

**END-OF-LIFE CARE IN IDAHO:
LAW, MEDICINE, POLICY, AND GEOGRAPHY**

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MERIDIAN -- An elderly couple is dead after shots were fired in a Meridian home Sunday evening.... Ada County Coroner Erwin Sonnenberg says 87-year-old Robert Emerson shot and killed his wife, 90-year-old Olive Emerson, and then turned the gun on himself. ...Meridian Police Lt. Tracy Basterrechea says investigators were told by family members that Robert and Olive were both suffering from terminal cancer....¹

I. INTRODUCTION

The news report above reflects a tragedy that arises when terminally ill patients feel trapped in a dying process they find unbearable, yet don't feel they can turn to their physician to obtain a prescription for medication that can be consumed to bring about a peaceful death. Idaho law empowers citizens with broad autonomy over medical decision-making, including specifically decisions relating to end-of-life care. However, Idaho has no legislation either permitting or prohibiting the end-of-life option known as "aid in dying." Aid in dying refers to the practice of a physician prescribing medication that a mentally competent, terminally ill patient, who finds his or her dying process

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¹ KTVB & Associated Press, April 5, 2010, *KTVB.COM*

unbearable, can ingest to bring about a peaceful death.² A fraction of terminally ill patients—including those who have excellent pain and symptom management—confront a dying process so prolonged, and marked by such extreme suffering and deterioration, that they decide aid in dying is preferable to the alternatives. This practice has become increasingly accepted among medical and health policy organizations, including the American Public Health Association.³ Having the option of aid in dying provides comfort to terminally ill patients even if they do not consume the medication to bring about death. The experience in Oregon, where aid in dying has been affirmatively legal for a dozen years, discussed in detail below, reflects this: roughly one third of the patients who obtain the medication each year do not

² “Aid in dying” is a recognized term of medical art. *See, e.g.*, American Medical Women’s Association Policy on Aid in Dying, *available at* <http://amwa-doc.org/index.cfm> (follow Advocacy link; then follow Position Statements link; found under Ethical Issues) (last visited April 16, 2010); American Public Health Association Policy on Patient Self Determination at the End of Life, *available at* <http://www.apha.org/advocacy/policy/policysearch/default.htm>. (search for Policy Number 20086) (last visited Apr. 16, 2010).

³ *See* Kathryn Tucker, *At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations*, 10 HARV. HEALTH POL’Y REV. 45 (2009), *available at* http://compassionandchoices.org/documents/Harvard_Health_Policy_Rvw_Tucker.pdf. The organizations adopting policy in support of aid in dying include the American Medical Women’s Association (AMWA), *available at* <http://amwa-doc.org/index.cfm> (follow Advocacy link; then follow Position Statements link; found under Ethical Issues) (last visited Apr. 16, 2010); the American Medical Students’ Association (AMSA), *available at* http://www.amsa.org/AMSA/Libraries/Exec_Docs/2009_AMSA_Preamble_Purposes_and_Principles.sflb.ashx (see p. 81) (last visited Apr. 16, 2010), the American College of Legal Medicine (ACLM), *available at* http://www.aclm.org/resources/amicus_briefs/ACLM%20Aid%20in%20Dying%20Policy.pdf, (last visited Apr. 16, 2010); and the American Public Health Association (APHA), *available at* <http://www.apha.org/advocacy/policy/policysearch/default.htm> . (search for Policy Number 20086) (last visited Apr. 16, 2010). Previously, organizations of this sort, like the American Medical Association (AMA) AMA Policy E-2.211 “Physician-Assisted Suicide” held positions opposing aid in dying *available at* <http://www.ama-assn.org/ama1/pub/upload/mm/31/policye-2-211.pdf> (last visited Apr. 16, 2010). Others, recognizing the split in views on the issue among members, had adopted a neutral position, such as that taken by the American Academy of Hospice and Palliative Medicine (AAHPM), *available at* www.aahpm.org/positions/suicide.html (last visited Apr. 16, 2010).

go on to ingest it. They are comforted to have this option, but die of their underlying disease. Oregon's data also tells us much about why patients choose aid in dying: loss of autonomy, loss of dignity, and decreasing ability to participate in activities that made life enjoyable are the most often mentioned reasons.

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

II. IDAHO LAW GOVERNING END-OF-LIFE CARE

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

(1) The legislature recognizes the established common law and *the fundamental right of adult persons to control the decisions relating to the rendering of their medical care*, including the decision to have life-sustaining procedures withheld or withdrawn

(2) *In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of this state shall recognize the right of a competent person to have his or her wishes for medical treatment and for the withdrawal of artificial life-sustaining procedures carried out even though that*

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

This provision is similar to that in many other states. For example, Washington has a Natural Death Act, which provides similar rights to citizens.⁵ The MCNDA includes a provision stating that this Act “does not make legal, and in no way condones, euthanasia, mercy killing, or assisted suicide or permit an affirmative or deliberate act or omission to end life, other than to allow the natural process of dying.”⁶ The question is whether aid in dying would fall within this exclusion. Those who consider the act of allowing a dying patient to ingest medication to achieve a peaceful death as a form of “suicide” would argue that it does. Others who recognize that the choice of a dying patient for a peaceful death is something fundamentally different from “suicide” would argue that this exclusion does not apply to aid in dying.⁷

A recent high court decision in the neighboring state of Montana, *Baxter v. Montana*, discussed *infra*, examined the Montana equivalent to the MCNDA, which includes a similar provision, and held that aid in dying is an end-of-life choice within the public policy of Montana, as reflected in Montana's statute empowering patients to refuse or direct the withdrawal of life-prolonging treatment.⁸

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

⁵ WASH. REV. CODE § 70.122 (1979), available at <http://apps.leg.wa.gov/rcw/default.aspx?cite=70.122>.

⁶ IDAHO CODE ANN. § 39-4514 (2) (2005). Idaho has no criminal statute that expressly criminalizes assisted suicide.

⁷ Mental health professionals recognize a distinct difference between “suicide” and the choice of a dying patient for a peaceful death. For example, The American Psychological Association advises: “It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide.” Brief of Amicus Curiae Coalition of Mental Health Professionals, WL 1749170 at 17, *Gonzales v. Oregon*, 126 S. Ct. 904 (2006) (No. 04-623); see also, Rhea K. Farberman, *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28 PROF'L PSYCHOLOGY: RESEARCH & PRACTICE 544 (1997). The question, whether aid in dying can be considered assisting a “suicide” and thus within reach of a criminal statute forbidding assisting a “suicide,” is at issue in the case *Blick v. Connecticut* (Conn. Super. Ct. HTFD, NO. HHD-CV-09-5033392-S). BBR T.1 available at, <http://civilinquiry.jud.ct.gov/CaseDetail/PublicCaseDetail.aspx>

⁸ 224 P.3d 1211 (Mont. 2009) (analyzing the Montana Rights of the Terminally Ill Act, MONT. CODE ANN. § 50-9-204).

Considering the stated policies in the MCNDA and the reasoning applied by the *Baxter* court that there is no logical distinction between a terminally ill patient's right to refuse life-sustaining treatment and such patient's right to have access to medication which the patient could ingest to bring about a peaceful death, a critical analysis of the law in Idaho supports the contention that Idaho patients should be able to access aid in dying.

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

Every person who, with intent to kill, administers or causes or procures to be administered, to another, any poison or other noxious or destructive substance or liquid, but by which death is not caused, is punishable by imprisonment in the state prison not less than ten (10) years, and the imprisonment may be extended to life.⁹

However, this statute only applies if the patient does not die. A patient who ingests medication prescribed by their physician for aid in dying will almost certainly achieve the desired death.¹⁰ If the patient does achieve the desired death, an aggressive prosecutor might argue that the physician could be prosecuted for homicide. Yet, this was exactly the situation in Montana, and the Montana Supreme Court squarely rejected the possibility of a homicide charge being brought against a physician who provided aid in dying, finding that it would conflict with the public policy expressed in the Montana statute, which is the equivalent of the MCNDA.¹¹

Based on this landscape, one can reasonably conclude that Idaho physicians can safely provide aid in dying to their competent, terminally ill patients, free of fear of criminal

⁹ IDAHO CODE ANN. § 18-4014 (1972).

¹⁰ OR. DEP'T OF HUMAN SERVS., ELEVENTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT (2009), available at <http://www.oregon.gov/DHS/ph/pas/docs/yr11-tbl-1.pdf> [hereinafter *Eleventh Annual Report*] (noting that only one person has awakened after taking medication since the law was enacted).

¹¹ *Baxter v. Montana*, 224 P.3d 1211, 1215 (Mont. 2009).

prosecution.¹² The matter has not been discussed in the medical or legal literature in Idaho. Yet, there is growing support for aid in dying, reflected in the fact that three neighboring states now affirmatively permit the practice, discussed below, and in the growing support for the practice in the medical and health policy communities, noted above. It is timely for the discussion to take place in Idaho, and for this option to be among those available to terminally ill patients.

In 1969, House Bill 143 was introduced, which sought to permit euthanasia when the patient had either:

(a) a condition of physical illness thought in the patient's case to be incurable and terminal and expected to cause him severe distress; or

(b) a condition of grievous physical affliction occasioning the patient serious injury or disability thought to be permanent and expected to cause him severe distress; or

(c) a condition of physical brain damage or deterioration such that the patient's normal mental faculties are severely and irreparably impaired.¹³

The measure failed to pass. The issue has not been addressed otherwise, and although some commentators claim that Idaho prohibits what is referred to as "assisted suicide" under the common law,¹⁴ there are no Idaho cases discussing "assisted

¹² Concerns about possible criminal prosecution are the primary reasons physicians fear providing aid in dying. Another concern is that professional disciplinary action can be taken against a physician for providing such care. However, with the broad and growing support for this practice among major national medical and health policy groups, disciplinary action appears highly unlikely.

¹³ H.B. 143, (Id. 1969); see also Ronald P. Kaplan, *Euthanasia Legislation: A Survey and a Model Act*, 2 AM. J.L. & MED. 41, 65 n.80 (1976).

¹⁴ See, e.g., Katherine A. Chamberlain, *Looking for a "Good Death": The Elderly Terminally Ill's Right to Die by Physician-Assisted Suicide*, 17 ELDER L.J. 61, 64 n.24 (2009); Stephanie Hendricks, *Pain Relief, Death with Dignity, and Commerce: The Constitutionality of Congressional Attempts to Regulate Physician-Assisted Suicide in Oregon via the Commerce Clause After Lopez and Morrison*, 37 WILLAMETTE L. REV. 691, 694 n.19 (2001); Christin A. Batt, *The Pain Relief Promotion Act of 1999 and Physician-Assisted Suicide: A Call for Congressional Self-Restraint*, 38 SAN DIEGO L. REV. 297, 326 n.165 (2001); Rima J. Oken, *Curing Healthcare Providers' Failure to Administer Opioids in the Treatment of Severe Pain*, 23 CARDOZO L. REV. 1917, 1950 n.165 (2002).

suicide.” Idaho has no law either affirmatively legalizing or plainly prohibiting aid in dying.

III. AID IN DYING IN IDAHO SHOULD BE GOVERNED AS A MATTER OF STANDARD OF CARE.

Most medical care is not governed by statute or court decision, but is instead governed by standard of care.¹⁵ In determining the standard of care, Idaho courts apply an objective community standard test that looks at what a similarly situated practitioner in the local community would do, with similar training and qualifications, taking into account his or her training, experience, and fields of medical specialization.¹⁶ “In the same community” refers to that geographic area ordinarily served by the licensed general hospital at or nearest to which such practice is conducted.¹⁷ The applicable community standard of care is essentially defined as:

- (a) the standard of care for the class of health care provider to which the defendant belonged and was functioning, taking into account the defendant’s training, experience, and fields of medical specialization, if any; (b) as such standard existed at the time of the defendant’s alleged negligence; and (c) as such standard existed at the place of the defendant’s alleged negligence.¹⁸

Idaho physicians who treat patients approaching death due to terminal illnesses no doubt encounter those who find themselves trapped in an unbearable dying process, over which the patients wish to exercise some measure of control. Some of these patients will ask their physicians for aid in dying. Some Idaho physicians will believe that providing aid in dying is medically and professionally appropriate. Among this cohort of physicians, the standard of care for aid in dying will emerge.

As previously noted, Idaho is surrounded by states affirmatively permitting mentally competent, terminally ill patients to choose aid in dying: Oregon, Washington and

¹⁵ See 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 189 (2002).

¹⁶ IDAHO CODE ANN. § 6-1012 (1976).

¹⁷ IDAHO CODE ANN. § 39-4506 (2007); see also IDAHO CODE ANN. § 6-1012 (1976).

¹⁸ *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 164, 45 P.3d 816, 820 (2002) (citations omitted); IDAHO CODE ANN. § 6-1012 (1976).

Montana. The practice in these states, discussed *infra*, appropriately will influence the standard of care in Idaho. This is even more likely given that Idaho participates in a longstanding partnership with the University of Washington (UW) School of Medicine, along with the states of Wyoming, Alaska, and Montana, to provide access to publicly supported medical education across the five-state region. The UW School of Medicine maintains a Dean's Office in each of the five states. These offices oversee clinical medical education for the School of Medicine within their regions. The program allows for publicly supported medical education in states where no freestanding medical school exists, such as Idaho. More than 60% of graduating students stay within the five-state area to practice. Accordingly, many Idaho physicians will have received some of their medical training in Washington and will likely have many peers in medical practice in Washington, where aid in dying is an openly available end-of-life option.

IV. AID IN DYING IN SURROUNDING STATES

1. Oregon

Oregonians approved the passage of the Oregon Death with Dignity Act (Dignity Act) in 1994¹⁹ and reaffirmed support for it in 1997.²⁰ The Dignity Act allows a mentally competent, terminally ill patient to obtain medication from his or her physician, which the patient can consume to bring about a peaceful death.²¹ The experience in Oregon demonstrates that when this option is available, it does not place patients at risk.²² In a report examining

¹⁹ OR. REV. STAT. § 127.800–995 (2005) (implementation of which was obstructed for several years by a lawsuit arguing that the law denied the terminally ill equal protection of the law). *See Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *vacated*, 107 F.3d 1382 (9th Cir. 1997). *Lee* involved a challenge to Oregon's Dignity Act on constitutional grounds, which was ultimately dismissed by the Ninth Circuit on the grounds that the plaintiffs lacked standing. *Id.*

²⁰ David J. Garrow, *The Oregon Trail*, N.Y. TIMES, Nov. 6, 1997, at A31. *See also* Kim Murphy, *Voters in Oregon Soundly Endorse Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at A1 (60% of Oregon voters rejected the repeal).

²¹ OR. REV. STAT. § 127.865. (2009). The Dignity Act requires that Oregon collect extensive data about who uses the Dignity Act each year and publish the findings in annual reports. *See* Or. Dep't of Human Servs., *Death with Dignity Act Annual Reports*, available at <http://oregon.gov/dhs/ph/pas/ar-index.shtml> [hereinafter *Annual Reports*]. A dozen years of data have been published and have been closely examined.

²² Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. MED. ETHICS 591 (2007); Timothy E. Quill & Christine K. Cassel, *Professional*

Oregon's experience to assess whether vulnerable populations were put at risk, researchers concluded that there was no evidence supporting this concern.²³ Oregon's experience has caused even staunch opponents to admit that continued opposition to such a law can only be based on personal moral or religious grounds.²⁴

The dire predictions of those initially opposed to the Dignity Act have been proven unfounded. The option of aid in dying has not been unwillingly forced upon those who are poor, uneducated, uninsured, or otherwise disadvantaged.²⁵ In fact, studies show just the opposite. A higher level of education is strongly associated with the use of the law; those with a baccalaureate degree or higher were 7.9 times more likely than those without a high school diploma to choose aid in dying.²⁶ 100% of patients opting for aid in dying had either private health insurance, Medicare, or Medicaid, and were overwhelmingly

Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality, 138 ANNALS INTERNAL MED. 208 (2003); Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 JAMA 2363 (2001) (reviewing Oregon's experience with its Death With Dignity Act and concluding no harm occurred to vulnerable populations); Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote: The Silver Lining*, 124 ANNALS INTERNAL MED. 267 (1996); Joseph B. Straton, *Physician Assistance with Dying: Reframing the Debate; Restricting Access*, 15 TEMP. POL. & CIV. RTS. L. REV. 475, 475 (2006).

²³ See Battin et al., *supra* note 22, at 591. The American Medical Student Association took note of the Battin study and findings in reaching its own policy to support aid in dying. AMSA Principles, Regarding Physician Aid in Dying, Resolution D01, AM. MED. STUDENT ASS'N H.D (March 15, 2008) ("WHEREAS the Oregon data showed 'no evidence of heightened risk for the elderly, women, the uninsured . . . people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities'" (quoting Battin, *supra*).

²⁴ See Daniel E. Lee, *Physician-Assisted Suicide: A Conservative Critique of Intervention*, 33 Hastings Center Rep.17, (Jan.–Feb. 2003).

²⁵ E.g., Ctr. for Disease Prevention & Epidemiology, Or. Health Div., Dep't of Human Res., *Oregon's Death with Dignity Act: The First Year's Experience*, 7 (1999), available at <http://oregon.gov/dhs/ph/pas/docs/year1.pdf> ("Patients . . . were *not* disproportionately poor (as measured by Medicaid status), less educated, lacking in insurance coverage, or lacking in access to hospice care."); see also Battin et al., *supra* note 22; Kant Patel, *Euthanasia and Physician-Assisted Suicide Policy in the Netherlands and Oregon: A Comparative Analysis*, 19 J. HEALTH & SOC. POL'Y 37 (2004) (finding no empirical evidence of a slippery slope in Oregon, but more potential for a slide in the Netherlands).

²⁶ Office of Disease Prevention & Epidemiology, Or. Dep't of Human Servs., *Eighth Annual Report on Oregon's Death with Dignity Act*, 12 (2006), available at <http://oregon.gov/dhs/ph/pas/docs/year8.pdf> [hereinafter Eighth Annual Report]. [pg 12 of report]

enrolled in hospice care.²⁷ Furthermore, use of aid in dying is limited. During the first twelve years in which it was a legal option, only 460 Oregonians chose it.²⁸ Although there has been a gradual increase in the rate of those opting for aid in dying, the overall rate remains low: the terminally ill adults who chose this option in 2009 represented only 19 deaths for every 10,000 Oregonians who died that year.²⁹ A 2000 survey of Oregon physicians found that they granted one in six requests for aid in dying, and that only one in ten of those requests resulted in hastened death.³⁰ Roughly one-third of those patients who complete the process of seeking medications under the Dignity Act do not go on to consume the medications.³¹ Instead, these individuals derive comfort from having the option to control the time of death, yet ultimately die of their underlying disease without exercising that control.³²

Outside observers, after carefully studying implementation of the Dignity Act, have concluded that the law poses no risk to patients. For example, a report prepared for the Vermont legislature, after thoroughly reviewing the Oregon experience, concluded that, “it is quiet [*sic*] apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options.”³³ Leading scholars have come to

²⁷ *Id.* at 23.

²⁸ OR. PUB. HEALTH DIV., OR. DEP’T OF HUM. SERV., DEATH WITH DIGNITY ANNUAL REPORTS: YEAR 12 – 2009 SUMMARY (2010), *available at* <http://oregon.gov/dhs/ph/pas/docs/year12.pdf>.

²⁹ *Id.*

³⁰ Linda Ganzini et al., *Physicians’ Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 557 (2000) (finding that the availability of palliative care led some, but not all, patients to change their mind about hastened death).

³¹ *Id.*

³² See Eleventh Annual Report, *supra* note 9 (showing number of prescription recipients each year compared to number of deaths from use of prescriptions).

³³ VT. LEGISLATIVE COUNCIL, OREGON’S DEATH WITH DIGNITY LAW AND EUTHANASIA IN THE NETHERLANDS: FACTUAL DISPUTES § 3E (2004), *available at* http://www.leg.state.vt.us/reports/05Death/Death_With_Dignity_Report.htm.

similar conclusions: “I worried about people being pressured to do this. But this data confirms . . . that the policy in Oregon is working. There is no evidence of abuse or coercion, or misuse of the policy.”³⁴

Indeed, rather than posing a risk to patients or the medical profession, the Dignity Act has galvanized significant improvements in the care of the dying in Oregon. Oregon doctors report that, since the passage of the Dignity Act, efforts have been made to improve their ability to provide adequate end-of-life care. These efforts include improving their knowledge of the use of pain medications for the terminally ill, improving their ability to recognize depression and other psychiatric disorders, and referring their patients to hospice programs with more frequency.³⁵ One survey on Oregon physicians’ efforts to improve end-of-life care since 1994 found that 30% of respondents increased their number of referrals to hospice care, and 76% made efforts to increase their knowledge of pain medication.³⁶ A survey of Oregon hospice nurses and social workers revealed that they observed, during a period from 1998 to 2003, an increase in physicians’ knowledge of palliative care, and willingness both to refer and care for hospice patients.³⁷

In addition to the improvement of end-of-life care, the option of aid in dying has psychological benefits for both the terminally ill and the healthy. The availability of the option gives the terminally ill autonomy, control, and choice, which physicians in Oregon have identified as the predominant motivational factors behind the decision to request assistance in dying.³⁸ Healthy Oregonians know that if they ever face a terminal illness, they will

³⁴ William McCall, *Assisted-Suicide Cases Down in ‘04*, COLUMBIAN (Vancouver, Wash.), Mar. 11, 2005, at C2 (quoting Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania School of Medicine).

³⁵ See Ganzini et al., *supra* note 22; see also Lee & Tolle, *supra* note 22, at 268–69; Lawrence J. Schneiderman, *Physician-Assisted Dying*, 293 JAMA 501, 501 (2005); Quill & Cassel, *supra* note 22, at 209.

³⁶ Ganzini et al., *supra* note 22, at 2363.

³⁷ Elizabeth R. Goy et al., *Oregon Hospice Nurses and Social Workers’ Assessment of Physician Progress in Palliative Care Over the Past 5 Years*, 1 PALLIATIVE & SUPPORTIVE CARE 215 (2003).

³⁸ See Kathy L. Cerminara & Alina Perez, *Therapeutic Death: A Look at Oregon’s Law*, 6 PSYCHOL. PUB. POL’Y & L. 503, 512–13 (2000) (acknowledging possible negative effects of legalized aid in dying, but concluding that the data from Oregon in one year justifies an optimistic view); See also Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance*

have control and choice over the manner of their death. Family members of those who choose aid in dying also benefit psychologically when their loved one is empowered to choose aid in dying.³⁹

Essentially, making the option of aid in dying available has galvanized improvements in end-of-life care and benefited all terminally ill Oregonians. A central argument against allowing patients access to aid in dying had been that risks would arise if the option were available.⁴⁰ Yet, evidence demonstrates that these risks do not, in fact, arise, and this demonstrated lack of risk undermines the argument against aid in dying. Such evidence has led many national medical and health policy organizations to adopt policies in support of aid in dying.⁴¹

with Suicide, 347 NEW ENG. J. MED. 582, 584-85 (2002) (reporting that nurses and social workers rated desire to control circumstances of death as the most important reason for requesting aid in dying); Linda Ganzini et al., *Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families*, 6 J. PALLIATIVE MED. 381, 385-87 (2003) (finding physicians receiving requests for lethal medication perceive patients as wanting to control their deaths).

³⁹ Linda Ganzini et al, [BB 15.1] *Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying*, 38 J. PAIN & SYMPTOM MGMT. 807 (2009).

⁴⁰ See, e.g., *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997) (“We have recognized . . . the real risk of subtle coercion and undue influence in end-of-life situations.”) (quoting *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 281 (1990)).

⁴¹ See Kathryn L. Tucker, *At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations*, 10 HARV. HEALTH POL’Y REV. 45 (2009); APHA.org, Policy Statement #20086: Patients’ Rights to Self-Determination at the End of Life, (adopted October, 2008), <http://www.apha.org/advocacy/policy/policysearch/default.htm> (Policy Number 20086) (last visited Apr. 6, 2010); Position Statement, Am. Med. Women’s Ass’n (“AMWA supports the passage of aid in dying laws which empower mentally competent, terminally ill patients and protect participating physicians, such as . . . the Oregon Death with Dignity Act.”) (adopted Sept. 9, 2007), available at <http://amwa-doc.org> (Follow Advocacy link; then follow Position Statements link; see under Ethical Issues) See also Principles Regarding Physician Aid in Dying, Resolution D01, Am. Med. Student Ass’n House of Delegates (March 15, 2008); American College of Legal Medicine Policy on Aid in Dying, adopted October, 2008, available at <http://www.aclm.org/resources/articles> (also available at <http://www.acslaw.org/files/Kathryn%20L.%20Tucker%20Issue%20Brief.pdf>); ACLM Policy on Aid in Dying, (adopted October, 2008), available at www.aclm.org/resources/amicus_briefs/ACLM_Aid_In_Dying_Policy.pdf (“The ACLM recognizes patient autonomy and the right of a mentally competent, though terminally ill, person to hasten what might otherwise be objectively considered a protracted, undignified, or painful death.”).

2. Aid in Dying in Washington

Washington, Idaho's neighbor to the west, passed a Dignity Act virtually identical to Oregon's in November, 2008.⁴² The data from more than a decade of implementation of the Oregon Death With Dignity Act was a critical element in the successful campaign to pass this similar measure in Washington. Washington began implementing its law in March, 2009. On its website, the Washington Department of Health publishes information about the types and quantities of forms received under the Dignity Act and updates this information weekly.⁴³ The Department of Health also publishes an annual report that includes information on how many prescriptions are written under the Act, and how many people ingest the prescribed medication. The first annual report will include data from March, 2009 through December 31, 2009. Statistical reports will be completed annually thereafter.

3. Aid in Dying in Montana

Montana, Idaho's neighbor to the east, recognizes the right of its citizens to choose aid in dying through a recent decision by the Montana Supreme Court. In *Baxter v. State of Montana*, Robert Baxter, a 75-year-old U.S. Marine veteran and long-haul truck driver dying of lymphocytic leukemia sued the State of Montana to establish his right to choose aid in dying.⁴⁴ Baxter was married, with four grown children, and was fiercely independent. He wanted the option for a peaceful death on his own terms if his suffering became unbearable.⁴⁵ Additional plaintiffs included four Montana physicians who treat patients with terminal illnesses, and Compassion & Choices, the national non-profit organization that advocates on behalf of terminally ill persons.⁴⁶

⁴² Washington Death with Dignity Act, WASH. REV. CODE § 70.245 (2008).

⁴³ Center for Health Statistics: Death with Dignity Act, <http://www.doh.wa.gov/dwda/formsreceived.htm> (last visited Apr. 6, 2010). The information available shows that 64 Written Requests for Medication to End Life in a Humane and Dignified Manner were submitted from March, 2009 through the end of 2009.

⁴⁴ 224 P.3d 1211, 1214 (Mont. 2009). The statements of Robert Baxter in support of his claims can be viewed on the Compassion & Choices website, *available at* http://www.compassionandchoices.org/act/legal_work/baxter (follow "Read Robert Baxter's Affidavit" hyperlink).

⁴⁵ *Id.* at 1224.

⁴⁶ *Id.* at 1214.

The plaintiffs challenged the application of Montana's homicide statute to a physician providing a prescription to a terminally ill, though mentally competent, patient for medication that the patient could consume to bring about a peaceful death if he found his dying process unbearable.⁴⁷ The plaintiffs argued that Montanans have a right protected by the Montana State Constitution's guarantees of privacy and dignity to choose to control their own death by obtaining medications from their physician for this purpose.⁴⁸ Commentators had speculated that constitutional claims of this nature would have a good chance of success in light of the state constitution's text and significant body of law construing these provisions, which is robustly protective of individual decision-making.⁴⁹

Alternatively, the plaintiffs argued that, under the consent as a defense doctrine to the Montana homicide statute, aid in dying could not be subject to prosecution.⁵⁰ Here, the patient would have consented to the physician's assistance in precipitating the patient's death, and the plaintiffs argued that there was no public policy reason to deny the consent defense under these circumstances.⁵¹ The plaintiffs in *Baxter* had the advantage of being able to point to many years of data from Oregon's implementation of its statute affirmatively making aid in dying legal, which made clear that risks to patients do not arise when patients have the option of choosing aid in dying.⁵² The argument—that risks will still be present if aid in dying is an option—had been central to various states' efforts to prevent courts from finding a right to choose this intervention.⁵³

⁴⁷ *Id.*

⁴⁸ MONT. CONST. art. II, § 10: Right of Privacy; (privacy) MONT. CONST. art. II, § 4: Individual Dignity. (dignity).

⁴⁹ Kathryn L. Tucker, *Privacy and Dignity at the End of Life: Protecting the Right of Montanans to Choose Aid in Dying*, 68 MONT. L. REV. 317 (2007); James E. Dallner & D. Scott Manning, *Death with Dignity in Montana*, 65 MONT. L. REV. 309 (2004); Scott A. Fisk, *The Last Best Place to Die: Physician-Assisted Suicide and Montana's Constitutional Right to Personal Autonomy Privacy*, 59 MONT. L. REV. 301 (1998).

⁵⁰ See MONT. CODE ANN. § 45-2-211(1) (2009) (which provides that the "consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense").

⁵¹ *Baxter*, 224 P.3d at 1215.

⁵² See DEATH WITH DIGNITY ACT., ANNUAL REPORTS, available at <http://www.oregon.gov/DHS/ph/pas/ar-index.shtml>.

⁵³ See, e.g., Kathryn L. Tucker, *The Chicken and the Egg: The Pursuit of Choice for a Humane Hastened-Death as a Catalyst for Improved End-of-Life Care; Improved End-of-Life Care as a Precondition for Legalization of Assisted Dying*, 60 N.Y.U. ANN.

On December 5, 2008, the Montana state district court in *Baxter* issued summary judgment in favor of the plaintiffs, holding that the state constitution's Individual Dignity Clause and the stringent right of privacy are "intertwined insofar as they apply to Plaintiffs' assertion that competent terminal patients have the constitutional right to determine the timing of their death and to obtain physician assistance in doing so."⁵⁴ The district court further concluded that "[t]he decision as to whether to continue life for a few additional months when death is imminent certainly is one of personal autonomy and privacy."⁵⁵ In an odd synchronicity, plaintiff Bob Baxter died the same day the lower court ruling was issued. The State appealed.

On appeal, the case generated broad interest with dozens of amicus briefs filed.⁵⁶ The Montana Supreme Court issued its opinion on December 31, 2009, holding 5-2 that terminally ill Montanans have the right to choose aid in dying under state law.⁵⁷ The Supreme Court declined to reach the constitutional issues.⁵⁸ Instead, it chose to resolve the case on the alternative ground under the consent defense to the homicide statute, holding:

[W]e find no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy.

SURV. AM. L. 355 (2004) (discussing the significance of state arguments regarding risk, and how data might undermine any such argument).

⁵⁴ *Baxter v. Montana*, No. 2007-787 (Mont. 1st Jud. Dist. Dec. 5, 2008).

⁵⁵ *Id.*

⁵⁶ *Baxter*, 224 P.3d at 1215-18. Amici supporting the plaintiffs included: Montana state legislators, MT Civil Liberties Union, Legal Voice (formerly the Northwest Women's Law Center), The National Institute for Reproductive Health (national), The MergerWatch Project (national), Women's Bioethics Project (national), National Health Law Program, LAMBDA, MT Human Rights Network, Billings Humanist Society, AMWA, AMSA and coalition of individual Montana clinicians including physicians, psychiatrists, psychologists, social workers, American College of Legal Medicine, leading constitutional scholars, religious leaders, survivors, and bioethicists.

⁵⁷ *Id.* at 1222.

⁵⁸ *Id.* at 1216. The supreme court's approach in *Baxter* is a common jurisprudential approach. *See* *Neese v. Southern Ry. Co.*, 350 U.S. 77, 78 (1955); *Peters v. Hobby*, 349 U.S. 331, 339 (1955) (as a general rule, courts decline to reach constitutional issues when an alternative ground for decision is presented).

. . . .[A] physician who aids a terminally ill patient in dying is not directly involved in the final decision *or* the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician-patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient's subsequent private decision whether to take the medicine does not breach public peace or endanger others.

....

. . . . There is thus no indication in the homicide statutes that physician aid in dying—in which a terminally ill patient elects and consents to taking possession of a quantity of medicine from a physician that, if he chooses to take it, will cause his own death—is against public policy.

. . . . The Rights of the Terminally Ill Act very clearly provides that terminally ill patients are entitled to autonomous, end-of-life decisions, even if enforcement of those decisions involves direct acts by a physician. Furthermore, there is no indication in the Rights of the Terminally Ill Act that an additional means of giving effect to a patient's decision—in which the patient, without any direct assistance, chooses the time of his own death—is against public policy.⁵⁹

Montana physicians can, under this decision, feel safe providing aid in dying to mentally competent, terminally ill Montanans. They are not subject to the statutory schemes that control the practice in Oregon and Washington. While those states enacted statutes with specific requirements governing provision of aid in dying, Montana has not done so.⁶⁰ Accordingly, the

⁵⁹ Baxter, 224 P.3d at 1215-18 (emphasis in original).

⁶⁰ It is possible that the Montana Legislature will take up the issue of regulation of aid in dying. Indeed, Sen. Greg Hinkle, R-Thompson Falls, quickly responded to the decision by filing a draft request for a bill with the short title "Prohibit physician-assisted suicide." He told OneNewsNow.com that he wanted to introduce the bill early "so that the candidates can use it as a campaign issue." *See*

limitations of those laws do not apply in Montana, although certain boundaries recognized by the Court⁶¹ are similar to the Oregon and Washington requirements: All three states require that the patient be terminally ill, mentally competent, and that the physician involvement be limited to providing a prescription that the patient can self-administer.

V. CONCLUSION: AID IN DYING CAN AND SHOULD EMERGE AS AN END-OF-LIFE OPTION IN IDAHO AS A PRACTICE GOVERNED BY STANDARD OF CARE

Idaho has not addressed the practice of aid in dying by statute, either to affirmatively regulate the practice or to prohibit it. Presumably, the Idaho legislature has not addressed the matter due to the natural reluctance of legislators to engage issues that will generate controversy. In recent attempts to enact legislation making aid in dying affirmatively legal in California, for example, media coverage reveals that the issue was considered a “hot button” by religious groups including the Catholic Church, whose leadership condemned the legislators sponsoring the measure. California Assembly Speaker, Fabian Núñez, a sponsor of the proposed aid-in-dying measure, the California Compassionate Choices Act, was subjected to public condemnation by the Cardinal of the Cathedral of Our Lady of the Angels in Los Angeles, who said: “We should be troubled that Fabian Núñez, who has worshipped here in this cathedral as a Catholic, somehow has not understood and grasped the culture of life, but has allowed himself to get into this other direction, the culture of death.”⁶² Whatever the reason for the Idaho legislature’s lack of engagement on the issue, it is time for Idaho to respect the choice of competent, terminally ill citizens for aid in dying.

Public support for empowering dying patients with the freedom to choose aid in dying is strong. A 2005 survey found that 60% of Americans “believe a person has a moral right to end their life if they are suffering great pain and have no hope of improvement,” an increase of nearly 20 percentage points since

http://www.bozemandailychronicle.com/news/article_90d2cbd4-966d-5901-9405-d10e053b983c.htm.

⁶¹ Baxter, 224 P.3d at 1215.

⁶² Editorial, *Lost Compassion: Cardinal Tars Speaker with “Culture of Death,”*

SACRAMENTO BEE, April 6, 2007, at B6. *see also*

http://compassionandchoices.org/documents/30_JLEGMED_495_12-28-09_1203.pdf.

1975.⁶³ It is critically important that patients can turn to their physician for aid in dying. When a patient does not feel able to discuss the desire for aid in dying with his or her physician, or cannot find a physician willing to provide it, the patient may seek assistance in precipitating death from a family member or loved one. Tragically, these incidents often involve a violent means to death, such as a gunshot. Cases of this nature appear with disturbing frequency in the newspapers, as noted at the outset of this article.⁶⁴

Idaho is surrounded by states in which aid in dying is an option available to mentally competent, terminally ill patients. Both Oregon and Washington regulate the practice by statute; and in Montana, a Supreme Court decision clarifies that the option to choose aid in dying is available in that state. Many Idaho physicians receive their medical education through the University of Washington School of Medicine whose medical educators teach and practice in a forum where aid in dying is an openly available end-of-life option. The practice in these neighboring communities and the medical training provided through the University of Washington School of Medicine will appropriately influence the standard of care within Idaho, particularly where large populations reside in close proximity to the University, such as Coeur D'Alene, Idaho and Spokane, Washington.

The trend among national medical and health policy associations to adopt a policy supportive of aid in dying reflects that this option is increasingly accepted by medical professionals. Idaho medical practice governing aid in dying can develop as a matter governed by the standard of care influenced by the practice in neighboring states and medical and health policy associations' policies regarding the practice. This would extend an important additional choice to mentally competent, terminally ill Idaho citizens who confront a dying process that they find unbearable. It would do so without the unusual and extraordinary step taken in Oregon and Washington of enacting statutes that govern a particular medical practice.

⁶³ News Release, Pew Research Center, For The People & The Press, *More Americans Discussing — and Planning — End-of-Life Treatment: Strong Public Support for Right to Die 1* (2006), <http://people-press.org/reports/pdf/266.pdf>.

⁶⁴ See also, Carla Rubinski, *Connecticut Case Puts Spotlight on Assisted Suicide*, Associated Press (2005) available at <http://www.neilrogers.com/news/articles/2005030818.html>.

The consensus regarding Oregon, where a dozen years of data has been published along with commentary examining the data, is that the practice has benefited patients and posed no risk. Accordingly, other states can feel comfortable addressing the matter in the more ordinary manner of subjecting the practice to governance via standard of care. Idaho is particularly well situated to be the first state that adopts this approach, given that it has no legislation specifically addressing the matter and is surrounded by states where the practice is now an established option available to patients dying of terminal illnesses.