Aid in Dying: An End of Life-Option Governed by Best Practices

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I. Introduction

Modern medicine can extend the dying process so long that a patient dying of a terminal illness may feel trapped in a torturous, inexorable lingering decline. Sometimes the process takes too long and suffering is unbearable. Some patients will want a swifter, gentler end achieved by ingesting medications prescribed to bring about a peaceful death. This option is known as aid in dying and refers to the practice of a physician prescribing medication to a mentally competent terminally ill patient, which the patient may ingest to bring about a peaceful death.¹

Enacting legislation to create an affirmative permission for aid in dying is difficult and has only been achieved to date in two states: Oregon and Washington.² Another state has recognized that its citizens may freely choose this option through a

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¹ See Kathryn Tucker, At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations, 10 HARV. HEALTH POL’Y REV. 45, 45 (2009). This term is increasingly widely accepted, including by the American Medical Women’s Association, the American Medical Students’ Association, and the American Public Health Association, among others. Id. In the past, this option was sometimes referred to as ‘physician assisted suicide’ but that term has since been rejected as inaccurate and pejorative. But see AMA – E-2.211, Physician-Assisted Suicide, AM. MED. ASS’N (Jun. 1996), https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fHnE%2fE-2.211.HTM.

² See Tucker, supra note 1, at 45-46.
state Supreme Court decision, *Baxter v. State of Montana.* Three states have passed legislation specifically outlawing aid in dying. In the other states, it is unclear whether providing aid in dying exposes physicians to prosecution under criminal laws. This paper will explore the issue with a focus on Hawaii, a jurisdiction where it appears that aid in dying can be provided without fear of criminal prosecution, yet physicians and patients are largely unaware of this.

In 2002, Hawaii nearly became the second state, after Oregon in 1994, to pass a law that would have established a statutory permission to choose aid in dying. However, the bill was voted down by a narrow margin on the final day of the session. Since the 2002 session, a proposal to establish specific statutory permission for this choice has not received a full floor vote in the Hawaii State Legislature.

Efforts to enact an affirmative permission for aid in dying are often politically and emotionally charged. This is due, in part, to misinformation promoted by a well-organized opposition, as evident in the recent consideration of Hawaii Senate Bill 803: Death with Dignity. Opponents misleadingly referred to the bill as “Doctor Prescribed Death.” It was evident from Hawaii’s Senate Health Committee hearing that such tactics are effective. Those opposing the bill testified that a law permitting aid in dying would lead to involuntary euthanasia and would create a culture in which there is a “duty

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3 224 P.3d 1211, 1221 (Mont. 2009) (arguing that with aid in dying, the patient is choosing his or her own method of dying, unsolicited by his or her physician).

4 See ARK. CODE ANN. § 5-10-106 (West 2011) (making “physician-assisted suicide a Class C felony); IDAHO CODE ANN. § 18-4017 (West 2011) (explaining that any physician who assists with a patient suicide is subject to a felony charge and license revocation).

5 See B.J. Reyes, Assisted Suicide Bill Stalls, HONOLULU STAR-ADVERTISER (Feb. 8, 2011), http://www.staradvertiser.com/news/20110208_Assisted_suicide_bill_stalls.html?id=115545194 (comparing this proposed law to Oregon’s Death with Dignity Act). Repeated introductions of a permission measure reflect the assumption that aid in dying is not currently an option that patients can choose, nor that physicians can provide. *Id.* The assumption has been that providing aid in dying would subject physicians to criminal exposure. *Id.* That assumption, this paper asserts, is unfounded and erroneous. See *id.* (arguing that the proposed bill would shield physicians from both civil and criminal liability).

6 See *id.* (noting that the Senate voted against the bill 14-11).

7 See *Reyes, supra note 5.*

8 S. 803, 26th Leg., Reg. Sess. (Haw. 2011).


to die.” Swayed by this testimony, legislators voted the measure down.12

Even though opponents have successfully defeated measures to specifically permit aid in dying, using inflammatory language and conjuring frightening images, they have not defeated broad public support for it among Hawaii residents: an overwhelming majority supports access to aid in dying.13 Interestingly, it appears that a change in law is not necessary for the practice to be among the range of end-of-life options available to dying patients in Hawaii.14

Medical care is typically governed by best practices, also referred to as standard of care, and not by statutes or court decisions that either prohibit or give affirmative permission to provide specific types of care.15 Hawaii’s existing statutory framework already empowers patients to make autonomous decisions regarding their end-of-life care and treatment for pain.16 Further, Hawaii does not have a criminal prohibition against aid in dying.17 Standard of care already accepts a variety of other life-ending practices such as withdrawing life-sustaining treatment, stopping of all food and fluids, and palliative sedation.18 It is reasonable to conclude, as discussed below, that amidst

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11 Death with Dignity Legislation: Hearing on SB803 Before the S. Committee on Health, 26th Cong. 2 (2011) (statement of William D. Heagney, participant at the hearing), available at http://www.capitol.hawaii.gov/session2011/testimony/SB803_TESTIMONY_HTH_02-07-11.pdf. “Anyone who had done research on ‘death with dignity’ that [sic] this process quickly escalates to euthanasia of those who don’t request it, and increases the pressure on the sickly to have a ‘duty to die’ taking away all their dignity.” Id.
12 See Catterall, infra note 10 (noting that Senator Josh Green commented that the sentiment of those testifying was “overwhelmingly opposed”).
14 See HAW. REV. STAT. §§ 327H-1, 327E-2 (2011). Other end-of-life choices dying patients may make which alter time of death include: refusing or directing the withdrawal of life prolonging treatment, refusing food and fluid while receiving supportive palliative care, and aggressive pain and symptom management, including palliative sedation. Id.
15 61 AM. JUR. 2D Physicians, Surgeons, and Other Healers § 189 (2012). “Generally, a physician is held to the standard of care and skill of the average practitioner of the medical specialty in question, taking into account advances in the profession, or the state of the medical profession at the time.” Id. (footnotes omitted).
16 See infra Part II.A.
17 See infra Part II.B.
18 Authoritative medical literature also recognizes this option. See, e.g., Paul Rousseau, Palliative Sedation in the Management of Refractory Symptoms, 2 J. SUPPORTIVE ONCOLOGY 181, 185 (2004); Susan D. Bruce et al., Palliative Sedation in End-of-Life Care, 8 J. HOSPICE & PALLIATIVE NURSING
this background Hawaii is a jurisdiction in which physicians can provide aid in dying subject to best practices.\textsuperscript{19}

II. Hawaii Law Governing End-of-Life Care

A. Hawaii Law Empowers Patients to Make Autonomous End-of-Life Treatment Decisions

Hawaii’s statutory framework recognizes and respects the autonomy of patients in their decisions over end-of-life care. A constellation of existing laws empower patients to ensure they are able to effectively treat their pain and to refuse or withdraw life-sustaining treatment. Hawaii, like many states, has passed its own version of the Uniform Health-Care Decisions Act, which allows patients to specify if and when they wish to refuse or withdraw life-sustaining medical care.\textsuperscript{20} Additionally, in 2004, Hawaii


\textsuperscript{20} HAW. REV. STAT. §§ 327E-2, -3 (2011) (intending to have the benefits of treatment outweigh the burdens of such treatment on the patient). Section 327E-2 defines "health care" as any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition, including: ... (3) [d]irection to provide, withhold, or withdraw artificial nutrition and hydration; provided that withholding or withdrawing artificial nutrition or hydration is in accord with generally accepted health care standards applicable to health-care
enacted the Pain Patient's Bill of Rights, recognizing that seriously ill patients have the right to choose to receive as much pain medication as needed to get relief.\textsuperscript{21}

Both measures contain provisions stating that the statute does not authorize euthanasia, suicide, or mercy killing.\textsuperscript{22} These provisions could be argued to prohibit aid in dying, however, they are common to many state statutes, and at least one state high court has held that the terms "mercy killing and euthanasia" do not encompass aid in dying.\textsuperscript{23} In \textit{Baxter v. State of Montana}, the Supreme Court of Montana concluded that aid in dying is a choice within the public policy of the state and that a patient's decision to self-administer medication to bring about a peaceful death is neither a mercy killing nor euthanasia.\textsuperscript{24} Moreover, the court held that the Rights of the Terminally Ill Act, a Montana statute that is comparable to the Uniform Health-Care Decisions Act, clearly provides that terminally ill patients are entitled to autonomous end-of-life decisions, even when a patient's decision involves the direct act of a physician.\textsuperscript{25} \textit{Baxter} suggests that Hawaii's Pain Patient's Bill of Rights and Uniform Health-Care Decisions Act should be seen as reflecting that the policy of the State of Hawaii is to support

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\item providers or institutions.
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\textit{Id.} § 327E-2.

\textsuperscript{21} \textit{Id.} § 327H-2. The legislature found that "\textit{[i]nadequate treatment of severe acute pain and severe chronic pain... is a significant health problem." \textit{Id.} § 327H-1. The legislature then noted that "\textit{[f]or some patients, pain management is the single most important treatment a physician can provide;} \textit{a} patient who suffers from severe acute pain or severe chronic pain should have access to proper treatment of pain\textit{]}" which may include the safe administration of opiates by "knowledgeable, ethical, and experienced pain management practitioners." \textit{Id.}

\textsuperscript{22} \textit{Id.} § 327E-13(c); see \textit{id.} § 327H-2(b)(3)(E).

\textsuperscript{23} \textit{Baxter v. State}, 224 P.3d 1211,1219 (Mont. 2009).

\textsuperscript{24} \textit{Id.} at 1217-19. The court emphasizes that "\textit{a physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act} but rather is "\textit{only provid[ing]} a means by which a terminally ill patient \textit{himself} can give effect to his life-ending decision. ..." \textit{Id.} at 1217. Moreover, in analyzing the Montana Rights of the Terminally Ill Act, the court found no suggestion that physician aid in dying is against public policy as homicide because of the homicide statute's limited scope, applying to one who "\textit{purposely or knowingly causes the death of another human being. ...}" \textit{Id.} The court noted that the terminally-ill patient's decision to self-administer medication causing his or her own death would not cause the death of "another" within the homicide statute but the death of oneself, which was not within the statute. \textit{Id.} Further, the court noted that the Act expressly "\textit{does not condone, authorize, or approve mercy killing or euthanasia," but also does not mention "physician aid in dying}" in what is prohibited. \textit{Id.} at 1219. In distinguishing physician aid in dying from mercy killing and euthanasia, the court looked to the definitions of "\textit{euthanasia}" and "\textit{mercy killing}," highlighting that neither is consent-based, nor do they involve a patient's "\textit{decision to self-administer drugs that will cause his own death}." \textit{Id.}

\textsuperscript{25} \textit{Baxter}, 224 P.3d at 1217.
autonomy in medical decision making and that this reasonably extends to the choice of a mentally competent, terminally ill patient to request medication to bring about a peaceful death.

Hawaii law also contains a unique provision that gives physicians broad discretion when treating terminally ill patients. Specifically, Hawaii law provides that:

[W]hen a duly licensed physician or osteopathic physician pronounces a person affected with any disease hopeless and beyond recovery and gives a written certificate to that effect to the person affected or the person’s attendant nothing herein shall forbid any person from giving or furnishing any remedial agent or measure when so requested by or on behalf of the affected person.26

Added in 1909, the purpose of this provision was to give terminally ill patients the option to access treatment not approved by the government.27 This provision, like the Pain Patient’s Bill of Rights and the Uniform Health-Care Decision Act, gives terminally ill patients significant freedom to determine their course of medical care at the end of life.28 Interestingly, the statute also appears to encompass a patient’s choice of aid in dying. Under the law, a physician may give or furnish any measure requested by a patient who is “hopeless or beyond recovery.”29

With aid in dying, a physician prescribes medication that may then be ingested by a terminally ill patient; a physician does not administer the medication.30 The clear purpose of Hawaii Revised Statute § 453-1 was to expand, rather than restrict, a patient’s end-of-life care options.

Finally, the Hawaii State Constitution’s explicit privacy clause is also part of the constellation of laws reflecting that it is the policy of the State to empower its citizens

28 Id. (noting the legislature’s motivation for the provision in 1909). The legislature sought to provide “dying patients ‘the opportunity of availing themselves of any hope of relief which might be offered without subjecting those willing to render them aid to the indignities of prosecution and persecution.’” Id. See also supra notes 20-22 and accompanying text (discussing the Pain Patient’s Bill of Rights and the Uniform Health-Care Decision Act).
30 See Kawai, supra note 27, at 806-07.
with autonomy over medical decision making.\textsuperscript{31} Section 6 of Hawaii's State Constitution ensures State constitutional protection of personal privacy.\textsuperscript{32} Hawaii cases have recognized § 6 to protect personal autonomy, which safeguards a person's freedom to make certain kinds of "important [personal] decisions" such as those relating to activities in one's own home, marriage, procreation, contraception, family relationships, and child rearing.\textsuperscript{33} Hawaii courts have not provided much guidance about which personal privacy interests are protected by § 6. Hawaii privacy jurisprudence recognizes the potential that state constitutional privacy may protect a more broad scope of interests than its federal counterpart, but only one case has actually applied the state constitution to protect interests slightly beyond those protected by federal law.\textsuperscript{34}

B. Criminal Prohibitions Governing End-of-Life Care

Hawaii's manslaughter statute provides, in part, that an individual commits the offense of manslaughter if, "[t]he person intentionally causes another person to commit suicide."\textsuperscript{35} It is critical to note that it is widely recognized by mental health professionals that there is a clear and distinct difference between the act of "suicide" and the choice of a terminally ill patient to bring about a peaceful death.\textsuperscript{36} Despite this clear distinction, were a physician to be prosecuted, he or she would likely face criminal liability under the

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\textsuperscript{31} HAW. CONST. art. I, § 6. See also Kawai, supra note 27, at 807 (noting the application and intent of the Right to Privacy of the Constitution of Hawaii).

\textsuperscript{32} HAW. CONST. art. I, § 6. Section 6 states, "the right of the people to privacy is recognized and shall not be infringed without the showing of a compelling state interest. The legislature shall take affirmative steps to implement this right." Id.


\textsuperscript{34} State v. Kam, 748 P.2d 372, 376 (Haw. 1988) (recognizing a right to sell and distribute pornography, extending the federally protected privacy right to merely possess pornography in one's own home recognized in Stanley v. Georgia, 394 U.S. 557 (1969)).

\textsuperscript{35} Offenses Against the Person, HAW. REV. STAT. § 707-702(1)(b) (2011). See Kawai, supra note 27, at 805-06. After analyzing the language of Hawaii's manslaughter statute, the author "physicians in Hawaii have always been legally permitted to prescribe lethal medication to be self-administered by the patient" because there is no ban on aiding in the statute. Id.

\textsuperscript{36} Mental health professionals recognize a distinct difference between "suicide" and the choice of aid in dying. For example, the American Psychological Association advises: "It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide." See Rhea K. Farberman, Terminal Illness and Hastened Death Requests: The Important Role of the Mental Health Professional, 28 PROFESSIONAL PSYCHOLOGY: RESEARCH AND PRACTICE 544 (1997); John M. Bostwick & Lewis M. Cohen, Differentiating Suicide from Life-Ending Acts and End-of-Life Decisions: A Model Based on Chronic Kidney Disease and Dialysis, 50 PSYCHOSOMATICS 1 (2009).
state’s manslaughter statute in the absence of a specific prohibition against aid in dying. Analysis of the statute, however, reveals that such conduct does not fall within its reach.

Under Hawaii’s manslaughter statute an individual must “cause” another to commit suicide in order to face criminal liability. A physician’s role in aid in dying could hardly be classified as “causing” a suicide because the physician, at the request of a competent terminally ill patient, merely provides a prescription that a patient can choose, or not choose, to take to bring about a peaceful death. Unlike Hawaii, many states criminalize the act of “assisting suicide” rather than “causing” another to commit suicide. While such statutes ultimately create ambiguity for the medical community, they illustrate that Hawaii has chosen to create a higher standard by requiring an individual be the legal cause of another’s suicide before they can be held liable for the offense of manslaughter.

38 HAW. REV. STAT. § 707-702(1)(b) (2011). “A person commits the offense of manslaughter if . . . the person intentionally causes another person to commit suicide” Id. (emphasis added).
41 Even in states where a statute criminalizes “assisting” a “suicide”, it ought not to be assumed that such a law reaches the conduct of a physician providing aid in dying. In the Georgia Supreme Court, State of Georgia v. Final Exit Network, the Court considered whether members of a citizen activist group are subject to prosecution under Georgia’s assisted suicide statute for their involvement in deaths in that state. No. S11A1960, 2012 WL 360523, at *1 (Ga. 2012). Georgia’s Attorney General filed a brief asserting that the statute, while it reaches the defendants’ conduct, would not reach aid in dying provided by a physician to a patient. See Brief for Appellee at 13-14, State of Georgia v. Final Exit Network, 2012 WL 360523 (2012) (No. S11A1960). Absent a prohibition of aid in dying, this option could be one among many that Georgia physicians make available to their terminally ill patients. As with all medical practice, it could likely be governed by best practices as they emerge in the physician community. The Georgia Supreme Court struck down the statute on free speech grounds, indicating that the legislature could enact a prohibition that would survive free speech scrutiny. Final Exit Network, 2012 WL 360523, at *3. Activists opposed to end of life choice and the option of aid in dying are quickly responding with a prohibition measure. See Charlie Butts, Supreme Court ruling a blessing in disguise, ONENEWSNOW.COM (Feb. 9, 2012, 4:15AM), http://www.onenewsnow.com/Legal/Default.aspx?id=1532406.
Hawaii’s manslaughter statute also requires that an individual act with the intent to cause another to commit suicide. This is an important distinction because in aid in dying a physician provides a prescription with the purpose of providing comfort and empowering a patient to have control over the time and manner of their death. Many individuals who obtain a prescription choose not to ingest the medication, but derive comfort from knowing they have the ability to exercise control over their time and manner of death: in Oregon, more than one-third of patients who obtain a prescription under the Dignity Act choose not to ingest the medication and die of their underlying disease. The experience in Oregon illustrates that with aid in dying physicians intend to comfort and empower their patients, not to “cause[ ] another person to commit suicide.”

Finding that a physician acts with the intent to cause another to commit suicide in providing aid in dying would also potentially criminalize other forms of end-of-life care. Practices such as palliative sedation, discontinuing life-sustaining medical care, and providing palliative support to a patient who chooses to stop eating and drinking could all be characterized as intending to end life. Yet, these practices are widely accepted as intending to comfort and empower patients who wish to have a peaceful death and these practices have not been found to be illegal or unprofessional under Hawaii law. Interpreting Hawaii’s manslaughter statute to reach aid in dying would also be incongruous with statutes such as the Pain Patient’s Bill of Rights, the Uniform Health-Care Decisions Act, Hawaii Revised Statute § 453-1, and the State Constitution’s guarantee of privacy, all of which support a terminally ill patient’s freedom of choice to determine their medical care in the end stages of life.

Other than Hawaii’s manslaughter statute, there are no laws or cases that may

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42 Offenses Against the Person, HAW. REV. STAT. § 707-702(1)(b)(2011) (indicating the statute includes the word “intentionally”).
45 See Uniform Health-Care Decisions Act, HAW. REV. STAT. § 327E-2 (2011) (describing when an individual has a right to discontinue life sustaining treatment); Vacco v. Quill, 521 U.S. 793, 802 (1997) (noting that prescribing “aggressive palliative care” is accepted to treat patient pain).
possibly apply to aid in dying. Given Hawaii’s laws which seek to empower patients to make autonomous decisions about end-of-life care and pain management, and the state’s lack of criminal prohibitions that could reach aid in dying, it is reasonable to conclude that Hawaii physicians can provide this intervention without fear of prosecution, subject to best practices.47

III. Aid in Dying Should be Governed by Best Practices

Most medical care is not governed by statute or court decision, but instead by best practices, also referred to as the standard of care.48 In Hawaii, the standard of care is an objective one.49 A physician has a duty to have and to utilize the knowledge and skill ordinarily possessed by a physician practicing in the same field under similar circumstances, as established by expert testimony.50 Some jurisdictions have adopted the “respectable minority” standard of care exception as a defense to medical negligence.51

The exception allows a physician to engage in one of several recognized courses of treatment, and a physician’s actions do not fall outside the standard of care merely because he or she pursued a treatment that is followed by only a minority of physicians.52 Hawaii has not considered the “respectable minority” rule, and therefore

47 But see Letter from Heidi Rian, Deputy Attorney General, to Joshua Green, Senator (Dec. 8, 2011), available at http://www.adfmedia.org/files/HawaiiAGLegalOpinion.pdf. In response to a request from a legislator opposed to aid in dying, the Hawaii Attorney General issued a letter, advising that a prosecution for manslaughter could be brought against a physician providing aid in dying, so long as the physician acted with the intent to cause death. Id. This position has not been tested in court and the analysis failed to take into account many of the arguments advanced in this article. It remains to be seen if this advisory will deter physicians from providing aid in dying, or if a prosecution will be filed against a physician for providing this option, or if supporters of aid in dying will seek clarification about the reach of the criminal statute in the courts.

48 61 AM. JUR. 2D Physicians, Surgeons, and Other Healers § 189 (2011).

49 Hirahara v. Tanaka, 959 P.2d 830, 834 (Haw. 1998). The Hawaii standard is well established as one where a “question of negligence must be decided by reference to relevant medical standards of care.” Id. (quoting Craft v. Peebles, 893 P.2d 138, 149 (Haw. 1995)).


52 See Chumbler, 505 F.2d at 492.

Where two or more schools of thought exist among competent members of
has neither embraced nor rejected the rule. Aid in dying certainly qualifies as a "recognized course of treatment," as the practice has become increasingly accepted among medical and health policy organizations. Surely, a respectable minority of Hawaii physicians who provide end-of-life care would provide aid in dying if they felt safe doing so.

As discussed supra, Hawaii's statutory framework empowers patients to make autonomous decisions regarding their end-of-life care. Under this framework a standard of care has already begun to emerge in which physicians engage in other potentially life-ending practices for terminally ill patients. For example, physicians can provide palliative support to patients who choose to stop eating and drinking. Physicians can

the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority in a given city who follow one of the accepted schools.

Id.

53 Searches in 2012 on westlaw.com produced no Hawaii cases concerning the "respectable minority" rule.


55 See Barbara Coombs Lee, Hawaii: The latest state where doctors can provide aid in dying, COMPASSION AND CHOICES BLOG (Oct. 5, 2011), http://blog.compassionandchoices.org/?cat=5. Indeed, the existence of a physicians' advisory group for aid in dying reflects this. See id. The group, known as the Hawaii Medical Advisory Council for End-of-Life Choices, was founded by three of Hawaii's most prominent end-of-life care providers. Id.

56 See HAW. REV. STAT. § 327H-2 (2011) (permitting physicians to prescribe pain medication to patients suffering acute pain, "provided that it is not 'causing, or assisting in causing, the suicide, euthanasia, or mercy killing of any individual").
also discontinue life-sustaining treatment such as pacemakers, dialysis, and medication for patients who wish to end life-prolonging interventions.\textsuperscript{57} Physicians in Hawaii have already witnessed the emergence of a standard of care that respects a patient’s autonomy and accepts potentially life-ending practices. These practices demonstrate that physicians may receive requests from mentally competent, terminally ill patients for a prescription to bring about a peaceful death. For those physicians who believe such care is medically appropriate, a standard of care for aid in dying will also emerge.\textsuperscript{58}

IV. Aid in Dying in Other States

A. Aid in Dying in Oregon

Oregonians approved the passage of its law permitting aid in dying, the Death with Dignity Act, in 1994;\textsuperscript{59} aid in dying began to be provided in an open manner in 1998.\textsuperscript{60} The act allows a mentally competent, terminally ill patient to request from his or her physician a prescription to bring about a peaceful death.\textsuperscript{61} Oregon’s experience, now spanning fourteen years, has shown that when aid in dying is an available option it does not harm vulnerable patients.\textsuperscript{62} In the face of overwhelming evidence, even


\textsuperscript{58} See supra note 45.

\textsuperscript{59} OR. REV. STAT. § 127.800-127.897 (2011).


\textsuperscript{61} OR. REV. STAT. § 127.805 (2011).

opponents recognize that opposition to the Dignity Act can only be based on personal moral or religious grounds.\textsuperscript{63}

Despite the speculations and conjecture of those opposed to aid in dying, once available none of the dire predictions of harm raised by opponents have been realized. The Oregon data shows that aid in dying is rare: In 2010, only ninety-seven prescriptions were written under the Dignity Act and of those only sixty-five patients died from ingesting the medication.\textsuperscript{64} Since access began in 1998 only 596 patients have chosen to utilize aid in dying to bring about a peaceful death.\textsuperscript{65} Most of the patients who have chosen aid in dying were Caucasian, well educated, insured, and suffering from cancer\textsuperscript{66}—contrary to fears that the act would lead to involuntary euthanasia of the poor, undereducated, and disadvantaged.\textsuperscript{67} No abuses have occurred.\textsuperscript{68}

Since its enactment, the law has had benefits for patients and physicians alike; a fact that has been recognized by outside observers. A Task Force in the State of Vermont thoroughly examined Oregon’s experience and concluded that it is “quite apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options.”\textsuperscript{69} The passage of the Dignity Act led to a greater effort by physicians

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\textsuperscript{65}Id. at 2.

\textsuperscript{66}Id. As in previous years, in 2010 most participants “were white (95.6\%), well-educated (48.5\% had a least a baccalaureate degree), and had cancer (82.4\%).” Id.


\textsuperscript{68}See Battin et al., \textit{supra} note 62, at 594-97 (concluding availability of aid in dying has not created a heightened risk for vulnerable groups).

\textsuperscript{69}ROBIN LUNGE ET AL., OREGON’S DEATH WITH DIGNITY LAW AND EUTHANASIA IN THE
and hospice care professionals to ensure adequate pain control. Because physicians no longer face a professional and legal deterrent against the use of palliative care, physicians can adequately treat pain without fear of prosecution and patients experience better end-of-life care. Since the passage of the Dignity Act, Oregon’s physicians have worked to improve end-of-life care, improving their knowledge of the use of pain medication for the terminally ill, their ability to recognize depression and other psychiatric disorders, and more frequently refer patients to hospice care.

B. Aid in Dying in Washington

In 2008, Washington voters approved a law specifically permitting aid in dying nearly identical to Oregon’s, through the initiative process. The positive experience in Oregon proved to be influential in the campaign to pass the Washington measure. Washington began implementing its law in March 2009 and gathers and publishes data...
collected from health care providers.\textsuperscript{75} As in Oregon, most who choose aid in dying under Washington's law are Caucasian, well educated, and suffering from cancer.\textsuperscript{76} Since the law went into effect, a total of 152 patients have received prescriptions and of those patients, eighty-seven chose to ingest the medication.\textsuperscript{77}

C. Aid in Dying in Montana

A 2009 decision by the Montana Supreme Court recognizes the right of its citizens to freely choose aid in dying. In Baxter v. State of Montana, Robert Baxter, a seventy-five-year-old patient dying of lymphocytic leukemia, sued the State of Montana to establish his right to choose aid in dying.\textsuperscript{78} Baxter argued (1) Montanans have a right to aid in dying protected by the Montana State Constitutional guarantees of privacy and individual dignity;\textsuperscript{79} (2) and, alternatively, physicians who provide aid in dying could not be subject to prosecution under the state’s consent as a defense doctrine to the Montana homicide statute.\textsuperscript{80}

The Montana Supreme Court declined to reach the constitutional issues and instead resolved the case on the alternative ground under the consent defense to the homicide statute.\textsuperscript{81} The court held that Montana statutes vest patients with broad autonomy over medical decision making reflecting the policy of the state to leave these decisions to the individual and that aid in dying is not against the state’s public policy.\textsuperscript{82}

\textsuperscript{77} See WASH. STATE DEPT. OF HEALTH, supra note 76, at 4-5. The report notes that there was a two person error and consequently, of the 152 patients, between 87 and 89 decided to ingest the pill. Id at 3-4.
\textsuperscript{79} Baxter, 224 P.3d at 1214.
\textsuperscript{80} Id.; see MONT. CODE ANN. § 45-2-211(1) (2009). The statute provides that the “consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense.” Id.
\textsuperscript{81} Baxter, 224 P.3d at 1215-1216.
\textsuperscript{82} Id. at 1215.
Accordingly, no prosecution of a physician providing aid in dying would be proper.\textsuperscript{83} Under this ruling, physicians can provide aid in dying to mentally competent, terminally ill patients without fear of prosecution.\textsuperscript{84} Montana physicians are not subject to the statutory frameworks that govern the practice in Oregon and Washington.\textsuperscript{85} Although the limitations provided by the Dignity Acts in Oregon and Washington do not apply to Montana physicians, the Montana Supreme Court recognized certain boundaries which are similar to the Oregon and Washington requirements: a patient must be terminally ill, mentally competent, and the physician is limited to providing a prescription which a patient may choose to ingest.\textsuperscript{86} In Montana, beyond the bright lines established in Baxter, the practice of aid in dying will develop in end of life care practice, subject to best practices.

V. Aid in Dying Can and Should Emerge as an End-of-Life Option in Hawaii Governed by Best Practices

For over a decade, Hawaii engaged in efforts to create an affirmative statutory permission to choose aid in dying. Beginning in 1997, then Governor Benjamin Cayetano established a “Blue Ribbon Panel on Living and Dying with Dignity” to study end-of-life issues, including aid in dying.\textsuperscript{87} A majority of the Panel, comprised of eighteen leading members of Hawaii’s medical, legal, and religious communities, recommended enacting legislation to create an affirmative right to aid in dying.\textsuperscript{88} A majority of the panel recognized that the benefits of aid in dying outweighed any potential risks.\textsuperscript{89}

\textsuperscript{83} Id.
\textsuperscript{84} Id. at 1222. Physicians need not fear disciplinary action either, at least no more than in case of providing any other medical procedure or intervention. See Physician Aid in Dying, MONTANA BOARD OF MEDICAL EXAMINERS, http://bsd.dli.mt.gov/license/bsd_boards/med_board/pdf/Final%20Draft%20Physician%20Aid%20in%20Dying%20Statement.pdf (last visited Mar. 24, 2012). The Montana Board of Medical Examiners adopted a position statement on aid in dying in January 2011, clarifying this position. Id. The Board will treat complaints regarding aid in dying as it would any other complaint reflects that the practice is becoming normalized and governed as all other medical practice. Id.
\textsuperscript{85} See supra notes 57 and 70 and accompanying text.
\textsuperscript{86} Baxter, 224 P.3d at 1217.
\textsuperscript{88} McAneeley, supra note 84, at 284-85.
\textsuperscript{89} See id. at 285; see also Pietsch, supra note 84, at 325. Eleven members of the panel voted to legalize patient aid with required safeguards, including written request from the patient, a two-week waiting period after which the patient must reaffirm their decision, and consultations with
Following the Blue Ribbon Panel’s findings, supporters attempted to pass legislation similar to Oregon’s Death with Dignity Act in 2002. The measure received strong support from organizations including the Hawaii State Commission on the Status of Women, ACLU of Hawaii, National Association of Social Workers, and Planned Parenthood. The measure ultimately failed on a close vote in the Senate. Since then, supporters of aid in dying have made multiple attempts to enact an affirmative permission to aid in dying, but have not been successful. The arguments raised in opposition have been disproved by the experiences in Oregon, Washington, and Montana, yet, legislators have been reluctant to address a hot button issue particularly during elections years. Attempts to pass legislation to create an affirmative permission to aid in dying lead to community dialogue and raise awareness of the issue, but such measures are unnecessary in the absence of a prohibition against aid in dying.

End of life medical practice with aid in dying in Oregon, Washington, and Montana, and a growing number of medical and health policy organizations with policy supportive of aid in dying, demonstrate that this choice is increasingly accepted. The emergence of these policies and the practice in Oregon, Washington, and Montana will certainly influence best practices elsewhere, including in Hawaii.

Against this backdrop, the time is ripe for the practice to emerge in Hawaii as an end-of-life option governed by best practices. The thirteen years of positive outcomes in Oregon, strong public support of aid in dying, the recent adoption of aid in dying by both Washington and Montana, and the trend of many major national medical and health policy groups to adopt policy supportive of the intervention, combined with the existing statutory landscape which vests patients with great autonomy in end-of-life decisions and has no prohibitory measure that could reach the practice, all support the conclusion that aid in dying can emerge within end-of-life medical practice governed by best practices. This would extend an important additional choice to mentally competent, terminally ill Hawaii residents who confront a dying process that they find

another physician, psychiatrist, social worker and/or pain management specialist. Pietsch, supra note 84, at 325.

90 See McAneeley, supra note 84, at 286; see also H.R. 2487, 21st Leg., Reg. Sess. (Haw. 2002).
91 McAneeley, supra note 84, at 287.
93 See McAneeley, supra note 84 at 287-88 (addressing the house bills presented in 2003 and 2005 which ultimately failed).
94 See id. at 287; see also supra notes 73-81 and accompanying text.
95 See Tucker, supra note 51, at 45-47.
unbearable.

VI. Conclusion

It is timely for aid in dying to be governed as is all other medical practice: subject to professional practice standards. End-of-life choice can be expanded to include aid in dying in Hawaii, and in other states where public support for the option is strong, there is no statutory prohibition of the practice, and existing law vests citizens with significant autonomy over medical decision-making.