

The aid-in-dying debate

Can a physician legally help a patient to die in Montana?

→ Court ruling still leaves the issue open to argument

Montana Supreme Court affirms legality of aid in dying

By State Senator Anders Blewett

In 2009, the Montana Supreme Court rendered the landmark decision *Baxter v. State*, which affirmed the legality of physician aid in dying in Montana and recognized the rights of terminally ill patients to request and self-administer life-ending medication.¹

Robert Baxter, who was suffering from lymphocytic leukemia, filed a declaratory action seeking affirmation that the Montana Constitution protected his legal right to seek physician aid in dying. Baxter was joined in his suit by physician plaintiffs who wanted assurance they could assist a patient with aid in dying and not be subject to criminal prosecution. On Dec. 5, 2008, District Court Judge Dorothy McCarter ruled, "The Montana constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally ill patient to die with dignity."² The Court further reasoned that "patients have the constitutional right to determine the timing of their death and to obtain physician assistance in doing so."³ Hours later, Robert Baxter died of his illness.

The Montana attorney general appealed Judge McCarter's ruling and in a 5-2 decision, the Montana Supreme Court upheld the District Court's entrance of summary judgment in favor of the plaintiffs, however, on separate legal grounds. The Court avoided the issue of whether the Montana Constitution protects the rights of terminally ill patients to choose physician aid in dying. Instead, it resolved the case based on statutory construction, determining that a doctor who provides aid in dying is shielded from criminal liability by the statutory defense of consent because aid in dying is not against the public policy of the state of Montana.⁴ Citing to the Rights of the Terminally Ill Act (Terminally Ill Act), the Court analogized a patient's decision to affirmatively withdraw life-sustaining medical therapies with a patient's decision to request and self-administer life-ending medication, concluding that Montana public policy affords patients the right to make their own end-of-life decisions.⁵

Baxter narrowly defines aid in dying: the patient must be terminally ill,⁶ mentally competent, and must self-administer

the life-ending medication.⁷ If any of these conditions are absent, the doctor cannot be said to have provided "aid in dying" pursuant to *Baxter* and may not avail himself to the statutory defense of consent for any criminal charges.

The availability of the defense of consent creates the legal basis for aid in dying as recognized by the Court.⁸ Establishing the defense of consent requires only nominal evidence from the defendant. In *State v. Desilva*, the Court recognized that "the State had the burden of proof beyond a reasonable doubt that [the victim] did not consent" to accepting defendant's bad check even though lack of consent was not a specific element of the crime.⁹ The Court essentially treated lack of consent as an additional element of the crime which the State must prove, and which a defendant must merely "raise a reasonable doubt regarding [the victim's] consent."¹⁰ Hence, a doctor who provides aid in dying bears the light burden of raising a reasonable doubt that he complied with *Baxter*, while the prosecution must prove lack of consent beyond a reasonable doubt.¹¹

By granting physicians the defense of consent, *Baxter* effectively legalized aid in dying. Critics argue that the availability of a statutory defense does not amount to legalization. However, this semantic argument ignores the reality that conduct which is not illegal, is necessarily legal. For instance, a doctor who removes the feeding tube of a terminally ill patient pursuant to the Terminally Ill Act is not considered to have performed illegal conduct subject to the statutory defenses provided by the Terminally Ill Act.¹² Just as the physician who removes the feeding tube relies on a statutory defense which makes his conduct lawful, so too does the physician who provides aid in dying. Neither the physician who removes the feeding tube nor the physician who provides aid in dying is entirely protected from prosecution.¹³ But the statutory defenses, which establish the legality of their conduct, shield them from criminal conviction, assuming they complied with the provisions of the Terminally Ill Act and *Baxter*, respectively.

While groundbreaking in that it affirmed the legality of aid in dying, *Baxter* did not conclusively resolve all aspects of aid in dying. For instance, *Baxter* does not delineate a detailed standard of care for physicians.¹⁴ Nor does it expressly immunize doctors from professional sanction or civil liability.¹⁵ *Baxter* also did not specifically address whether someone under the age of 18 can request aid in dying.¹⁶

In an effort to codify *Baxter* and provide further clarity in

the law, I introduced SB 167 in the 2011 Legislative Session. This bill sought to clarify the definition of aid in dying set forth in *Baxter*, provide doctors with express immunity from civil and professional sanction so long as they complied with state law, and protect doctors who provide aid in dying from arbitrary increases to their malpractice insurance premiums. In some ways SB 167 narrowed the scope of aid in dying set out in *Baxter*. For instance, it prohibited physician aid in dying for non-residents and persons under the age of 18. It also imposed additional patient protections, which are not required by *Baxter*, including a stringent standard of care for physicians.¹⁷ While SB 167 ultimately died, its defeat signified a disagreement over proper regulation, rather than a rejection of physician aid in dying.

Meanwhile, opponents of aid in dying introduced two bills in the 2011 Legislative Session which sought to overturn *Baxter* and outlaw physician aid in dying in Montana. However, a bipartisan majority of the Senate Judiciary Committee, and the full Senate, rejected the bills.¹⁸ Adding weight to the decision by the Montana Supreme Court, in *Baxter*, a bipartisan majority of the Senate expressly defended the rights of terminally ill patients to make their own end-of-life decisions through legislative action.

The ultimate issue of whether the Montana Constitution protects the rights of terminally ill patients to opt for physician aid in dying would be resolved only if the Legislature outlaws aid in dying. Hopefully, that day will never come. In the meantime, physician aid in dying is the law of the land. Doctors who follow *Baxter* will not go to jail and terminally ill patients, rather than moralistic crusaders, get to choose how they live out their last days.

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NOTES

1. 2009 MT 449.
2. 2008 Mont. Dist. LEXIS 482, *64.
3. *Id.* at *46.
4. Although the Court's holding applied solely to homicide charges under MCA 45-5-102(1), the Court ruled out the viability of other criminal charges brought against physicians who provide aid in dying. *Baxter*, ¶ 44.
5. *Id.* at ¶ 32.
6. *Baxter* does not define "terminal illness." Instead it leaves this determination to the physician. Although *Baxter* relied on the Terminally Ill Act, the Court clearly did not adopt the definition of "terminal condition" contained in MCA 50-9-102(16). Mr. Baxter, who was found to have a "terminal illness," would not have fit the definition of "terminal condition" because he did not require "life-sustaining treatment."
7. ¶¶ 12, 13, 49. The Court also noted that in the typical aid in dying situation, the solicitation comes from the patient, not the doctor. ¶ 44. However, merely informing the patient of her legal right to aid in dying is unlikely to constitute "solicitation" so as to make the consent defense unavailable.
8. MCA 45-2-211.
9. 209 Mont. 169, 174, 679 P.2d 1237, 1240 (1984).
10. *Id.*
11. Neither the statute nor caselaw describe the defense of "consent" as an affirmative defense. While most affirmative criminal defenses require proof beyond a preponderance of the evidence, the affirmative defense of self-defense requires the prosecution to prove beyond a reasonable doubt that the defendant did not use justifiable use of force after "the defendant has offered evidence of justifiable use of force." MCA 46-16-131. Even if the Court disregards *Desilva*, in no case will doctors charged with homicide, be required to do more than prove it was more probable than not they complied with *Baxter*.
12. MCA 50-9-106.
13. A prosecutor, in theory, could prosecute anyone for virtually any reason.
14. The standard of care simply requires doctors providing aid in dying to follow the requirements set forth in *Baxter*.
15. It is unlikely that a doctor who complies with *Baxter* could breach a duty of care to a patient. Additionally, the patient's self-administration of the life-ending medication could be treated as a superseding/intervening cause.
16. The public policy supporting aid in dying is derived from the Terminally Ill Act which the Court specifically noted only applies to individuals over the age of 18. *Baxter*, ¶¶ 29, 38. Hence, a strong presumption exists that the Court implicitly intended aid in dying to apply to individuals over the age of 18. The consent defense may further limit aid in dying for some minors because it cannot be invoked when consent is "given by a person who by reason of youth...is unable to make a reasonable judgment as to the nature or harmfulness of the conduct charged to constitute the offense." MCA 45-2-211(2)(b).
17. SB 167; available at <http://data.opi.mt.gov/bills/2011/billhtml/SB0167.htm>
18. SB 116, SB 169.

No, physician-assisted suicide is not legal in Montana

It's a recipe for elder abuse and more

By State Senator **Jim Shockley** and **Margaret Dore**

There are two states where physician-assisted suicide is legal: Oregon and Washington. These states have statutes that give doctors and others who participate in a qualified patient's suicide immunity from criminal and civil liability. (ORS 127.800-995 and RCW 70.245).

In Montana, by contrast, the law on assisted suicide is governed by the Montana Supreme Court decision, *Baxter v. State*, 354 Mont. 234 (2009). *Baxter* gives doctors who assist a patient's suicide a potential defense to criminal prosecution. *Baxter* does not legalize assisted suicide by giving doctors or anyone else immunity from criminal and civil liability. Under

Baxter, a doctor cannot be assured that a suicide will qualify for the defense. Some assisted suicide proponents nonetheless claim that *Baxter* has legalized assisted suicide in Montana.

Legalizing assisted suicide in Montana would be a recipe for elder abuse. The practice has multiple other problems.

What is physician-assisted suicide?

The American Medical Association (AMA) states: "Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." (Code of Medical Ethics Opinion 2.211). For example, a "physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide." (*Id.*)

Baxter found that there was no indication in Montana law that physician-assisted suicide, which the Court termed "aid in dying," is against public policy. (354 Mont. at 240, Para 13, 49- 50). Based on this finding, the Court held that a patient's consent to aid in dying "constitutes a statutory defense to a

charge of homicide against the aiding physician.” (*Id.* at 251, Para 50).

Baxter, however, overlooked elder abuse. The Court stated that the only person “who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication.” (354 Mont. at 239, Para 11). The Court thereby overlooked criminal behavior by family members and others who benefit from a patient’s death, for example, due to an inheritance.

Baxter also overlooked caselaw imposing civil liability on persons who cause or fail to prevent a suicide. See *Krieg v. Massey*, 239 Mont. 469, 472-3 (1989) and *Nelson v. Driscoll*, 295 Mont. 363, Para 32-33 (1999). *Baxter* is, regardless, a narrow decision in which doctors cannot be assured that a suicide will qualify for the defense. Attorneys Greg Jackson and Matt Bowman provide this analysis:

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,” . . . , 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.

No doctor can prevent these human contingencies from occurring in a given case . . . in order to make sure that he can later use the consent defense if he is charged with murder. (Analysis of Implications of the *Baxter* Case on Potential Criminal Liability, Spring 2010, at www.montanansagainstaassistedsuicide.org/p/baxter-case-analysis.html)

The 2011 Legislative Session

The 2011 legislative session featured two bills in response to *Baxter*, both of which failed: SB 116, which would have eliminated *Baxter*’s potential defense; and SB 167, which would have legalized assisted suicide by providing doctors and others with immunity from criminal and civil liability.

During a hearing on SB 167, the bill’s sponsor, Senator Anders Blewett, said: “[U]nder current law, there’s nothing to protect the doctor from prosecution.” (http://maasdocuments.files.wordpress.com/2011/07/blewett_speckhart_trans_001.pdf). Dr. Stephen Speckart made a similar statement: “[M]ost physicians feel significant dis-ease with the limited safeguards and possible risk of criminal prosecution after the *Baxter* decision.” (*Id.* at p.2)

Legalization would create new paths of abuse

In Montana, there has been a rapid growth of elder abuse. Elders’ vulnerabilities and larger net worth make them a target for financial abuse. The perpetrators are often family members motivated by an inheritance. See e. g. www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf.

Preventing elder abuse is official Montana state policy. See e.g., 52-3-801, MCA. If Montana would legalize physician-

assisted suicide, a new path of abuse would be created against the elderly, which would be contrary to that policy. Alex Schadenberg, chair of the Euthanasia Prevention Coalition, International, states:

With assisted suicide laws in Oregon, perpetrators can . . . take a “legal” route, by getting an elder in Washington and to sign a lethal dose request. Once the prescription is filled, there is no supervision over the administration . . . [E]ven if a patient struggled, “who would know?” (<http://www.isb.idaho.gov/pdf/advocate/issues/adv10oct.pdf>, p. 14.)

“Terminally ill” does not mean dying

Baxter’s potential defense applies when patients are “terminally ill,” which *Baxter* does not define. In Oregon, “terminal” patients are defined as those having less than six months to live. Such persons are not necessarily dying. Doctors can be wrong. Moreover, treatment can lead to recovery. Oregon resident Jeanette Hall, who was diagnosed with cancer and told that she had six months to a year to live, said:

I wanted to do our [assisted suicide] law and I wanted my doctor to help me. Instead, he encouraged me to not give up . . . I had both chemotherapy and radiation . . . It is now 10 years later. If my doctor had believed in assisted suicide, I would be dead. (http://mstandard.com/news/opinion/mailbag/article_aeef3982-9a98-11df-8db2-001cc4c002e0.html)

Legal physician-assisted suicide empowered the Oregon Health Plan, not individual patients

Once a patient is labeled “terminal,” an easy argument can be made that his treatment should be denied. This has happened in Oregon where patients labeled “terminal” have not only been denied coverage for treatment, they have been offered assisted-suicide instead.

The most well known cases involve Barbara Wagner and Randy Stroup. (KATU TV, at www.katu.com/news/26119539.html. ABC News, at www.abcnews.go.com/Health/Story?id=5517492, and Ken Stevens, MD, at pp. 16-17, at <http://choiceillusionoregon.blogspot.com/p/oregons-mistake-costslives.html>). The Oregon Health Plan refused to pay for their desired treatments and offered to pay for their suicides instead. Neither Wagner nor Stroup saw this as a celebration of their “choice.” Wagner said: “I’m not ready to die.” Stroup said: “This is my life they’re playing with.”

Stroup and Wagner were steered to suicide and it was the Oregon Health Plan doing the steering. Oregon’s law empowered the Oregon Health Plan, not individual patients.

Oregon’s studies are invalid

Oregon’s statute does not require a doctor to be present when the lethal dose is administered. (ORS 127.800-995). During a hearing on SB 167, Senator Jeff Essmann made a related point, as follows:

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[A]ll the protections [in Oregon's law] end after the prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is self-administered.

So frankly, any of the studies that come out of the state of Oregon's experience are invalid because no one who administers that drug. . . to that patient is going to be turning themselves in for the commission of a homicide. (Senate Judiciary Hearing Transcript, Feb. 10, 2011, p. 15, at www.margaretdore.com/pdf/senator_essmann_sb_167_001.pdf)

Public confusion

In Montana, the moving force behind legalizing assisted suicide is Denver-based Compassion & Choices. On Sept. 15, 2011, that organization's president published an article on Huffington Post claiming that under *Baxter* physicians in Montana are "safe from prosecution." www.huffingtonpost.com/barbara-coombs-lee/aid-in-dying-montana_b_960555.html) This is clearly not the case and propaganda. A physician relying on her advice could be charged with homicide.

Conclusion

Baxter is a flawed decision that overlooked elder abuse. *Baxter* has created confusion in the law, which has put Montana citizens at risk. Neither the legal profession nor the medical profession has the necessary guidance to know what is lawful.

Legalizing assisted suicide is bad public policy. Doctors' diagnoses can be wrong and legalization is a recipe for abuse. Legalization would also allow the state government to encourage citizens to kill themselves. This is an area where the government does not belong. Montana consistently has one of the highest suicide rates in the nation. Montana doesn't need the "Oregon Experience."

Legislation should be enacted to overrule *Baxter* and clearly declare that assisted suicide is not legal in Montana.

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