

VERMONT'S PATIENT CHOICE AT END OF LIFE ACT: A HISTORIC "NEXT GENERATION" LAW GOVERNING AID IN DYING

Kathryn L. Tucker*

INTRODUCTION

On May 20, 2013, a landmark law empowering mentally competent, terminally ill patients to choose aid in dying took effect in Vermont.¹ The Patient Choice at the End of Life Act (PCEOL) is similar in some ways to Oregon's Death with Dignity Act (DWDA), the first law in the nation to explicitly permit aid in dying,² and in other ways is starkly different. A "next generation" model for legislation, the PCEOL expands end-of-life choice to include aid in dying, an option favored by a majority of Americans.³ It is of historic significance, both because this is the first time a legislature has adopted a statute specifically permitting aid in dying, and because of the unusual structure built into the law that causes it to transition to a very different law in three years.

Oregon led the way in expanding end-of-life choice when voters passed an initiative permitting aid in dying in 1994.⁴ Oregon's success followed two failed initiative efforts: Washington in 1991⁵ and California in

* Ms. Tucker served for twenty-two years as Director of Legal Affairs and Advocacy at Compassion & Choices, the nation's largest and oldest organization dedicated to protecting and expanding the rights of terminally ill persons. Prior to joining C&C, she was in private practice with Perkins Coie in Seattle, Washington. She teaches *Law, Medicine and Ethics at the End of Life* at law schools, including the University of Washington, Seattle University, and Loyola/Los Angeles. Ms. Tucker testified in both the House and Senate in the Vermont Legislative Session in 2013 in support of the Patient Choice at the End of Life Act. Ms. Tucker wishes to commend the ability of the Vermont legislature to reach the compromise reflected in the enactment discussed in this Article, with special recognition of the vision, courage, and diplomacy of Senator Peter Galbraith. Ms. Tucker extends special thanks to Jenny Prosser, Vermont Law School Juris Doctor Candidate 2014, for her able assistance in the preparation of this Article.

1. Patient Choice and Control at End of Life Act (PCEOL), 2013 Vt. Acts & Resolves 292, 296 (codified at VT. STAT. ANN. tit.18, ch. 133 (Supp. 2013)).

2. OR. REV. STAT. ANN. §§ 127.800–127.897 (West, Westlaw through 2013 Reg. and Spec. Sess. 2013).

3. *Large Majorities Support Doctor Assisted Suicide for Terminally Ill Patients in Great Pain*, HARRIS INTERACTIVE (Jan. 25, 2011), <http://www.harrisinteractive.com/NewsRoom/HarrisPolls/tabid/447/mid/1508/articleId/677/ctl/ReadCustom%20Default/Default.aspx>.

4. For a discussion of utilizing the direct democracy mechanism of voter initiative in the context of aid in dying, see Kathryn L. Tucker, *When Dying Takes Too Long: Activism for Social Change to Protect and Expand Choice at the End of Life*, 33 WHITTIER L. REV. 109, 114 (2011) [hereinafter Tucker, *When Dying*]; K.K. DuVivier, *Fast Food Government and Physician-Assisted Death: The Role of Direct Democracy in Federalism*, 86 OR. L. REV. 895, 904, 961–62 (2007).

5. Ellis E. Conklin, *Support for Initiative 119 Slipped Away in Final Hours*, SEATTLE POST-INTELLIGENCER, at A9 (November 7, 1991), available at 1991 WLNR 1397851.

1992.⁶ In response, Oregon voters tailored the measure to address the key issues that caused previous measures to fail at the ballot box.⁷

Vermont legislators are the first to enact a statute explicitly permitting aid in dying and protecting physicians who provide it.⁸ The PCEOL's unusual structure reflects a compromise between legislators who saw Oregon's law as a tried-and-true model to be replicated and others who favored less government intrusion into the physician-patient relationship.⁹ The compromise was to adopt an Oregon-style measure for a period of three years, after which most statutory mandates expire and default to the professional practice standards by which most medicine is governed.¹⁰

The PCEOL establishes two phases: the first governs for the three years following enactment, May 20, 2013 to June 30, 2016 (Phase I); the second commences July 1, 2016 (Phase II).¹¹ This Article reviews key PCEOL provisions in Phases I and II—specifically, those pertaining to

6. *Chronology of Assisted Dying*, DEATH WITH DIGNITY NAT'L CENTER, <http://www.deathwithdignity.org/historyfacts/chronology> (last visited Apr. 2, 2014).

7. For a full discussion of the Oregon initiative and its predecessors, see Tucker, *When Dying*, *supra* note 4, at 115.

8. Kevin Liptak, *Vermont Moves to Pass End-of-Life Choice Law*, CNN.COM BLOGS (May 14, 2013, 8:13 AM), <http://politicalticker.blogs.cnn.com/2013/05/14/vermont-moves-to-pass-end-of-life-choice-law/>. The willingness of legislators to address this issue, which raises opposition from vocal well-funded activists, reflects a sea change, as noted by commentators discussing the Act. *See id.* (demonstrating the Vermont Legislature's willingness to address controversial, end-of-life decisions). For discussion of the politics of the issue, see generally Tucker, *When Dying*, *supra* note 4.

9. *See* Alicia Freese, *Vt. Senate Volleys Hybrid End of Life Bill Back to House*, VTDIGGER.ORG (May 8, 2013), <http://vtdigger.org/2013/05/08/senate-volleys-hybrid-end-of-life-bill-back-to-house/> (featuring conversation with Senator Claire Ayer, who described the final bill as a compromise between factions supporting government safeguards and those promoting physician independence).

10. PCEOL, §§ 2–3, 2013 Vt. Acts & Resolves 292, 296. This author has long advocated for normalizing governance of aid in dying within the practice of medicine. *See* Tucker, *When Dying*, *supra* note 4, at 113.

[I]t is time for aid in dying to become more widely available without enactment of statutes specifically authorizing, or court decisions protecting, the practice. Aid in dying can and should be governed, as is other medical care, by professional practice standards, also referred to as best practice or standard of care.

Id.; Kathryn L. Tucker, *Aid in Dying: Guidance for an Emerging End-of-Life Practice*, 142 CHEST J. 218, 220 (2012) [hereinafter Tucker, *Aid in Dying*], available at <http://journal.publications.chestnet.org/pdfaccess.ashx?ResourceID=3619562&PDFSource=13> (explaining that physician liability is determined by applicable standard of care, which is based on peer practice and may be governed by state statutes, medical board policy, or guidelines and authoritative literature).

11. *See* § 2, 2013 Vt. Acts & Resolves at 296 (repealing Phase I immunities concerning prescription and documentation on July 21, 2016); *id.* § 3 (making Act effective on passage, except postponing Phase II protection of patient choice at the end of life and corresponding physician immunity until July 1, 2016).

eligibility, the physician–patient relationship, procedures for patients and physicians, limitations on a physician's practice of aid in dying, and immunities—comparing them to each other and to Oregon's DWDA.¹² Comparison is also made to aid-in-dying practices in Washington, which adopted a Death with Dignity Act modeled after Oregon's law in a 2008 voter initiative;¹³ in Montana, where a decision of the State Supreme Court protects the choice;¹⁴ and in Hawaii, where a constellation of statutory enactments creates an environment in which this option can be provided and is practiced subject to professional medical practice standards.¹⁵

I. PATIENT ELIGIBILITY

A. Prognosis

In all states where it is openly practiced, aid in dying is available only to patients in the terminal phase of illness, defined in Oregon,¹⁶ Washington,¹⁷ and Vermont¹⁸ as having six months to live or less.

In Montana, the *Baxter* decision recognizes aid in dying as an option limited to terminally ill patients,¹⁹ but the decision does not define the term. However, the statute the court relied upon in finding policy supportive of aid in dying includes a definition: a terminal condition is one where death is

12. Washington adopted a Death with Dignity Act modeled after Oregon's in 2008. WASH. REV. CODE ANN. § 70.245 (West, Westlaw through 2013 Sess.). Most of the comparisons between Vermont and Oregon also apply as between Vermont and Washington.

13. *Id.*; see also *Chronology of Assisted Dying*, *supra* note 6.

14. *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009).

15. For a full discussion of law and policy pertinent to aid in dying in Hawaii, see Tucker, *Aid in Dying*, *supra* note 10, at 220, 222; see also Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices*, 8 J. HEALTH & BIOMEDICAL L. 9, 12–20 (2012) [hereinafter Tucker, *Best Practices*].

16. OR. REV. STAT. ANN. § 127.805(1) (West, Westlaw through 2013 Reg. and Spec. Sess. 2013) (confining who may initiate a “written request for medication” to “[a]n adult who is . . . suffering from a terminal disease”); *id.* § 127.800(12) (“‘Terminal disease’ means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”).

17. WASH. REV. CODE ANN. § 70.245.010 (“‘Terminal disease’ means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”).

18. VT. STAT. ANN. tit. 18, § 5281(a)(10) (Supp. 2013) (defining “terminal condition” as “an incurable and irreversible disease which would, within reasonable medical judgment, result in death within six months” as applied to both Phases I and II of the PCEOL).

19. *Baxter v. State*, 224 P.3d 1211, 1215 (Mont. 2009) (“[W]e find no indication in Montana law that physician aid in dying provided to *terminally ill*, mentally competent adult patients is against public policy.” (emphasis added)).

expected “within a relatively short time.”²⁰ Accordingly, in Montana, a patient whose death is expected within a relatively short time is eligible to receive a prescription for medication that the patient could ingest to achieve a peaceful death.

In Hawaii, although no explicit statute specifically governs aid in dying, a constellation of laws reflects that it is the policy of the state to vest citizens with broad autonomy over medical and end-of-life decision making.²¹ An open practice of aid in dying has been available in Hawaii since the fall of 2011, governed by professional practice standards.²² Hawaii physicians are likely guided by medical practice in states where aid in dying has been practiced openly for a longer period of time, and they may adopt the six-month prognosis requirement used in Oregon and Washington.²³ Alternatively, physicians could look to the Hawaii advance directive statute, which provides for an advance directive to take effect when a patient has “an incurable and irreversible condition that will result in . . . death within a relatively short time.”²⁴ Otherwise, statutory guidance can be found in a Hawaiian insurance law, which provides: “‘Terminally ill’ means having an illness or sickness that can reasonably be expected to result in death in twenty-four months or less.”²⁵

B. Mental State of Patient

Vermont, in both Phases I²⁶ and II,²⁷ limits eligibility for aid in dying to “capable” patients. Capable is defined as having the ability to make and

20. Rights of the Terminally Ill Act, MONT. CODE ANN. § 50-9-102(16) (West, Westlaw through 2013 Sess.) (“‘Terminal condition’ means an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician or attending advanced practice registered nurse, result in death within a relatively short time.”).

21. See Tucker, *Aid in Dying*, *supra* note 10, at 220 (describing Hawaii as a state that “empower[s] [its] citizens with broad autonomy over medical and end-of-life decision-making”); see also Tucker, *Best Practices*, *supra* note 15.

22. Kathryn L. Tucker, *Give Me Liberty at My Death: Expanding End-of-Life Choice in Massachusetts*, 58 N.Y.L. SCH. L. REV. 259, 261 (2013) [hereinafter Tucker, *Give Me Liberty*], available at http://www.nylslawreview.com/wordpress/wp-content/uploads/2014/01/NYLS_Law_Review.Volume-58_Issue-2_Tucker-Article.pdf.

23. Federal law defines terminal illness for purposes of Medicare’s hospice benefit, also employing a six month prognosis. See 42 U.S.C. § 1395x(dd)(3)(A) (2006) (defining one as “‘terminally ill’ if the individual has a medical prognosis that [his or her] life expectancy is 6 months or less”). Because physicians who provide end-of-life care are familiar with the hospice benefit eligibility determination, they may incorporate this into practice.

24. HAW. REV. STAT. § 327E-16 (West, Westlaw through 2013 2nd Spec. Sess.) (providing a sample form for an advance health care directive).

25. *Id.* § 431C-2.

26. VT. STAT. ANN. tit. 18, § 5283(a)(5)(B) (Supp. 2013).

27. *Id.* § 5289(1).

communicate health care decisions.²⁸ This is similar to statutory requirements in Oregon²⁹ and Washington.³⁰ In Montana, the Supreme Court recognized the right of “mentally competent” patients to choose aid in dying.³¹ Hawaii physicians likely look to practice in these states to inform best practices, as well as to other authoritative sources such as policies and guidelines adopted by medical and health policy groups.³² Best practices would likely incorporate mental competency eligibility criteria.³³

C. Age and Residency

Vermont, in both Phases I and II, limits eligibility to persons who are over the age of 18 and Vermont residents.³⁴ This is similar to Oregon³⁵ and Washington.³⁶ In Montana, the *Baxter* decision speaks to the rights of an

28. *Id.* § 5281(a)(2) (“‘Capable’ means that a patient has the ability to make and communicate health care decisions to a physician, including communication through persons familiar with the patient’s manner of communicating if those persons are available.”).

29. OR. REV. STAT. ANN. § 127.800(3) (West, Westlaw through 2013 Reg. and Spec. Sess.)

“Capable” means that in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.

Id.

30. WASH. REV. CODE ANN. § 70.245.010(3) (West, Westlaw through 2013 Sess.).

31. *Baxter v. State*, 224 P.3d 1211, 1215 (Mont. 2009) (“[W]e find no indication in Montana law that physician aid in dying provided to terminally ill, *mentally competent* adult patients is against public policy.” (emphasis added)).

32. A growing number of medical and health policy professional organizations have adopted policy supportive of aid in dying. *See, e.g., Patients’ Rights to Self-Determination at the End of Life*, AM. PUB. HEALTH ASS’N (Oct. 28, 2008), <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372> (“[T]he American Public Health Association [s]upports allowing a mentally competent, terminally ill adult to obtain a prescription for medication that the person could self-administer to control the time, place, and manner of his or her impending death . . .”).

33. *See Tucker, Aid in Dying, supra* note 10, at 220 (asserting that since Hawaiian physicians have developed a standard of care that respects patient autonomy and permits potentially life-ending practices, these physicians may receive requests from mentally competent, terminally-ill patients for medically appropriate aid in dying); *see also Tucker, Best Practices, supra* note 15.

34. VT. STAT. ANN. tit. 18, § 5281(a)(8) (Supp. 2013) (“‘Patient’ means a person who is 18 years of age or older, a resident of Vermont . . .”).

35. OR. REV. STAT. ANN. §§ 127.800(1), (11), 127.805(1) (West, Westlaw through 2013 Reg. and Spec. Sess.).

36. WASH. REV. CODE ANN. §§ 70.245.010(1)(11), 70.245.020(1) (West, Westlaw through 2013 Sess.).

“adult.”³⁷ Hawaii physicians, looking to other jurisdictions where aid in dying is openly practiced and to authoritative literature governing the practice, would likely incorporate similar age and residency requirements.

II. PHYSICIAN–PATIENT RELATIONSHIP

Phase I of the PCEOL does not appear to require a treating relationship. The statutory provisions governing during this time use the term “physician,” which is defined without any reference to a treating relationship.³⁸ However, when the measure transitions to Phase II, a treating relationship is required: Phase II calls for a “bona fide physician patient relationship.”³⁹

In Oregon, the DWDA requires that there be a treating relationship. The “attending physician”—defined as the “physician who has primary responsibility for the care of the patient and treatment of the patient’s terminal disease”⁴⁰—provides the information that enables a patient to make an “informed decision” for aid in dying.⁴¹ The attending physician determines if the patient is eligible and, if so, the physician may write the prescription.⁴²

Neither Montana nor Hawaii imposes any mandate related to the relationship between physician and patient; however, in both jurisdictions best practices may incorporate a treating relationship. Similarly, even though the PCEOL does not mandate a treating relationship in Phase I, it is likely that best practices will call for such.

37. *Baxter v. State*, 224 P.3d 1211, 1215 (Mont. 2009) (“The consent statute would shield physicians from homicide liability if, with the patients’ consent, the physicians provide aid in dying to terminally ill, mentally competent *adult* patients.” (emphasis added)).

38. VT. STAT. ANN. tit. 18, § 5281(a)(9) (Supp. 2013) (“‘Physician’ means an individual licensed to practice medicine under 26 V.S.A. chapter 23 or 33.”). Phase I seems to contemplate that the physician providing aid in dying is not the primary care physician. *See id.* § 5283(a)(9) (providing immunity from liability for a physician who provided aid in dying if the physician complied with statutory requirements, including, “[i]f applicable, [that] the physician consulted with the patient’s primary care physician with the patient’s consent”).

39. *Id.* § 5281(a)(1) (“‘Bona fide physician–patient relationship’ means a treating or consulting relationship in the course of which a physician has completed a full assessment of the patient’s medical history and current medical condition, including a personal physical examination.”). The new law also protects such physicians. *See id.* § 5289 (“A physician with a bona fide physician–patient relationship with a patient with a terminal condition shall not be considered to have engaged in unprofessional conduct . . . if . . .”).

40. OR. REV. STAT. ANN. § 127.800(2) (West, Westlaw through 2013 Reg. and Spec. Sess.).

41. *Id.* § 127.800(7) (“‘Informed decision’ means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed *by the attending physician* of . . .” (emphasis added)).

42. *Id.* § 127.815(1)(a), (1)(L).

III. PROCEDURES FOR PATIENTS

During Phase I, patients in Vermont must make two oral requests for aid in dying, separated by at least fifteen days. Additionally, Phase I requires one written request, witnessed by a minimum of two disinterested witnesses.⁴³ This is similar to Oregon's requirements, although in Oregon only one of the two witnesses need be disinterested.⁴⁴ In Phase II, none of these procedures are mandated. Neither Montana nor Hawaii impose any mandates related to the number, form, or witnessing of requests. However, best practices in any of these jurisdictions may evolve to include procedures to ensure the request for aid in dying is deliberative, enduring, and free of coercion, if physicians believe these practices are appropriate and serve patient interests.

IV. PROCEDURES FOR PHYSICIANS

During Phase I of the PCEOL, a participating physician must meet extensive procedural requirements, including:

- documenting the patient's requests;⁴⁵
- advising the patient of the option to rescind the request;⁴⁶
- complying with extensive informed consent provisions, including, for example, advising of alternative options such as hospice;⁴⁷
- confirming diagnosis, prognosis, and mental state;⁴⁸
- waiting forty-eight hours from any of three prerequisite events before writing the prescription;⁴⁹
- making a referral for a second opinion;⁵⁰ and
- complying with extensive record keeping and reporting requirements.⁵¹

43. VT. STAT. ANN. tit. 18, § 5283(a)(1), (2), (4) (Supp. 2013).

44. OR. REV. STAT. ANN. § 127.810(1), (2).

45. VT. STAT. ANN. tit. 18, § 5283(a)(14)(A), (B).

46. *Id.* § 5283(a)(10).

47. *Id.* § 5283(a)(6).

48. *Id.* § 5283(a)(5)(A)–(B), (14)(C).

49. *Id.* § 5283(a)(12).

50. *Id.* § 5283(a)(7).

51. *Id.* § 5283(a)(14)(D), (15).

These requirements are similar to those in Oregon⁵² and Washington.⁵³

With regard to reporting the cause of death, Washington specifies that the attending physician is to report the underlying terminal disease as the cause of death on the death certificate.⁵⁴ Specification of cause of death is not addressed by statute in either Oregon or Vermont. The PCEOL provides, however, that “[a]ction taken in accordance with this chapter shall not be construed for any purpose to constitute suicide, [or] assisted suicide.”⁵⁵ This is consistent with the Oregon and Washington statutes,⁵⁶ although Vermont’s enactment represents the first explicit legislative recognition that aid in dying is not “assisted suicide.”⁵⁷ In all jurisdictions, the likely professional practice is to record the underlying disease as the cause of death.

In Montana and Hawaii there are no detailed mandates of the nature described above, nor will there be in Vermont after Phase I concludes, although some of these practices may be incorporated in professional practice standards as physicians determine what practices best serve patients.

52. OR. REV. STAT. ANN. § 127.815 (West, Westlaw through 2013 Reg. and Spec. Sess.).

53. WASH. REV. CODE ANN. § 70.245.040 (West, Westlaw through 2013 Sess.).

54. *Id.* § 70.245.040(2).

55. VT. STAT. ANN. tit. 18, § 5292.

56. OR. REV. STAT. ANN. § 127.880 (“Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide”); accord WASH. REV. CODE ANN. § 70.245.180.

57. A lower court in New Mexico found the conduct of aid in dying to be within the ambit of a statute prohibiting assisted suicide, but went on to hold that the statute violated the state’s constitution. *Morris v. Brandenburg*, No. D-202-CV-2012-02909, slip op. at 6, 13–14 (N.M. Dist. Ct. Jan. 13, 2014), available at <https://newmexico.tylerhost.net/ServeDocument.ashx?SID=0730da82-c2ce-4331-9d34-98fe74190124&RID=001664dd-e045-4d6c-b5ce-1294189b0a7a>.

This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying. If decisions made in the shadow of one’s imminent death regarding how they and their loved ones will face that death are not fundamental and at the core of these constitutional guarantees, than what decisions are? . . . The Court therefore declares that the liberty, safety and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right under our New Mexico Constitution.

Id. at 12–13. The decision has been appealed.

V. ABILITY OF A HEALTH CARE FACILITY TO PROHIBIT CONDUCT
PERMITTED BY THE ACT

In both Oregon⁵⁸ and Washington,⁵⁹ a health care entity can prohibit an individual provider from participating in conduct permitted by aid-in-dying statutes *on the premises* of the entity. Because most patients who choose aid in dying are not residents in a health care facility,⁶⁰ this has limited impact on practice. A physician can write a prescription off premises for a patient who, if she or he chooses to do so, ingests the medication off premises.⁶¹ Vermont's law allows a facility to prohibit a physician from writing a prescription for aid in dying for a patient who is a resident in the facility and intends to use the medication on the facility's premises.⁶² This slightly different variation, which seeks to preserve the ability of hospitals and nursing homes to opt out of participation at their facilities, appears likely to have limited effect because nearly all aid-in-dying deaths occur in the patient's home.⁶³

VI. SAFE HARBOR PROVISIONS

A. Physicians

In order for patients to be able to access aid in dying, physicians need to feel safe in providing this option to their patients. A clear "safe harbor" ensures that physicians feel safe. Oregon,⁶⁴ Washington,⁶⁵ and Vermont in both phases⁶⁶ provide clear statutory immunity from civil, criminal, and disciplinary sanction for physicians providing aid in dying.

58. OR. REV. STAT. ANN. § 127.885(5)(a).

59. WASH. REV. CODE ANN. § 70.245.190.

60. *See, e.g.*, OR. PUB. HEALTH DIV., OREGON'S DEATH WITH DIGNITY ACT—2011, at 2 (2012) available at: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf> (reporting that 94% of patients who ingested medications for aid in dying during first 15 years under the Death with Dignity Act did so at home).

61. WASH. REV. CODE ANN. § 70.245.190(1)(b), (2)(a).

62. VT. STAT. ANN. tit. 18, § 5286 (Supp. 2013).

63. *See, e.g.*, OR. PUB. HEALTH DIV., *supra* note 60, at 5 (reporting that 94% of patients who ingested medications for aid in dying during first 15 years under the Death with Dignity Act did so at home).

64. OR. REV. STAT. ANN. § 127.885(1).

65. WASH. REV. CODE ANN. § 70.245.190(1)(a).

66. In Phase I, "[a] physician shall not be subject to any civil or criminal liability or professional disciplinary action if the physician prescribes," VT. STAT. ANN. tit. 18, § 5283(a) (Supp. 2013), although liability can attach if the physician engages in "gross negligence, recklessness, or intentional misconduct." *Id.* § 5283(b). In Phase II, "[a] physician shall be immune from any civil or criminal liability or professional disciplinary action for actions performed in good faith compliance with the provisions of this chapter." *Id.* § 5290.

Physicians in Montana are protected from criminal exposure under the *Baxter* ruling.⁶⁷ With regard to potential disciplinary exposure, a Statement adopted by the Montana Board of Medical Examiners makes clear that a complaint about aid in dying will be subject to the same review applicable to any other medical practice.⁶⁸

In Hawaii there are no specific statutory, judicial, or executive immunities, yet physicians are openly providing aid in dying despite the lack of a safe harbor as clear as in other states.⁶⁹ As noted above, a constellation of laws reflects the policy of Hawaii to vest citizens with broad autonomy over medical and end-of-life decision making, such that there would appear to be no basis to initiate any sort of action seeking sanction of a physician providing aid in dying in Hawaii.⁷⁰

B. Pharmacists

Pharmacists play a role in patient access to medication. The PCEOL, however, leaves the question of pharmacist immunity for filling a prescription for aid in dying somewhat unaddressed. Similarly, the responsibilities of those pharmacists who choose to “opt out” of filling

67. *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009) (holding that “a terminally ill patient’s consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician”).

68. *Montanans Against Assisted Suicide (MAAS) v. Bd. of Med. Exam’rs*, No. ADV-2012-1057, slip op. at 3 (Mont. Dist. Ct. Dec. 13, 2013), available at <http://maasdocuments.files.wordpress.com/2013/12/order-on-defendants-motion-to-dismiss.pdf> (providing the Montana Board of Medical Examiners’ position regarding physician aid in dying: “If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention . . .”).

69. See Tucker, *Give Me Liberty*, *supra* note 22, at 261, 275 (explaining that Hawaii has no laws permitting aid in dying, but that physicians publically offer it without being prosecuted).

70. See generally Tucker, *Aid in Dying*, *supra* note 10, at 220 (arguing that the assumption that “aid in dying might expose physicians to prosecution for assisting suicide under state criminal statutes” is rebutted by a recognition, embodied in Hawaii statute, that “the choice of a dying patient for a peaceful death is starkly and fundamentally different from suicide”). Opponents of aid in dying sought and obtained an opinion from the Hawaii Attorney General’s Office, which takes the position that a criminal prosecution could be brought. Letter from David M. Louie, Haw. Att’y Gen., to Joshua Booth Green, Haw. State Senator (Dec. 8, 2011), available at <http://www.hawaiiexpress.com/ArticlesMain/tabid/56/ID/5714/Full-Text-AG-Louie-Assisted-Suicide-Not-Legal-in-Hawaii.aspx>. The reasoning in this opinion is unpersuasive for a number of reasons, including failure to recognize the constellation of Hawaii laws reflecting that it is the policy of the state to vest its citizens with broad autonomy over end-of-life decisions. There have been no prosecutions of physicians for providing aid in dying in Hawaii, despite media attention to the fact that the practice is ongoing. See Steve Lopez, *Chorus of Voices Grows Stronger for ‘Death with Dignity’*, L.A. TIMES (Dec. 18, 2012), <http://www.latimes.com/news/local/la-me-lopez-dignity-20121219,0,2923995,full.column> (following a patient as she obtains her prescription for life-ending medication); Tucker, *Give Me Liberty*, *supra* note 22, at 275 (noting that Hawaii has not prosecuted any physicians for offering aid in dying).

prescriptions are only partially addressed by the PCEOL. This Part discusses how the PCEOL may impact both categories of pharmacists.

1. Pharmacists Willing to Fill Prescriptions for Aid in Dying

Phase I of the PCEOL specifies that a physician writing a prescription for aid in dying will either dispense the medication directly or contact and inform a pharmacist about the prescription.⁷¹

Pharmacists willing to fill a prescription for aid in dying might be concerned that doing so could give rise to liability. Some courts have found that a pharmacist can be held liable for filling a prescription which calls for an obviously lethal dose of medication or for failing to verify an unusual dose with the prescribing physician.⁷² Of course, those cases do not deal with medications prescribed for the purpose of precipitating death, as would be the case with a prescription for aid in dying.

The general rule is:

A pharmacist has a duty to accurately fill a prescription and to be alert for clear errors or mistakes in the prescription, but the pharmacist does not have a duty to question a judgment made by the physician as to the propriety of a prescription, or to warn customers of the hazardous side effects associated with a drug⁷³

In the case of prescriptions for aid in dying, the pharmacist will be contacted by the physician about the prescription and will certainly know the intended use of the medications. In an abundance of caution, a pharmacist could, but is not required to, discuss with the patient the likely

71. VT. STAT. ANN. tit. 18, § 5283(a)(13) (Supp. 2013).

72. *E.g.*, *People's Serv. Drug Stores v. Somerville*, 158 A. 12, 14 (Md. 1932) (suggesting that a pharmacist has a duty to verify or refuse to fill a prescription calling for an inappropriate dose of medication). *See generally* Laura W. Smalley, *Cause of Action Against Pharmacist for Injury or Death Caused by Prescription Drugs*, 41 CAUSES OF ACTION 2D 297, § 4 (2013) (discussing a pharmacist's duty to exercise reasonable care). The fact that the prescribed dose will precipitate death does not make it an inappropriate dose. The U.S. Supreme Court has recognized that aid in dying can be a "legitimate medical practice" for purposes of federal controlled substances law and held that federal law cannot nullify state law permitting aid in dying; states, not the federal government, are primarily responsible for the regulation of the practice of medicine. *Gonzales v. Oregon*, 546 U.S. 243, 249, 275 (2006); *see also* Kathryn L. Tucker, *U.S. Supreme Court Ruling Preserves Oregon's Landmark Death with Dignity Law*, 2 NAT'L ACAD. ELDER L. ATT'YS J. 291, 291, 293–94 (2006) (elaborating on the Supreme Court's conclusion that Oregon's physician assisted dying law is "legitimate regulation of medicine").

73. *Kampmann v. Mason*, 42 So. 3d 411, 419 (La. Ct. App. 2010); *Jones v. Irvin*, 602 F. Supp 399, 402 (S.D. Ill. 1985).

effect of ingesting the medication. This would fulfill any possible “duty to warn” that the pharmacist might be concerned about.

2. Pharmacists Who “Opt Out”

The PCEOL explicitly provides that a pharmacist has no duty to fill a prescription for aid in dying.⁷⁴ Thus, it is permissible for pharmacists to “opt out” of participation in the PCEOL. Some pharmacists might hold religious views that would counsel them to opt out.⁷⁵ One Vermont pharmacist has written of his intention not to fill prescriptions for aid in dying.⁷⁶ It is plainly his right to choose not to participate. However, this pharmacist goes on to state: “[The law] says nothing about any requirement to refer the patient to a pharmacy that can fill the prescription.”⁷⁷ While the law does not explicitly address the duty to refer a patient to a willing pharmacist or the duty to transfer a prescription, such a duty may well arise under the professional standard of care.

In Wisconsin, a pharmacist refused to fill or transfer a patient’s prescription for an oral contraceptive on religious grounds.⁷⁸ The court held that the pharmacist engaged in unprofessional conduct under the standard of care applicable to all pharmacists, and that the pharmacist did not show that his rights under the freedom of conscience provision of the state constitution were violated.⁷⁹

74. See VT. STAT. ANN. tit. 18, § 5285(a) (Supp. 2013) (“A physician, nurse, pharmacist, or other person shall not be under any duty, by law or contract, to participate in the provision of a lethal dose of medication to a patient.”).

75. For example, a Catholic pharmacist might base a decision to opt out on the statement made by Pope John Paul II that “[c]ausing death’ can never be considered a form of medical treatment.” Ioannes Paulus P.P. II, *Evangelium Vitae*, VATICAN.VA § 89 (2005), http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html.

76. Bob Orleck, *Will Healthcare Professionals Face Lawsuits Over Vermont’s Assisted Suicide Law? A Pharmacist Analyzes Vermont Law*, SUICIDELAWSUITS.ORG, <http://suicidelawsuits.org/a-pharmacist-analyzes-vermont-law/> (last visited Apr. 10, 2014) (“I have decided that I will never participate in such a filling.”).

77. *Id.*

78. *Noesen v. State Dep’t of Regulation & Licensing, Pharmacy Examining Bd.*, 751 N.W.2d 387, 388–89 (Wis. Ct. App. 2008).

79. *Id.* at 392–93; see also Joe Miles, Annotation, *Propriety of Pharmacy and Pharmacist’s Refusal to Fill Prescription for Contraceptives*, 41 A.L.R. 6th 555, 555 (2009) (discussing the intersection between a woman’s right to contraceptives and pharmacist’s right to practice his or her religion); Smalley, *supra* note 72, § 4 (discussing a pharmacist’s duty to exercise reasonable care); Andrea Lee, Note, *Conscientious Objection and Pharmacists’ Professional Obligation to Ensure Access to Legitimately Prescribed Medication*, 33 WOMEN’S RTS. L. REP. 150, 150–51 (2011) (discussing the intersection between a woman’s right to contraceptives and pharmacist’s right to practice his or her religion).

CONCLUSION

When the United States Supreme Court declined in 1997 to find a federal constitutional right to choose aid in dying,⁸⁰ it invited the states to grapple with this issue.⁸¹ Vermont's PCEOL represents a new and different approach to aid in dying, demonstrating that the "laboratory of the States" is open and serving its intended function. The PCEOL embraces briefly the tried-and-true approach employed for more than 15 years in Oregon, and then transitions to an approach that essentially leaves the practice to traditional medical practice governance while continuing to provide a clear safe harbor for physicians.

The growing support for empowering patients with the option of aid in dying is reflected in Vermont's enactment of the PCEOL. This support is a natural response to the reality articulated by a leading medical commentator: "For all but our most recent history, dying was typically a brief process These days, swift catastrophic illness is the exception; for most people, death comes only after long medical struggle with an incurable condition"⁸² Sometimes the struggle is unbearable. The PCEOL empowers terminally ill Vermonters who find themselves trapped in an unbearable dying process with the option of a more peaceful death.⁸³ Establishing this freedom is squarely in keeping with the revered tradition of the State "as a resolute champion of individual freedom."⁸⁴

80. *Vacco v. Quill*, 521 U.S. 793, 807–08 (1997); *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997).

81. *Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring) (noting that the Court invites the states to act as "laborator[ies]" to explore viable options for aid in dying (quoting *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 292 (1990) (O'Connor, J., concurring))).

82. Atul Gawande, *Letting Go: What Should Medicine Do When It Can't Save Your Life?*, *NEW YORKER*, August 2, 2010, http://www.newyorker.com/reporting/2010/08/02/100802fa_fact_gawande.

83. Vermonters who choose aid in dying will find insurance covers this treatment choice. The Vermont Department of Financial Regulation announced that aid in dying under the PCEOL may not be excluded by the health plans it regulates. DIV. OF INS., VT. DEP'T OF FIN. REGULATION, *INSURANCE BULLETIN NO. 180* (2013), http://www.dfr.vermont.gov/sites/default/files/Bulletin_180.pdf (stating that coverage is "necessary to promote quality care" and "such services . . . represent medically necessary care" (emphasis added)). Such coverage reflects normalization of aid in dying within the practice of medicine.

84. MICHAEL SHERMAN ET AL., *FREEDOM AND UNITY: A HISTORY OF VERMONT* 617 (2004) ("The Record of Vermont as a resolute champion of individual freedom" (quoting George Harvey, a Vermont and United States Ambassador to Great Britain)). These words are emblazoned on a plaque hanging in the Vermont Statehouse.

