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ARTICLES

AID IN DYING IN MONTANA: TEN YEARS AFTER *STATE V. BAXTER*

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I. INTRODUCTION: *STATE V. BAXTER*

In 2009, the Montana Supreme Court heard a case brought by a man dying of cancer and several Montana physicians whose medical practice included providing end of life care.¹ The plaintiffs-appellees, Bob Baxter, et al., argued that a mentally competent, terminally ill patient had the right to obtain a prescription from their physician which the patient could ingest to achieve a peaceful death.² A physician who provided such a prescription could not be prosecuted for homicide.³ The plaintiffs-appellees asserted that the Montana Constitution's guarantees of dignity⁴ and privacy⁵ protected

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1. *Baxter v. State*, 224 P.3d 1211, 1214 (Mont. 2009).

2. *Id.*

3. *Id.*

4. MONT. CONST. art. II, sec. 2 ("The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws. Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color, sex, culture, social origin or condition, or political or religious ideas.").

this choice.⁶ In the alternative, Montana’s homicide statute would not support a criminal prosecution of a physician providing the prescription.⁷ The lower court embraced the constitutional grounds in finding for the plaintiffs.⁸ The Montana Supreme Court declined to rule on the constitutional issues and instead found for plaintiffs-appellees on statutory grounds.⁹

Montana’s homicide statute contains a “consent” exception,¹⁰ which the Court found applicable to these facts.¹¹ The Court’s majority, written by Justice Leaphart, reasoned that since the dying patients sought the medication to achieve a peaceful death, and state policy generally empowered patients with broad medical decision-making autonomy, there would not be grounds for a prosecution of a physician providing such a prescription under the state’s homicide statute.¹²

II. MONTANA’S STANDARD OF CARE APPROACH TO AID-IN-DYING

The *Baxter* decision opened the door to the practice of aid in dying (“AID”) in Montana. The decision came at a time when grassroots support for this compassionate end of life option was growing across the country.¹³ Oregon pioneered the practice, enacting AID through citizen initiative in 1994, but litigation prevented implementation until 1998.¹⁴ Washington, following Oregon’s lead, enacted a citizen initiative permitting the practice in 2008.¹⁵ Efforts were underway in other states to establish access to AID.¹⁶

5. MONT. CONST. art. II, sec. 10 (“The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest.”).

6. *Baxter*, 224 P.3d at 1214–15.

7. *Id.*

8. *Id.*

9. *Id.* at 1214 (“[T]his Court is guided by the judicial principle that we should decline to rule on the constitutionality of a legislative act if we are able to decide the case without reaching constitutional questions.”).

10. MONT. CODE ANN. § 45–2–211 (2019).

11. *Baxter*, 224 P.3d at 1215.

12. *Id.* at 1222; *See also*, Barry A. Bostrom, *Baxter v. State of Montana*, 26 ISSUES L. & MED. 79, 81 (2010); Thaddeus Mason Pope, *Legal History of Medical Aid In Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. REV. 267, 298 (2018); Christina White, Comment, *Physician Aid-In-Dying*, 53 HOUS. L. REV. 595, 613 (2015).

13. *See generally* Pope, *supra* note 12, at 301.

14. Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800–897 (2018); *Lee v. Oregon*, 107 F.3d 1382, 1386 (9th Cir. 1997); Linda Ganzini, *Death with Dignity Law*, THE OREGON ENCYCLOPEDIA (Mar. 17, 2018), <https://perma.cc/8PR9-XHCC>.

15. Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.01–903 (2020).

16. Pope, *supra* note 12, at 277–83.

Since the *Baxter* decision, there have been repeated efforts in the Montana legislature to enact statutes which either outlaw AID or regulate it.¹⁷ None of these have succeeded to date.¹⁸ Thus in Montana, the practice of AID is governed by the *Baxter* decision.¹⁹ To date, Montana is the only state to have a state supreme court decision that protects this end of life choice.²⁰ *Baxter* embraced several “bright lines” for AID, including that the patient be mentally competent, terminally ill, and self-administer the medication.²¹ Beyond these parameters, the practice is left to standard of care or best practices.²²

The extent of the practice of AID in Montana post-*Baxter* is not known. Because there is no statute governing the practice, as is the case in other states,²³ there is no mandated annual collection and reporting of data. Anecdotal evidence reflects that some Montana physicians provide AID.²⁴ Even so, it seems that clinicians consider the practice to be “in the closet,” despite the *Baxter* decision.

17. *E.g.*, Assoc. Press, Doctors Who Assist in Suicides Could Be Charged, Under Bill, BILLINGS GAZETTE, Feb. 24, 2017, <https://perma.cc/D23C-UV4A>; Joan S. Perry, Opinion, Protect Rights of Dying Montana Patients, BILLINGS GAZETTE, Feb. 19, 2019, <https://perma.cc/JE7J-REXH>; Montana, DEATH WITH DIGNITY, <https://perma.cc/2P3C-K86Y> (last visited Mar. 5, 2020).

18. Montana, *supra* note 17.

19. State v. Baxter, 224 P.3d 1211, 1222.

20. Death with Dignity Acts, DEATH WITH DIGNITY, <https://perma.cc/9UNX-B25A> (last visited July 13, 2020).

21. *Id.* at 1214–15.

22. Governance of medical practice by standard of care or best practices is normal. This author has commented that AID ought to become so governed and thereby normalized within the practice of medicine. *See, e.g.*, Kathryn L. Tucker, *Aid in Dying in North Carolina*, 97 N.C. L. REV. ADD. 1, 14–20 (2019); Kathryn L. Tucker, *Aid in Dying: An End-of-Life Option Governed by Best Practices*, 8 J. OF HEALTH & BIOMEDICAL L. 9, 9–26 (2012).

23. AID has been made available by statute in Oregon (1994), Washington (2008), Vermont (2013), California (2015), Colorado (2016), Washington, D.C. (2017), Hawaii (2018), New Jersey (2019), and Maine (2019). Death with Dignity Acts, *supra* note 20. These statutes mandate collecting and reporting of data annually. *Compare, e.g.*, CAL. HEALTH & SAFETY CODE ANN. § 443.9(a) (2020) (“Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician shall submit to the State Department of Public Health a copy of the qualifying patient’s written request, the attending physician checklist and compliance form, and the consulting physician compliance form”), *and* CAL. HEALTH & SAFETY CODE ANN. § 443.19(a)–(b) (“The State Department of Public Health shall collect and review the information submitted pursuant to Section 443.9. . . .(b) . . . each year thereafter, based on the information collected in the previous year, the department shall create a report with the information collected from the attending physician followup form and post that report to its Internet Web site.”), *with* VT. STAT. ANN. TIT. 18, § 5293(a) (2019) (“The Department of Health shall adopt rules . . . to facilitate the collection of information regarding compliance with this chapter”). Deaths by AID are explicitly recognized not to be “suicide.” *See* CAL. HEALTH & SAFETY CODE ANN. § 443.13(a)(2) (“[D]eath resulting from the self-administration of an aid-in-dying drug is not suicide”).

24. *See* Hospice of Missoula, “Physician Aid in Dying”, w/ Eric Kress, MD, HOSPICE OF MISSOULA, <https://perma.cc/B5QA-TCYW>, Dec. 1, 2013; Eric Kress, MD Don’t Criminalize Medical Aid in Dying for Terminally Ill Patients, MISSOULIAN, Feb. 20, 2019, <https://perma.cc/2Z57-UJBS>; Leslie Mutchler, Opinion, Guest Opinion: Medical Aid in Dying for Terminally Ill Montanans, BILLINGS GAZETTE, Feb. 21, 2019, <https://perma.cc/Y4P7-R8QR>.

A symposium was held at the Alexander Blewett III School of Law at the University of Montana on September 6, 2019, to review a decade of practice with AID. While many Montana clinicians spoke at this event about the inclusion of AID in their medical practices, it was apparent that they did not speak openly about it with colleagues. These physicians suggested that there is little sharing of information among themselves about best practices for AID. It does not appear that the practice of AID is included in continuing medical education courses offered to Montana clinicians. There does not seem to be significant patient/public education about the availability of this option.

It also appears Montana coroners are insufficiently educated about AID as well: in a concerning instance a Montana county coroner demanded that a physician who had provided AID revise the death certificate to record cause of death as drug overdose and “suicide.” The possibility that a coroner, state medical examiner, or a county attorney would deem a death via AID to be a “suicide” reflects disturbing ignorance and does not reflect best practices. This sort of ignorance shows the urgent need for robust education of these professionals on this matter, and others related to AID. This is vital for access to AID in Montana. AID is not considered suicide in states that recognize the practice; those states call for the cause of death to be reported as the underlying illness.²⁵ Many national medical, mental health, and public health professional organizations have considered this issue and determined that a death through AID is no sort of suicide, and ought not be confused or conflated with suicide.²⁶ For example, the American Association of Suicidology’s statement on this issue:

The American Association of Suicidology (AAS) recognizes that the practice of physician aid in dying is distinct from the behavior that has been traditionally and ordinarily described as “suicide,” the tragic event our or-

25. See e.g., WASH. REV. CODE § 70.245.040(2) (2020) (“The attending physician . . . shall list the underlying terminal disease as the cause of death.”); WASH. REV. CODE § 70.245.180(1) (2020) (“Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide . . . under the law [of Washington]. State reports must not refer to practice under this chapter as “suicide” or “assisted suicide.”).

26. See e.g., COD Addresses Medical Aid in Dying, American Academy of Family Physicians (Oct. 10, 2018), <https://perma.cc/KCW4-U2ZV>; Statement On Physician-Assisted Dying, AM. ACAD. OF HOSPICE & PALLIATIVE CARE, June 24, 2016, <https://perma.cc/T6TX-W4TX>; STATEMENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY: “SUICIDE” IS NOT THE SAME AS “PHYSICIAN AID IN DYING”, American Association of Suicidology 1 (Oct. 30, 2017), <https://perma.cc/75VD-67N7>; Miles J. Zaremski, ACLM POLICY ON AID IN DYING, AMERICAN COLLEGE OF LEGAL MEDICINE 1 (Oct. 6, 2008), <https://perma.cc/KYF9-46LP>; Constitution and Bylaws of the American Medical Student Association, AMERICAN MEDICAL STUDENT ASSOCIATION 78 (July 2017), <https://perma.cc/DB26-894U>; Patients’ Rights to Self-Determination at the End of Life, THE AMERICAN PUBLIC HEALTH ASSOCIATION, Oct. 28, 2008, <https://perma.cc/GF8E-49P4>; Kirsten Weir, Assisted dying: The motivations, benefits, and pitfalls of hastening death, AMERICAN PSYCHOLOGICAL ASSOCIATION (Dec. 2017), <https://perma.cc/FS9E-2EM7>.

ganization works so hard to prevent. This recognition does not assume that there cannot be “overlap” cases, but only that the two practices can in principle be conceptually distinguished and that the professional obligations of those involved in suicide prevention may differ.²⁷

III. CONCLUSION

AID practice is expanding, evolving, and maturing across the country. This is reflected in the growing number of states which permit the practice²⁸ and the growing number of states considering allowing it.²⁹ The emergence of national conferences, such as the National Clinicians’ Conference on Medical Aid in Dying,³⁰ the first convening of which took place at UC Berkeley in February 2020, and formation of a specialty medical society for clinicians who practice AID, the American Clinicians Academy on Medical Aid in Dying, announced at the UC Berkeley conference, also reflects this expanding and evolving practice.³¹ This evolution and maturation may well help support Montana clinicians providing AID.

Montanans who know the significance of empowering dying patients to choose AID must continue to press for more robust public and professional education and for the practice to be normalized within the practice of medicine. There are many Montanans with compelling stories to share. Leslie Mutchler of Billings has a unique story of how AID has impacted her life. Not only is she a daughter of Bob Baxter, who brought the lawsuit which established AID in Montana, but her son, T.J., benefitted from AID when dying of pancreatic cancer.³² As Leslie attests:

T.J. gained so much peace of mind when he got the prescription, and ultimately the medications, knowing he could be in control at the end. When the time finally came that his body was shutting down, he chose to ingest the aid-in-dying medications. Our family was able to gather together so he could say goodbye and we could be with him when he succumbed to the

27. STATEMENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY: “SUICIDE” IS NOT THE SAME AS “PHYSICIAN AID IN DYING”, *supra* note 26; *See also*, Lois A. Weithorn, Psychological Distress, Mental Disorder, and Assessment of Decisionmaking Capacity Under U.S. Medical Aid in Dying Statutes, 71 HASTINGS LJ 637 n. 5(2020) (“experts in mental health distinguish suicide from (AID)”).

28. Death with Dignity Acts, *supra* note 20, at 1.

29. Take Action, DEATH WITH DIGNITY, <https://perma.cc/66HM-5YPR> (last visited Mar. 6, 2020) (comprehensive, interactive map which shows which state’s legislatures are considering AID legislation).

30. National Clinicians Conference On Medical Aid In Dying, NATIONAL CLINICIANS CONFERENCE ON MEDICAL AID IN DYING, <https://perma.cc/UF5D-5VHY> (visited Mar. 5, 2020).

31. American Clinicians Academy on Medical Aid in Dying, AMERICAN CLINICIANS ACADEMY ON MEDICAL AID IN DYING, <https://perma.cc/E4G9-AF34> (visited Mar. 10, 2020).

32. Mutchler, *supra* note 24.

disease. It was peaceful for all of us. T.J. experienced a gentle death, which was our goal and indeed is the intent of medical aid in dying.³³

Montana, in the wake of the *Baxter* decision, is pioneering a “standard of care” approach to AID, where the practice is not governed by a statute replete with mandates, requirements, and restrictions, as is the case in states with a statute permitting and regulating the practice.³⁴ Montana is free to evolve its practice different from the practice in states where there are governing statutes.³⁵ But given the lack of data about practice of AID in Montana, we do not really know how much this is occurring. Montana, and interested outside observers, could benefit from research into the extent of AID practice in the state, AID’s accessibility, patient, and physician, awareness of the availability of the option, and whether and to what extent practice in Montana mimics or differs from that in other states, where the practice is governed by statute.³⁶ More public education about this end of life option is needed, so patients are aware it is available should they find themselves suffering to the extent they conclude their least worst option is to achieve a peaceful death. More professional education of clinicians about AID would benefit those who include this option in their medical practice, so that they stay informed of evolving best practices and feel supported in providing AID.³⁷

33. *Id.*; See also Kress, *supra* note 24 (discussing how Dr. Kress has personally prescribed AID medication in the western Montana area, and specifically how a long-time patient of his chose AID to end his battle with ALS); Eric Kress, MD, Thoughts From a Physician Who Prescribes Aid in Dying, *MISSOULIAN*, Apr. 7, 2013, <https://perma.cc/N6M7-BBBU>.

34. Pope, *supra* note 12, at 299.

35. In so doing, Montana can serve as an example to states where practice can proceed without a statutory permission. For example, North Carolina has no law which could be deemed to prohibit the practice of AID, and a constellation of law which suggests state policy supports patient autonomy to make informed medical decisions. Hence, this author has argued that practice can proceed absent enactment of any legislation, governed by standard of care. Kathryn L. Tucker, *Aid in Dying in North Carolina*, 97 N.C. L. REV. ADD. 1, 14–20 (2019).

36. Research of the sort undertaken in other states into the experience with AID ought to be done in Montana. See e.g., MARA BUCHBINDER et al., *Health Care Providers’ Experiences with Implementing Medical Aid-in-Dying in Vermont: A Qualitative Study*, 34 J. OF GEN. INTERNAL MED., 636–41 (2019); MARA BUCHBINDER et al., *Caregivers’ Experiences with Medical Aid-in-Dying in Vermont: A Qualitative Study*, 56 J. PAIN & SYMPTOM MGMT. 936, 936–43 (2018).

37. Even in states with a governing statute, the need for more robust professional education for clinicians has been demonstrated. See, e.g., Landry et al., *Experience and Attitudes Regarding Medical Aid in Dying, Act 39, among Vermont Specialty Practices*, 23 J. PALLIATIVE MED. 375, 375–378 (2020) (finding that under the Vermont Patient Choice and Control at End-of-Life Act, which legalized AID, physicians in Vermont most likely to care for dying patients felt that they could benefit from more information about best practices).