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PRIVACY AND DIGNITY AT THE END OF LIFE: PROTECTING THE RIGHT OF MONTANANS TO CHOOSE AID IN DYING*

Kathryn L. Tucker**

I. INTRODUCTION

Could a state version of the landmark federal cases *Vacco v. Quill*¹ and *Washington v. Glucksberg*² succeed in Montana? Yes. Such a case would likely assert that mentally competent, terminally ill Montanans have a right protected under the Montana State Constitution's guarantees of privacy and dignity to choose to control their own deaths by obtaining medications from their physicians for this purpose.

A number of factors suggest that protecting Montanans' choice to receive aid in dying is likely to be recognized by the Montana Supreme Court under the Montana Constitution: (1) the language of the state constitution, specifically the explicit guarantees of privacy and dignity;³ (2) state constitutional precedent; (3) developments in Oregon (the only state to have yet legalized aid in dying) under Oregon's Death with Dignity Act;⁴ (4) the growing societal acceptance for this end-of-life option; and (5) Montana's demonstrated commitment to ensuring that all terminally ill Montanans receive good end-of-life care, including excellent pain and symptom management.

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1. *Vacco v. Quill*, 521 U.S. 793 (1997) (holding that New York's ban on assisted suicide did not violate the Equal Protection Clause).

2. *Wash. v. Glucksberg*, 521 U.S. 702 (1997) (holding that the right to assistance in committing suicide was not a fundamental liberty interest and that the State of Washington's ban on assisted suicide was rationally related to several governmental interests).

3. Mont. Const. art. II, § 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."); *Id.* at § 4 ("The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws.").

4. Or. Rev. Stat. Ann. §§ 127.800–127.897 (West 2005).

II. MONTANA'S RIGHT TO PRIVACY

The people of Montana ratified a new state constitution in 1972 that included an explicit right to privacy. The Montana Constitution states that the right to privacy is "essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest."⁵ Since its ratification, the Montana Supreme Court has consistently and unequivocally held that the Montana Constitution provides broader protection than the U.S. Constitution. As the court explained in *State v. Burns*,⁶ "Montana adheres to one of the most stringent protection of its citizens' right to privacy in the country."⁷

Three years later, in *State v. Bullock*,⁸ the court reiterated that Montana provides a greater protection of the right to privacy, noting the significance of the explicit constitutional language creating it.⁹ The U.S. Constitution contains no such explicit right; instead the U.S. Supreme Court has inferred it from the penumbras of the First and Fourth Amendments.¹⁰ The Montana Constitution, on the other hand, expressly guarantees a right of individual privacy that "shall not be infringed without the showing of a compelling state interest."¹¹

As early as 1984, the Montana Supreme Court applied Montana's broader protection to individuals' right of privacy in search-and-seizure cases, departing from the lower federal standard of protection. In *State v. Solis*,¹² the court unhesitatingly rejected federal precedent that allowed government officials to record conversations without the other participant's knowledge. Instead, the court turned to Montana's privacy provision and held that it protected the defendant's expectation that his conversation would be private and would not be recorded without his consent.¹³

5. Mont. Const. art. II, § 10.

6. *State v. Burns*, 830 P.2d 1318 (Mont. 1992).

7. *Id.* at 1320.

8. *State v. Bullock*, 901 P.2d 61 (Mont. 1995).

9. *Id.* at 75.

10. *Griswold v. Conn.*, 381 U.S. 479, 484 (1965) (holding that "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance"). These rights are protected from infringement by the states through the incorporation doctrine of the Fourteenth Amendment to the U.S. Constitution. U.S. Const. amend. XIV.

11. Mont. Const. art. II, § 10.

12. *State v. Solis*, 693 P.2d 518 (Mont. 1984).

13. *Id.* at 521-22.

Twenty years ago, in *Cottrill v. Cottrill Sodding Service*,¹⁴ the Montana Supreme Court categorized privacy as a fundamental right that triggers a strict scrutiny analysis in an equal protection challenge.¹⁵ Likewise, in *State v. Siegal*,¹⁶ the court applied strict scrutiny to a government intrusion on the privacy right.¹⁷ Thus, in Montana, any infringement on the right to privacy is subject to the highest level of review, requiring demonstration of a compelling governmental interest, narrowly tailored in its means so as to achieve that interest, and only that interest.¹⁸

Montana's dignity¹⁹ and equal protection²⁰ clauses, like its privacy clause, are also broader than their federal counterparts and are treated as fundamental rights.²¹ Montana's dignity clause states that "[t]he dignity of the human being is inviolable. No person shall be denied the equal protection of the laws."²² Therefore any infringement of an individual's dignity or equal protection under the law, like the right to privacy, also triggers the court's highest level of scrutiny and protection.²³

A significant line of precedent interprets the privacy clause as broadly protecting individual autonomy over one's physical person. Three years ago, in deciding whether a plaintiff can be compelled to submit to a painful and burdensome medical examination in *Simms v. Montana Eighteenth Judicial District*,²⁴ the court held that the personal autonomy element of privacy must take

14. *Cottrill v. Cottrill Sodding Serv.*, 744 P.2d 895 (Mont. 1987).

15. *Id.* at 897. When a right that is "less than fundamental is infringed upon by classification," it triggers only rational basis review, a lower level of scrutiny which requires the government to demonstrate "a legitimate governmental objective bear[ing] a rational relationship to [the] discriminatory classification." *Id.*

16. *State v. Siegal*, 934 P.2d 176 (Mont. 1997).

17. *Id.* at 184, *overruled in part*, *State v. Kuneff*, 970 P.2d 556, 559 (Mont. 1998) (citing *State v. Pastos*, 887 P.2d 199, 202 (Mont. 1994) (holding a governmental intrusion of privacy requires a compelling state interest and must be narrowly tailored to effectuate only that interest)).

18. *Id.* at 184.

19. Mont. Const. art. II, § 4.

20. *Id.*

21. *Walker v. State*, 68 P.3d 872, 882–83 (Mont. 2003) (holding that individual dignity is a fundamental right under the Montana Constitution); *Snetsinger v. Mont. U. Sys.*, 104 P.3d 445, 452 (Mont. 2004). The court held that a state university policy denying insurance coverage to employees' same-sex partners violates the state constitution's guarantee of equal protection because Montana's equal protection clause provides more protection than the Equal Protection Clause of the U.S. Constitution. *Id.* at 449.

22. Mont. Const. art. II, § 4.

23. *Snetsinger*, 104 P.3d at 449–50 (discussing the levels of scrutiny a court uses when addressing an equal protection argument, noting that strict scrutiny analysis is used when addressing a fundamental right infringement).

24. *Simms v. Mont. 18th Jud. Dist. Ct.*, 68 P.3d 678 (Mont. 2003).

into account the individual's "inalienable right to the integrity of, and personal autonomy over, his body."²⁵

The Montana Supreme Court first recognized a "personal autonomy component" as part of the state right to privacy in its 1997 case, *Gryczan v. State*.²⁶ There the court acknowledged that the right to privacy is fundamental,²⁷ and expanded that right to include consensual same-gender sexual conduct,²⁸ even though U.S. Supreme Court jurisprudence at the time denied federal recognition of such a right.²⁹ The Montana Supreme Court found that the State lacked the required compelling interest in prohibiting such conduct, and therefore the law failed under strict scrutiny.³⁰

In 1999, the court decided a case with even more significant ramifications for the question of whether an individual's access to physician aid in dying is part of the fundamental right to privacy, dignity, and equal protection. In *Armstrong v. State*,³¹ the court held that the Montana Constitution's privacy clause protects a woman's right to choose an abortion and an abortion provider, because it broadly guarantees each individual the right "to make medical judgments affecting her or his bodily integrity and health . . . free from the interference of the government."³² The court further held that the state constitutional right of individual privacy "requires the government to leave us alone in all these most personal and private matters."³³

Specifically, the court stated, "if the right to privacy includes anything, it . . . encompasses a woman's choice of whether or not to end her pregnancy."³⁴ Furthermore, the court held that "[i]mplicit in this right of procreative autonomy is a woman's moral right and moral responsibility to decide . . . what her preg-

25. *Id.* at 685.

26. *Gryczan v. State*, 942 P.2d 112, 126 (Mont. 1997) (holding Montana's right to privacy extends to consensual same-gendered sexual activity because the state has no compelling interest in prohibiting such activity).

27. *Id.* at 122. The court noted that the right to privacy is "perhaps, one of the most important rights guaranteed to the citizens of this State, and its separate textual protection in our Constitution reflects Montanans' historical abhorrence and distrust of excessive governmental interference in their personal lives." *Id.* at 125.

28. *Id.* at 122.

29. *Id.* at 121 (citing *Bowers v. Hardwick*, 478 U.S. 186, 199 (1986) (Blackmun, J. dissenting)).

30. *Id.* at 125-26.

31. *Armstrong v. State*, 989 P.2d 364 (Mont. 1999).

32. *Id.* at 375.

33. *Id.* at 383.

34. *Id.* at 376.

nancy demands of her *in the context of her individual values, her beliefs as to the sanctity of life, and her personal situation.*"³⁵

Upon determining that a woman's right to terminate a pregnancy constituted a fundamental right of privacy, dignity, and equal protection, the court found that a Montana law requiring pre-viability abortions to be performed by a physician did not pass strict scrutiny review because, although the statute was narrowly drawn, the State failed to show it had a compelling interest for the law in the first place.³⁶ The court stated,

The government can demonstrate no compelling interest for legislating on the basis of any sectarian doctrine nor may the state infringe individual liberty and personal autonomy because of majoritarian demands to safeguard some intrinsic value unrelated to the protection of the rights and interest of persons with constitutional status.³⁷

Finally, the court held that the State had no greater interest in a pregnancy a woman sought to terminate than in one she chose to carry to term.³⁸ This is critical, the court said, because a government that has the power to pass laws prohibiting abortion also has the power to pass laws requiring it.³⁹ In other words, either such a personal decision is none of the government's business, or it is wholly its business, for better or worse.

As a reminder that such a scenario is not unimaginable, the court referenced *Buck v. Bell*,⁴⁰ a 1927 U.S. Supreme Court decision holding that involuntary sterilization of mentally disabled adults was constitutional.⁴¹ The Montana Supreme Court noted that this caveat should be even more alarming to those who would oppose a certain right, as the possibility of the government imposing that right as a requirement "is no more remote than a change in prevailing political ideology."⁴²

Armstrong demonstrates the State's strong presumption in favor of the individual's right to privacy over his or her physical being, consistent with the strict scrutiny analysis applied in that case. Rather than characterizing an act like terminating a pregnancy as an act a woman may not commit unless the State gives

35. *Id.* at 377 (emphasis added).

36. *Id.* at 382.

37. *Armstrong*, 989 P.2d at 382.

38. *Id.* at 377.

39. *Id.*

40. *Buck v. Bell*, 274 U.S. 200 (1927).

41. *Armstrong*, 989 P.2d at 377-78 (citing *Buck*, 274 U.S. at 207).

42. *Id.* at 377.

her that right, the court placed the burden on the State to show a compelling interest justifying its intrusion.⁴³

Based on *Armstrong*, this presumption of one's control over his or her body would likely extend to the choice to receive aid in dying. Like a woman faced with the difficult decision whether to terminate a pregnancy, a terminally ill individual similarly has that same "moral right and moral responsibility" to determine what the ongoing pain and debilitation of her illness demands of her, "in the context of her individual values, her beliefs as to the sanctity of life, and her personal situation."⁴⁴

The court in *Armstrong* could find no compelling state interest to infringe on a woman's decision to terminate a pregnancy with the provider of her choice. Principled application of precedent suggests the court would likewise be unable to find a compelling state interest to infringe on a terminally ill person's choice to ease and possibly hasten the end of his or her own life in a dignified manner. The court made it clear that neither "majoritarian demands" nor "any sectarian doctrine" may justify the state's infringement on the privacy right.⁴⁵

The court's warning regarding the double-edged sword of recognizing a compelling state interest in infringing a privacy right applies with equally chilling implications to the right to aid in dying. As the court reminded us in *Armstrong*, either the State has no interest in an individual's decision, or it has an ever-present interest that can be used to compel choice in either direction.⁴⁶ If the State can prohibit an individual's choice of aid in dying, it can require it. As the latter flies in the face of widely held ideas regarding personal autonomy and the right to refuse treatment, so the former must be equally repugnant to Montana's constitutional right to privacy.

Interestingly, one of Montana's most recent cases addressing the right to privacy affected an individual's right to die, albeit indirectly. In *State v. Dawson*,⁴⁷ the court held that a prisoner facing the death penalty had the right to withdraw his appeal so long as he was mentally competent.⁴⁸ The court further held that, due to his right to privacy, the prisoner could refuse additional medi-

43. *Id.* at 375.

44. *Id.* at 377.

45. *Id.* at 382.

46. *Id.* at 377.

47. *State v. Dawson*, 133 P.3d 236 (Mont. 2006).

48. *Id.* at 249.

cal examinations even though such examinations might discover evidence that he was not competent to withdraw his appeal.⁴⁹

It is not suggested here that *Dawson* addresses an individual's right to aid in dying under the privacy right of the Montana Constitution. However, the case nonetheless provides a glimpse at the court's unwavering and absolute respect for the right of individuals to exercise autonomy over their physical bodies, even if that exercise makes the individuals' pending deaths certain.

Montana legal commentators, notably Scott Fisk in *The Last Best Place to Die: Physician-Assisted Suicide and Montana's Constitutional Right to Personal Autonomy Privacy*,⁵⁰ have speculated that such a case brought by a plaintiff seeking aid in dying has a good chance of success in light of the state constitution's text and precedent. Since publication of the Fisk article, additional favorable court opinions⁵¹ and commentary⁵² have been published.

In addition, more than nine years of data from Oregon's implementation of its Death with Dignity Act now exist. The data confirm that allowing dying patients to choose aid in dying poses no risks to patients, doctors or society.⁵³ This finding is significant because the argument that risks will arise has been central to other states' defenses of laws prohibiting what some have labeled "assisted suicide."⁵⁴ The term "assisted suicide" is not used

49. *Id.*

50. 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).

51. *E.g. Armstrong*, 989 P.2d 364; *Walker v. State*, 68 P.3d 872 (Mont. 2003); *Snetsinger v. Mont. U. Sys.*, 104 P.3d 445 (Mont. 2004).

52. James E. Dallner & D. Scott Manning, *Death with Dignity in Montana*, 65 Mont. L. Rev. 309 (2004). The authors point out that "[t]he Montana Constitution was drafted with explicit acknowledgment of the changes which have occurred in the past century and with the clear intention to replace obsolete legal concepts." *Id.* at 337. Thus, the Montana Supreme Court, instead of looking to the past and to history as the U.S. Supreme Court did in *Glucksberg*, would base "its decisions on a constitution which exists because the ways of the past were found to have become outmoded and inadequate." *Id.* at 337-38. The authors contend that a claim under the right to individual dignity may be more likely to succeed than a claim under the privacy clause, as the right of individual dignity is described as "inviolable" and is thus less likely to be "outweighed by a competing state interest." *Id.* at 339.

53. *Infra* nn. 61-74.

54. Kathryn L. Tucker, *The Chicken and the Egg: The Pursuit of Choice for a Human 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. Annual Survey Am. L. 355, 366 (2004) (discussing the significance of states' argument regarding risk, and how available data might undermine any such argument).

in Oregon's Death with Dignity Act and is being increasingly rejected by medical experts.⁵⁵

One thing is certain: when the 1972 Constitutional Convention delegates included an explicit right of privacy in the Montana Constitution, they intentionally left it broad and open for future courts to interpret.⁵⁶ The court in *Armstrong* concluded that, while the right to privacy may not be absolute,

no final boundaries can be drawn around the personal autonomy component of the right of individual privacy. It is . . . as narrow as is necessary to protect against a specific unlawful infringement of individual dignity and personal autonomy by the government . . . and as broad as are the State's ever innovative attempts to dictate in matters of conscience, to define individual values, and to condemn those found to be socially repugnant or politically unpopular.⁵⁷

III. CHOICE OF AID IN DYING IN OREGON⁵⁸

Oregon is the only state to date to explicitly allow a mentally competent, terminally ill patient to receive medications from an attending physician that the patient could consume to bring about a peaceful and dignified death.

The Oregon Death with Dignity Act⁵⁹ ("Dignity Act") was passed in 1994 through Oregon's initiative process.⁶⁰ The Dignity Act establishes tightly controlled procedures under which a competent, terminally ill adult, who is under the care of an attending physician, may obtain a prescription for medication to allow the patient to control the time, place, and manner of his or her own impending death.⁶¹ The attending physician must determine that the patient is suffering from a terminal disease.⁶² To qualify as having a "terminal disease," a person must have "an incurable and irreversible disease that has been medically confirmed and will,

55. *Infra* nn. 100–04.

56. *Armstrong*, 989 P.2d at 374.

57. *Id.* at 375.

58. Most of Section III was first published in the *Willamette Law Review*. Kathryn L. Tucker, *Federalism in the Context of Assisted Dying*, 41 *Willamette L. Rev.* 863, 867–71 (2005).

59. Or. Rev. Stat. Ann. §§ 127.800–127.897 (West 2005).

60. Implementation was obstructed for several years by a lawsuit brought by opponents who argued that a law permitting terminally ill patients to choose physician assistance in dying denied the terminally ill equal protection of the laws. The Ninth Circuit dismissed the case on the grounds that the plaintiffs lacked standing. *Lee v. Or.*, 107 F.3d 1382, 1386–90 (9th Cir. 1997).

61. Or. Rev. Stat. Ann. § 127.805.

62. *Id.* at § 127.815.

within reasonable medical judgment, produce death within six months.”⁶³

The attending physician must also determine that the patient is mentally competent and an Oregon resident, and inform the patient requesting such medication of the physician’s diagnoses and prognoses of the patient’s condition, the risks and probable results of taking the medication, and alternatives to taking his or her own life, including, but not limited to, hospice care and pain relief.⁶⁴ As an added precaution, a consulting physician must confirm the attending physician’s medical opinion.⁶⁵

Once a request from a qualifying patient has been properly documented and witnessed, and all waiting periods have expired,⁶⁶ the attending physician may prescribe, but not administer, medication to enable the patient to end his or her life in a humane and dignified manner. The Dignity Act immunizes physicians and pharmacists who act in compliance with its comprehensive procedures from civil or criminal sanctions, and from any professional disciplinary actions based on that conduct.⁶⁷

The Dignity Act also requires healthcare providers to file reports with the State documenting their actions.⁶⁸ To date, the Oregon Department of Human Services’ Office of Disease Prevention and Epidemiology has issued nine annual reports that present and evaluate the state’s experience with the Dignity Act.⁶⁹ Oregon’s experience with legal aid in dying has been studied and discussed by a closely watching nation. These reports have shown that the dire predictions of those initially opposed to the Dignity Act are baseless. The data demonstrate that the option of aid in dying has not been unwillingly forced upon those who are poor, uneducated, uninsured or otherwise disadvantaged.⁷⁰ In fact, the studies show just the opposite. For example, the *Eighth Annual Report* found that a higher level of education is strongly associated with the use of aid in dying; those with a baccalaureate degree or

63. *Id.* at § 127.800(12).

64. *Id.* at § 127.800(7).

65. *Id.* at §§ 127.800(8), 127.820.

66. *Id.* at §§ 127.840, 127.845, 127.850.

67. Or. Rev. Stat. Ann. § 127.885.

68. *Id.* at § 127.865.

69. Or. Dept. of Health Serv., *Oregon’s Death with Dignity Act*, <http://oregon.gov/DHS/ph/pas/index.shtml> (accessed Feb. 23, 2007).

70. Or. Dept. of Hum. Res., *Oregon’s Death with Dignity Act: The First Year’s Experience 7*, <http://oregon.gov/DHS/ph/pas/docs/year1.pdf> (Feb. 18, 1999) (“Patients who chose physician-assisted suicide were *not* disproportionately poor (as measured by Medicaid status), less educated, lacking in insurance coverage, or lacking in access to hospice care.”).

higher were 7.9 times more likely than those without a high school diploma to choose aid in dying.⁷¹ The *Eighth Annual Report* also found that 99% of patients who opted for aid in dying during the first eight years had either private health insurance or Medicare/Medicaid, and 92% were enrolled in hospice care.⁷²

Furthermore, the Annual Reports demonstrate that use of aid in dying is limited. During the first nine years in which this was a legal option, a total of only 292 Oregonians chose it.⁷³ Although there has been a gradual increase in the rate of those opting for aid in dying, the overall rate remains low: the thirty-eight terminally ill adults who chose this option in 2005 represented only twelve deaths for every 10,000 Oregonians who died that year.⁷⁴ The State of Vermont recently concluded, after a thorough review of the Oregon experience, that “it is [quite] 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.”⁷⁵ Individual observers have reached similar conclusions: “I worried about people being pressured to do this. But this data confirms, for the seventh year, that the policy in Oregon is working. There is no evidence of abuse or coercion or misuse of the policy.”⁷⁶

Indeed, rather than posing a risk to patients or the medical profession, the Dignity Act has galvanized significant improvements in the care of dying Oregonians. 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.⁷⁷ These efforts include improving their knowledge of the use of pain medications for the terminally ill, improving their ability to recognize

71. Or. Dept. of Hum. Servs., *Eighth Annual Report on Oregon's Death with Dignity Act* 12, <http://oregon.gov/DHS/ph/pas/docs/year8.pdf> (Mar. 2007) [hereinafter *Eighth Annual Report*].

72. *Id.* at 23.

73. Or. Dept. of Hum. Servs., *Ninth Annual Report on Oregon's Death with Dignity Act* 1, <http://oregon.gov/DHS/ph/pas/docs/year9.pdf> (Mar. 2007).

74. *Eighth Annual Report*, *supra* n. 71, at 5.

75. Robin Lunge, Maria Royle & Michael Slater, *Oregon's Death with Dignity Law and Euthanasia in the Netherlands: Factual Disputes, 2004* at 26, http://www.leg.state.vt.us/reports/04Death/Death_With_Dignity_Report.htm (accessed Mar. 17, 2007).

76. William McCall, *Assisted-Suicide Cases Down in '04*, *The Columbian* (Vancouver, Wash.) C2 (Mar. 11, 2005) (quoting Arthur Caplan, Director of the Center for Bioethics at the University of Pennsylvania School of Medicine).

77. *Id.*

depression and other psychiatric disorders, and more frequently referring their patients to hospice programs.⁷⁸

In light of the Oregon experience, even previously staunch opponents have recognized that continued opposition to such a law can only be based on personal moral or religious grounds.⁷⁹

In sum, the data demonstrate that making the option of aid in dying available, far from posing any hazard to patients or the practice of medicine, has galvanized improvements in end-of-life care, benefiting all terminally ill Oregonians.

IV. GROWING SOCIETAL ACCEPTANCE FOR AID IN DYING

It is now possible to argue persuasively that there is growing societal acceptance for aid in dying.⁸⁰ This can be influential to courts considering whether to extend constitutional protection to certain conduct, as seen recently in the U.S. Supreme Court's *Lawrence v. Texas* decision.⁸¹

A poll conducted by the Pew Research Center in November 2005, and released in January 2006, 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," and 53% "believe a person has a moral right to end their life if suffering from an incurable disease."⁸² Nearly half of Americans, 46%, support laws allowing doctors to prescribe lethal medication to assist terminally ill patients in ending their lives.⁸³ The percentage of Americans supporting a moral right of individuals suffering great pain with no hope of improvement to end their lives has risen

78. Lawrence J. Schneiderman, Book Review, 293 *J. Am. Med. Assoc.* 501 (2005) (reviewing *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice* (Timothy E. Quill & Margaret Battin eds., JAMA 2005)) ("Indeed, one of the unexpected yet undeniable consequences of Oregon's Death with Dignity Act permitting physician aid-in-dying is that 'many important and measurable improvements in end-of-life care' occurred following the Act's implementation. Rather than becoming the brutal abattoir for hapless patients that some critics predicted, the state is a leader in providing excellent and compassionate palliative care.")

79. See Daniel Lee, *Physician-Assisted Suicide: A Conservative Critique of Intervention*, 33 *Hastings Ctr. Rpt.* 17–19 (Jan.–Feb. 2003).

80. Public opinion polls suggest that this is the case. *Infra* nn. 82–98.

81. *Lawrence v. Tex.*, 539 U.S. 558, 570–71 (2003). See also Laurence H. Tribe, *Lawrence v. Texas: The "Fundamental Right" that Dare Not Speak Its Name*, 117 *Harv. L. Rev.* 1894, 1901 (2004); Diana Hassel, *Sex and Death: Lawrence's Liberty and Physician-Assisted Suicide*, 9 *U. Pa. J. Const. L.* 1003 (2007).

82. The Pew Research Ctr., *More Americans Discussing—and Planning—End-of-Life Treatment: Strong Public Support for the Right to Die* 8, <http://people-press.org/reports/display.php3?ReportID=266> (accessed Mar. 17, 2007) [hereinafter Pew Research Ctr. Poll].

83. *Id.* at 2, 5.

nearly twenty percentage points since 1975, although most of the increase (41% to 55%) occurred between 1975 and 1990.⁸⁴

Similarly, the poll found that support for the moral right of a patient to end his or her life has increased in the United States since 1990.⁸⁵ Total support for the moral right to end life when a patient has an incurable disease has increased from 49% in 1990 to 53% in 2005.⁸⁶ Total support for the moral right to end life when a patient is suffering great pain and has no hope for improvement has increased from 55% in 1990 to 60% in 2005.⁸⁷ There has been a particularly striking increase in support for the moral right of a patient to end life among those aged fifty and older. The support for a moral right to end life when a patient has an incurable disease has increased from 42% in 1990 to 56% in 2006 among participants aged fifty to sixty-four.⁸⁸ In the same age group, the support for a moral right to end life when a patient is suffering great pain and has no hope of improvement has increased from 47% in 1990 to 62% in 2005.⁸⁹ Among those sixty-five and older, support for the moral right to end life when a patient has an incurable disease has increased from 33% in 1990 to 45% in 2005, and support for the moral right to end life when a patient is suffering great pain and has no hope for improvement has increased from 39% in 1990 to 50% in 2005.⁹⁰

A 2005 Gallup poll released in May 2005 found that 75% of Americans believe that doctors should be allowed to aid terminally ill people in hastening their deaths.⁹¹ A Harris poll released in April 2005 found that 70% of American adults favor a law that would “allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended,” up from 65% in 2001 (although less than the 73% in favor in 1993).⁹² The same poll found that 67% of American adults would like their

84. *Id.* at 12.

85. *Id.* at 3.

86. *Id.* at 1.

87. *Id.*

88. Pew Research Ctr. Poll, *supra* n. 82, at 3.

89. *Id.* at 7.

90. *Id.*

91. David W. Moore, *Three in Four Americans Support Euthanasia*, <http://www.galluppoll.com/content/?CI=16333> (May 17, 2005).

92. Harris Interactive, *Majorities of U.S. Adults Favor Euthanasia and Physician-Assisted Suicide by More than Two-to-One*, http://www.harrisinteractive.com/harris_poll/index.asp?PID=561 (Apr. 27, 2005).

states to pass laws similar to the Oregon Death with Dignity Act, up from 61% in 2001.⁹³

A 2006 California Field poll found that 70% of all California adults believe “incurably ill patients should have the right to ask for and get life-ending medication.”⁹⁴ Sixty-two percent of Californians “would want their doctor to be able to assist them in dying” if they were “terminally ill and expected to die within six months.”⁹⁵ In previous years, between 67% and 72% of Californians would like the option of aid in dying if faced with this situation. Support in California for aid in dying has ranged from 64% to 75% in eight polls taken between 1979 and 2006.⁹⁶

A study by Wake Forest University researchers published in 2005 found that 58% of American adults disagreed with the statement that “they would trust their doctor less if ‘euthanasia were legal [and] doctors were allowed to help patients die.’”⁹⁷ Nearly 60% of doctors themselves believe they should be “legally permitted to dispense prescriptions for life-ending drugs to terminally ill patients who request them,” according to a poll released in October 2005.⁹⁸ While doctors support legal aid in dying at lower rates than patients, support among doctors increased two percentage points since a February 2005 poll.⁹⁹

The medical community also reflects society’s changing perception of a patient’s choice to use physician aid in dying. Medical experts have discussed in detail why the terms “suicide” or “assisted suicide” are inappropriate when discussing the choice of a mentally competent, terminally ill patient to seek medications that he or she could consume to bring about a peaceful and dignified death.¹⁰⁰ The American Psychological Association has recognized that “[i]t is important to remember that the reasoning on

93. *Id.*

94. Mark DiCamillo & Mervin Field, *Continued Support for Doctor-Assisted Suicide; Most Would Want Their Physician to Assist Them if They Were Incurably Ill and Wanted to Die* 1–3, <http://www.field.com/fieldpollonline/subscribers/RLS2188.pdf> (Mar. 15, 2006).

95. *Id.*

96. *Id.*

97. Mark A. Hall, F. Trachtenberg & E. Dugan, *The Impact on Patient Trust of Legalising Physician Aid in Dying*, 31 *J. Med. Ethics* 693, 694 (2005).

98. Kevin B. O’Reilly, *Doctors Favor Physician-Assisted Suicide Less than Patients Do; But an Opinion Poll Shows Doctors’ Support up 2 Percentage Points from a Poll Earlier This Year*, <http://www.ama-assn.org/amednews/2005/11/21/prsa1121.htm> (Nov. 21, 2005).

99. *Id.*

100. See e.g. Charles F. McKhann, *A Time to Die: The Place for Physician Assistance* 4–5 (Yale U. Press 1999) (renowned oncologist and professor of medicine at Yale University exploring the language issue extensively).

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.”¹⁰¹

“Suicide” and the choice of a dying patient to hasten impending death in a peaceful and dignified manner are starkly different from a mental health perspective. Profound psychological differences distinguish suicide from actions under the Dignity Act. As one psychiatrist recently summarized,

The term “assisted suicide” is inaccurate and misleading with respect to the DWDA [Death with Dignity Act]. These patients and the typical suicide are opposites:

- The suicidal patient has no terminal illness but wants to die; the DWDA patient has a terminal illness and wants to live.
- Typical suicides bring shock and tragedy to families and friends; DWDA deaths are peaceful and supported by loved ones.
- Typical suicides are secretive and often impulsive and violent. Death in DWDA is planned; it changes only timing in a minor way, but adds control in a major and socially approved way.
- Suicide is an expression of despair and futility; DWDA is a form of affirmation and empowerment.¹⁰²

The Oregon Department of Human Services, which is vested with the responsibility to report on the Dignity Act, recently adopted the policy that it will no longer refer to aid in dying as “assisted suicide” or “physician-assisted suicide.” As explained by a medical epidemiologist at the Department of Human Services, it “probably has not been correct for us to be using this language all along.”¹⁰³

This is consistent with the Dignity Act itself, which clearly states that “[a]ctions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”¹⁰⁴ Similarly, the American Public

101. Br. of Amicus Curiae Coalition of Mental Health Prof. 17, *Gonzales v. Or.*, 546 U.S. 243 (2006) (quoting Am. Psychol. Assn., *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional* 1 (1997)); see also, David M. Smith & David Pollack, *A Psychiatric Defense of Aid in Dying*, 34 *Community Mental Health J.* 547, 548–49 (1998); Rhea K. Farberman, *Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional*, 28 *Prof. Psychol.: Research & Prac.* 544, 545 (1997).

102. E. James Lieberman, Ltr. to the Ed., *Death with Dignity*, 41 *Psychiatric News* 29, 29 (2006) (available at “past issues”, <http://pn.psychiatryonline.org>).

103. Kevin B. O’Reilly, *Oregon Nixes Use of Term “Physician-Assisted Suicide”*, <http://www.ama-assn.org/amednews/2006/11/06/prsc1106.htm> (Nov. 6, 2006) (quoting Katrina Hedberg, a DHS Public Health Division medical epidemiologist).

104. Or. Rev. Stat. Ann. § 127.880 (West 2005).

Health Association adopted a policy to this effect at its 2006 annual meeting.¹⁰⁵

Other professional societies are reaching the same conclusion regarding terminology: the American Academy of Hospice and Palliative Medicine adopted a policy on terminology used to discuss the choice made by a mentally competent, terminally ill patient to self-administer medication for the purpose of hastening death, calling the practice “Physician-Assisted Death,” and rejecting the term “Physician-Assisted Suicide” as “emotionally charged” and less accurate.¹⁰⁶

V. MONTANA’S DEMONSTRATED COMMITMENT TO EXCELLENT END-OF-LIFE CARE

Finally, when patients can expect good pain and symptom management, judges are less likely to conclude that all that is re-

105. Am. Pub. Health Assn., *Supporting Appropriate Language Used to Discuss End of Life Choices*, http://www.compassionandchoices.org/pdfs/APHA_Policy.pdf (Nov. 8, 2006). Similarly, the American College of Legal Medicine (ACLM) argued in an amicus brief submitted to the U.S. Supreme Court in 1996:

A. The Term “Physician-Assisted Suicide” Colors the Issue.

Semantics, of course, do not resolve the instant issue. Yet, the term “physician-assisted suicide” is arguably a misnomer that unfairly colors the issue, and for some, evokes feelings of repugnance and immorality. The appropriateness of the term is doubtful in several respects. First, neither the New York nor the Washington statute at issue in these cases contain the phrase “physician-assisted suicide.” . . . Second, the word “suicide” itself is defined not only as the “taking of one’s own life” but also as the “destruction or ruin of one’s own interests.” As exemplified in the discussion below, it seems inappropriate to characterize requests for treatment that ends life, made by suffering, terminally-ill patients, as any form of destruction or ruination of their interests. Assuming a patient’s mental competence, and recognizing this Court’s long-held commitment to the principles of personal autonomy and free will . . . , prescribing medication intended to end life in the subject context serves—not destroys or ruins—a patient’s interests. For these reasons, ACLM questions whether the subject statutes even apply to the situation in which a physician cares for a mentally-competent adult in the end-stages of a terminal illness with medical treatment intended to end life. Notwithstanding that fact, ACLM rejects the term “physician-assisted suicide,” and instead refers herein to the practice in question as “treatment intended to end life.”

Br. of Amicus Curiae Am. College of Leg. Med. at 4–5, *Vacco v. Quill*, 521 U.S. 793 (1997) (citation omitted).

106. Am. Acad. Hospice & Palliative Med., *Policy on Physician-Assisted Death*, <http://www.aahpm.org/positions/suicide.html> (Feb. 14, 2007). This 2007 policy replaces an outdated policy adopted in 1997, which used the less accurate and “emotionally charged” term “physician assisted suicide.” Am. Acad. Hospice & Palliative Med., *Policy on Comprehensive End-of-Life Care and Physician-Assisted Suicide* (Sept. 1, 1997) (available in *Medical Ethics: Codes, Opinions, and Statements* 367 (Baruch L. Brody et al. eds., BNA Books 2000)).

ally needed is simply better pain and symptom management.¹⁰⁷ Montana has long had the issue of pain management and palliative care in the public eye. The state created a high profile pain management and palliative care program, initially known as the Missoula Demonstration Project, led by a nationally prominent palliative care clinician.¹⁰⁸ The Project was established in 1996, and was later renamed Life's End Institute, Missoula Demonstration Project.¹⁰⁹ The Montana Board of Medical Examiners has adopted a guideline promoting pain management, and a Joint Policy Statement of the Boards of Medical Examiners, Nursing, and Pharmacy promoting pain management.¹¹⁰ Additionally, the Legislature has formed a Montana pain and symptom management task force.¹¹¹

VI. CONCLUSION

It is important to the nation, and the federalism experiment invited by the U.S. Supreme Court in *Glucksberg*, to have a second state join Oregon and serve as a "laboratory" for legalized aid in dying.¹¹² Montana is uniquely situated to become that second state, as it has a rich, robust tradition of respecting individual liberty, privacy and dignity under an unusually protective state Constitution. That tradition, which has provided broad protection to life-shaping life-course determinative decisions, ought to result in the Montana Supreme Court embracing the right of mentally competent terminally ill Montanans to choose aid in dying. Further, the Montana Supreme Court can consider the issue with more than nine years of data from the State of Oregon. The data inform the analysis of whether recognition of a right to choose aid in dying would pose unacceptably high risks to patients or physicians, outweighing the rights of patients to have access to this option. Finally, Montana has a demonstrated commitment to providing all terminally ill patients good end-of-life care, ensuring that no

107. See Tucker, *supra* n. 54, at 359–63.

108. Life's End Inst., *History*, <http://www.lifes-end.org/about/> (accessed April 4, 2007). The Institute was led by the respected palliative care physician Ira Byock. *Id.*

109. *Id.*

110. Mont. Bd. of Med. Examrs., Mont. Bd. of Nursing & Mont. Bd. of Pharm., *Joint Policy Statement: Statement of the Prescribing and Filling of Controlled Substances in the Treatment of Chronic Pain*, http://mt.gov/dli/bsd/license/bsd_boards/med_board/pdf/chronic_pain.pdf (accessed May 10, 2007).

111. Mont. Sen. Jt. Res. 28, 2005 Sess. 59th Leg. (Apr. 19, 2005).

112. *Wash. v. Glucksberg*, 521 U.S. 702, 737 (1997).

terminally ill Montanan need choose aid in dying due to inadequate pain and symptom management.

A fraction of dying patients, even with excellent pain and symptom management, confront a prolonged dying process marked by extreme suffering and deterioration. Some of these patients determine that hastening impending death is the better alternative. Recognition of such a right would harm no one, and would benefit both the relatively few patients *in extremis* who would make use of it, and a great many more who would draw comfort from knowing this option is available should their dying process become intolerable to them.

