IN THE SUPREME COURT OF THE STATE OF MONTANA

No. DA 09-0051

ROBERT BAXTER, et al.,

Plaintiffs-Appellees,

v.

STATE OF MONTANA and STEVE BULLOCK,

Defendants-Appellants

On Appeal from the First Judicial District Court of Lewis and Clark County

---

BRIEF *AMICUS CURIAE* of INTERNATIONAL TASK FORCE ON EUTHANASIA & ASSISTED SUICIDE, HERBERT HENDIN, MD, and PROFESSOR YALE KAMISAR IN SUPPORT OF DEFENDANTS-APPELLANTS

Nickolas C. Murnion (Bar No. 1106)
Nickolas C. Murnion Law Firm
417 Main Street; P.O. Box 375
Jordan, MT 59337
406-557-2480 (telephone)
406-557-2595 (facsimile)

Rita L. Marker
1233 Maryland Avenue
Steubenville, OH 43952
740-632-1032 (telephone)
740-282-0769 (facsimile)
Admitted *pro hac vice*

TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES iii

STATEMENT OF INTEREST 1

STATEMENT OF ISSUES 2

STATEMENT OF CASE 2

SUMMARY OF ARGUMENT 2

ARGUMENT 3

I. Lack of Transparency in Its Practice of Assisted Suicide Renders Oregon an Unreliable Laboratory for Assessing Assisted Suicide 3

A. Lack of Evidence Is Not Evidence that Abuse Has Not Occurred 5

B. Studies of Oregon's Law Are Misleading 7

C. Claims that Pain Control In Oregon Has Improved Are Deceiving 9

D. Complications Are Unknown and Unknowable. 10

II. Requirements in Oregon's Law Give a False Impression of Protection 11

A. Doctors Can Prescribe Assisted Suicide for Mentally Ill or Depressed Patients 12

B. Doctor Shopping Takes Place until a Willing Prescriber Is Found 13

C. Physicians Prescribe Assisted-Suicide Drugs for Patients Whom They Have Known for Less than One Week 14

III. Once Assisted Suicide Is Transformed from a Crime into a Medical Treatment, the Force of Economic Gravity Assures that Health Insurance Programs Will More Readily Authorize It over More Costly Treatments Patients Need and Want..... 15

IV. Legalized Assisted Suicide Can Mask Domestic and Elder Abuse 17

A. An Heir Can Serve as One of Two Witnesses to a Patient's Death Request 18

B. Patients Are at Greatest Risk after the Prescription Is Written..... 19

CONCLUSION 20

CERTIFICATE OF COMPLIANCE 21

CERTIFICATE OF SERVICE..... 21

TABLE OF AUTHORITIES

Cases

Baxter v. Montana, Cause No. ADV-2007-787, Dec. 5, 2008 (2008 Mont. Dist. LEXIS 482).....2, 4

Washington v. Glucksberg, 521 U.S. 702 (1997)..... 4

Statutes

Mont. Code Ann. § 45-5-102 (2007)..... 2

Mont. Code Ann. § 45-5-105 (2007)..... 2

Or. Rev. Stat. §§ 127.800 - .897 (2007) 2, 4

Or. Rev. Stat. § 127.810 (2007) 18

Or. Rev. Stat. § 127.825 (2007) 12

Or. Rev. Stat. § 127.865 (2007) 6

Or. Rev. Stat. § 127.890 (2007) 18

Rev. Code Wash. §§ 70.245.010 - .903 (2009)..... 8

Other Authorities

Phil Alderson, *Absence of evidence is not evidence of absence*, 328 Brit. Med. J. 476 (2004)..... 5

Margaret Pabst 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)..... 7

Margaret Pabst Battin, *Safe, Legal, Rare? Physician-Assisted Suicide and Cultural Change in the Future,* in *Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy. An International Perspective* 37 (Dieter Birnbacher & Edgar Dahl eds., 2008) 9

Daniel Callahan, *Organized Obfuscation: Advocacy for Physician-Assisted Suicide,* 38 Hastings Center Rep. 30 (2008) 11

Centers for Disease Control and Prevention, *National Vital Statistics Reports,* Vol. 56, No. 10 3

Compassion in Dying of Oregon, *Summary of Hastened Deaths*, Data attached to Compassion in Dying of Oregon's IRS Form 990 for 2003 15

Tom Daschle, *Critical: What We Can Do about the Health-Care Crisis,* (2008) 15

Death with Dignity National Center (DDNC) staff and board, *available at* http://www.deathwithdignity.org/whatwedo/staff.asp 8

Dept. of Human Services, *FAQs about the Death with Dignity Act, available at* http://www.oregon.gov/DHS/ph/pas/faqs.shtml 11, 16

Dept. of Human Services, *Oregon's Death with Dignity Act: Three years of legalized physician-assisted suicide,* Feb. 22, 2001, Table 3, *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year3.pdf 14

Dept. of Human Services, *Sixth Annual Report,* March 10, 2004, Table 4, *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year6.pdf 12

Dept. of Human Services, *Seventh Annual Report,* March 10, 2005, Table 4, *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year7.pdf 12

Dept. of Human Services, *Eighth Annual Report*, March 9, 2006, Table 4, *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year8.pdf 12

Dept. of Human Services, *Ninth Annual Report*, March 8, 2007, Methods, *available at* http://www.oregon.gov/DHS/ph/pas/docs/Methods.pdf 10

Dept. of Human Services, *Ninth Annual Report*, March 8, 2007, Table 1, *available at* http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf 12

Dept. of Human Services, *Tenth Annual Report*, March 18, 2008, Table 1, *available at* http://www.oregon.gov/DHS/ph/pas/docs/yr10-tbl-1.pdf ...10, 12, 14

Nadeem Esmail, *"Too Old" for Hip Surgery*, Wall St. J., Feb. 9, 2009..... 15

Erick K. Fromme et al., *Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002*, 7 J. of Palliative Med. 431 (2004) 10

Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia*, Princeton University Press (2006)..... 5

Herbert Hendin and Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 Mich. L. Rev. 1613 (2008)..... 7

House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]*, *Volume II: Evidence*, Apr. 4, 2005, *available at* http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf 10, 11, 19

Susan Donaldson James, *Death Drugs Cause Uproar in Oregon*, ABCNews.com, Aug. 6, 2008, *available at* http://abcnews.go.com/print?id=5517492 17

KATU, *Letter noting assisted suicide raises questions*, July 30, 2008, *available at* http://www.katu.com/news/26119539.html 17

Bill Kettler, *A death in the family: "We knew she would do it,"* Mail Trib. (Medford, OR), June 25, 2000 13

National Center on Elder Abuse, *A Response to the Abuse of Vulnerable Adults* (Washington, DC 2000) 17

National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect, *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America* (2003) 17

Oregon Health Division, 48 *CD Summary*, No. 6 (1999), *available at* http://egov.oregon.gov/DHS/ph/cdsummary/1999/ohd4806.pdf 6

Linda Prager, *Details emerge on Oregon's first assisted suicides*, Am. Med. News, Sept. 7, 1998 6

Tristan Scott, *Suicide Rate in Missoula County up; Montana No. 1 in U.S.*, Billings Gazette, Feb. 10, 2008 3

Kristen Stewart, *U. study shows no abuse of legal doctor-assisted suicide*, Salt Lake Trib., Sept. 26, 2007 7

Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon – The Second Year*, 342 New Eng. J. Med. 598 (2000) 12, 14

Washington State Public Disclosure Commission, "Yes on I-1000," C-3 donation report form, Record No. 100263159, July 22, 2008 8

STATEMENT OF INTEREST

The International Task Force on Euthanasia and Assisted Suicide (ITF), is an international leader in the debate over assisted suicide and euthanasia. It addresses legal and public policy implications of assisted suicide and their impact on health care delivery, pain control, the rights of the terminally ill, and persons at risk of abuse.

Herbert Hendin, MD, Professor of Clinical Psychiatry at New York Medical College, is a nationally recognized authority on suicide and assisted suicide. He has researched and written extensively on the topics, most recently addressing physician-assisted suicide in Oregon from a medical perspective.

Yale Kamisar, Professor of Law at the University of San Diego and Professor Emeritus of Law at the University of Michigan, is widely recognized for his expertise on euthanasia, physician-assisted suicide and constitutional-criminal procedure. His writings on the topics have been widely published for more than fifty-one years, beginning with a landmark article in the *Minnesota Law Review* and, most recently, in the March 4, 2009 *New Jersey Law Journal.*

Amici's particular expertise in analyzing practical implications and specific information related to Oregon's experience will assist this Court in assessing the validity of relying on Oregon as a laboratory in which legalized assisted suicide

has been tested and its results scrutinized. Additionally, it will assist this Court in determining whether guidelines, such as those in Oregon, are real or illusory.

Amici believe that their perspective and arguments will not be adequately presented by others.

STATEMENT OF ISSUES

Amici adopt Defendants-Appellants Statement of Issues.

STATEMENT OF CASE

Amici adopt Defendants-Appellants Statement of the Case.

SUMMARY OF ARGUMENT

In its ruling in *Baxter v. Montana*,[1] the District Court ruled that physicians who assist patients' suicides are protected from liability under the State's homicide statute.[2] The Court mistakenly relied on Oregon as a laboratory in which legalized assisted suicide has been tested and its results scrutinized. The lack of transparency in implementation of Oregon's "Death with Dignity Act"[3] renders Oregon an unreliable laboratory for assessing its social, economic and medical experiment with assisted suicide. The Oregon law's requirements, often referred to

---

[1] *Baxter v. Montana*, Cause No. ADV-2007-787, Dec. 5, 2008 (2008 Mont. Dist. LEXIS 482).

[2] *Id*. at ¶ 64, referring to the state's homicide statute, Mont. Code Ann. § 45-5-102 (2007). Inexplicably, the District Court neglected to address the potential of prosecution under the State's assisted-suicide statute, Mont. Code Ann. § 45-5-105 (2007), raising the question as to whether the physician is only protected if the patient actually dies of the prescribed lethal drugs.

[3] Or. Rev. Stat. §§ 127.800 - .897 (2007).

as safeguards, give a false impression of patient protection.

The District Court failed to address the context in which assisted suicide would be carried out in Montana. The State already has the highest suicide rate in the nation, twice the national average.[4] So dire is the state's suicide rate that the legislature spends hundreds of thousands of dollars on suicide prevention programs.[5]

Montana's health care system, like that in all states, is under strain, setting the stage for assisted suicide becoming an acceptable, inexpensive method of health care cost containment. Furthermore, legalized assisted suicide can mask patient abuse and elder abuse.

Removing the time-tested barriers that protect patients by giving doctors the power to prescribe lethal drugs does not enhance patient privacy and dignity. Instead, it subjects patients to dangers that are uncontrollable and untraceable.

ARGUMENT

I. Lack of Transparency in Its Practice of Assisted Suicide Renders Oregon an Unreliable Laboratory for Assessing Assisted Suicide.

In 1997, before Oregon's assisted-suicide law went into effect, the United States Supreme Court concluded in *Glucksberg* that "Americans are engaged in an

[4] Centers for Disease Control and Prevention, *National Vital Statistics Reports,* Vol. 56, No. 10, p. 93.
[5] Tristan Scott, *Suicide Rate in Missoula County Up; Montana No. 1 in U.S.*, Billings Gazette, Feb. 10, 2008.

earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide."[6] In her concurrence, Justice O'Connor noted the importance of "protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not be truly voluntary...." She wrote that the democratic process would strike the proper balance "in protecting those who might seek to end life mistakenly or under pressure." She said the task of striking that balance was to be left to the "'laboratory' of the States."[7]

The District Court acknowledged that "the State has a compelling interest in preventing abuses stated by Justice O'Connor" but then dismissed the prospect of those abuses. The District Court mistakenly declared that "abuses can be controlled by state law,"[8] citing the "numerous requirements to avoid such potential abuses"[9] in Oregon's law.

Oregon's "laboratory" results are inconclusive, at best, since what takes place in that laboratory is shrouded in secrecy, precluding the possibility of knowing whether there are individuals whose lives have ended mistakenly or under pressure. In 2006, reflecting on that secrecy, Neil M. Gorsuch explained, "[W]hile

---

[6] *Washington v. Glucksberg,* 521 U.S. 702, 735, 117 S. Ct. 2258, 117 S. Ct. 2302, 138 L. Ed. 772 (1997).
[7] *Id.* at 737.
[8] *Supra,* n. 1 at ¶ 56.
[9] *Id.* at ¶ 57, citing Or. Rev. Stat. § 127.800 - .897 (2007).

Oregon is often touted as a 'laboratory' or 'experiment' for whether assisted suicide can be successfully legalized elsewhere in the United States, Oregon's regulations are crafted in ways that make reliable and relevant data and case descriptions difficult to obtain. Given this, it is unclear whether and to what extent Oregon's experiment, at least as currently structured, will ever be able to provide the sort of guidance needed and wanted by other jurisdictions considering whether to follow Oregon's lead."[10]

A. Lack of Evidence of Abuse Is Not Evidence that Abuse Has Not Occurred.

Oregon's Death with Dignity Act changed medical practice in that state. It transformed the crime of assisted suicide into a medical treatment. Normally, medical treatments or interventions are subjected to intense scrutiny with meticulous attention paid to all aspects, including behavioral characteristics, before determining they are beneficial. That scrutiny entails careful examination of data, openness, and disclosure of any conflicts of interest. Failing to do so can skew results, rendering them misleading and dangerous.[11] The intense secrecy surrounding implementation of the Oregon law precludes any ability to objectively determine its impact.

---

[10] Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia,* Princeton University Press 119 (2006).

[11] See, *e.g.,* Phil Alderson, *Absence of evidence is not evidence of absence,* 328 Brit. Med. J. 476 (2004).

The Oregon law mandates that physicians report activities carried out under the Death with Dignity Act and that the state issue an annual report based on that data.[12] Oregon's annual official reports convey the notion that assisted suicide in the state has not resulted in any problems or abuses. However, information in those reports is questionable at best since it is based on self-reports by the same doctors who are carrying out assisted suicide.

Ever since the Oregon law was implemented, the problematic nature of that self-reporting has been apparent. In its official summary for the first annual report, the state (using rather surprising language) noted: "For that matter the entire account could have been a cock-and-bull story. We assume, however, that physicians were their usual careful and accurate selves."[13] Furthermore, Oregon officials in charge of formulating annual reports have conceded "there's no way to know if additional deaths went unreported" because the Oregon Department of Human Services "has no regulatory authority or resources to ensure compliance with the law."[14] The Oregon Public Health Division charged with monitoring the law "does not collect the information it would need to effectively monitor the law and its actions and publications act as the defender of the law rather than as the

---

[12] Or. Rev. Stat. § 127.865: 3.11.

[13] Oregon Health Division, 48 *CD Summary*, No. 6 at 2 (1999), *available at* http://egov.oregon.gov/DHS/ph/cdsummary/1999/ohd4806.pdf (last visited March 4, 2009).

[14] Linda Prager, *Details emerge on Oregon's first assisted suicides*, Am. Med. News, Sept. 7, 1998.

protector of the welfare of terminally ill patients."[15]

All that can be stated with certainty regarding the number of deaths, complications, and other data in official Oregon reports is that they reflect "reported" deaths, "reported" complications and other "reported" information. No one can say with certainty whether those figures are or are not accurate.

But those annual reports, based on unverified and unverifiable data, are used as the basis for studies that claim to prove that the Oregon law is problem free.

B. Studies of Oregon's Law Are Misleading.

In October 2007, just as the Washington State campaign to legalize assisted suicide was getting underway, a study published in the *Journal of Medical Ethics*[16] was receiving coverage in newspapers across the country. Articles about it quoted Compassion & Choices legal director Kathryn Tucker who called the study "the most pre-eminent examination" to date showing that assisted suicide is abuse and problem free, even for vulnerable people.[17] The data upon which the study's conclusions were based, however, came from Oregon's 2007 official report.

This highlights the circular nature of such data and studies. First, data is

---

[15] Herbert Hendin and Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective,* 106 Mich. L. Rev. 1613 (2008).
[16] Margaret Pabst 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 591-597 (2007).
[17] See, *e.g.,* Kristen Stewart, *U. study shows no abuse of legal doctor-assisted suicide,* Salt Lake Trib., Sept. 26, 2007.

obtained from flawed official reports and used in a "neutral" study to "prove" the absence of problems or abuses. Then, the academic study, rather than the official report, becomes a primary source cited as definitive proof that assisted suicide is working flawlessly in Oregon.

In addition to the dubious nature of the study's statistics, those who read it or saw news coverage about it were led to believe that the study had been done by dispassionate, neutral academics. Crucial affiliations of its lead author, University of Utah professor Margaret Pabst Battin, Ph.D., were not disclosed. She has long advocated assisted suicide, is a member of the advisory board of the Death with Dignity National Center,[18] and was a donor[19] to the campaign to legalize assisted suicide in Washington.[20]

Recently, Battin wrote favorably about the prospect of assisted suicide becoming a normal, accepted way of dying. She opined that current assisted-suicide promotion, based on assurances that it is intended to be "safe, legal and rare," will change, and planned death will be the norm. This, she wrote, "would be good" and would provide the "practical and legal freedom to plan whatever family

---

[18] Death with Dignity National Center (DDNC) staff and board, *available at* http://www.deathwithdignity.org/whatwedo/staff.asp (last visited Feb. 28, 2009). The DDNC spearheaded the drive to legalize assisted suicide in Washington.
[19] Washington State Public Disclosure Commission, "Yes on I-1000," C-3 donation report form, Record No. 100263159, July 22, 2008.
[20] Washington State Initiative 1000, approved by voters, Nov. 4, 2008. Codified as Rev. Code Wash. §§ 70.245.010 - .903 (2009).

gatherings, ceremonies, and religious observances they might wish – not as a desperate last resort or reactive escape from bad circumstances, but as a preemptively prudent, significant, culminative experience."[21]

Few people who read Battin's journal article or have seen it cited as a definitive study in other publications are aware of her pervasive bias in favor of assisted suicide.

C. Claims that Pain Control in Oregon Has Improved Are Deceiving.

Among the claims made by those who support Oregon's law is that a high percentage of patients are in hospice care and that pain control has been enhanced as a result of the Death with Dignity Act. However, the number of patients in hospice care is not evidence of good pain control. Indeed, unless there is adequate information about the type of palliative care provided by a particular hospice or the experience and training of its staff, it is possible that those patients may receive substandard care which does not alleviate their symptoms.

Increasing awareness of the need to control pain does not, of itself, result in better pain management. Since Oregon's law went into effect, effective pain management has actually decreased due, at least in part, to understaffing and

[21] Margaret Pabst Battin, *Safe, Legal, Rare? Physician-Assisted Suicide and Cultural Change in the Future,* in *Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy. An International Perspective* 37, 46 (Dieter Birnbacher & Edgar Dahl eds., 2008).

underfunding for effective symptom management.[22] As of 2004, Oregon nurses reported that the inadequacy of meeting patients' pain needs had increased "up to 50 percent even though the emphasis on pain management has remained the same or is slightly more vigorous" and "[m]ost of the small hospitals in the state do not have pain consultation teams at all."[23]

D. Complications Are Unknown and Unknowable.

Oregon's official reports list the number of reported complications. But physicians who submit data about the lack of complications were present at fewer than 28 percent of reported assisted-suicide deaths.[24] Thus, any information submitted by the physicians who were not present at the remaining deaths might have come from secondhand accounts of those present at the deaths[25] or on guesswork.

---

[22] Erick K. Fromme et al., *Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002*, 7 J. of Palliative Med. 431, 439 (2004).

[23] House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]*, *Volume II: Evidence*, Apr. 4, 2005, Hereafter cited as *HL*. Testimony of Sue Davidson of the Oregon Nurses Association, response to question 1098. Note: The hearings were held in Portland, Oregon in Dec. 2004 and published in Apr. 2005. *Available at* http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf (last visited March 3, 2009).

[24] DHS, *Tenth Annual Report on Oregon's Death with Dignity Act*, March 18, 2008, Table 1, *available at* http://www.oregon.gov/DHS/ph/pas/docs/yr10-tbl-1.pdf (last visited March 3, 2009).

[25] DHS, *Ninth Annual Report on Oregon's Death with Dignity Act,* March 8, 2007, Methods, *available at* http://www.oregon.gov/DHS/ph/pas/docs/Methods.pdf (last visited March 3, 2009).

Asked if there is any way to determine complications, Dr. Katrina Hedberg, a lead author of most of Oregon's official reports, replied, "Not other than asking physicians."[26] She said, "[A]fter they write the prescription, the physician may not keep track of the patient."[27] In addition, the Oregon Department of Human Services admits that "[a]pproximately one year from publication of the Annual Report, all source documentation is destroyed."[28] Therefore, even if investigations were provided for under the law, there would be no way to check on information that had been submitted after one year had elapsed.

Nonetheless, Oregon's official reports continue to be used as the basis for demonstrating that all is well under Oregon's assisted-suicide law.

II. Requirements in Oregon's Law Give a False Impression of Protection.

Requirements, often called safeguards, in Oregon's Death with Dignity Act give the illusion of protection. But, in reality, "[r]egulations of that kind, protected from public scrutiny, but with the ring of authority and oversight, are a Potemkin-village form of regulatory obfuscation. They look good, sound good, feel good, but have nothing behind them."[29]

---

[26] *HL*, *supra*, n. 23 at question 597. Testimony of Dr. Katrina Hedberg.
[27] *Id*. at question 567.
[28] Dept. of Human Services, *FAQs about the Death with Dignity Act*, *available at* http://www.oregon.gov/DHS/ph/pas/faqs.shtml (last visited Feb. 16, 2009).
[29] Daniel Callahan, *Organized Obfuscation: Advocacy for Physician-Assisted Suicide*, 38 Hastings Center Rep. 30, 32 (2008).

A. Doctors Can Prescribe Assisted Suicide for Mentally Ill or Depressed Patients.

Under Oregon's Death with Dignity Act, even if a patient is mentally ill or depressed, a referral for counseling or psychological evaluation is required only if the doctor believes that the patient's mental illness or depression is "causing impaired judgment."[30]

Over the years, the reported number of patients referred for counseling declined from a high of ten patients in the second year, to two patients in sixth through the ninth years and to zero in the tenth official report.[31]

Even when an evaluation is done, it may be more for the protection of the physician than for the patient. In addition, there is no way to know if the evaluation meets any degree of professional standards since the only information about such assessments has come from media interviews with physicians or family

[30] Or. Rev. Stat. §127.825: 3.03.

[31] Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon – The Second Year*, 342 New Eng. J. Med., 598, 601, Table 2 (2000);
DHS, *Sixth Annual Report*, March 10, 2004, Table 4, *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year6.pdf (last visited March 3, 2009);
DHS, *Seventh Annual Report*, March 10, 2005, Table 4, *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year7.pdf (last visited March 3, 2009);
DHS, *Eighth Annual Report*, March 9, 2006, Table 4, *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year8.pdf (last visited March 3, 2009);
DHS, *Ninth Annual Report*, March. 8, 2007, Table 1, *available at* http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf (last visited March 3, 2009); and
DHS, *Tenth Annual Report*, March 18, 2008, Table 1, *available at* http://www.oregon.gov/DHS/ph/pas/docs/yr10-tbl-1.pdf (last visited March 3, 2009).

members who are willing to discuss an assisted-suicide death.

The circumstances surrounding the death of Joan Lucas illustrate the cavalier reasoning about psychological evaluations and the casual manner in which they are carried out.

After several doctors had refused to prescribe assisted suicide for Lucas, a willing physician was found. The physician asked Lucas to undergo a psychological test. The Minnesota Multiphasic Personality Inventory (MMPI), ordered by a psychologist and administered at her home by Lucas' children, consisted of questions such as, "How is your sex life? How many times have you been on the cover of a magazine?" Without ever seeing her in person and, based on her reported answers to the MMPI, the psychologist determined that Lucas' judgment was not impaired.

The lethal prescription was written, and Lucas died a short time later. In a newspaper interview, the prescribing physician described his motivation for ordering the evaluation. "I elected to get a psychological evaluation because I wanted to cover my ass," he said.[32]

B. Doctor Shopping Takes Place until a Willing Prescriber Is Found.

Many other patients seeking assisted suicide have also had to ask more than

[32] Bill Kettler, *A death in the family: "We knew she would do it,"* Mail Trib. (Medford, OR), June 25, 2000.

one physician for the lethal prescription.[33] There is no way to know if physicians declined due to personal convictions, because they believed the patients were not terminal ill or because they determined that the patients had impaired judgment. During the first three years of legal assisted suicide in Oregon, reports indicated that, in 59 percent of cases, patients had to ask two or more physicians before receiving the lethal drugs.[34] After the third year, official reports stopped including this category. Patients or their families can doctor shop until a willing physician is found. And, since non-prescribing physicians are not interviewed for official state reports, there is no way to know why they refused to lethally prescribe.

C. Physicians Prescribe Assisted-Suicide Drugs for Patients Whom They Have Known for Less than One Week.

Assisted-suicide advocates describe it as something that is between patients and their own long-time, trusted physicians. That portrayal is inaccurate. In some reported assisted-suicide deaths, physicians have prescribed lethal drugs for patients whom they have known for less than one week.[35] Patients frequently end up going to an assisted-suicide doctor who is working in concert with an assisted-suicide advocacy organization. The Oregon branch of Compassion & Choices

[33] Sullivan, *supra*, n. 31 at 603.
[34] DHS, *Oregon's Death with Dignity Act: Three years of legalized physician-assisted suicide*, Feb. 22, 2001, Table 3, *available at* http://egov.oregon.gov/DHS/ph/pas/docs/year3.pdf (last visited March 3, 2009).
[35] *Supra*, n. 24.

acknowledged its involvement in 79 percent of reported assisted-suicide deaths.[36]

III. Once Assisted Suicide Is Transformed from a Crime into a Medical Treatment, the Force of Economic Gravity Assures that Health Insurance Programs Will More Readily Authorize It over More Costly Treatments Patients Need and Want.

Concern about health care costs and general financial uncertainty, along with serious discussions about limiting health care for the elderly,[37] are currently reaching a boiling point. If assisted suicide is added to the cauldron, the final result can be deadly.

When assisted suicide becomes a medical treatment, it is only one among many options for the treatment of certain conditions. But assisted suicide differs in a major way from other treatments. It is extremely cost effective.

In Oregon, "death with dignity" is covered by health insurance. Referring to payment for assisted suicide, the Oregon Department of Human Services explains, "Individual insurers determine whether the procedure is covered under

---

[36] Compassion in Dying of Oregon, *Summary of Hastened Deaths*, Data attached to Compassion in Dying of Oregon's IRS Form 990 for 2003.

[37] Discrimination against the elderly within the medical care system is an additional prospect. Highly respected policy makers have touted the cost-saving aspects of Britain's National Institute for Health and Clinical Excellence (NICE) and Canada's health care delivery system. See, for example: Tom Daschle, *Critical: What We Can Do about the Health-Care Crisis*, 12, 32-33, 127-128, 159, 173 (2008). However, both countries' programs have protocols that deny such routine interventions as hip surgery for those deemed "too old." For example, although his doctor recommended hip resurfacing surgery (a procedure that gives better results than basic hip replacement), a 57-year-old man from Alberta, Canada was denied the procedure on the basis of his being too old to enjoy the benefits of the surgery. Nadeem Esmail, *"Too Old" for Hip Surgery*, Wall St. J., Feb. 9, 2009.

their policies (just as they do with any other medical procedure)" and the Oregon Medicaid program "ensures that charges for the services of the [Death with Dignity] Act are paid for with only state funds."[38]

When assisted suicide is a legally-accepted, inexpensive medical treatment, the force of economic gravity can lead to increased pressure on patients to request, and doctors to prescribe, assisted suicide.

Patients in Oregon have already encountered the cost containment reality of assisted suicide.

In May 2008, 64-year-old retired school bus driver Barbara Wagner received bad news from her doctor. Namely, her cancer, which had been in remission for two years, had returned. Then, she got some good news. Her doctor gave her a prescription for Tarceva.[39] He said it would likely slow the cancer's growth and extend her life. Wagner was relieved by the news and comforted by the fact that she had health care coverage through the Oregon Health Plan (OHP). But it didn't take long for her hopes to be dashed.

She was notified by letter that the OHP wouldn't cover the prescribed drug. The letter didn't leave it at that. It also informed her that, although it wouldn't cover her prescription, it would cover any cost related to her assisted suicide.

---

[38] *Supra*, n. 28.

[39] Tarceva was approved for use in 2004. It costs approximately $4000 for a one month supply of the pills.

Her case would not have been known if she had not told her story to a local Oregon television station. Wagner said, "I told them [the OHP] 'Who do you guys think you are?' You know, to say that you'll pay for my dying, but you won't pay to help me possibly live longer?"[40]

Wagner's case was not isolated. Other patients received similar letters. After public outrage over Wagner's story, OHP spokesperson Jim Sellers said the letters were a public relations blunder. He said that, in the future, insurance officials will "pick up the phone and have a conversation" to avoid putting the decision in writing.[41]

IV. Legalized Assisted Suicide Can Mask Domestic and Elder Abuse.

An estimated 1 to 2 million Americans age 65 or older are injured, exploited, or otherwise mistreated each year by a person on whom they depend for care or protection.[42] And, according to the National Center on Elder Abuse, 48 percent of perpetrators of elder abuse are a spouse, an intimate partner or an adult child.[43]

---

[40] KATU, *Letter noting assisted suicide raises questions*, July 30, 2008, *available at* http://www.katu.com/news/26119539.html (last visited March 1, 2009).
[41] Susan Donaldson James, *Death Drugs Cause Uproar in Oregon,* ABCNews.com, Aug. 6, 2008, *available at* http://abcnews.go.com/print?id=5517492 (last visited March 1, 2009).
[42] National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect, *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America* (2003).
[43] National Center on Elder Abuse, *A Response to the Abuse of Vulnerable Adults* (Washington, DC 2000).

Oregon's law specifically prohibits coercing or exerting undue influence on a patient to request assisted suicide,[44] however, this does not preclude a family member or a new "best friend" from urging or encouraging the patient to request assisted suicide.

A. An Heir Can Serve as One of Two Witnesses to a Patient's Death Request.

The Oregon law's requirement of two oral requests and one written request[45] seems to insure that patients have three opportunities to meet with their physicians and discuss their decision prior to receiving the lethal prescription. But nothing in the law requires that those requests be made in person. A patient can make the oral requests by phone. Indeed, they can be left on an answering device at the physician's office. The written request can be sent to the physician by mail, e-mail or fax.

Furthermore, the requirement that the written request be witnessed by two people appears to offer a degree of protection since one of those witnesses may not be a relative, a person who would inherit the patient's property, or the owner, operator or employee of a health care facility where the patient is being treated.[46] But this means that one of the two witnesses may fall within the prohibited category and the second witness may be a friend or acquaintance of that first

[44] Or. Rev. Stat. § 127.890: 4.02 (2).
[45] Or. Rev. Stat. § 127.810: 2.03.
[46] *Id.*

witness.

This sets the stage for elder abuse and premature transfer of assets. It allows those who will benefit from the patient's death to play a key role in facilitating an assisted-suicide prescription. Since victims of domestic abuse, including elder abuse, are extremely vulnerable to persuasion from their abusers, it takes little imagination to understand how the witnessing requirements could be manipulated to lead an at-risk patient into requesting assisted suicide.

B. Patients Are at Greatest Risk after the Prescription Is Written.

Oregon's law covers only the time until the prescription for lethal drugs is written. The drugs can be stored over time, with no concern for public safety or patient protection. There are no provisions to insure that the patient knowingly and/or willingly takes the overdose.

According to Dr. Katrina Hedberg, the state's job "is to make sure that all the steps happened up to the point the prescription was written." Furthermore, she explained, "[The] law itself only provides for writing the prescription, not for what happens afterwards."[47]

Due to this lack of protection at the time of their deaths, Oregon's law puts patients at enormous risk. No disinterested witnesses are required at the time of death. Once the prescription is written, there are no safeguards in the law. The

[47] *HL, supra,* n. 23 at question 567.

law does not require that the patient be competent at the time the lethal drugs are taken nor is there any way to determine that the patient was not tricked into consuming them. The same individuals who have witnessed a death request could easily orchestrate what, under the law, would be deemed a death with dignity.

CONCLUSION

The District Court's ruling, in light of what is known and unknowable about Oregon's law and its implementation, subjects vulnerable Montanans to abuse and exploitation. In a society where virtually everyone is pressed for time and for money, the convenience and cost efficiency of legalized assisted suicide could subject Montana's citizens to great risk.

Transforming the crime of assisted suicide into a medical treatment is not about personal privacy or individual dignity. It is about changing public policy and removing necessary patient protections.

Legalized assisted suicide is bad public policy, bad ethics and bad medicine.

For these reasons, *Amici* International Task Force, Herbert Hendin and Yale Kamisar request that this Court uphold the time-tested barriers between caring and killing and reverse the First Judicial District Court of Lewis and Clark County.

Respectfully submitted this 24th day of April, 2009.

Nickolas C. Murnion

Rita L. Marker

CERTIFICATE OF COMPLIANCE

This document is double-spaced in proportionately spaced Times New Roman font of 14 point size. The word count is 4716, exclusive of the Table of Contents, Table of Authorities, Certificate of Compliance and Certificate of Service.

Nickolas C. Murnion (Bar No. 1106)
Local counsel for *Amici Curiae*
Nickolas C. Murnion Law Firm
417 Main Street; P.O. Box 375
Jordan, MT 59337
406-557-2480 (telephone)
406-557-2595 (facsimile)

Rita L. Marker
Counsel for *Amici Curiae*
1233 Maryland Avenue
Steubenville, OH 43952
740-632-1032 (telephone)
740-282-0769 (facsimile)
Admitted *pro hac vice*

CERTIFICATE OF SERVICE

This is to certify that on April 24, 2009, a true and accurate copy of this document was served by U.S. mail, postage prepaid, to each of the following:

Steve Bullock, Montana Attorney General
Jennifer Anders, Assistant Attorney General
215 N. Sanders
PO Box 201401
Helena, MT 59620-1401

Mark S. Connell
Connell Law Firm
502 W. Spruce
PO Box 9108
Missoula, MT 59807-9108

Kathryn L. Tucker
c/o Compassion and Choices
PO Box 6404
Portland, OR 97228-6404

By: _____
Nickolas C. Murnion

_____
Rita L. Marker