

IN THE SUPREME COURT OF MONTANA
NO. DA 09-0051

ROBERT BAXTER, *et al.*)
)
 Plaintiffs-Appellees,)
)
 vs.)
)
 STATE OF MONTANA AND)
 STEVE BULLOCK, ATTORNEY GENERAL)
)
 Defendants-Appellants)

BRIEF OF *AMICUS CURIAE*
AMERICAN COLLEGE OF
LEGAL MEDICINE IN SUPPORT
OF PLAINTIFFS-APPELLEES

FILED

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ON APPEAL FROM THE MONTANA FIRST JUDICIAL
DISTRICT, LEWIS & CLARK COUNTY
CAUSE NO. ADV-2007-787, HON. DOROTHY MCCARTER

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STATEMENT OF INTEREST

Upon approaching its 50th anniversary since its incorporation in 1960 as the only professional organization in the United States whose membership is principally composed of those professionals possessing the medical and juris doctor degrees, the American College of Legal Medicine (“ACLM”) is an educational, non-profit organization with nearly 1100 members. Members also include attorneys, physicians, nurses, individuals in health care administration and government service, as well as those who hold full time academic positions in health care and in health care law.

The mission of the ACLM is to educate, train, and advance dialogue and discussion for those who have a sustained interest in issues at the crossroads of law, medicine and health care delivery. This includes promoting the administration of justice. The ACLM also draws upon its participation in the network of organizations worldwide whose members possess degrees, background, interest, and relevant expertise in the fields of medicine, forensic science and medical-legal jurisprudence to address the issues such as are now before this Court.

The ACLM has been engaged in the debate, analysis and research over the rights of the competent though terminally ill patient who wishes to

be aided in dying since it filed its brief as an *amicus* party in the *Vacco* and *Glucksberg* cases decided by the United States Supreme Court in 1997. Notably, the ACLM is also the first organization in the country to advocate elimination of the words, “suicide” or “assisted-suicide” as part of the nomenclature in describing what is being sought by those competent Americans with a terminal illness who wish to be aided in their deaths. 1996 WL 668827, *4 (1996). *See also amicus* briefs filed by the ACLM in *State of Oregon v. Ashcroft* (9th Cir.), 2002 WL 32290872 (*see* Zaremski & Mehlman, “Brief of the American College of Legal Medicine in Oregon v. Ashcroft”, 3 Hous. J. Health L. & Pol’y 331-340 (2003)); and in *Gonzales v. State of Oregon*, 2005 WL 1687165.

On October 6, 2008, the ACLM adopted the following resolution:

WHEREAS, the American College of Legal Medicine (“ACLM”) is an organization of professionals engaged in issues where the disciplines of medicine and law converge, including the debate and discussion surrounding end-of-life treatment options and decisions, and has been so engaged in this debate for over a decade; and

WHEREAS, the ACLM acknowledges that a continuum of views exist within its membership concerning end-of-life treatment options, and that it respects these views in accordance with the personal feelings and conscience of each of its members; and

WHEREAS, the ACLM has recognized there has been considerable literature and data surrounding whether or not there is a need to implement such options, including the 10

years of experience now from the State of Oregon with its Death With Dignity Act; and

WHEREAS, the ACLM filed an *Amicus* brief before the United States Supreme Court in 1996 in which it stated, “The term ‘physician-assisted suicide’ is arguably a misnomer that unfairly colors the issue, and for some, evokes feelings of repugnance and immorality....(I)t seems inappropriate to characterize requests for treatment that end life, made by suffering, terminally ill patients, as any form of destruction or ruination of their interests. Assuming a patient’s mental competence, and recognizing (the Supreme) Court’s long-held commitment to the principles of personal autonomy and free will, prescribing medication intended to end life in the subject serves --- not destroys or ruins --- a patient’s interests....ACLM rejects the term ‘physician-assisted suicide,’ and instead refers herein to the practice in question as ‘treatment intended to end life’ “; and finally,

WHEREAS, the ACLM is the first such organization to publicly advocate elimination of the word “suicide” from the lexicon created by a mentally competent, though terminally ill, person who wishes to be aided in dying; NOW THEREFORE

BE IT RESOLVED:

That the ACLM recognizes patient autonomy and the right of a mentally competent, though terminally ill, person to hasten what might otherwise be objectively considered a protracted, undignified, or painful death, *provided*, however, that such person strictly complies with law specifically enacted to regulate and control such a right; and

BE IT FURTHER RESOLVED:

That the process initiated by a mentally competent, though terminally ill, person who wishes to end his or her suffering and hasten death according to law *specifically* enacted to regulate and control such a process shall not be described using the word

“suicide”, but, rather, as a process intended to hasten the end of life.

BE IT FINALLY RESOLVED:

The ACLM continues to strongly support the use of palliative and hospice care for mentally competent though terminally ill persons.

The ACLM thus substantially supports the Plaintiffs-Appellees (“Appellees”) in this matter as described more fully in this brief. While the Montana Constitution should embrace the principle that a competent though terminally ill person who wishes to self-medicate in order to bring about his or her dignified and humane death, the ability to do so lies with a legislative scheme intended to implement this principle.

STATEMENT OF FACTS

Amicus adopts and incorporates Appellees’ statement of facts relevant to the issues to be presented for review within their opening brief.

SUMMARY OF ARGUMENT

The arguments advanced by the Appellants and their *amici* are neither new nor novel; they are but a reiteration of what other individuals and entities have advocated in years past. But there is a sea change of public thought and experience now occurring that can no longer be ignored. By

recognizing, constitutionally, the rights of competent, terminally ill citizens who wish to self-medicate from being provided a prescription for medication in order to bring about a humane and dignified death, this Court would place itself at the helm of judicially recognizing this sea change. To do this requires, as a predicate, pronouncing that the issues at stake do not involve what has long been considered the taking of one's life, or assisting in this taking, as a suicide, a murder, or even a killing. To be clear, what occurs at the end of life as depicted by the facts herein is *not* a suicide, nor a physician-assisted suicide; what takes place is treatment to end life for a terminally ill patient deemed medically competent who wishes to self-medicate.

There also exists a continuum of healthcare throughout our existence. Decisions made at the end of life are no less part of this continuum. But seeking such aid must be prescribed by carefully crafted legislation, such as Oregon has undertaken and, now, passed in the State of Washington. Oregon has certainly shown, as one of those "laboratories" Justice Sandra O'Connor spoke of in her concurring opinions in the *Quill* and *Glucksberg* cases*, and, before that, in *Cruzan*, that a legislative scheme if prudently crafted, will provide the necessary safeguards to satisfy any compelling state interests the State of Montana has for enabling Montanans in similar

situations to have the choice that Oregonians and Washingtonians now possess (* “challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the ‘laboratory’ of the states. . . .” *Vacco v. Quill*; *Washington v. Glucksburg*, 521 U.S., at 737; *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S., at 292; see also *New State Ice Co. v. Liebman*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

Concomitantly, sufficient protections must be afforded the ethics and integrity of those within Montana’s medical community who are either willing to assist, or who do not wish to be engaged by, mentally competent, terminally ill patients seeking aid in their death from that provider; and, that the use of palliative care be offered, encouraged, and continue to be firmly advocated for those in the last days of their lives. The experience of Oregon is proof that there is no slippery slope for vulnerable populations, *i.e.*, minorities, disabled, the poor, and the uninformed, since aid in dying not only can co-exist with palliative care, but it (aid in dying) has been a catalyst for promoting this type of care by physicians.

The time has arrived in the State of Montana to declare that a competent, terminally ill citizen of the state who wishes to self-medicate in order to bring about a humane and dignified death has a constitutionally-

protected right to do so, provided implementing legislation is in place to accomplish this result.

ARGUMENT

I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys its faculties one by one, if it leaves me not life but breath, I will depart from the putrid or tottering edifice. I will not escape by death from disease so long as it may be healed, and leave my mind unimpaired. I will not raise my hand against myself on account of pain, for so to die is to be conquered. But I know that if I must suffer without hope of relief, I will depart, not through the fear of pain itself, but because it prevents all for which I would live.

Lucius Annaeus Seneca
Roman Orator
Circa, 3 B.C.-A.D. 65

I. This Court Should Acknowledge that the Proper Nomenclature is, Aid-in-Dying, or, Treatment to End Life.

As the ACLM first recognized in its 1996 *amicus* brief to the Supreme Court, a request to obtain treatment intended to end life made by a competent Montanan suffering from a terminal illness serves only the free will and personal autonomy of that individual - - - not intentionally destroying or ruining the worthiness of that person. Of interest in this regard is the declaration announced over two years ago by the American Academy of Hospice and Palliative Medicine (“AAHPM”) that the term, “physician-

assisted suicide” is “emotionally charged” and less accurate than the description, “physician-assisted death” when a patient self-administers medication for the purpose of hastening death. AAHPM Position on comprehensive end-of-life care and “Physician-Assisted Death” (February 14, 2007). And this past March author Ronald Lindsay in cataloging Oregon’s Death With Dignity Act (“Oregon’s Experience: Evaluating the Record”, 9(3) Am. J. Bioethics 19, 20 (2009)) used the terms, “assistance in dying” or “assisted dying”, rather than assisted suicide. Why? Because under the Oregon statute, a patient must not only first be terminally ill before requesting a prescription for a lethal dose of medication from his physician, but is in control of the process throughout and decides when, if at all, the patient will ingest the medication. More than one-third of the patients obtaining this medication never take it; others let months pass from obtaining a prescription to ingesting the drug. “Under these circumstances, it seems more accurate to describe the practice as *physician-assisted dying...*” *Id.* Emphasis in original.

Moreover, laced throughout the briefs by Appellants and their *amici* is the use of such words as “suicide”, “assisted suicide”, “murder”, “physician-assisted suicide”, and “killing”. For example, one of Appellants’ *amicus* states that physicians are not licensed to assist their patients in killing

themselves (Phys. For Compassionate Care, Br., at 8-9) - - - as if to say a patient who is terminally ill and competent is no different than, let's say, an individual who has become so despondent from shame, guilt, depression, financial ruin, or other deplorable conditions that (s)he takes his own life. Appellants even talk in terms of intentional killing, committing homicide and killing as the only available means of a humane death. App. Br., at 12-13,15,33. There is a substantial difference between seeking death with dignity and other circumstances. With the former, the request to be aided in dying comes from knowing life will end from the ravages of illness or disease waiting around the next corner and seeking therefore a death with dignity, *i.e.*, without having to endure the burden of intractable pain and suffering that palliative care cannot alleviate. This person is not seeking from another that his own life be terminated as the historical usage of the words "suicide" and "assisted-suicide" connotes.

Another of Appellants' *amici* references this Court to a time over a century ago when Montana prohibited assisted suicide. Montana Legislators, Br., at 2. But that was then; as we know, times, and consequently thinking, evolves due to advancements in various fields, such as medicine and science, philosophy, and cultural mores. For instance, during the early days of anesthesia, if a gunslinger was shot with a pistol and

wounded, he would need to have the bullet removed. The best remedy perhaps (besides ether or chloroform) was probably to take a shot of whiskey, bite down on something hard, and let the frontier doctor use a sharp instrument to remove the foreign object from his body. Analogously, if Montana outlawed assisted suicide as far back as 1877, it was no doubt without even thinking about whether a terminally ill citizen of Montana who was competent could be aided in dying- - all to avoid the indignities of intractable pain and suffering for which palliative care, like anesthesia, had either not come into being, could not be of assistance or was in its infancy.

Additionally, suicide or attempted suicide is not illegal. It is said that this is so because they are, “an expression of mental illness that punishment cannot remedy.” *In re Joseph G.*, 34 Cal.3d 429, 433-434 (1983). Surely, a Montanan medically determined to be competent whose body and mind are subjected to excruciating pain and discomfort from a disease about to take his life who, because of this condition, then requests aid in dying cannot be said to be suffering from a mental illness.

In furtherance of having this Court consider eliminating what occurs from the facts here as a suicide (and therefore a physician who assists with a suicide) are thoughts of a soldier in a war zone who throws his body on an explosive, exemplifying perhaps what Gen'l. MacArthur said, (for) “duty,

honor and country". While this will cause death, we never view it as a suicide, though it is an intentional act surely to end life, and fits the dictionary definition of "suicide". Instead, we may view that individual as a hero to be awarded a service medal because he may have saved the lives of his buddies. The day has arrived when dying for others is no greater of an act than allowing a terminally ill, competent Montanan who wishes to self-medicate to die humanely while preserving his dignity. Both situations should be described in similar rhetoric.

This Court is also urged to consider those who leaped to a certain death from the World Trade Center twin towers on 9-11 rather than face suffering and imminent death from raging fires. We would no further term the decisions of these individuals to be suicides or a product of a mental illness, than would we use that word(s) to describe competent persons already sentenced to an involuntary hastening of life due to terminal illnesses but who want to forego the considerable pain and suffering occasioned before death occurs. Cast in another light, **would this Court want the Montana Constitution to cast a blind eye by failing to say it is no less dignified to be aided in dying under the circumstances described here than for a soldier sacrificing his life for others, or for a person wanting to escape from a tall building on fire?** We surely think not.

Accordingly, this Court is urged to remove from the nomenclature the words “suicide” and “physician-assisted suicide”, and, instead, lead in judicial thinking by adopting the description, “aid-in-dying”, or “treatment to end life”.

II. End of Life Decisions Are Part of a Continuum of Health Care Decision-Making.

*Birth is a Beginning
And death a destination
And life is a journey*

* * *

*Until, looking forward or ahead,
We see that victory lies
Not at some high place along the way,
But in having made the journey, stage
by stage,
A sacred pilgrimage.*

Alvin Fine, GATES OF REPENTENCE
(New Union Prayerbook, at 283 (1996))

Appellants and their *amici* portray end-of-life decisions as if in their own vacuum, aside and apart from the (here, healthcare) decisions made throughout one’s journey in life, as the above section of a prayer would indicate. The “victory” in our lives is, as is also pointed out in the quote, the ability to travel its roads with the freedom and autonomy to make decisions in our best interests as we move along these paths. (This notion was

captured in the district court's recitation to the Clifford and Huff law-review article (Dist. Ct. Op., at 14)). That road thus ends with our death, which means that there exists a continuum of healthcare for which treatments are constantly sought, a part of which are those that are provided shortly before we die. The latter, then, necessarily includes the right of a terminally ill, competent Montanan to request treatment (by way of a prescription for medication) to assist in death. Thus, it is untenable and fails logic to believe the words, as one *amicus* party so states, "Protection of the individual's right 'to make medical judgments affecting his or her bodily integrity and health' differs radically from an asserted right in self-destruction where not health, but death, is the desideratum". Phys. for Compassionate Care, Br., at 7. Similarly, it is hardly the case, as the State says in its brief, that assisted suicide "erases (these) lines between caring and killing". App. Br., at 36. To be sure, a person whose body and soul is tormented by a terminal state of disease or illness does not seek out death like we might seek a cool drink to quench our thirst on a hot, summer's day - - -that person does not wish to destroy health, but only to preserve one's autonomy and dignity---seeking to shorten the time of having to continue experiencing the toll brought on by a terminal condition.

A. Health Care is the Responsibility of the State.

For over at least 150 years, states have been given great latitude under their police powers to legislate as, “ ‘to the protection of the lives, limbs, health, comfort, and quiet of all persons.’ “ *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S.724, 105 S. Ct. 2380, 2398 (1985) (citing to *Slaughter-House Cases*, 16 Wall. 36, 62, 21 L.Ed. 394 (1873), quoting *Thorpe v. Rutland & Burlington R. Co.*, 27 Vt. 140, 149 (1855). This precept is carried forth to this day. *See Gonzales v. Oregon*, 546 U.S. 243, 923 (2006) (“The silence is understandable given the structure and limitations of federalism, which allow States “ ‘great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort and quiet of all persons.’ (citations omitted)”.) What is involved in this matter thus falls squarely within state jurisprudence.

While looking to federal law, and perhaps the law of other states, are useful as guideposts, they are not precedential. *Columbia Falls Elem. Schl. Dist. No. 6 v State of Montana*, 326 Mont. 304, 308 (2005) (“...in interpreting our own Constitution, this Court need not defer to the United States Supreme Court”.) This is so even to the extent of the state constitution supporting a claim absent the existence of common law or statute. *Shammel v. Canyon Resources Corp.*, 338 Mont. 541, 544, at para. 8

(2007) (citing to *Sunburst v. Texaco*, 338 Mont. 259, 279, at para. 64 (2007), which in turn cites to *Dorwart v. Caraway*, *infra*, at 22). To thus say, “The decision of whether our citizens have a ‘right to die’ rests with the legislature, and not a court” (Montana Legislators, Br., at 4) eviscerates Montana’s Constitution.

The District Court merely interpreted the language of the Montana Constitution to be inclusive enough to, “encompass the right of a competent terminally (sic) patient to die with dignity” and look for medically trained assistance to achieve this objective. Dist. Ct. Op., at 23, ll. 17-18. As this Court itself held in *Columbia Falls*, 326 Mont., at 309, *supra*, “the courts, as final interpreters of the Constitution, have the final ‘obligation to guard, enforce, and protect every right granted or secured by the Constitution....’ *Robb v. Connolly*, 111 U.S. 624, 637 (1884).” *See Groves v. Slaughter*, 40 U.S. 449, 483 (1841) (“The nature of constitutions is to establish and declare principles; and, except in some particular casee (sic), to leave to the legislature the enactment of laws, to carry out the principles thus declared”.) What Montana’s Constitution provides is consistent with the humane treatment within Montana’s definition of practicing medicine, referenced by Appellants in their brief, at p.29.

B. Rights for Human Dignity Survive the Ages.

Atop the Argument section of this brief is a passage attributed to the noted Roman orator and philosopher, Seneca. The words he scribed centuries ago concerning the human condition attacked or wracked by pain and suffering, without any hope of relief, at the end of life is no less true today than when he penned them. This state of human thought is as old as the ages. What has changed and expanded is defining human dignity.

In the brief the ACLM filed with the Supreme Court thirteen years ago, we devoted a section to the recognition of an individual's right to personal autonomy and bodily integrity, *i.e.*, human dignity. For this, we cited to *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (a case cited as well by the District Court), Justice Benjamin Cardozo in *Schloendorff v. Soc. of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914), Justice Louis Brandeis in *Olmstead v. United States*, 277 U.S. 438, 478 (1928), and then on to Justice O'Connor's words in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 287 (1990). Articulation of this right repeats itself as shown in even more recent opinions, the most current of which in Montana is the District Court's decision. *See Walker v. State*, 316 Mont. 134, para. 81 (2003) (*see Dist. Ct. Op.*, at 14).

In this quiver of broad-based judicial thinking are now the following: (1) the particular wording in the relevant sections of the Montana Constitution (Art II, sec. 4: “The dignity of the human being is inviolable”); and Art. II, Sec 10: “The right of individual privacy is essential to the well being of a free society and shall not be infringed without the showing of a compelling state interest”); and (2) the experience of the State of Oregon with its Death With Dignity Act. We take the latter first.

Appellants and their *amici* take the “sky is falling” approach in order to try and convince this Court that a Montanan does not have a constitutionally-scripted right to be aided in dying because vulnerable populations, like the poor, aged, disabled, and misinformed, will be subject to such abuse that Montana has to assert its compelling state interest to preserve life. It is worthy to note that the decade-old experience in Oregon has dispelled this fear. Montanans aided in dying will not cause other segments of the state’s citizenry to encounter a slippery slope from which they will not escape. Fear mongering, as Appellants and their supporters have undertaken, cannot be replaced by data and facts that now exist in Oregon which contradict this “sky is falling” mentality. *See, e.g.*, Lindsay, *supra*, at 8; Tucker, “At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy

Associations, 10-1 Harv. Health Policy Review 43 (Spring 2009); and, Jackson, “The Inevitable-Death: Oregon’s End-of-Life Choices”, 55-1 Willamette L. Rev. 137 (2008).

The statement about dignity being inviolable is (said to be) “secured by treating (Montanans) equally with others and by prohibiting discrimination”. Phys. For Compassionate Care, Br., at 14. Another brief dwells on the legislative history of Art. II. Sec. 4’s reference to inviolability of dignity, claiming that dignity exists only as defined by all Montanans being treated the same way without any discriminatory treatment. This argument fails, since the instant case does not address whether an already existing statute applies indiscriminately to all persons similarly situated. The issue here is framed tightly: *is it a principle within the framework of Montana’s Constitution to allow a competent, terminally ill Montanan a right to be aided in dying through self-medication so as to die with dignity?* By affirming this precept here, then Montanans who wish to be aided in dying with dignity may then be guided in their conduct through legislation to be passed by the Montana legislature. *See Groves v. Slaughter*, 40 U.S., at 483, *supra*, at 15.

To say that a right to be aided in death for all cannot arise out of dignity and privacy from which enabling legislation is then crafted is not an

equal protection issue. Any such legislation would apply equally to any individuals meeting the medical criteria and statutory procedures. Nor is aid in dying to be viewed through the prism of a statutory scheme that exhibits discriminatory behavior. If aid in dying is recognized constitutionally, followed by implementing legislation, any Montanan so qualified under the statute could avail him/herself of the procedures for treatment to end life at their option if they so wish.

The Declaration of Independence states, “that all men are created equal; that they are endowed by their Creator with inherent and inalienable rights: that among them are life, liberty and the pursuit of happiness; that to secure these rights, governments are instituted among men, deriving their just powers from the consent of the governed....” Inalienable rights are those not capable of being surrendered or transferred without the consent of the one possessing such rights; typically these are the ones recognized in constitutions. An inalienable right is also called a natural, or moral, right. Possessing dignity within the framework of privacy exemplifies this. It is the breadth of this framework that is constantly being judicially examined.

The advances in medical science over the decades continually prolong life. Yet, with such advances come instances where a life may have no further meaning or purpose. This is particularly so when intractable pain is

no longer capable of being alleviated by palliative care. It is for this reason that dignity and privacy under the Montana Constitution should be construed as being sufficiently flexible and expansive enough to provide for the right of being aided in dying. At the same time, to read that life as, “worthy only of alienable, that is, *contingent* protection” as one of Appellant’s other *amici* has done (Institute For the Study of Disability & Bioethics..., at 15) is to miss the point of life in its truest sense. If death is part of life, then aid-in-dying should be no less inalienable than an individual’s pursuit of life, liberty and happiness. *See* Mont. Const. Art. 2, sec. 3.

III. Palliative Care Remains Part of the Continuum of Healthcare.

In its resolution adopted in October 2008, the ACLM emphasized the role that palliative care must continue to play with even those who may now be accorded a right to be aided in death if its implementation is established legislatively. The fallacy put forth by the opponents in this case on the issue of palliative care is that to die with dignity inclusive of an aid-in-dying request will destroy the advances and significance of palliative care. The ACLM continues to advance that palliative care is a part of the continuum of health care. But, palliative care can *co-exist* and even be extended with the right to be aided in death. The experiences in Oregon, once more, show all this to be true. There is no doubt that palliative care is effective for many

terminally ill patients experiencing excruciating pain; but what palliative care offers can in no measure be considered mutually exclusive of the option to seek treatment to aid in dying.

IV. Protecting The Integrity of The Medical Profession Must Continue.

The District Court in its decision recognized that the integrity and ethics of the medical profession must be maintained and protected too (Dist. Ct. Op., at, 21-23). The ACLM in its 1996 *amicus* brief similarly recognized this (1996 WL 668827, *26-27), and continues to support it.

The District Court went on to say that any such protections are the task of the Montana legislature. These protections should certainly include protecting physicians from the criminal and civil laws for assisting aid-in-dying patients. The ACLM also recognizes that a physician may not wish to establish a patient-physician relationship with a Montanan seeking treatment to end life for any reason, including on moral, ethical or religious grounds. These health care providers must be similarly protected by any such legislation.

V. Conclusion.

The ACLM views this case as involving one basic premise: whether the Montana Constitution embraces the principle that dignity and privacy are broad enough to allow a competent, terminally ill, patient to seek aid-in-

dying. That answer should be a considered and reasoned “yes”. Once this principle is declared, its implementation becomes a matter for the Montana legislature to establish.

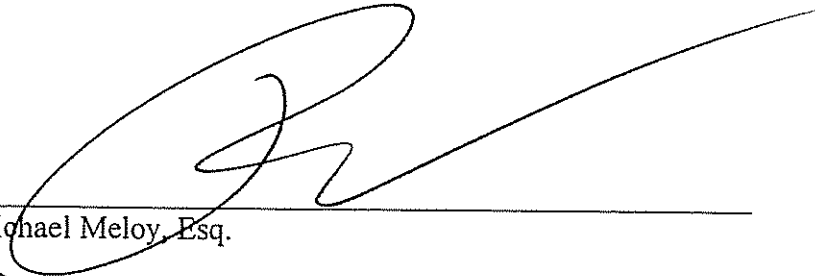
Concomitantly, as human thought advances over time, our views of issues once held sacrosanct change. This is part of the human condition and ingrained within the fabric of social transition. Particularly given the experiences with Oregon’s death with dignity statute, this Court is presented with an opportunity to change judicial thinking warranted by the times and circumstances. By doing so, a principle within the Constitution of the State of Montana previously unrecognized can be established (*see Dorwart v. Caraway*, 2002 MT 240, 312 Mont. 1, 28, 29-30, paras. 94, 96-99, *et seq.* (Nelson, J., specially concurring in which Trieweiler, J., concurred) (recognizing that, “. . . ‘new safeguards’ had been added to the Declaration (Bill) of Rights ‘to meet the changing circumstances of contemporary life.’ “) (even unenumerated rights can be so fundamental to be significant components of liberty, “. . . any infringement of which will trigger the highest level of scrutiny and thus the highest level of protection by the courts.”).

The District Court’s decision should consequently be affirmed.

RESPECTFULLY SUBMITTED this 12th day of June

2009.

BY:


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CERTIFICATE OF COMPLIANCE

I certify that pursuant to Rule 11 of the Montana Rules of Appellate Procedure, this *Amicus* brief is proportionately spaced Times New Roman text typeface of 14 point and double spaced except for quoted and indented material; and that the word count is 4,998 words according to the Word Count feature in the word processing software within Microsoft Word for Apple computers, except for table of contents, table of citations, certificate of service and certificate of compliance.

By: 

Miles J. Zaremski

CERTIFICATE OF SERVICE

I hereby certify that I have served true and accurate copies of the foregoing BRIEF OF *AMICUS CURIAE* AMERICAN COLLEGE OF LEGAL MEDICINE IN SUPPORT OF PLAINTIFFS-APPELLEES by depositing said copies into the U.S. Postal Service, postage prepaid and properly addressed, as follows:

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