

AID IN DYING: LAW, GEOGRAPHY AND STANDARD OF CARE IN IDAHO

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MERIDIAN -- An elderly couple is dead after shots were fired in a Meridian home Sunday evening. . .

Ada County Coroner . . . 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 . . . say investigators were told by family members that Robert and Olive were both suffering from terminal cancer . . . ¹

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 decisions, 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 can ingest to bring about a peaceful death if the dying process becomes unbearable.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



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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, reflects this: roughly one-third of the patients who obtain the medication each year do not go on to ingest it. They are comforted by 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 frequently mentioned reasons.

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 with 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 the standard of care.

Idaho law governing end of life care

Idaho statutes include The Medical Consent and Natural Death Act (MC-NDA), I.C. §§ 39-4501 to -4515. This statute empowers citizens to refuse or di-

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rect 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

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 permits an affirmative or deliberate act or omission to end life, other than to allow the natural process of dying.”⁵

This raises the question whether aid in dying could fall within this exclusion. Those who consider the act of allowing a dying patient to ingest medication to achieve a peaceful death 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.⁶ In any event, the statute does not contain a prohibition against aid in dying.

A critical analysis of the law in Idaho supports the contention that Idaho patients should be able to access aid in dying because 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.

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.⁷

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.⁸ If the patient does achieve the desired death, an aggressive prosecutor might argue that the physician could be prosecuted for homicide. This situation was recently addressed 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.⁹

Based on this landscape, Idaho physicians should feel safe to provide aid in dying to their competent, terminally-ill patients, free of fear of criminal prosecu-

tion.¹⁰ 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, and in the growing support for the practice in the medical and health policy communities.

Aid in dying in surrounding states

Oregon

Oregonians approved the passage of the Oregon Death with Dignity Act (Dignity Act) in 1994.¹¹ 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.¹² The experience in Oregon demonstrates that when this option is available, it does not place patients at risk, as those who oppose aid in dying have advocated.¹³ Oregon’s experience has caused even staunch opponents to admit that continued opposition to such a law can only be based on moral or religious grounds.¹⁴

The option of aid in dying has not been unwillingly forced upon those who are poor, uneducated, uninsured, or otherwise disadvantaged.¹⁵ In fact, 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.¹⁶ One hundred percent of patients opting for aid in dying had private health insurance, Medicare, or Medicaid, and were overwhelmingly enrolled in hospice care.¹⁷ Furthermore, during the first 12 years in which it was a legal option, only 460 Oregonians chose it.¹⁸ Terminally ill adults who chose this option in 2009 represented 19 deaths for every 10,000 Oregonians who died that year. 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.¹⁹

Simultaneously, Oregon doctors increased efforts to improve their ability

to provide adequate end-of-life care, including increasing their knowledge of pain medication usage for the terminally ill, becoming more informed at recognizing depression and other conditions that could impair decision making, and referring their patients to hospice programs with greater frequency.²⁰ The option of aid in dying also has psychological benefits for terminally ill patients. The availability of the option gives a terminally-ill patient autonomy, control, and choice, which physicians in Oregon have identified as the predominant motivational factors behind the decision to request assistance in dying.²¹

Washington

Washington passed a Dignity Act virtually identical to Oregon’s in November 2008.²² The Washington Department of Health publishes information about the types and quantities of forms received under the Dignity Act on its website²³ and updates this information weekly.²⁴ 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 includes data from March 2009 through December 31, 2009.²⁵ Statistical reports will be completed annually thereafter.

Montana

Montana recognizes the right of its citizens to choose aid in dying through a decision of the Montana Supreme Court. In *Baxter v. State*, Robert Baxter, a 75-year-old U.S. Marine veteran and long-haul truck driver dying of lymphocytic leukemia, sued the State to establish his right to choose aid in dying.²⁶ 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.²⁷ Additional plaintiffs included four Montana physicians who treat patients with termi-

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nal illnesses and Compassion & Choices, the national non-profit organization that advocates on behalf of terminally ill persons.²⁸

The plaintiffs challenged the application of Montana's homicide statute to a physician providing a prescription to a terminally-ill, mentally-competent patient for medication that the patient could consume to bring about a peaceful death if he found his dying process unbearable.²⁹ The case invoked the Montana State Constitution's guarantees of privacy and dignity.³⁰ Commentators speculated that constitutional claims of this nature had a good chance of success given the state constitution's text and the body of law construing these provisions, which was robustly protective of individual decision-making.³¹

Plaintiffs asserted an alternative argument that under the consent as a defense doctrine, a doctor who provided aid in dying could not be subject to prosecution for homicide.³² The patient would have consented to the physician's assistance in precipitating the patient's death and there was no public policy reason to deny the consent defense under these circumstances.³³ 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 to choose aid in dying.³⁴ The argument—that risks will still be present if aid in dying is an option—had been central to the states' efforts to prevent courts from finding a right to choose this intervention.³⁵

On December 5, 2008, the Montana State District Court 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."³⁶ 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."³⁷ In an odd synchronicity, Plaintiff Bob Baxter died the same day the lower court ruling was issued. The State appealed.

The Supreme Court held 5-2 that terminally ill Montanans have the right to choose aid in dying under state law.³⁸ The court declined to reach the constitutional issues.³⁹ Instead, it resolved the case on the alternative ground under the consent defense to the homicide statute, finding:

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"no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy."⁴⁰

... [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.⁴¹

Montana has not enacted statutes with specific requirements governing provi-

sion of aid in dying.⁴² Accordingly, the limitations of the laws in Oregon and Washington do not apply in Montana, although certain boundaries recognized by the Court 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.

Aid in dying in Idaho should be governed by the standard of care

Most medical care is not governed by statute or court decision, but is instead governed by the standard of care.⁴³ 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, taking into account his or her training, experience, and fields of medical specialization.⁴⁴

Oregon's, Washington's and Montana's practices of affirmatively permitting mentally competent, terminally ill patients to choose aid in dying will appropriately influence the standard of care in Idaho. 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.

Conclusion

Most Americans "believe a person has a moral right to end their life if they are suffering great pain and have no hope of improvement."⁴⁵ 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 gunshot.

Cases of this nature appear with disturbing frequency in the newspapers, as noted at the outset of this article.⁴⁶ However, should aid in dying emerge as an end-of-life option in Idaho, it is hopeful that such tragedies can be avoided in the future.

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Endnotes

- ¹ KTVB & Associated Press, *Coroner: Meridian couple planned murder-suicide*, KTVB.COM, April 5, 2010, available at <http://www.ktvb.com/news/Meridian-police-involved-death-investigation-89888732.html>.
- ² "Aid in dying" is a recognized term of medical art. See, e.g., 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, 45 (2009), available at http://www.compassionandchoices.org/documents/Harvard_Health_Policy_Rvw_Tucker.pdf.
- ³ See *id.*
- ⁴ IDAHO CODE ANN. § 39-4509(1), (2) (2005) (emphasis added).
- ⁵ IDAHO CODE ANN. § 39-4514(2) (2005).
- ⁶ Mental health professionals recognize a distinct difference between "suicide" and the choice of a dying patient for a peaceful death. See *Gonzales v. Oregon*, 126 S. Ct. 904 (2006).
- ⁷ IDAHO CODE ANN. § 18-4014 (1972).
- ⁸ OR. DEP'T OF HUMAN SERVS., TWELFTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT tbl.1 at 2 (2010), available at <http://www.oregon.gov/DHS/ph/pas/docs/yr12-tbl-1.pdf>.

- ⁹ *Baxter v. State*, 224 P.3d 1211, 1215 (Mont. 2009).
- ¹⁰ Concerns about possible criminal prosecution are the primary reason physicians fear providing aid in dying. Another concern is that professional disciplinary action can be taken against a physician for providing such care.
- ¹¹ OR. REV. STAT. § 127.800-995 (2005); see *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), vacated, 107 F.3d 1382 (9th Cir. 1997).
- ¹² 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 [hereinafter ANNUAL REPORTS], available at <http://oregon.gov/dhs/ph/pas/ar-index.shtml>.
- ¹³ 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).
- ¹⁴ See Daniel E. Lee, *Physician-Assisted Suicide: A Conservative Critique of Intervention*, 33 Hastings Center Rep. 17, (Jan.-Feb. 2003).
- ¹⁵ 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>.
- ¹⁶ 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>.
- ¹⁷ *Id.* at 23.
- ¹⁸ ANNUAL REPORTS, *supra* note 12, YEAR 12 - 2009 SUMMARY (2010).
- ¹⁹ *Id.*
- ²⁰ See Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide*, 347 NEW ENG. J. MED. 582, 584-85 (2002); Lawrence J. Schneiderman, *Physician-Assisted Dying*, 293 JAMA 501, 501 (2005).
- ²¹ See Kathy L. Cerminara & Alina Perez, *Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 512-13 (2000); See also Ganzini, *supra* note 20.
- ²² Washington Death with Dignity Act, WASH. REV. CODE § 70.245 (2008).
- ²³ WASH. STATE DEP'T OF HEALTH, CENTER FOR HEALTH STATISTICS, DEATH WITH DIGNITY ACT, <http://www.doh.wa.gov/dwda> (last visited July 1, 2009).
- ²⁴ *Id.*, FORMS RECEIVED, <http://www.doh.wa.gov/dwda/formsreceived.htm> (last visited Apr. 6, 2010).
- ²⁵ *Id.*, 2009 DEATH WITH DIGNITY ACT REPORT, http://www.doh.wa.gov/dwda/forms/DWDA_2009.pdf (last visited July 1, 2009).

- ²⁶ 224 P.3d at 1214.
- ²⁷ *Id.* at 1224.
- ²⁸ *Id.* at 1214.
- ²⁹ *Id.*
- ³⁰ MONT. CONST. art. II, §§ 4, 10.
- ³¹ 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).
- ³² MONT. CODE ANN. § 45-2-211(2)(d) (2009).
- ³³ *Id.*
- ³⁴ OR. REV. STAT. §§ 127.800-897 (2003). See also ANNUAL REPORTS, *supra* note 14.
- ³⁵ 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. SURV. AM. L. 355 (2004).
- ³⁶ *Baxter v. Montana*, No. 2007-787 (Mont. 1st Dist. Dec. 5, 2008).
- ³⁷ *Id.*
- ³⁸ *Baxter*, 224 P.3d at 1222.
- ³⁹ *Id.* at 1216.
- ⁴⁰ *Id.* at 1215.
- ⁴¹ *Id.* at 1217-18.
- ⁴² 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." See Dan Person, *Political notes*, BOZEMAN DAILY CHRONICLE, Feb. 14, 2010, available at http://www.bozemandailychronicle.com/news/article_90d2cbd4-966d-5901-9405-d10e053-b983c.htm.
- ⁴³ See 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 189 (2002).
- ⁴⁴ IDAHO .CODE ANN. § 6-1012 (1976); see also *Dulaney v. St. Alphonsus Reg'l Med. Ctr.*, 137 Idaho 160, 164, 45 P.3d 816, 820 (2002).
- ⁴⁵ 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 (Jan. 5, 2006), <http://people-press.org/reports/pdf/266.pdf>.
- ⁴⁶ See also, Carla Rubinski, *Spotlight on Assisted Suicide in Connecticut*, available at <http://www.neilrogers.com/news/articles/2005030818.html> (last visited July 1, 2010).

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