
GUEST EDITORIAL

Baxter v. Montana: What the Montana Supreme Court said about dying, dignity, and palliative options of last resort

In his thoughtful and heartfelt editorial on the Montana Supreme Court decision concerning the case of *Baxter v. Montana* (2009), William Breitbart expressed the hope that readers of this journal would submit guest editorials on the topic of legalizing the provision of a lethal prescription at the request of a terminally ill patient. His editorial focused on the language of the Montana Constitution cited by the plaintiffs in the litigation and the decision of the trial court, as well as the reasons for the medical profession's traditional opposition to assisted suicide and euthanasia. My response to this invitation will delve more deeply into what the Montana Supreme Court majority decision actually concluded and why, the plight of the patient who was the lead plaintiff in the case and others who seek this option, and the implications of the reasoning underlying this decision for palliative medicine, in particular the clinical, ethical, and legal perspectives on the purported ethical distinction between palliative sedation and a lethal prescription, as well as that between killing and allowing to die in the context of terminal illness.

THE CASE OF *BAXTER V. MONTANA*

As Breitbart notes, the original complaint in this case and the decision of the trial court were based on the contention that certain provisions of the Montana State Constitution should be interpreted as insuring that terminally ill patients have a right to die with dignity, and that death with dignity should encompass access to a lethal prescription when a patient with decisional capacity requests, and a physician is willing to provide, this means of orchestrating the end of life. It is important to emphasize the point that recognition of such a right, as found in the State Constitution by the Montana trial court, does not create a legal duty on the part of any physician to honor such a patient request. It simply holds that the state

may not act in such a way as to come between a terminally ill patient who makes such a request and a physician who, in the exercise of his or her clinical judgment and personal conscience, is prepared to honor that request. The same is true of the judicially recognized right to terminate a pregnancy. As the data definitively (and from the perspective of the pro-choice advocates distressingly) indicate, a steadily diminishing number of physicians are willing to perform abortions in the United States despite the fact that reasonable access to the procedure has been recognized as a federal constitutional liberty of pregnant women for almost 40 years (Henshaw & Finer, 2003). Indeed, the demonization of such providers by the right-to-life movement and its chilling effect on access to abortion continues unabated (Hitt, 1998). Therefore, it is perplexing when Dr. Breitbart insists in his editorial commentary that “when something like abortion is the law of the land there is great pressure to comply with a legal request of a patient” (Breitbart, 2010). One of the clear insights from the Oregon Death With Dignity Act (ODWDA) experience of 12 years is that an exceedingly small percentage of terminally ill patients actually utilize this option, and there is no indication that physicians in Oregon are yielding to social pressure to offer this last resort option, as the percentage of physicians who have actually written such prescriptions is miniscule (<http://www.oregon.gov/DHS/ph/pas/docs/year12.pdf>).

The *Baxter* case was filed by a patient, Robert Baxter, four Montana physicians, and the national patient advocacy organization Compassion and Choices. Mr. Baxter (now deceased) was a retired truck driver diagnosed with lymphocytic leukemia with diffuse lymphadenopathy. The Court's opinion notes that during and after undergoing multiple rounds of chemotherapy, Baxter experienced infections, chronic fatigue and weakness, anemia, night sweats,

nausea, massively swollen glands, chronic digestive problems, and generalized pain. In a very long concurring opinion, Judge Nelson quotes the following statement by Mr. Baxter explaining why he would not accept palliative sedation as a reasonable alternative to a lethal prescription in order to manage his intractable suffering:

I understand that terminal or palliative sedation would involve administering intravenous medication to me for the purpose of rendering me unconscious, and then withholding fluids and nutrition until I die, a process that may take weeks. During this final period of my life I would remain unconscious, unaware of my situation or surroundings, unresponsive from a cognitive or volitional standpoint, and uninvolved in my own death . . . My family would be forced to stand a horrible vigil while my unconscious body was maintained in this condition, wasting away from starvation and dehydration, while they waited for me to die. I would want to do whatever I could to avoid subjecting my family to such a painful and pointless ordeal.

While the option of terminal sedation might be acceptable to some individuals – and I respect the right of others to choose this course if they wish to – it is abhorrent to me. The notion that terminal sedation should be the only option available to me if my suffering becomes intolerable is an affront to my personal values, beliefs, and integrity.

THE MONTANA SUPREME COURT DECISION

The Montana Supreme Court declined to address the question of whether the privacy and dignity provisions of the Montana Constitution recognized the right of a terminal patient to access a lethal prescription – the basis for the trial court ruling – but nevertheless determined that nothing in current state law would permit the prosecution of a physician who responded to such a request by a terminally ill patient with decisional capacity. The focus of the Court was on the language of two particular statutes, one concerning criminal prosecution for homicide, and the other the Montana Rights of the Terminally Ill Act. As to the former, the homicide statute provides that the consent of the victim is a defense to a prosecution under the statute if, but only if, none of four exceptions apply. Therefore the victim's consent would be ineffective if:

1. It is given by a person who is legally incompetent to authorize the conduct charged to constitute the offense
2. It is given by a person who by reason of youth, mental disease or defect, or intoxication is unable to make a reasonable judgment as to the nature of the harmfulness of the conduct charged to constitute the offense
3. It is induced by force, duress, or deception, or
4. It is against public policy to permit the conduct or the resulting harm, even though consented to.

Noting that the first three exceptions would have to be considered on a case-by-case basis, the Court shifted its focus to the public policy exception. After reviewing a number of state homicide prosecutions in which violations of public policy were found, the court majority noted that all of the cases involved assaults in which the defendant alone performed a direct and violent act causing the harm. In stark contrast, the court states, and I quote the language used because of its significance to the ultimate issue:

. . . a physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician–patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient's subsequent private decision whether to take the medicine does not breach public peace or endanger others.

This perspective strongly resembles the language of the federal Ninth Circuit Court of Appeals in the case of *Washington v. Glucksberg* (2007) (challenging the constitutionality of applying a Washington state criminal statute to a physician who provides a lethal prescription in response to a request by a terminally ill patient). In framing the core issue of the case, the Ninth Circuit Court stated that it was most reasonably characterized as whether the United States Constitution recognizes a liberty interest on the part of terminally ill patients to determine the time and manner of their own death. The United States Supreme Court reframed the issue when it overturned that decision.

Moving from case to statutory law, the Montana Supreme Court majority examined the Rights of the Terminally Ill Act (hereinafter the Act), the primary focus of which is the recognition of the patient's right to cause life-sustaining treatment to be withheld or withdrawn. The Act shields physicians, healthcare facilities, or the patient's proxy decision maker from

any civil, professional, or criminal liability for the act of withholding or withdrawing life-sustaining treatment from a terminally ill patient who requests it and also provides that a failure to give effect to a patient's declaration is a crime. Although the Act specifically notes that it does not authorize or condone mercy killing or euthanasia, the Court majority concluded that physician aid in dying by means of a lethal prescription requested and ingested by a patient with decisional capacity is neither of those. After reviewing and rejecting a number of arguments by the dissenting judges on the Court, the majority reaffirmed its position that no existing Montana case or statutory law can be reasonably interpreted to reflect a public policy against the provision of a lethal prescription to a terminally ill patient who requests it. In so ruling the Court places its analysis of such circumstances in direct opposition to the United States Supreme Court and prevailing opinion of the medical profession. To that we now turn.

CAUSATION, INTENT, AND THE ETHICS END-OF-LIFE DECISIONS

The Court majority in *Baxter v. Montana* has thrown down the gauntlet. In the unanimous decision by the United States Supreme Court in the companion physician-assisted suicide cases of *Glucksberg* (2007) and *Quill* (2007), after reiterating its stance on the federal constitutional liberty interest in declining life-sustaining treatment, the Supreme Court declared: "The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct." It is the legitimacy of and rationale for this distinction that the Montana Supreme Court challenges. In doing so in *Baxter*, that Court stands with what might be termed a "respectable" but nevertheless still distinct and insular minority of clinicians and ethicists who maintain that the physician's complicity in the ultimate death of patient is as direct and immediate, if not more so, in the discontinuation of life-sustaining measures than it is in the writing of a lethal prescription,

One of the most recent in a long line of critiques of the purported ethical distinction between "killing" (by means of a lethal prescription or injection) and merely "allowing to die" (withholding or withdrawing life-sustaining measures) appeared in a major bioethics journal the same year as the *Baxter* decision (Miller et al., 2009). Characterizing this distinction as a "moral fiction," the authors note that they are in a long line of expert commentators who have over many years challenged the lack of a cogent

basis for treating withdrawing life-sustaining treatment as fundamentally different from assisted suicide and active euthanasia from an ethical perspective (Beauchamp & Childress, 2009). Someone sympathetic to this respectable minority view might even contend that these authors concede too much in accepting the characterization of "physician-assisted suicide" with regard to provision of a lethal prescription at the request of a terminally ill patients. During the last decade a number of respected professional organizations, including the American Psychological Association, the American Public Health Association, the American Academy of Hospice and Palliative Medicine, the American College of Legal Medicine, the American Medical Women's Association, and the American Medical Student Association have gone on record, in the form of policies or position statements, declaring their opposition to the use of that term to describe the practice originally legalized by the ODWDA and subsequently legitimized by a similar statute in Washington and most recently by the *Baxter* decision (Tucker, 2009). Such opposition does not constitute a formal endorsement of legalization and regulation of lethal prescriptions for the terminally ill, but it does argue that stigmatizing those who choose this option where available with the suicide label is inappropriate, if not indefensible. A robust series of recent studies to which I now turn provide credible evidence to support this shift in position on how we refer to, and hence how we think about, lethal prescriptions as a potential palliative option of last resort.

WHO PURSUES THE OPTION OF A LETHAL PRESCRIPTION AND WHY?

In his editorial, Breitbart identifies himself as "a researcher whose focus has been PAS [physician-assisted suicide], desire for a hastened death, suicide, and the development of interventions for the terminally ill to help deal with the suffering and despair that leads to requests for PAS and a desire for a hastened death." Indeed, drawing upon the meaning-centered logotherapy of Victor Frankl, Breitbart has developed meaning-centered interventions for patients with terminal illness (Breitbart et al., 2004). Similarly, Harvey Chochinov has developed what he describes as "dignity-conserving care" for the dying patient (Chochinov, 2002), and Davis Kissane has argued for some time that terminally ill patients who express a desire for a hastened death may not necessarily meet the criteria for clinical depression but may nevertheless be manifesting symptoms of what he labels "demoralization syndrome" (Kissane & Clarke, 2002). It is most certainly the case that when patients confronting advanced terminal illness express a

desire to truncate a dying process that they believe to be without dignity, meaning, or purpose, the proper clinical response is to engage with the patient in an extended and candid conversation concerning the underlying basis for this expression and the interventions as yet untried or that have proven inadequate to the task of meeting the patient's needs. However, those whose professional responsibilities focus on the care of dying patients should acknowledge the possibility that in a small percentage of patients the nature and extent of the suffering they experience is genuinely refractory to even the most innovative of palliative measures. It is important that in our zeal to provide all patients with a dying process infused with dignity, meaning, and purpose, we do not inadvertently and unintentionally cross the line and deprive them of one that is authentic and true to their own needs, values, and priorities, i.e., the kind sought by William Baxter.

Studies of patients in Oregon who requested a lethal prescription reflect attitudes and concerns similar to that of Baxter, with fears of the future, negative experiences with dying, and a desire for control being the prominent motivating factors (Ganzini et al., 2008). The official data developed pursuant to the ODWDA similarly reflect the fact that loss of autonomy and the ability to engage in activities valued by the patient significantly predominate over unrelieved physical symptoms (OR Dept. Health Services, 2009). Depressive disorders have not been found to be widely prevalent among those who seek a lethal prescription (Ganzini et al., 2008).

From a public policy perspective, none among the "parade of horrors" predicted by the opponents of the ODWDA has resulted. Indeed, in most instances the exact opposite has been the case. Overwhelmingly the patients who secured and ultimately utilized a lethal prescription had health insurance, were enrolled in hospice, had adequate pain control, and were well educated and not economically disadvantaged. Even 12 years after the ODWDA went into effect, most patients who died after a prolonged illness did not seek a lethal prescription, and palliative care in the state has continued to flourish, with only a small percentage of physicians providing lethal prescriptions upon request. Finally, there has been no evidence of a slippery slope effect such as increased efforts to extend the law to non-terminally ill patients or to authorize lethal injections for patients who cannot ingest the lethal prescription on their own. Indeed, one might reasonably infer that the adoption of the Oregon approach 2 years ago by the State of Washington was motivated in part by the generally positive Oregon experience.

CONSIDERING THE WAY FORWARD

The art and science of palliative medicine has advanced significantly during the past two decades. Most patient suffering in the advanced stages of a terminal condition can be effectively managed in a manner that does not entail either palliative sedation or a lethal prescription. There is no indication that making such palliative options of last resort available to the few patients whose terminal suffering is refractory to less-drastic measures will either impede continued progress in palliative medicine or induce patients to prematurely or unnecessarily pursue these options. The Oregon experience provides clear and convincing evidence that "the damage such practice can bring to the profession of medicine and to the care of the terminally ill" that Breitbart fears has not materialized. Despite the best palliative care available, including innovative psychiatric interventions such as those he and his colleagues have developed, some small percentage of patients do experience unbearable suffering at the end of life, a medical fate worse than death in which the burdens of the dying process so far exceed such meager benefits as these patients may reasonably hope to experience that palliative sedation or a humane hastened death with a lethal dose of medication becomes their strong preference. Ultimately only the patient can determine when that point has been reached. As a society we should be circumspect in the imposition of barriers to clinicians who would choose to be responsive to the wishes of patients such as Robert Baxter.

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