

THE SUPREME COURT OF THE STATE OF MONTANA

No. DA 09-0051

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ROBERT BAXTER, STEVEN STOELB, STEPHEN SPECKHART, M.D., C.  
PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D., and  
COMPASSION & CHOICES,

*Plaintiffs and Appellees*

v.

STATE OF MONTANA and STEVE BULLOCK,

*Defendants and Appellants.*

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**AMICUS CURIAE BRIEF BY  
MONTANA RESIDENTS WITH DISABILITIES AND AUTONOMY, INC.**

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ON APPEAL FROM THE FIRST JUDICIAL DISTRICT COURT  
LEWIS AND CLARK COUNTY, CAUSE NO. ADV-2007-787

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## **I. INTERESTS OF *AMICI CURIAE***

As explained in *Amici's* Motion for Leave to File *Amicus Curiae* Brief, Robert Heinle and Mike Manthey are Montana residents with disabilities. Autonomy is a national disability-rights organization incorporated in Oregon and currently headquartered in Massachusetts.

## **II. SUMMARY OF ARGUMENT**

*Amici* understand well the nature of the debate before this Court. The Appellants and the *amici* who support them have alleged that a parade of horrors will befall the citizens of Montana should the right to physician-assisted dying be upheld. But, as *Amici* can attest, the empirical data collected from Oregon's eleven years with the Death With Dignity Act disprove such outdated contentions: Physician-assisted dying is rarely used and is easily regulated, and in actual practice there is no evidence of undue influence or coercion. Indeed, their fears are not borne out in jurisdictions where physician-assisted dying is legal, but instead where it is illegal and thus unregulated.

Some argue that the District Court's Order devalues the lives of those with disabilities, but nothing could be further from the truth. Rather, as Justice Souter previously explained, such a right "gives proper recognition to the individual's interest in choosing a final chapter that accords with her life story, rather than one that demeans her values and poisons memories of her." *Washington v. Glucksberg*,

521 U.S. 702, 746-47 (1997) (Stevens, J., concurring). Neither does the Order promote suicide. Suicide is the irrational decision of death over a life that could be lived. Those who can take advantage of the Order, however, do not have that choice: they are going to die, irrespective of their wishes, and will do so soon. Their decision is thus whether to let the illness take their lives, or to end their lives at a time and in a manner of their own choosing.

Some argue that physician-assisted dying is contrary to the role of a physician, but this perspective takes too narrow a view of the doctor's role. Others argue that Montana's "flawed" healthcare system and the lack of concrete definitions for "competent" and "terminally ill" vitiate the right, but these are legislative issues and are beyond the ken of the Montana Constitution. Finally, yet others imply that the slippery slope passes quickly from physician-assisted dying to euthanasia for all disabled individuals, an assertion utterly without support.

### **III. ARGUMENT**

#### **A. The Available, Empirical Evidence Disproves Appellants' and Their Amici's Dire Predictions**

The Appellants and the *amici* who support them predict dire consequences should this Court affirm the existence of the right to physician-assisted dying. Tellingly, however, they ignore the existence of evidence which disproves their fears: the data collected from Oregon's experience with the Oregon Death with Dignity Act ("Dignity Act"), Or. Rev. Stat. §§ 127.800-127.995 (2005). Some

note the Dutch experience, but in doing so ignore its lesson that legislation protects against abuses.

### 1. The Oregon Experience

In its right-to-die cases that preceded the Dignity Act, the United States Supreme Court declined to recognize a generalized right to commit suicide and found two state laws prohibiting physician-assisted dying not invalid under the Constitution. *See Glucksberg*, 521 U.S. at 734-35; *Vacco v. Quill*, 521 U.S. 793, 808-09 (1997). At the time *Glucksberg* and *Vacco* were decided, no U.S. jurisdiction had implemented a statute authorizing physician-assisted dying and the Court expressed concern about the absence of empirical data to show that state regulation could adequately safeguard the state's legitimate interests. *See Glucksberg*, 521 U.S. at 735; *see also id.* at 785-86 (Souter, J., concurring). The Court emphasized, however, that the states are ideally positioned to grapple with nascent issues such as assisted dying and anticipated that states would do so, serving as laboratories entrusted with the challenging task of crafting appropriate protections. *Id.* at 735; *see also id.* at 737 (O'Connor, J., concurring). Since the implementation of the Dignity Act, Oregon has served as such a laboratory.<sup>1</sup>

The Dignity Act was a citizen's initiative first voted into law in 1994. Implementation was delayed by an injunction, but the Ninth Circuit Court of

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<sup>1</sup> Washington State passed a similar law in 2008.

Appeals lifted the injunction in October 1997 following the Supreme Court's denial of a petition for *certiorari*. In November 1997, Oregon voters reaffirmed the Dignity Act by a margin of 60% to 40%.

a. Physician-Assisted Dying Poses No Threat to Public Health or Welfare

The Dignity Act contains detailed reporting and monitoring requirements<sup>2</sup> that have generated a sizeable amount of data on the circumstances and demographics of the terminally ill individuals who have sought their physicians' aid in dying. There is, simply, no evidence of inappropriate use of the statute, nor of discrimination against nor abuse of terminally ill individuals. Indeed, conspicuously absent from Appellant's and their *amici*'s briefs is a single, confirmed instance in which any of the dangers feared by the statute's opponents actually materialized.

Oregon doctors wrote 88 prescriptions under the Dignity Act in 2008 for the State's nearly 3,690,000 residents. *See* DHS, *2008 Summary of Oregon's Death*

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<sup>2</sup> The Dignity Act requires that Oregon's Department of Human Services ("DHS") collect information on hastened dying under the Dignity Act. Or. Rev. Stat. § 127.865. Physicians must timely notify the DHS of any lethal prescription written and document their compliance with the law. Or. Rev. Stat. §§ 127.815, 127.855. The DHS, in turn, must annually issue a report assessing the collected information. Or. Rev. Stat. § 127.865. In recent years, the DHS also conducted telephone interviews with all of the prescribing physicians. *See, e.g.*, DHS, *Seventh Annual Summary on Oregon's Death with Dignity Act* at 10 (2005) ("2004 Summary") (Appendix 1). The annual reports are available on the DHS's website at <http://oregon.gov/DHS/ph/pas/ar-index.shtml> (last visited June 19, 2009).

with Dignity Act at 1 (2008) (“2008 Summary”), available at

<http://oregon.gov/DHS/ph/pas/docs/year11.pdf> (last visited on June 19, 2009)

(Appendix 2); U.S. Census Bureau, *American FactFinder: Oregon*, available at

[http://factfinder.census.gov/servlet/ACSSAFFacts?\\_event=Search&\\_state=04000](http://factfinder.census.gov/servlet/ACSSAFFacts?_event=Search&_state=04000)

[US41&\\_lang=en&\\_sse=on](http://factfinder.census.gov/servlet/ACSSAFFacts?_event=Search&_state=04000) (last visited on June 19, 2009) (Appendix 3). Of the 88

prescriptions, 54 patients took the medications, 22 died of the underlying disease

and 12 were still alive at the end of 2008. In addition, six patients prescribed

medication in 2007 took it in 2008, thus bringing the total number of deaths under

the Dignity Act in 2008 to 60.

The “Disability *Amici Curiae*” in support of Appellants, lead by Not Dead Yet, raise the case of Kate Cheney as supposed “[e]vidence . . . that some persons killed under the assisted suicide laws may ‘choose’ suicide under pressure from others”:

In the Oregon case of Kate Cheney, an 85-year old woman with cancer, her psychologist was concerned that Ms. Cheney was not competent to make the decision to die and that her daughter was unduly pressuring her to choose assisted suicide. The daughter simply obtained an opinion from a second psychologist, who determined Ms. Cheney was competent. Ms. Cheney was accordingly prescribed lethal medication and died on August 29, 1999.

Amicus Brief of the Disability *Amici Curiae*: Not Dead Yet, *et al.*, in Support of Appellants the State of Montana and Steve Bullock (hereinafter “Not Dead Yet”) at 17-18. A simple review of the cited article, however, vitiates this allegation.

Indeed, it shows that Kate Cheney was in control of her faculties and her decision. See Erin Hoover Barnett, *A Family Struggle: Is Mom Capable of Choosing to Die?*, The Oregonian, Oct. 17, 1999 at G1-2. (“Kate, less fiery than her daughter but no less pragmatic, firmly said she didn't feel pressured. ‘She makes more noise than I do,’ she said. ‘But that doesn't make me any less serious.’”) (Appendix 4). In addition, Kate Cheney’s psychiatrist disputed Not Dead Yet’s spin on the situation:

I was the psychiatrist who determined that Ms. Cheney did not meet the requirements of the law, but concern regarding coercion was not the primary basis. This woman had mild, potentially reversible cognitive deficits that interfered with her ability to understand her options. I agreed with the need for a second opinion and assisted in finding a qualified mental health professional to give one.

Dr. Linda Ganzini, *Letter to the Editor*, Am J Psychiatry, 163:6, 1109 (June 2006), available at <http://ajp.psychiatryonline.org/cgi/content/short/163/6/1109-a?rss=1> (last visited on June 19, 2009) (Appendix 5). That this is the *only* instance of supposed abuse that the Appellants and their *amici* raise is informative.

b. The Dignity Act Protects All Terminally Ill People from Abuse, Coercion and Societal Indifference

Opponents of physician-assisted dying argue that recognition of the right would inevitably result in undue pressures being placed upon vulnerable citizens, but in so doing denigrate those they would protect. For example, the Family Research Counsel argues that “assisted suicide threatens the easily-influenced and

vulnerable.” Brief of *Amici Curiae* Family Research Counsel, et al., in Support of Appellants (hereinafter “Family Research Counsel”) at 11; *see also, e.g.*, Brief of Appellants at 31. This paternalistic view is anathema to *Amici* and numerous members of the disability community; moreover, it threatens to set back decades of legislation and advocacy devoted to empowering persons with disabilities.

Similarly, Not Dead Yet asserts that “[t]here is no way to ensure that persons are not unduly pressured by family members, because of financial, emotional or other reasons.” Not Dead Yet at 18. However, this erroneously assumes that individuals with disabilities are incapable of making rational, voluntary and independent decisions to hasten their own imminent and inevitable deaths.

Moreover, these views ignore the provisions of the District Court’s Order which restrict physician-assisted dying to those who are (1) competent and (2) terminally ill. These provisions ensure that a terminally ill individual’s choice to hasten death with a physician’s assistance is made voluntarily and free of coercion.

Some assert that people with disabilities are more vulnerable than others when assisted dying is authorized by statute. However, as noted above, the demographic information collected under the Dignity Act puts to rest this concern. For example, the 2008 participants were, on the whole, highly educated, with 60% holding at least a baccalaureate degree. 2008 Summary at 2; *see also* DHS, Table 1, available at <http://oregon.gov/DHS/ph/pas/docs/yr11-tbl-1.pdf> (“Table 1”) at 1

(providing data about all patients who died under the Dignity Act) (last visited on June 19, 2009) (Appendix 6).<sup>3</sup> Further, 98% of the 2008 participants were non-minorities. 2008 Summary at 2. The study also found that neither depression, nor uncontrollable pain nor financial implications were strong predictors of the likelihood that a terminally ill individual would seek physician-assisted dying. Rather, the most common reasons given were loss of autonomy, a decreasing ability to participate in activities that make life enjoyable and loss of dignity. *Id.* Finally, 97% of the 2008 participants had health insurance and all but one were enrolled in hospice care.

At its core, the danger posed by coercion and societal indifference is that patients will be pressured to choose paths that they would not otherwise take. The irony is that opponents to physician-assisted dying seek to do just that, by substituting their own moral, philosophical or religious views for that of all patients through the elimination of this choice. The District Court's Order, however, protects the decision-making autonomy of patients by insulating them from these coercive forces and thus giving effect to their wishes.

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<sup>3</sup> Since the institution of the Dignity Act, 92.5% of the participants had at least a high school degree and nearly 67% had at least some college education. Table 1 at 1.

## 2. The Dutch Experience

Opponents of physician-assisted dying often point to the Netherlands as proof that the practice cannot be limited to people with terminal illnesses and that it will lead to voluntary (or involuntary) euthanasia. *See, e.g.*, Family Research Counsel at 2-5. The Netherlands example, however, merely underscores the need for state regulation, which *Amici* support.

Until recently, both physician-assisted suicide and euthanasia were illegal under the Dutch Criminal Code, but conditionally legalized by the Dutch Courts, which developed guidelines delineating the circumstances under which a physician would be exempt through a defense of “necessity” from criminal liability for participating in either practice. Roger S. Magnusson, “*Underground Euthanasia and the Harm Minimization Debate*,” 32 *J. L. Med. & Ethics* 486, 490 (2004) (“*Underground Euthanasia*”) (Appendix 7); Kelly Green, Note, *Physician-Assisted Suicide and Euthanasia: Safeguarding Against the “Slippery Slope” – The Netherlands Versus the United States*, 13 *Ind. Int’l & Comp. L. Rev.* 639, 665-71 (2003) (“*Safeguarding Against the Slippery Slope*”) (Appendix 8). These guidelines were adopted by the Royal Dutch Medical Association in 1984, and codified with little modification in 2002 as the Termination of Life on Request and Assisted Suicide Act (“TLRASA”). *Safeguarding Against the Slippery Slope*, 13 *Ind. Int’l & Comp. L. Rev.* at 667, 670. In contrast to the Dignity Act and the

District Court's Order, the TLRASA does not require that patients be terminally ill, does not require that patients be mentally competent and permits euthanasia. Rather, the TLRASA requires only that (1) the patient's "suffering" be "unbearable" "with no prospect of improvement"; (2) the patient's request be voluntary; and (3) there be "no reasonable alternative available to the patient." *Id.* at 670; *see generally Termination of Life on Request and Assisted Suicide Act*, Staatsblad, 2002, 165, *available at* <http://www.nvve.nl/assets/nvve/english/euthlawenglish.pdf> (last visited June 19, 2009) (Appendix 9).

There is nothing to indicate that the District Court's Order marks a point on the slippery slope towards euthanasia. Indeed, the evidence indicates that terminally ill individuals with disabilities are less vulnerable to abuses and undue influences where assisted dying is legal than where it is prohibited and practiced surreptitiously.

That the practice of assisted dying persists in jurisdictions that outlaw it "is not seriously open to challenge;" there are, simply, no safeguards in such places. *Underground Euthanasia*, 32 J. L. Med. & Ethics at 486; *see also* Jody B. Gabel, *Release from Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 Fla. St. U. L. Rev. 369, 372-73 (1994) (Appendix 10). Indeed, covert assisted dying occurs in prohibitionist states at rates that rival those

of the Netherlands. See Anthony L. Back, *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 924 (1996) (Appendix 11); “*Underground Euthanasia*”, 32 J. L. Med. & Ethics at 490-92 (“[Opponents to the practice argue] that if [assisted dying] is legalized, bad things will start to happen. The fact is, harmful, unsafe things are already happening.”).

A nationwide study of physicians found that, notwithstanding the current legal restraints, 8% had participated in assisted suicide or euthanasia, with 3.3% admitting that they had written at least “one lethal prescription” and 4.7% admitting that they had administered at least one lethal injection. *Underground Euthanasia*, 32 J. L. Med. & Ethics at 486. Another survey included 852 intensive care nurses who practiced exclusively in intensive care units for adults. David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374, 1374-75 (1996) (Appendix 12). Of these, 141 (17%) reported requests from patients or family members for euthanasia or assisted dying and 129 (15% of the total) complied. *Id.* at 1374-79. An additional 4% admitted they had facilitated a terminally ill patient’s death by pretending to provide life-sustaining treatment ordered by a physician. *Id.*

As one expert explained, covert assisted dying and voluntary euthanasia “has spawned a culture of deception, . . . encompass[ing] the methods used to procure

euthanasia drugs, the planning of the death itself, and the disposal of the body and associated paperwork.” *Underground Euthanasia*, 32 J. L. Med. & Ethics at 488.

In many instances, patients die without being evaluated for depression or impaired judgment, without adequate palliative care or counseling and without assessment as to the patient’s diagnosis, prognosis, and available treatment alternatives. *Id.*

The question is thus not whether the option of assisted dying should be available or not. In reality, it *is* practiced. Rather, the question is whether it should be regulated to prevent the harms that occur in the absence of regulation.

B. The District Court’s Order Does Not Devalue the Lives of People with Disabilities Nor Foster Suicide

1. Assisted Dying Does Not Devalue Life

Some assert that the District Court’s Order will have the cumulative impact of devaluing the lives of people with disabilities. *See, e.g., Not Dead Yet* at 16-17.

In short, they argue that if the loss of independence and the change in lifestyle which accompany disabilities are the primary reasons people choose physician-assisted dying, then this *de facto* devalues their existence. And, implicit in this argument is the assertion that by delineating certain conditions as qualifying individuals for physician-assisted dying, the State implies that those who are eligible have a lower quality of life than others and that they are less valuable members of society.

The Order's distinction, however, between individuals with terminal conditions and those without does not manifest such judgments on behalf of the State. Quality of life is a subjective valuation that belongs to the individual. More to the point, it is not the disability that qualifies one for physician-assisted dying, but a terminal illness. Under the Order, only the individual facing imminent death can decide whether her quality of life justifies enduring whatever pain and suffering she is experiencing. By permitting that individual "to make [a] judgment about the quality of life that [she] may enjoy," the Order thus "gives proper recognition to the individual's interest in choosing a final chapter that accords with her life story, rather than one that demeans her values and poisons memories of her." *Glucksberg*, 521 U.S. at 746-47 (Stevens, J., concurring) (internal quotation marks and citations omitted) (citing and quoting *Washington v. Glucksberg*, No. 96-110, *Amici Br. of Bioethicists* at 11; Ronald M. Dworkin, *Life's Dominion* 213 (1993)). The Order simply recognizes that this choice belongs neither to the State nor healthcare providers, but instead to the individual alone.

## 2. Assisted Dying Does Promote Suicide

Some assert that the District Court's Order promotes suicide. Suicide, in essence, represents a choice between life and death, and is commonly perceived as a self-destructive act motivated by mental impairment—a condition for which treatment might avoid death. In the case of a terminally ill individual, however,

one's death is already determined and imminent; such an individual is "faced not with the choice of whether to live, only of how to die." *Glucksberg*, 521 U.S. at 746 (Stevens, J., concurring).

Terminally ill individuals who choose to hasten their deaths seek to avoid a prolonged and dehumanizing process of dying. They do so because, in their view, "the quality of life during the time remaining . . . ha[s] been terribly diminished," and because their lives "ha[ve] been physically destroyed and [their] quality, dignity and purpose gone." *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 304-05 (Cal. Ct. App. 1986). Under these circumstances, the choice to hasten death is more akin to the legally condoned decision to refuse life-sustaining measures than what is commonly perceived as "suicide."

While a terminally ill person might suffer from depression or other mental disorder, the District Court's Order requires doctors to screen out those who with impaired judgment. The efficacy of this safeguard is evident from Oregon's experience, with its proven track record of ensuring that terminally ill individuals seeking assisted dying are competent. Linda Ganzini, *et al.*, *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 New Eng. J. Med. 557, 562-63 (2000) (Appendix 13).

Moreover, the notion that legalized physician-assisted dying and the development of excellent palliative care are mutually exclusive has been largely

debunked. See Timothy E. Quill, *Dying and Decision-Making – Evolution of End of Life Options*, 350 *New Eng. J. Med.* 2029, 2030 (2004) (Appendix 14). Indeed, it appears that the percentage of patients who have had *discussions* about palliative care, including hospice care, is barely above 50% among states without laws providing for assisted dying, see Haiden A. Huskamp, *et al.*, *Discussions with Physicians About Hospice Among Patients with Metastatic Lung Cancer*, 169 *Archive of Internal Med.* 954 (May 25, 2009) (Appendix 15), whereas in Oregon more than 85% of all Dignity Act participants were *enrolled* in hospice care, see Table 1 at 2.

In fact, protection of the right to physician-assisted dying encourages doctors “to address other end-of-life care options more effectively.” 2004 Summary at 17. Oregon physicians report that since the passage of the Dignity Act in 1994, they have taken steps to increase their knowledge of palliative care for the terminally ill, to improve their ability to identify mental impairments such as depression and to refer more patients to hospice care. *Id.*

### C. Refutation of Certain Arguments of *Amici Curiae* Submitted in Support of Appellants

The undersigned *Amici* are well positioned to counter certain arguments raised by several *amici* in support of Appellants and shall hereafter briefly do so.

1. *Amicus* Physicians for Compassionate Care Take Too Narrow a View of the Physician’s Role in the Physician-Patient Relationship

*Amicus* Physicians for Compassionate Care assert that physician-assisted dying would “change the role of the physician in society from the traditional one of healer to that of one who facilitates killing . . . .” Brief of Physicians for Compassionate Care Education Foundation as *Amicus Curiae* in Support of Defendants-Appellants (“Physicians for Compassionate Care”) at 2. This argument is based on a viewpoint of the physician-patient relationship that minimizes the complex obligations physicians have towards their patients, particularly at the end of life. See Bryan Hilliard, *Evaluating the Dissent in Oregon v. Ashcroft: Implications for the Patient-Physician Relationship and the Democratic Process*, 33 J. L. Med. & Ethics 142, 147 (2005) (Appendix 16).

This argument also conflicts with the ethical obligations of doctors to respect patient autonomy, to provide comfort and to alleviate pain and suffering. See *American Medical Association Council on Ethical and Judicial Affairs, Code of Medical Ethics*, Opinion E-2.20 (2005) (instructing that where the physician’s duty to “sustain life” conflicts with his duty to “relieve suffering” that “the preferences of the patient shall prevail”); *id.* (“Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care.”). Indeed, physicians have an obligation not to abandon patients “once it is

determined that cure is impossible.” *Id.* at E-2.211 (2005). In its opinion on physician-assisted dying, the American Medical Association instructs that “[p]atients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.” *Id.* Thus, as Justice Souter noted, during the period when death is imminent and suffering becomes intolerable, the decision to hasten imminent death is most analogous “to decisions that are generally accepted as proper instances of exercising autonomy over one’s own body, instances recognized under the Constitution and the State’s own law in which a physician’s assistance is accepted as falling within the traditional ethical norm of professional conduct.” *Glucksberg*, 521 U.S. at 779-80 (Souter, J., concurring).

In fact, the Supreme Court implicitly rejected the one-dimensional understanding of the physician-patient relationship advanced by Appellants and their *amici*. See *Roe v. Wade*, 410 U.S. 113, 153 (1973) (declining to limit the physician’s participation to curative measures and recognizing the physician’s obligation to provide and the patient’s right to receive counsel and care in the abortion context). In his concurring opinion in *Glucksberg*, Justice Souter expressed concern that terminal sedation might be the only option available to terminally ill patients seeking to hasten an end to their suffering. *Glucksberg*, 521 U.S. at 779 (Souter, J., concurring). Recognizing that “[t]here can be no stronger

claim to a physician’s assistance than at the time when death is imminent,” he observed that the Court’s abortion cases illustrate a broader view of the physician’s role that would encompass assisted dying. *Id.* at 779-81. “[The Court has recognized that] the good physician is not just a mechanic of the human body whose services have no bearing on a person’s moral choices, but one who does more than treat symptoms, one who ministers to the patient.” *Id.* at 779 (citing *Roe*, 410 U.S. at 153, and *Griswold v. Connecticut*, 381 U.S. 479, 482 (1965)).

2. *Amicus* Disability Rights Montana’s Arguments Support Legislation, Not the Vitiating of a Constitutional Right

While *amicus* Disability Rights Montana raises several valid concerns, each of its arguments are, upon reflection, support for legislation and not vitiating of the right. As the lower court noted, certain things must be left to the legislature and others to the courts. *See* Order at 24. It is a court’s function to determine whether competent, terminally ill individuals have the right to physician-assisted dying under the Montana Constitution. Having so found, it is then the Legislature’s function—within the precepts of this right—to set its boundaries.

Disability Rights Montana argues that Montana’s healthcare system is “flawed,” *see* Brief of Disability Rights Montana as *Amicus Curiae* in Support of Defendants-Appellants at 4-8, and *Amici* do not necessarily disagree. However, this does not mean that a constitutional right does not exist, but instead that the system should be fixed.

Disability Rights Montana next argues that the District Court erred by failing to define “terminal.” *Id.* at 8-16. This is, however, too fine a distinction to expect from the Constitution, and thus the court left it for the Legislature. Similarly, Disability Rights Montana’s argument regarding the definition of “competent” misses the mark, *id.* at 16-18, as it is the Legislature’s obligation, in the first instance, to define this concept.

Also without support is the argument that the District Court erred in failing to require referral to a mental health professional for determination of competence. *Id.* at 18. The Montana Constitution says nothing about such intricacies; rather, it sets forth *rights*. So too does Disability Rights Montana ask too much of the Constitution when it argues that the court failed to limit constitutional protection to voluntary requests and situations where palliative care has not sufficiently addressed the pain and suffering caused by terminal illness. *Id.* at 18-22. By analogy, the United States Constitution was held to protect a woman’s right to terminate a pregnancy. However, states may, within the confines of this right, regulate the practice. So too here does the Montana Constitution protect the *right* to physician-assisted dying, which right may be tailored by reasonable *legislation*.

The undersigned *Amici* support legislation to refine and define the boundaries of the exercise of this right. However, one cannot argue that the right

does not exist—or may not be exercised—until legislation is in place; otherwise, it is no “right” at all.<sup>4</sup>

### 3. *Amicus* Not Dead Yet’s Arguments in Support of Appellants Are Misguided

As an initial matter, *amicus* Not Dead Yet’s arguments rest upon faulty logic. It begins by asserting that “the only class of people who will be adversely affected and impacted were [a right to ‘assisted suicide’] to be found [are] people with disabilities.” Not Dead Yet at 2, 3 (“People who are labeled ‘terminal,’ based on a medical prediction that they will die within six months, are invariably disabled.”). Thus, under Not Dead Yet’s logic, anyone who could possibly qualify for physician-assisted dying must be disabled. It next states that all disabled individuals are threatened by the very availability of physician-assisted dying. *See id.* at 7; *see also, e.g., id.* at 2. Thus, Not Dead Yet first subsumes every possible disability into its tent and then dispenses with the distinctions between terminal and disabling, and between competent and not. *See, e.g., id.* at 9, 13-14. Taken together, it attempts to paint a dystopian world wherein the constitutional right for competent, terminally ill individuals to physician-assisted dying leads inevitably to

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<sup>4</sup> *Amici* note that Disability Rights Montana attached to its brief the apparently self-published *Withdrawal of Life Sustaining Treatment: Eleven Case Studies*. *See* Disability Rights Montana at 8; *see also, e.g., id.* at 9-12 (discussing several of the case studies “[i]n *Amicus*’ experience”). Whatever Disability Rights Montana’s experience might be, the unattested report is neither a scientific study nor in evidence.

the threat of euthanasia applied to every individual with a disability, from amputees to the terminally ill. As the undersigned *Amici* establish, Not Dead Yet does not represent the entire spectrum—or even a majority—of the disabled community. And, as the Oregon experience has well established, Not Dead Yet’s Orwellian view of physician-assisted dying is fictional.

Ultimately, the central tenants of the disability movement are equality and choice. The entire point behind the Americans with Disabilities Act was to give disabled individuals equal access to the world, and the choice of what to do within it. Not Dead Yet derides the constitutional right to physician-assisted dying as one that creates “barriers and prejudices,” but in the next breath advances the very stereotypes it (theoretically) abhors: that the disabled are vulnerable and easily coerced. *Id.* at 9-10. Indeed, it derogates the fortitude of disabled individuals to the point where it asserts that there is no way to be sure that disabled individuals could *ever* make an independent decision to engage in assisted dying. *Id.* at 18, 22. However, the point of this right is not to coerce disabled individuals into euthanasia and deny them suicide prevention services, *see id.* at 12, but instead provide them with additional options.

Quite simply, those who might take advantage of the right to physician-assisted dying are, by definition, *already going to die and do so in short order.*

The right, then, provides these individuals with the choice of how, when and where their inevitable death will occur.

#### **IV. CONCLUSION**

For decades, individuals with disabilities have had to defend their right to make choices and maintain control over all aspects of their lives. *Amici* believe that this right to autonomy and self-determination applies with no less force to the most uniquely personal, moral and religious choice of all: the choice of whether to hasten impending death from a terminal illness. Most importantly, it is a choice that is protected by Montana's Constitution. For all the foregoing reasons, *Amici* respectfully submit that the decision of the District Court should be affirmed.

Dated this 22d day of June, 2009.

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**CERTIFICATE OF COMPLIANCE**

Pursuant to Rule 16 of the Montana Rules of Appellate Procedure, I certify that this Motion by Montana Residents with Disabilities and AUTONOMY, Inc. for Leave to File *Amicus Curiae* Brief is printed with the proportionately spaced Times New Roman typeface of 14 points, is double spaced, and the word count calculated by Microsoft Word is 4,993 words, excluding any table of contents, table of citations, certificate of service, certificate of compliance and any appendix containing statutes, rules, regulations and other pertinent matters.

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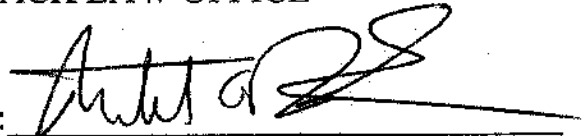
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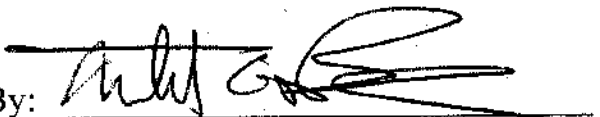
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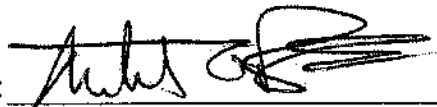
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THE SUPREME COURT OF THE STATE OF MONTANA

No. DA 09-0051

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PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D., and  
COMPASSION & CHOICES,

*Plaintiffs and Appellees*

v.

STATE OF MONTANA and STEVE BULLOCK,

*Defendants and Appellants.*

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**APPENDICES TO  
AMICUS CURIAE BRIEF BY  
MONTANA RESIDENTS WITH DISABILITIES AND AUTONOMY, INC.**

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ON APPEAL FROM THE FIRST JUDICIAL DISTRICT COURT  
LEWIS AND CLARK COUNTY, CAUSE NO. ADV-2007-787

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