no requirement that the patient consent when the lethal dose is administered. Someone other than the patient is allowed to administer the lethal dose.

Intentionally killing an incompetent person or intentionally killing some other person without his consent, is homicide.<sup>10</sup>

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<sup>10</sup> Cf. § 45-5-102, MCA (defining "deliberate homicide").

Oregon's law, however, allows this result as long as the action taken is according to its law. Oregon's law states:

Actions taken in accordance with [this chapter] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. (Emphasis added.)

ORS 127.880 §3.14 *infra* at Exhibit 1, p. 7.

Oregon's law allows involuntary killing. The district court's finding that Oregon's law controls abuses, *i.e.*, involuntary deaths, is clearly erroneous.

**4. Oregon's Official Reports and Forms Support that its Law Allows Involuntary Killing**

Physicians and pharmacists who participate in the lethal dose request process are required to complete official forms. (Exhibits 11-16, *infra*). The data collected is summarized in annual statistical reports, which are displayed on Oregon's official website, at <http://www.oregon.gov/DHS/ph/pas>. (Exhibit 5, *infra*). The most recent reports are attached hereto. (Exhibits 7 and 8, *infra*).

None of these official documents ask about or report on patient competency and consent at the time of administration, or whether the patient administered the lethal dose to himself. These factors are not relevant under Oregon's law.

5. Liability for Undue Influence is Illusory, Subject to Proof Problems and/or Void; No Potential Liability Provided for Undue Influence at the Time of Administration

Appellees may counter that Oregon's law actually protects patients from involuntary killing due to criminal liability for undue influence. Oregon's law states:

A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, . . . shall be guilty of a Class A felony.

ORS 127.890 §4.02(2), *infra* at Exhibit 1, p. 10.

The purported liability is illusory because conduct that would normally support a finding of undue influence is specifically allowed by Oregon's law. For example, a circumstance relied on to prove undue influence in Oregon is the participation of a beneficiary or heir in the "preparation of the will." Harris v. Jourdan, 180 P. 3d 119, 131 (Or. App. 2008). Oregon's law, however, specifically allows an heir to participate in the lethal dose process.<sup>11</sup> No liability for undue influence would be imposed for such participation due to the rule of construction, that a statute that allows specific behavior, overrides a general prohibition against such behavior.<sup>12</sup>

In addition, a defendant would be protected by the high

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<sup>11</sup> Per ORS 127.810 §2.02, one of two required witnesses on the lethal dose request form is allowed to be the patient's heir.

<sup>12</sup> Cf. Powers v. Quigley, 198 P.3d 919, 923 (Or 2008) ("if two statutes are inconsistent, the more specific statute will control over the general one"); and Yellowstone Federal Credit Union v. Daniels, 342 Mont. 451, 456 (2008) ("more specific statutes prevail over general provisions of law").

burden of proof required for a criminal conviction. How do you prove beyond a reasonable doubt that undue influence occurred when the statute prohibiting undue influence also specifically allows conduct and circumstances generally used to prove undue influence? You can't.

Criminal statutes also require that a defendant be given clear notice of prohibited conduct. City of Billings v. Albert, 349 Mont. 400, 402-403, 203 P.3d 828 (2009). The above prohibition against undue influence in Oregon's law is not defined and has no elements of proof. (*Infra* at Exhibit 1, p.10). Similarly, in Montana, the test for undue influence is five nonexclusive factors. Estate of Bradshaw, 305 Mont. at 182-183. Where the conduct prohibited is unclear, a statute is void for vagueness.<sup>13</sup>

More importantly, Oregon's law does not purport to impose criminal liability for undue influence when the lethal dose is administered, which is when actual damage (the patient's death) would occur.<sup>14</sup> Oregon's law instead provides immunity. Oregon's law states:

No person shall be subject to civil or criminal liability . . . for participating in good faith compliance with [this chapter]. This includes being present when a qualified

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<sup>13</sup> Cf. Yurczyk v Yellowstone County, 319 Mont. 169, 180, 83 P.3d 266 (2004) (regulation requiring "on-site construction" with was void for vagueness where county officials could not agree to the term's meaning).

<sup>14</sup> ORS 127.890 §4.02(2), *supra*, only applies to the lethal dose request, not administration of the lethal dose. See *infra* at Exh. 1, p.10.

patient takes the [lethal dose]. ORS 127.885 §4.01(1), *infra* at Exhibit 1, p.7.

**6. The Right to Rescind is not a Substitute for Requiring Consent and Competency**

Appellees may also point to the patient's right to rescind a request for the lethal dose. (ORS 127.845 §3.07, *infra* at Exhibit 1, p.5). A right to rescind is not a substitute for consent and competency. An incompetent or unaware (sleeping) patient would not necessarily have the ability to rescind.

**7. No Witnesses at the Death**

If for the purpose of argument, Oregon's law does not "allow" involuntary killing, the patient is, nonetheless, unprotected from involuntary killing due to the lack of required witnesses at the death. This situation creates the opportunity for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi.

Without disinterested witnesses, the patient's control over the "time, place and manner" of his death, is not guaranteed.

**8. The Oregon Statistical Reports**

Oregon's annual statistical reports support that the majority of persons dying via Oregon's law have been those with money.<sup>15</sup> These statistics can be explained by patients with

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<sup>15</sup> The Oregon statistics do not specifically track patient income or net worth. The statistics, however, do show that the majority of people who used Oregon's law in 2008 were: white (98%); well educated (60% had at least a BA); and with private insurance (88%). *See*: Exhibit 7, page 2. Typically,

money feeling a "duty to die" so as to pass on funds and assets to their heirs. Cf. *Infra* at Exhibit 19, p.2. The statistics are also consistent with undue influence and worse. A California case, People v. Stuart, 67 Cal Rptr. 3<sup>rd</sup> 129, 143 (2007), states:

Financial reasons [are] an all too common motivation for killing someone . . .

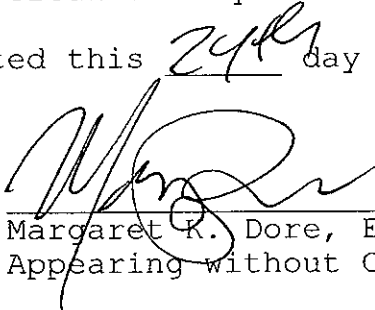
**F. CONCLUSION**

The emperor has no clothes or maybe it's a "big lie." The Oregon Death with Dignity Act is not what it appears to be. The law enables people to pressure others towards death or even cause that death, individual "choice" is not ensured.

The finding that Oregon's law controls abuses such as involuntary killings, is clearly erroneous because the law allows involuntary killing. With the lack of witnesses at the death, the patient's control over the "time, place and manner" of his death is not guaranteed.

The conclusion that the State's compelling interest in preventing involuntary killing is satisfied, is without factual basis and/or speculative. Reversal is required.

Respectfully submitted this 24<sup>th</sup> day of April, 2009.

  
Margaret K. Dore, Esq.  
Appearing without Counsel

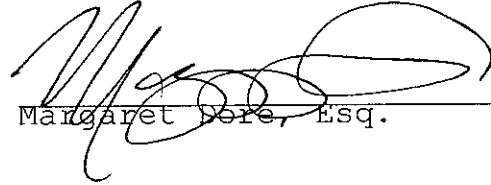
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people with these attributes would be those with money.

**CERTIFICATE OF COMPLIANCE**

The undersigned, Margaret Dore, certifies that this Brief complies with the requirements of Rule 11(4)(d). The lines in this document are double-spaced, except for footnotes and quoted and indented material, and the document is mono-spaced Courier New typeface consisting of 10.5 characters per inch. The total number of pages is 14 or less excluding caption, table of contents, table of authorities and certificate of compliance.

Dated this 29<sup>th</sup> day of April, 2009.

  
Margaret Dore, Esq.

## APPENDIX

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# THE OREGON DEATH WITH DIGNITY ACT

## OREGON REVISED STATUTES

(General Provisions)

(Section 1)

**Note:** The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

**127.800 §1.01. Definitions.** The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

- (1) "Adult" means an individual who is 18 years of age or older.
- (2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- (3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
- (4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- (5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- (6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.
- (7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

**EXHIBIT 1**

Page 1

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 §1.01; 1999 c.423 §1]

(Written Request for Medication to End One's Life in a Humane and Dignified Manner)

(Section 2)

**127.805 §2.01. Who may initiate a written request for medication.** (1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 §2.01; 1999 c.423 §2]

**127.810 §2.02. Form of the written request.** (1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the

**EXHIBIT 1**

*1 of 2  
resid witnesses  
on the left  
dose request  
form may be  
on view.*

- (2) One of the witnesses shall be a person who is not:
  - (a) A relative of the patient by blood, marriage or adoption;
  - (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
  - (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services by rule. [1995 c.3 §2.02]

(Safeguards)

(Section 3)

**127.815 §3.01. Attending physician responsibilities.** (1) The attending physician shall:

- (a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;
- (b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;
- (c) To ensure that the patient is making an informed decision, inform the patient of:
  - (A) His or her medical diagnosis;
  - (B) His or her prognosis;
  - (C) The potential risks associated with taking the medication to be prescribed;
  - (D) The probable result of taking the medication to be prescribed; and
  - (E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;
- (d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

- (e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;
- (f) Recommend that the patient notify next of kin;
- (g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;
- (h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;
- (i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;
- (j) Fulfill the medical record documentation requirements of ORS 127.855;
- (k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and
- (L)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or
- (B) With the patient's written consent:
  - (i) Contact a pharmacist and inform the pharmacist of the prescription; and
  - (ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.
- (2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 §3.01; 1999 c.423 §3]

**127.820 §3.02. Consulting physician confirmation.** Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision. [1995 c.3 §3.02]

**127.825 §3.03. Counseling referral.** If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [1995 c.3 §3.03; 1999 c.423 §4]

**127.830 §3.04. Informed decision.** No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision. [1995 c.3 §3.04]

**127.835 §3.05. Family notification.** The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason. [1995 c.3 §3.05; 1999 c.423 §6]

**127.840 §3.06. Written and oral requests.** In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request. [1995 c.3 §3.06]

**127.845 §3.07. Right to rescind request.** A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request. [1995 c.3 §3.07]

**127.850 §3.08. Waiting periods.** No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897. [1995 c.3 §3.08]

**127.855 §3.09. Medical record documentation requirements.** The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

- (2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
- (3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
- (4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
- (5) A report of the outcome and determinations made during counseling, if performed;
- (6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and
- (7) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 §3.09]

**127.860 §3.10. Residency requirement.** Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:

- (1) Possession of an Oregon driver license;
- (2) Registration to vote in Oregon;
- (3) Evidence that the person owns or leases property in Oregon; or
- (4) Filing of an Oregon tax return for the most recent tax year. [1995 c.3 §3.10; 1999 c.423 §8]

**127.865 §3.11. Reporting requirements.** (1)(a) The Department of Human Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The department shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the department.

(2) The department shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The department shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 §3.11; 1999 c.423 §9; 2001 c.104 §40]

**127.870 §3.12. Effect on construction of wills, contracts and statutes.** (1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 §3.12]

**127.875 §3.13. Insurance or annuity policies.** The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 §3.13]

**127.880 §3.14. Construction of Act.** Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 §3.14]

(Immunities and Liabilities)

(Section 4)

**127.885 §4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions.** Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

*Circular provision* X

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent

contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS 127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (2) or (3).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community. [1995 c.3 §4.01; 1999 c.423 §10]

**Note:** As originally enacted by the people, the leadline to section 4.01 read "Immunities." The remainder of the leadline was added by editorial action.

**127.890 §4.02. Liabilities.** (1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897. [1995 c.3 §4.02]

**127.892 Claims by governmental entity for costs incurred.** Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to the provisions of ORS 127.800 to 127.897 in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim. [1999 c.423 §5a]

(Severability)

(Section 5)

**127.895 §5.01. Severability.** Any section of ORS 127.800 to 127.897 being held invalid as to any person or circumstance shall not affect the application of any other section of ORS 127.800 to 127.897 which can be given full effect without the invalid section or application. [1995 c.3 §5.01]

(Form of the Request)

(Section 6)

**127.897 §6.01. Form of the request.** A request for a medication as authorized by ORS 127.800 to 127.897 shall be in substantially the following form:

---

REQUEST FOR MEDICATION  
TO END MY LIFE IN A HUMANE  
AND DIGNIFIED MANNER

I, \_\_\_\_\_, am an adult of sound mind.

I am suffering from \_\_\_\_\_, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

\_\_\_\_\_ I have informed my family of my decision and taken their opinions into consideration.

\_\_\_\_\_ I have decided not to inform my family of my decision.

\_\_\_\_\_ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

DECLARATION OF WITNESSES

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We declare that the person signing this request:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed this request in our presence;
- (c) Appears to be of sound mind and not under duress, fraud or undue influence;
- (d) Is not a patient for whom either of us is attending physician.

*1 of 2 witnesses  
is allowed to  
be an heir*

\_\_\_\_\_ Witness 1/Date

\_\_\_\_\_ Witness 2/Date

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

\_\_\_\_\_  
[1995 c.3 §6.01; 1999 c.423 §11]

#### PENALTIES

**127.990:** [Formerly part of 97.990; repealed by 1993 c.767 §29]

**127.995 Penalties.** (1) It shall be a Class A felony for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument or any other evidence or document reflecting the principal's desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration which hastens the death of the principal.

(2) Except as provided in subsection (1) of this section, it shall be a Class A misdemeanor for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a health care decision. [Formerly 127.585]

1 treatment. This has been codified in many states, including Montana which has  
2 legislatively carved out an exception to the homicide statute to protect physicians who,  
3 in compliance with a patient's wishes, withhold or remove unwanted life-extending  
4 treatment.

5 To date, however, no court of final jurisdiction has determined that an  
6 individual has a right, under either federal or state constitutional protections, to  
7 "physician-assisted suicide" under even the limited circumstances here – i.e. a  
8 competent person with a terminal medical condition expected to end in death within six  
9 months who wishes to obtain a prescription for a lethal dose of drugs to be self-  
10 administered, if and when the individual elects to hasten death rather than await an  
11 inevitable end to life.

12 In 1997, the United States Supreme Court held that no such right is found  
13 under either the Due Process Clause or the Equal Protection Clause of the United  
14 States Constitution. *Washington v. Glucksberg*, 521 U.S. 702 (1997), involved a  
15 challenge by several doctors and terminally ill plaintiffs to a Washington statute  
16 criminalizing assisting a suicide. They asserted the statute violated their liberty  
17 interest protected by the Fourteenth Amendment's Due Process Clause. The Ninth  
18 Circuit Court of Appeals held that the Due Process Clause encompasses a due process  
19 liberty interest in controlling the time and manner of one's death, which includes a  
20 "right to die," and found Washington's assisted-suicide ban unconstitutional as applied  
21 to terminally ill competent adults who wish to hasten their deaths with medication  
22 prescribed by their physicians. *Compassion in Dying v. Wash.*, 79 F.3d 790 (9<sup>th</sup> Cir.  
23 1996). The United States Supreme Court overruled the Ninth Circuit and held that the  
24 statute did not violate the Due Process Clause. *Glucksberg*, 521 U.S.  
25 at 735.

1 the most appropriate drug for life termination, leaving the ultimate decision and timing  
2 up to the patient.

3 But for such a relationship, the patient would increasingly become  
4 physically unable to terminate his life, thus defeating his constitutional right to die with  
5 dignity. If the patient were to have no assistance from his doctor, he may be forced to  
6 kill himself sooner rather than later because of the anticipated increased disability with  
7 the progress of his disease, and the manner of the patient's death would more likely  
8 occur in a manner that violates his dignity and peace of mind, such as by gunshot or by  
9 an otherwise unpleasant method, causing undue suffering to the patient and his family.

10 The Court concludes that a competent terminally ill patient has the  
11 constitutional right to die with dignity. This right is protected by Article II, sections 4  
12 and 10, of the Montana Constitution and necessarily incorporates the assistance of his  
13 doctor, as part of a doctor-patient relationship, so that the patient can obtain a  
14 prescription for drugs that he can take to end his own life, if and when he so  
15 determines.

16 This right is fundamental and, therefore, cannot be limited by the State  
17 without a showing of a compelling state interest. Any limitation on that right must be  
18 narrowly tailored to effectuate only that compelling interest. *Gryczan*, 283 Mont. at  
19 449, 942 P.2d at 122; *State v. Pastos*, 269 Mont. 43, 47, 887 P.2d 199, 202 (1994).

### 20 **Compelling State Interests**

21 The State asserts numerous compelling state interests with respect to the  
22 terminal patient's right to die with dignity.

#### 23 1. **Preserving Human Life**

24 The first, and perhaps the foremost, compelling interest is the interest in  
25 protecting and defending human life. The State argues that the homicide statutes are

1 narrowly tailored to effectuate the State's interest in preventing intentional killing. The  
2 homicide statutes do not, however, address the terminal patient's right to die with  
3 dignity. It is easy to acknowledge the State's interest in preserving human life in  
4 general, but it is difficult to imagine a compelling interest in preserving the life of an  
5 individual who is suffering pain and the indignity of his disease; whose life is going to  
6 end within a relatively short period of time; and for whom palliative care is inadequate  
7 to satisfy his personal desire to die with dignity. In such a case, the State's interest in  
8 preserving life in general diminishes in the delicate balance against the individual's  
9 constitutional rights of privacy and individual dignity. The Court concludes that the  
10 competent terminal patient's rights of privacy and dignity overcome the State's general  
11 interest in preserving human life.

12 **2. Protecting Vulnerable Groups from Potential Abuses**

13 This concern was articulated by Justice O'Connor in her concurring  
14 opinion in *Glucksberg*: "The difficulty in defining terminal illness and the risk that a  
15 dying patient's request for assistance in ending his or her life might not be truly  
16 voluntary justifies the prohibition on assisted suicide we uphold here." 521 U.S. at  
17 738. It is important to note at this point that the United States Supreme Court needed  
18 only to find a legitimate basis for such prohibition on assisted death. As discussed  
19 previously, Montana law requires a compelling state interest in such a prohibition, with  
20 limitations narrowly tailored to effectuate the State's interest without unduly  
21 interfering with the individual's constitutional rights.

22 Certainly the State has a compelling interest in preventing the abuses  
23 stated by Justice O'Connor. However, those abuses can be controlled by state law,  
24 such as requiring the written opinion of one or more physicians as to the medical status  
25 of the patient, his or her terminal state, and the patient's competence to make the

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1 decision as to the time and manner to end his or her life.

2           The State of Oregon's Death with Dignity Act contains numerous  
3 requirements to avoid such potential abuses: The individual must be an adult; be a  
4 legal resident of the state; be suffering from a terminal illness; must make two oral  
5 requests not less than fifteen days apart to receive a lethal dose of drugs; and must have  
6 executed a written request for such medication in the presence of two witnesses, one of  
7 whom is not a relative. The attending physician must confirm the diagnosis of terminal  
8 illness; must determine that the patient is mentally competent and that the request is  
9 voluntary; and must inform the patient of the diagnosis, his/her medical prognosis, the  
10 risk of lethal medication, the results of ingesting the lethal medication, the availability  
11 of "feasible alternatives" to taking the lethal drugs, and the patient's right to rescind the  
12 request for the drugs. The physician must also refer the patient to another physician to  
13 confirm the terminal diagnosis, the patient's mental competence, and the voluntary  
14 nature of the decision; must refer the patient for counseling if the physician believes  
15 that the patient may be suffering from a psychiatric disorder or depression causing  
16 impaired judgment; and must verify immediately prior to writing the prescription for  
17 the lethal drugs that the patient is making an informed decision. Or. Rev. Stat.  
18 § 127.800-.897.

19           The State of Montana can effectuate this compelling interest without  
20 denying the individual's constitutional right to die with dignity.

21           **3. Protecting the Integrity and Ethics of the Medical Profession**

22           The United States Supreme Court has recognized a substantial state  
23 interest in protecting the integrity of the medical profession, and this Court would  
24 agree that the State has a compelling interest in protecting the integrity of the medical  
25 profession. Again, this concern can be addressed by the State. For example, the State

1 can provide an express provision that excludes physicians who do not wish to  
2 participate and can further protect participating physicians with appropriate legislation  
3 and guidelines.

4           It is interesting to note at this point that the medical community shows  
5 growing support for dispensing prescriptions for lethal doses for terminal patients. An  
6 opinion poll was conducted in 2005 by an independent market research firm, HCD  
7 Research, of 677 randomly selected doctors. Fifty-nine percent of the doctors  
8 answered "yes" when asked if physicians should be given the right to dispense  
9 prescriptions to patients to end their lives. Forty-one percent of the doctors answered  
10 "no." When asked who should decide whether physician-assisted suicide is a  
11 legitimate medical purpose, fifty-four percent of the doctors said that the issue should  
12 not be decided by either state or federal government. Kevin O'Reilly, *Doctors Favor*  
13 *Physician-Assisted Suicide Less Than Patients Do*, Am. Med. News, Nov. 21, 2005,  
14 *available at amednews.com*. That poll showed doctors' support up two percentage  
15 points from a poll taken earlier that year.

16           The State contends that declaring constitutional rights for a competent  
17 terminally ill patient is premature because there is no definition of "competent" or  
18 "terminally ill." Competency is easily determined by the patient's doctor. Treating  
19 physicians are frequently called upon to determine competency of their patients for  
20 purposes of guardianship and other legal proceedings. Whether a patient is terminally  
21 ill can also be determined by the physician as an integral component of the physician-  
22 patient relationship. These issues are insufficient to impinge on the patient's right to  
23 die with dignity.

24           The State also urges this Court to decline to rule that Plaintiffs have a  
25 constitutional right to die with assistance of their physicians, asserting that the issue is

1 properly determined by the legislature. The Court acknowledges that the issues raised  
2 in this lawsuit contain a mixture of legal and non-legal decisions. The question of  
3 whether Plaintiffs have a fundamental right to die with dignity, with assistance, is a  
4 constitutional question to be decided by the courts. The question of whether the  
5 homicide statute is unconstitutional as applied to these Plaintiffs is also a legal one to  
6 be decided by the courts. Where, as here, the Court has concluded that Plaintiffs do  
7 have a fundamental right as they request, the implementation of that right to effect the  
8 compelling state interests as discussed herein is properly left to the legislature.

9 If we were to wait for the legislature to enact a death with dignity law  
10 that permits assistance in dying, similar to the Oregon statute, then the Court would  
11 eventually be considering the validity of that statute in light of the various provisions  
12 of the Montana Constitution. Here, the Court is simply the first in line to deal with the  
13 issue, followed by the legislature to implement the right. Thus, both the courts and the  
14 legislature are involved either way.

## 15 CONCLUSION

16 The Montana constitutional rights of individual privacy and human  
17 dignity, taken together, encompass the right of a competent terminally patient to die  
18 with dignity. That is to say, the patient may use the assistance of his physician to  
19 obtain a prescription for a lethal dose of medication that the patient may take on his  
20 own if and when he decides to terminate his life. The patient's right to die with dignity  
21 includes protection of the patient's physician from liability under the State's homicide  
22 statutes.

23 The Court recognizes compelling State interests in protecting patients  
24 and their loved ones from abuses, in protecting life in general, and in protecting the  
25 integrity and ethics of the medical profession. However, those interests can be

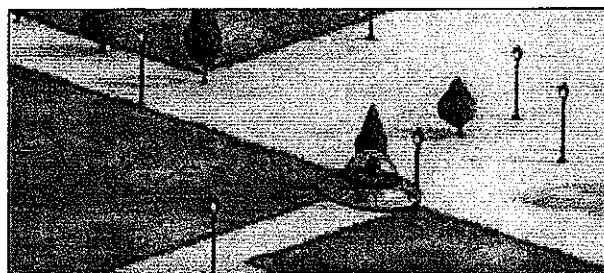


# Terminal Uncertainty

## 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?

By Nina Shapiro

published: January 14, 2009



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Maryanne Clayton with her son, Eric, in the Fred Hutch waiting room: "I just kept going."

Details:

— Study: [Why Now?](#)  
Timing and  
Circumstances of  
Hastened Deaths

— [Dilemmas by caretakers](#)  
and other Oregon  
studies

— [Stats on people who](#)  
have used Oregon's  
Death with Dignity  
law.

— [Harvard professor](#)  
[Nicholas Christakis](#)  
looking at the  
accuracy of  
prognosis.

**She noticed the back pain first.**

Driving to the grocery store, Maryanne Clayton would have to pull over to the side of the road in tears. Then 62, a retired computer technician, she went to see a doctor in the Tri-Cities, where she lived. The diagnosis was grim. She already had Stage IV lung cancer, the most advanced form there is. Her tumor had metastasized up her spine. The doctor gave Clayton two to four months to live.

That was almost four years ago.

Prodded by a son who lives in Seattle, Clayton sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center. Too weak to endure the toxicity of chemotherapy, she started with radiation, which at first made her even weaker but eventually built her strength. Given dodgy prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called pemetrexate.

Her response was remarkable. The tumors shrunk, and although they eventually grew back, they shrunk again when she enrolled in a second clinical trial. (Pemetrexate has since been approved by the FDA for initial treatment in lung cancer cases.) She now comes to the Hutch every three weeks to see Martins, get CT scans, and undergo her drug regimen. The prognosis she was given has proved to be "quite wrong."

"I just kept going and going," says Clayton. "You kind of don't notice how long it's been." She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. "I had to have cancer to have nice hair," she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip to Hawaii, and a tour of the Southwest that culminated in a

EXHIBIT 3

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— JAMA study examining the accuracy of prognosis.

**UPDATE:** "It Felt Like the Big One"

visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

"We almost lost her because she was having too much fun, not from cancer," Martins chuckles.

Her experience underscores the difficulty doctors have in forecasting how long patients have to live—a difficulty that is about to become even more pertinent as the Washington Death With Dignity Act takes effect March 4. The law, passed by initiative last November and modeled closely on a 14-year-old law in Oregon, makes Washington the only other state in the country to allow terminally ill patients to obtain lethal medication. As in Oregon, the law is tightly linked to a prognosis: Two doctors must say a patient has six months or less to live before such medication can be prescribed.

The law has deeply divided doctors, with some loath to help patients end their lives and others asserting it's the most humane thing to do. But there's one thing many on both sides can agree on. Dr. Stuart Farber, head of palliative care at the University of Washington Medical Center, puts it this way: "Our ability to predict what will happen to you in the next six months sucks."

**In one sense**, six months is an arbitrary figure. "Why not four months? Why not eight months?" asks Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, adding that medical literature does not define the term "terminally ill." The federal Medicare program, however, has determined that it will pay for hospice care for patients with a prognosis of six months or less. "That's why we chose six months," explains George Eighmey, executive director of Compassion & Choices of Oregon, the group that led the advocacy for the nation's first physician-assisted suicide law. He points out that doctors are already used to making that determination.

To do so, doctors fill out a detailed checklist derived from Medicare guidelines that are intended to ensure that patients truly are at death's door, and that the federal government won't be shelling out for hospice care indefinitely. The checklist covers a patient's ability to speak, walk, and smile, in addition to technical criteria specific to a person's medical condition, such as distant metastases in the case of cancer or a "CD4 count" of less than 25 cells in the case of AIDS.

No such detailed checklist is likely to be required for patients looking to end their lives in Washington, however. The state Department of Health, currently drafting regulations to comply with the new law, has released a preliminary version of the form that will go to doctors. Virtually identical to the one used in Oregon, it simply asks doctors to check a box indicating they have determined that "the patient has six months or less to live" without any additional questions about how that determination was made.

Even when applying the rigid criteria for hospice eligibility, doctors often get it wrong, according to Nicholas Christakis, a professor of medicine and sociology at Harvard University and a pioneer in research on this subject. As a child, his mother was diagnosed with Hodgkin's disease. "When I was six, she was given a 10 percent chance of living beyond three weeks," he writes in his 2000 book, *Death Foretold: Prophecy and Prognosis in Medical Care*. "She lived for nineteen remarkable years...I spent my boyhood always fearing that her lifelong chemotherapy would stop working, constantly wondering whether my mother would live or die, and both craving and detesting prognostic precision."

Sadly, Christakis' research has shown that his mother was an exception. In 2000, Christakis published a study in the *British Medical Journal* that followed 500 patients admitted to hospice programs in Chicago. He found that only 20 percent of the patients died approximately when their doctors had

predicted. Unfortunately, most died *sooner*. "By and large, the physicians were overly optimistic," says Christakis.

In the world of hospice care, this finding is disturbing because it indicates that many patients aren't being referred early enough to take full advantage of services that might ease their final months. "That's what has frustrated hospices for decades," says Wayne McCormick, medical director of Providence Hospice of Seattle, explaining that hospice staff frequently don't get enough time with patients to do their best work.

Death With Dignity advocates, however, point to this finding to allay concerns that people might be killing themselves too soon based on an erroneous six-month prognosis. "Of course, there is the occasional person who outlives his or her prognosis," says Robb Miller, executive director of Compassion & Choices of Washington. Actually, 17 percent of patients did so in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13 percent of hospice patients around the country outlived their six-month prognoses.

It's not that prognostication is completely lacking in a scientific basis. There is a reason that you can pick up a textbook and find a life expectancy associated with most medical conditions: Studies have followed *populations* of people with these conditions. It's a statistical average. To be precise, it's a median, explains Martins. "That means 50 percent will do worse and 50 percent will do better."

Doctors also shade their prognoses according to their own biases and desires. Christakis' study found that the longer a doctor knew a patient, the more likely their prognosis was inaccurate, suggesting that doctors who get attached to their patients are reluctant to talk of their imminent demise. What's more, Christakis says, doctors see death "as a mark of failure."

Oncologists in particular tend to adopt a cheerleading attitude "right up to the end," says Brian Wicks, an orthopedic surgeon and past president of the Washington State Medical Association. Rather than talk about death, he says, their attitude is "Hey, one more round of chemo!"

But it is also true that one more round of chemo, or new drugs like the one that helped Clayton, or sometimes even just leaving patients alone, can help them in ways that are impossible to predict. J. Randall Curtis, a pulmonary disease specialist and director of an end-of-life research program at Harborview Medical Center, recalls treating an older man with severe emphysema a couple of years ago. "I didn't think I could get him off life support," Curtis says. The man was on a ventilator. Every day Randall tested whether the patient could breathe on his own, and every day the patient failed the test. He had previously made it clear that he did not want to be kept alive by machines, according to Curtis, and so the doctor and the man's family made the wrenching decision to pull the plug.

But instead of dying as expected, the man slowly began to get better. Curtis doesn't know exactly why, but guesses that for that patient, "being off the ventilator was probably better than being on it. He was more comfortable, less stressed." Curtis says the man lived for at least a year afterwards.

Curtis also once kept a patient on life support against his better judgment because her family insisted. "I thought she would live days to weeks," he says of the woman, who was suffering from septic shock and multiple organ failure. Instead she improved enough to eventually leave the hospital and come back for a visit some six or eight months later.

"It was humbling," he says. "It was not amazing. That's the kind of thing in medicine that happens

frequently."

**Every morning** when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.

"There's always a little triumph," Bud chimes in. "I made it for another day."

It's been like this for years. A decade ago, after clearing a jungle of blackberries off a lot he had bought adjacent to his secluded ranch house south of Tacoma, Bud came down with a case of pneumonia. "Well, no wonder he's so sick," Heidi recalls the chief of medicine saying at the hospital where he was brought. "He's in congestive heart failure."

Then 75, "he became old almost overnight," Heidi says. Still, Bud was put on medications that kept him going—long enough to have a stroke five years later, kidney failure the year after that, and then the onset of severe chest pain known as angina. "It was scary," says Heidi, who found herself struggling at 3 a.m. to find Bud's veins so she could inject the morphine that the doctor had given Bud for the pain. Heidi is a petite blond nurse with a raucous laugh. She's 20 years younger than her husband, whom she met at a military hospital, and shares his cigar-smoking habit. Bud was a high-flying psychiatrist in the '80s when he became the U.S. Assistant Secretary of Defense, responsible for all Armed Forces health activities.

After his onslaught of illnesses, Bud says, his own prognosis for himself was grim. "Looking at a patient who had what I had, I would have been absolutely convinced that my chance of surviving more than a few months was very slim indeed."

Bud's doctor eventually agreed, referring him to hospice with a prognosis of six months. That was a year and a half ago. Bud, who receives visits from hospice staff at home, has since not gotten much worse or much better. Although he has trouble walking and freely speaks of himself as "dying," he looks like any elderly grandfather, sitting in a living room decorated with mounted animal heads, stuffing tobacco into his pipe and chatting about his renewed love of nature and the letter he plans to write to Barack Obama with his ideas for improving medical care. Despite his ill health, he says the past few years have been a wonderful, peaceful period for him—one that physician-assisted suicide, which he opposes, would have cut short.

A year after he first began getting visits from the Franciscan Hospice, the organization sent Dr. Bruce Brazina to Mayer's home to certify that he was still really dying. It's something Brazina says he does two to four times a week as patients outlive their six-month prognoses. Sometimes, Brazina says, patients have improved so much he can no longer forecast their imminent death. In those cases, "we take them off service"—a polite way of saying that patients are kicked off hospice care, a standard procedure at all hospices due to Medicare rules. But Brazina found that Mayer's heart condition was still severe enough to warrant another six-month prognosis, which the retired doctor has just about outlived again.

"It's getting to the point where I'm a little embarrassed," Mayer says.

What's going on with him is a little different than what happened to Randall Curtis' patients or to Maryanne Clayton. Rather than reviving from near death or surviving a disease that normally kills quickly, Mayer is suffering from chronic diseases that typically follow an unpredictable course. "People can be very sick but go along fine and stable," Brazina explains. "But then they'll have an acute attack." The problem for prognosis is that doctors have no way of knowing when those attacks will be or whether patients will be able to survive them.

When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the *Journal of the American Medical Association*.

Given these two studies, it's no surprise that in Oregon some people who got a prescription for lethal medication on the basis of a six-month prognosis have lived longer. Of the 341 people who put themselves to death as of 2007 (the latest statistics available), 17 did so between six months and two years after getting their prescription, according to state epidemiologist Katrina Hedberg. Of course, there's no telling how long any of the 341 would have lived had they not killed themselves. The Department of Health does not record how long people have lived after getting prescriptions they do not use, so there's no telling, either, whether those 200 people outlived their prognosis. Compassion & Choices of Oregon, which independently keeps data on the people whom it helps navigate the law, says some have lived as long as eight years after first inquiring about the process (although it doesn't track whether they ever received the medication and a six-month prognosis).

The medical field's spotty track record with prognosis is one reason Harborview's Curtis says he is not comfortable participating in physician-assisted suicide. It's one thing to make a six-month prognosis that will allow patients access to hospice services, he says, and quite another to do so for the purpose of enabling patients to kill themselves. "The consequences of being wrong are pretty different," he says.

Under the law, doctors and institutions are free to opt out, and several Catholic institutions like Providence Hospice of Seattle have already said they will do so. Medical director McCormick finds the idea of patients killing themselves particularly troubling because "you can't predict what's going to happen or who's going to show up near the end of your life." He says he has watched people make peace with loved ones or form wonderful new connections. He's preparing a speech in case patients ask about the new law: "I will stop at nothing to ensure that you're comfortable. I won't shorten your life, but I will make it as high-quality as possible."

Thomas Preston, a retired cardiologist who serves as medical director of Compassion & Choices of Washington, says he has in mind a different kind of speech: "You have to understand that this prognosis could be wrong. You may have more than six months to live. You may be cutting off some useful life."

He also says he will advise doctors to be more conservative than the law allows. "If you think it's going to be six months, hold off on it [writing a prescription]—just to be sure." Instead, he'll suggest that doctors wait until they think a patient has only one or two months to live.

The UW's Farber leans toward a different approach. While he says he hasn't yet decided whether he himself will write fatal prescriptions, he plans at least to refer patients to others who will. Given that prognostic precision is impossible, he says, "I personally just let go of the six months." Instead, he says he would try to meet what he sees as the "spirit of the law" by assessing that someone is "near" the end of their life, so that he could say to them, "You're really sick and you're not going to get better."

Knowing exactly when someone is going to die, he continues, is not as important as knowing when someone "has reached the point where their life is filled with so much suffering that they don't want to be alive."

**Randy Niedzielski** reached that point in the summer of 2006, according to his wife Nancy. Diagnosed with brain cancer in 2000, the onetime Lynnwood property manager had been through several rounds

of chemotherapy and had lived years longer than the norm. But the cancer cells had come back in an even more virulent form and had spread to his muscle system. "He would have these bizarre muscle contractions," Nancy recalls. "His feet would go into a cone shape. His arms would twist in weird angles." Or his chest would of its own volition go into what Nancy calls a "tent position," rising up from his arms. "He'd just be screaming in pain."

Randy would have liked to move to Oregon to take advantage of the Death With Dignity Act there, according to Nancy. But he didn't have time to establish residency as required. That was about six weeks before his death.

Nancy, who has become an advocate for physician-assisted suicide, says that typically people are only weeks or days away from death when they want to kill themselves. Oregon's experience with people hanging onto their medicine for so long, rather than rushing to use it as soon as they get a six-month prognosis, bears this out, she says: "A patient will know when he's at the very end of his life. Doctors don't need to tell you."

Sometimes, though, patients are not so near the end of their life when they're ready to die. University of Washington bioethics professor Helene Starks and Anthony Back, director of palliative care at the Seattle Cancer Care Alliance, are two of several researchers who in 2005 published a study that looked at 26 patients who "hastened" their death. A few were in Oregon, but most were in Washington, and they brought about their own demise mostly either by refusing to eat or drink or by obtaining medication illegally, according to Back and Starks. Three of these patients had "well over six months" of remaining life, Starks says, perhaps even years.

The paper, published in the *Journal of Pain and Symptom Management*, quotes from an interview with one of these patients before she took her life. Suffering from a congenital malformation of the spine, she said it had reached the point that her spine or neck could be injured even while sitting. "I'm in an invisible prison," she continued. "Every move I make is an effort. I can't live like this because of the constant stress, unbearable pain, and the knowledge that it will never be any better."

Under the law, she would not be eligible for lethal medication. Her case was not considered "terminal," according to the paper. But for patients like her, the present is still unbearable. Former governor Booth Gardner, the state's most visible champion of physician-assisted suicide, would have preferred a law that applied to everyone who viewed their suffering this way, regardless of how long they were expected to live. He told *The New York Times Magazine*, for a December 2007 story, that the six-month rule was a compromise meant to help insure the passage of Initiative 1000. Gardner has Parkinson's disease, and now can talk only haltingly by phone. In an interview he explained that he has been housebound of late due to several accidents related to his lack of balance.

Researchers who have interviewed patients, their families, and their doctors have found, however, that pain is not the central issue. Fear of future suffering looms larger, as does people's desire to control their own end.

"It comes down to more existential issues," says Back. For his study of Washington and Oregon patients, he interviewed one woman who had been a successful business owner. "That's what gave her her zest for life," Back says, and without it she was ready to die.

Maryanne Clayton says she has never reached that point. Still, she voted for the Death With Dignity Act. "Why force me to suffer?" she asks, adding that if she were today in as much pain as she was when first diagnosed with lung cancer, she might consider taking advantage of the new law. But for now, she still

enjoys life. Her 35-year-old son Eric shares a duplex with her in the Tri-Cities. They like different food. But every night he cooks dinner on his side, she cooks dinner on her side, and they eat together. And one more day passes that proves her prognosis wrong.

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West's RCWA 70.245.010

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in the state of Washington.

(11) "Qualified patient" means a competent adult who is a resident of Washington state and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.

(12) "Self-administer" means a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner.

(13) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

CREDIT(S)

[2009 c 1 § 1 (Initiative Measure No. 1000, approved November 4, 2008), eff. March 5, 2009.]

West's RCWA 70.245.010, WA ST 70.245.010

Current with 2009 Legislation effective through April 26, 2009

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**EXHIBIT 4**