

The Washington State

By Kathryn L. Tucker

I. Introduction

On November 4, 2008 voters in the state of Washington adopted Initiative Measure 1000 (I-1000), the Washington Death with Dignity Act by the significant margin of 59 percent to 41 percent.¹ The Washington measure was modeled on a virtually identical measure approved by Oregon voters in 1994.² Passage of I-1000 came some 17 years after voters in Washington rejected a conceptually similar, but significantly broader, measure in 1991. In a decision issued by a Montana State court soon after I-1000 was approved, Montana became the third state to allow aid in dying. In each of these states, a mentally competent terminally ill patient can obtain a prescription for medication which the patient can self administer to bring about a peaceful death.

Washington voters' approval of aid in dying appears to be part of a broader trend of public support for this end of life choice. In the past year four major national medical and health policy organizations have adopted policies in support of aid in dying. These include the American Medical Women's Association,³ the American Medical Students' Association,⁴ the American College of Legal Medicine,⁵ and the American Public Health Association.⁶ Opinion polls

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show that a substantial majority of those asked about aid in dying for terminally ill patients support it.⁷

What might account for the trend in support of this practice? It appears that an influential factor is that data from Oregon, where the practice has been legal for more than a decade, has put to rest concerns that aid in dying would jeopardize patient care at the end-of-life. Washington voters, and each of these medical professional associations, examined the Oregon experience and concluded that the option of aid in dying had not put patients at risk but rather had galvanized improvements in end of life care and largely eliminated in that state the illicit, unregulated prescription and use of death-hastening medication that is known to be prevalent in jurisdictions that do not currently permit aid in dying..

II. An Overview of Oregon's Dignity Act

In Oregon, mentally competent individuals who have less than six months to live and can ask for a prescription for medication that can be self administered to bring about a peaceful death.⁸ Oregon's law has survived a series of attacks brought by opponents in court, by federal legislators, and by a former United States Attorney General.⁹

Under the Dignity Act, patients must follow a strict set of procedures to establish eligibility. A physician must determine that the patient has less than six months life expectancy; this diagnosis must be confirmed by a second opinion. The patient must make multiple requests, waiting at least 15 days between the first and last request, must establish capacity to make medical decisions; and must be informed of palliative care options such as hospice, if not already receiving such services.¹⁰ If all of these procedures are followed, and the patient is deemed eligible by the physician to obtain the

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life-ending medication, an Oregon physician can provide a prescription for such medication.

Over the decade that aid in dying has been legal in Oregon, roughly 30 terminally ill individuals each year have gone through the process, obtained and taken the medication, and died peacefully. Those present at these deaths report that the patient was enormously relieved to be able to make this choice. On a date chosen by the patient, loved ones may gather around for a final goodbye. The patient consumes the medication, becomes drowsy, falls deeply asleep, and after a short period of time ceases to breathe.¹¹ The long road from diagnosis to curative treatment to palliative care to death has ended on terms acceptable to this patient. More patients obtain the medication than go on to use it: some fraction each year are prescribed aid in dying medication, put it in the medicine cabinet, feel comforted to know it is there, and never take it.¹²

Oregon's demographic data about the patients who choose to use the Dignity Act show that most patients have cancer.¹³ The next most common condition is ALS (Lou Gehrig's Disease). Those using the law are insured, well educated, and receiving comprehensive pain and symptom management,

typically through hospice services.¹⁴ Opponents to the Oregon legislation had argued that such a law would be forced on uninsured, the poor, minorities, or disabled persons. The evidence is that this has not happened.¹⁵

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A number of unexpected but enormously important developments have occurred in Oregon following the Dignity Act's passage. For example, referral of patients to hospice care and physician enrollment in continuing education courses on how to treat pain and symptoms associated with terminal illness increased dramatically.¹⁶ It is likely that physicians want to ensure that no patient makes use of the Dignity Act due to inadequate pain and symptom management. This in turn has galvanized both the increase in hospice referrals and physician efforts to learn more about treating pain and symptoms.

III. Washington: Moving Out of the Back Alley

The Washington Death with Dignity Act approved in November has the same safeguards and procedures as does Oregon's. Terminally ill Washingtonians no longer need to resort to the "back alley" to access aid in dying measures. It is well known that terminally ill patients across the nation ask their physicians — most often their oncologists — for aid in dying.¹⁷ Many, though certainly not all, physicians agree to help.¹⁸ When

this occurs, there are no safeguards or procedures to follow. Many physicians, in so murky a legal environment, decline to assist, even if they would do so if the practice were legal.

When a patient must "go underground" for medical care, the risk of encountering a provider who does not practice competent, ethical medicine is greatly increased. Researchers have found that in the

underground, complications are more likely to occur.¹⁹ For example, there is greater chance of an extended time until death after consuming lethal medications.²⁰ In addition, the stress and anxiety for the patient and family is much higher when no physician can legally be involved to counsel the patient and family and provide a prescription.²¹

When a patient does not feel able to discuss the desire for aid in dying with the personal physician, or cannot find a physician willing to prescribe appropriate medication, the patient may seek assistance in hastening death from a family member or loved one. Unfortunately, these incidents often involve a violent means to death, such as gunshot. Such deaths are not peaceful or dignified. The situation for a patient seeking aid in dying in the back alley is reminiscent of the situation faced by women seeking to terminate unwanted pregnancies in the pre-Roe v. Wade era.

While Oregon's experience in successfully implementing its Dignity Act appears to have been a critical factor in Washington's adoption of a similar measure, other factors played a role. Washington citizens had considered, and almost passed, a broader measure in 1991. The issue of permitting death with dignity was widely discussed in the popular media in the state during the years that *Glucksberg v Washington*²² case was litigated in the federal courts, all the way to the United States Supreme Court. The nonprofit organization Compassion in Dying (now Compassion and Choices) opened its doors in Washington in 1993, providing information, education, counseling and support to terminally ill patients about all end of life options, including aid in dying.²³ A highly regarded former Washington Governor, Booth Gardner, was a vocal proponent of the Initiative. Washington's media market is relatively small, making the cost of the campaign relatively modest, enabling supporters to cover the cost of radio and television ads to explain the measure to voters. All of these factors combined to make passage of the Washington Initiative possible in 2008.

Washington will now move forward to implement its new Dignity Act. Much guidance is available from Oregon, and this should make implementation smooth in Washington. Oregon's Department of Health forms for reporting on the act are all available on its website.²⁴ A guidebook, *Oregon Death with Dignity Act — A Guidebook for Health Care Professionals*, was developed by a team of Oregon physicians,



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hospice personnel, ethicists, pharmacists and others, and is an excellent resource. The *Guidebook* has been updated several times since its initial printing in 1998.²⁵

IV. Aid in Dying in Montana: Protected as a Right of Privacy and Dignity.

Washington’s I-1000 initiative attracted national attention over the course of the campaign. Less well known is that the right to aid in dying is again before the courts. *Baxter v. Montana*,²⁶ was by filed terminally ill patients, Montana physicians, and Compassion & Choices, asserting that that the Montana Constitution’s guarantees of privacy and dignity protect the choice of aid in dying. On December 5, District Court Judge Dorothy McCarter issued summary judgment to plaintiffs, holding that the state constitution’s individual dignity clause and the constitution’s “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.”

“The decision as to whether to continue life for a few additional months when death is imminent certainly is one of personal autonomy and privacy,” the court said.

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The “fundamental” right to die with dignity is constitutionally protected in Montana and “necessarily incorporates the assistance” of a doctor, the court said.

The court concluded that the state can address its interests in preventing potential abuses while allowing patients to choose to die with dignity by adopting safeguards.

The State plans to appeal, and has filed a Motion for a Stay.

Plaintiffs have reason to be optimistic that the lower court will be affirmed: Montana’s state constitution is the broadest and most protective of individual privacy in the nation, and it includes unique language explicitly protecting individual dignity. Further, the Montana court will consider the aid in dying issue with the benefit of a decade of experience in Oregon that shows there is no harm to patients, physicians or society when this choice is available, undermining arguments about the risks advanced by the state.²⁷

In *Baxter*, plaintiffs acknowledged that the State could act to protect legitimate state interests with narrowly tailored regulation. The District Court agreed that the State could do this. When the Montana legislature convenes in January 2009, legislation regulating aid in dying is likely to be introduced. It is important to keep in mind that while the provisions of Oregon’s law might offer ideas on possible regulation, any such regulation would need to meet constitutional scrutiny. Neither Oregon nor Washington courts have considered the question whether their Constitutions protect a citizen’s right to choose aid in dying. The situation in Montana is quite different; the question for any measure regulating aid in dying in Montana is whether the measure would impose an undue burden on exercise of a right recognized as protected by Montana’s Constitution. If so, the measure ought not be enacted, or if enacted it would be vulnerable to challenge.

V. A Call to Action

Public support for aid in dying is strong. A poll published in January 2002 found that 65% of respondents support legalization of the right to aid in dying.²⁸ In California, surveys in 2006 and 2005 found that 70 percent of California residents support the idea that “incurably ill patients have the right to ask for and get life-ending medication.”²⁹

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Certain religious groups, most notably the Catholic Church, and some disability groups continue to oppose passage of laws making this choice available. The vocal, well-funded opposition was not, however, able to prevent Washington from adopting a Death with Dignity Act in 2008.

Around the country, some dying patients — even those who experience excellent pain and symptom management — find themselves trapped in an unbearable dying process, so prolonged and marked by such extreme suffering and deterioration that they determine that hastening impending death is the least bad alternative. Having the option of aid in dying harms no one. Having this choice benefits both the relatively few patients in extremis who make use of it and a great many more who draw comfort from knowing it is available should their dying process become intolerable.

The Bar is a recognized leader in advocating for individual rights and extending law to protect such rights. It should adopt policy in support of empowering terminally ill individuals to choose the course of care most consistent with the patient's values and wishes. It should endorse measures to expand choice at the end of life. Bar Associations like the National Academy of Elder Law Attorneys, and Sections of the American Bar Association, such as Individual Rights and Responsibilities, the Senior Lawyer Division, and the Health Law Section, should support and advocate for adoption of policy by their organizations expanding freedom in end of life decision making, including aid in dying. Such policy statements could have influence in both judicial and legislative forums, where choice at the end of life is under consideration.

Footnotes

- ¹ The full text of I-1000 is available from the Washington Secretary of State's office at <http://wei.secstate.wa.gov/osos/en/Documents/I1000-Text%20for%20web.pdf>
- ² The Oregon Dignity Act is codified at Or. Rev. Stat. §§ 127.800-.995 (2005). General information about the Dignity Act is available at <http://www.oregon.gov/DHS/ph/pas/>
- ³ The American Medical Women's Association (AMWA), founded in 1915, is an organization of women physicians, medical students and other persons dedicated to serving as the unique voice for women's health and the

advancement of women in medicine. Its policy statement on aid in dying is available at <http://www.amwa-doc.org/index.cfm?objectId=242FFEF5-D567-0B25-585DC5662AB71DF9>.

- ⁴ The 67,000-member American Medical Student Association is the oldest and largest independent association of physicians-in-training in the United States. Its statement of principles regarding physician aid in dying is available at <http://www.amsa.org/about/ppp/pas.cfm>
- ⁵ The American College of Legal Medicine is the official organization for professionals who focus on issues where law and medicine converge. The ACLM membership includes physicians, attorneys, healthcare professionals, administrators, scientists, and others with a sustained interest in medical legal affairs. Its resolution on aid-in-dying is available at <http://www.aclm.org/resources/articles/ACLM%20Aid%20in%20Dying%20Policy.pdf>
- ⁶ The American Public Health Association is the oldest and most diverse organization of public health professionals in the world and has been working to improve public health since 1872. APHA and its state affiliates represent over 50,000 health professionals and others who work to promote health, prevent disease and ensure conditions in which we all can be safe and healthy. (See <http://www.apha.org/advocacy/policy/policysearch/>. As of December 16, 2008, the policy statement was not yet available online.)
- ⁷ See discussion *infra* Part V.
- ⁸ Or. Rev. Stat. §§ 127.800-.995 (2005).
- ⁹ See generally Kathryn Tucker, U.S. Supreme Court Ruling Preserves Oregon's Landmark Death with Dignity Law, 2 *NAELA Journal* 291-301 (2006).
- ¹⁰ Or. Rev. Stat. §§ 127.800-.995 (2005).
- ¹¹ For a detailed account of one such death, see D. Colburn, "She Chose It All on the Day She Died", *Oregonian*, p. 1, September 30, 2007 (profiling the death of Lovelle Svart, who was terminally ill with inoperable, metastatic lung cancer and chose the aid in dying pursuant to the Dignity Act).
- ¹² *Id.* See also Death with Dignity Act Annual Reports,

Oregon Department of Human Services, <http://oregon.gov/dhs/ph/pas/ar-index.shtml>.

¹³ Id.

¹⁴ Id.

¹⁵ See generally 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).

¹⁶ See e.g., Linda Ganzini et al., Oregon Physicians’ Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act, 285 Jour. Am. Med. Ass’n 2363 (2001); Melinda A. Lee & Susan W. Tolle, Oregon’s Assisted Suicide Vote: The Silver Lining, 124 Ann. Int. Med. 267 (1996).

¹⁷ H. Starks et al, Family Member Involvement in Hastened Death, 31 DEATH STUDIES 105-30 (2007);

¹⁸ Id.

¹⁹ Id. The most well known “back alley” provider for patients seeking control over their own death may be Jack Kevorkian, the Michigan pathologist who assisted patients with chronic and terminal conditions to end their lives, often in the back of an old Volkswagon van. Kevorkian was ultimately convicted of homicide in the death of Thomas Youk. After serving part of his prison sentence Kevorkian was granted parole and released on June 1, 2007.

²⁰ Id.

²¹ Id.

²² 521 U.S. 702 (1997)

²³ See <http://www.compassionandchoices.org/>

²⁴ <http://www.oregon.gov/DHS/ph/pas/pasforms.shtml>

²⁵ <http://www.ohsu.edu/ethics/guidebook.pdf>

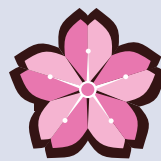
²⁶ No. 2007-787 (1st Jud. Dist. Mont.)

²⁷ For a full discussion of Montana law and how such a claim might fare see 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. 317-333(2007).

²⁸ Humphrey Taylor, Press Release, Harris Interactive,

2-to-1 Majorities Continue to Support Rights to Both Euthanasia and Doctor-Assisted Suicide (Jan. 9, 2002), http://www.harrisinteractive.com/harris_poll/index.asp?PID=278

²⁹ Mark DiCamillo & Mervin Field, Press Release, Field Research Corp., Release #2188: Continued Support for Doctor-Assisted Suicide, at 2 (Mar. 15, 2006), <http://www.field.com/fieldpollonline/subscribers/RLS2188.pdf>.



The Boomers Are Coming! What You Can Do

By Robert C. Anderson, CELA

Every NAELA member is aware that the Baby Boomer generation has just reached retirement age. The question is what NAELA members should do about it.

The multifaceted answer will be on the docket in two general and five break-out presentations comprising the Boomer Track at NAELA’s Annual Meeting to be held this April 1–5, in Washington, D.C.

The Boomers presentations are a must attend. Keep in mind that the Boomers are unique — decidedly different from the war and depression-era generation we have been serving in past years of practice. Their specific needs and expectations in retirement will present new practice challenges for NAELA members. To be prepared, clear your calendar and attend these important presentations during the Annual Meeting.

These presentations will help you get ready:

- David Solie, MS, PA, a nationally recognized expert in geriatric communication speaking on “The Secret Mission of Seniors.”
- Cynthia Barrett, CELA, speaking on “The Growing, Vast, and Untapped Markets of Elder Law Estate Planning.”
- Thomas Begley, Jr., CELA and Andrew Hook, CELA, speaking on “Lawyering for Boomers: What Will Your Office Look Like for the Next 20 Years?”
- Michael Gilfix, Esq., and Vincent Russo, CELA, speaking on “The Boomers are Coming! What to Do?” They will focus on marketing strategies.
- Hyman Darling, CELA, Stephen Spanos, CELA, and Robert Anderson, CELA, speaking on “I Do or I Don’t — Counseling the Elder Client as to Marriage.”

Let’s face it. We all need to know how to position ourselves to be successful and profitable in providing services to Boomers and their families. Don’t miss this opportunity.