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FROM THE EDITOR

## Physician-Assisted Suicide Ruling in Montana: Struggling with Care of the Dying, Responsibility, and Freedom in Big Sky Country

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Like many Americans, especially New Yorkers like me, and probably most readers of *Palliative & Supportive Care* around the world, I don't often think about the great state of Montana (aka Big Sky Country) in the Western United States. It usually doesn't make news, and because it's ranked 44<sup>th</sup> in population (about 1 million people) and has very few electoral college votes, it isn't even one of those states that ends up determining who wins a U.S. Presidential election. So Montana, despite being the 4<sup>th</sup> largest state in terms of land area in the U.S., does not typically influence the *Zeitgeist*. Many of us in palliative care are mainly familiar with Montana through our awareness of Ira Byock, M.D. and his groundbreaking work in Missoula Montana, through the Missoula Demonstration Project, as described in his book *Dying Well* (1997). So, it is with some surprise that I awoke on December 31, 2009 to news from Montana that, for reasons that I will explore in this editorial, disturbed me greatly!

On Dec 31, 2009, the Montana Supreme Court ruled that nothing in state law prevents patients from seeking physician-assisted suicide (PAS), thus paving the way for the procedure to take place legally in Montana, without any of the guidelines in place in states like Oregon and Washington where PAS is already legal. A year earlier, a Montana state District Court judge had ruled that the Montana state constitutional rights to *privacy* and *dignity* protected the rights of terminally ill Montanans to request physicians to prescribe the drugs they needed to die peacefully. Physicians who prescribe and patients who use these drugs to suicide are now protected from prosecution in Montana by the Supreme Court's decision to uphold the lower court decision. The Montana Supreme Court did not go as far as the lower court in asserting that PAS was a state constitutionally protected right, but it did essentially legalize PAS in Montana. As I alluded to earlier, Montana is in

the Western United States and while a very large state, it is sparsely populated. It is likely that there are more bears in Montana than physicians, particularly palliative care physicians. Like Oregon and Washington states, its original settlers were highly independent and rugged individualists; self-reliance, freedom and responsibility were likely closely held virtues and values that have remained ingrained in today's Montanans. I suspect that religious faith and practice were also important in establishing the communities of Montana, with Jesuit missionaries playing an important early role in establishing the first settlements and converting the indigenous Salish Indians who originally inhabited the land so rich in copper, gold and silver. According to the U.S. Census (2000) estimates for 2008, Montana is 93% white, and 82% Christian, with 18% of the population declaring itself *Non-Religious*.

I was curious about the Montana Constitution, so I looked it up on-line (<http://leg.mt.gov/css/Laws/Constitution.asp>). I was particularly interested in the sections on the Right for Individual Dignity, and the Right of Privacy. The Right of Privacy states: The right of individual privacy is essential to the well-being of a free society and shall not be infringed without showing of a compelling state interest. The Right of Individual Dignity states: The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws. Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color sex, culture, social origin or condition, or political or religious ideas. Well, I am not a lawyer, and my legal education is limited to watching every episode of *Law and Order*, but I think I would have to agree with the Supreme Court of Montana that there is no guarantee of PAS as a right that I can easily interpret from these sections of the Montana Constitution.

I can note that the section on individual dignity does not specifically identify such vulnerable populations as the medically ill, physically or mentally disabled, etc. in the list of those whose dignity must be protected. The Right of Privacy is rather brief, but I was struck by the relationship between individual privacy and the well-being of the society. These two concepts will reappear later in a different context.

So, while the rights of privacy and dignity seem straight forward in the Montana Constitution and one could envision how, in a convoluted way, they might lead a judge to conclude they are the constitutional basis for a right to PAS for the terminally ill, I was most struck by a different section of the Montana Constitution; its Preamble.

The Montana Constitution Preamble states: We the people of Montana grateful to God for the quiet beauty of our state, the grandeur of our mountains, the vastness of our rolling plains and desiring to improve the quality of life, equality of opportunity and to secure the blessings of liberty for this and future generations do ordain and establish this constitution. What is striking to me about this constitution's preamble is the central role of what can only be described as a personal God, a biblical God, responsible for the creation of the land and a God who is being asked to respond to the prayers of a people to have blessings bestowed on its citizens. I suppose God is mentioned in most, if not all state constitutions in the United States, but in the Montana Constitution the reference is specific and essential to all that follows the preamble. It is striking that the Montana judiciary would look to its constitution for a basis to legalize PAS when its constitution is based on the existence of a personal God, a God who is the Creator. Such a basic element of a state constitution would imply that God is the creator of human life; that life is a gift from God, a gift that humans must cherish, protect and preserve; and only God has the right to give or take a human life. This would seem to contradict any constitutional basis for legal PAS. I am not sure if this issue of religion was considered in the legal and judicial deliberations. I would assume that issues related to separation of church and state made this a non-issue in the legal proceedings. However, the contradictions are striking to me.

I am not a lawyer or an ethicist or a theologian. I am not a religious man. I am a proud ethnic Jew, who is well educated in Orthodox liturgy and a descendent of a long line of Orthodox Jewish practitioners and scholars, but I do not keep kosher, or pray, or attend synagogue or observe the Sabbath. I am a seeker of meaning and transcendence and an explorer and questioner of the mysteries of the beyond; a spiritual person perhaps, but I am not a person of religious faith or convictions. So, when

I describe being disturbed by the ruling on PAS in Montana, I am not disturbed by the re-emergence and new momentum of a movement to legalize PAS because of any legal expertise or religious dogma. I am however, a physician; an internist and psychiatrist, a psycho-oncologist, a psychiatric palliative care practitioner with 25 years of intensive clinical experience; a researcher whose focus has been PAS, desire for 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 desire for hastened death. It is because I am a palliative care psychiatric clinician and researcher that I am disturbed by a new momentum towards the legalization of PAS in the United States. My discomfort with legalizing PAS has both a rational/cognitive argument against legalizing PAS, but I want to emphasize here that there is also an emotional component that is profound and should not be dismissed. I have virtually been on the front lines for years. I have been asked by dozens and dozens of terminally ill patients to prescribe drugs for them to use to commit suicide. I have managed many hundreds of suicidal cancer patients and patients who have lost all sense of meaning, value and purpose and have asked me to kill them if I really want to help them. I encounter despair and suffering and demoralization on a daily basis in my very busy practice. So, from this perspective I can tell you that, in a very profound way, it just feels very, very wrong for me to view PAS as a legitimate treatment option. It just feels very wrong. It feels wrong for me, and I would argue that it probably feels wrong for most of my colleagues in palliative care. I would go further to say that, in my opinion, legalized PAS would be destructive to the practice of palliative care, and to the role of physicians in our society.

### **PAS AS AN EXISTENTIAL VERSUS A RELIGIOUS ISSUE**

I must admit that when I first struggled with my attitudes towards the legalization of PAS as a younger clinician and researcher, I often relied on a belief that taking a human life was not my right or my privilege. A belief that human life was a gift; and that we, as human beings, had a responsibility to care for that life; to live our lives to their unique and fullest potential. Life was not ours to do with as we pleased, nor was it within our rights as human beings to take another's life. The natural extension of the belief that life was a gift implies that this gift was given by some force or entity. A religious person would view the source of this gift of life as God and view God as having the sole right to determine when that life was over. Not being a religious person,

and growing more and more agnostic or even atheistic as I grew older, this position seemed less tenable for me to maintain and still be rational and consistent in my world views. As I grew more familiar with existential philosophy and began to incorporate its concepts into my life experience and view, I came to believe profoundly not only in the value of Responsibility (the imperative to respond to being alive by choosing to be engaged in life and the world and becoming who only I could become as a unique individual), but also with the value of Freedom and Free Will. If Sartre (1984) is correct, and God is dead (or abandoned us), then we are indeed left groundless with ultimate Freedom and Free Will. We can choose to live and die as we want. We have the right to end our lives when we feel that our work is done, or when life ceases to have value. In other words we own our lives and have the right to suicide. But there are limitations to this Freedom; moral and ethical limitations. For instance, do we have the right to be suicide bombers and kill others (often children and women) as part of one's suicide. Existentialists like Frankl (1969) would argue that moral values still exist in the midst of Free Will and Freedom. Harming others in the pursuit of our free will is immoral and unjustifiable. Furthermore the right to take your own life does not imply the right to ask another to provide the means for your death or to participate in the killing of your self (as in PAS). In fact, even Sartre would point out that each individual human act is not merely an individual act but an act that represents what we believe is a moral and just way of being in the world (1988). So the act of suicide, and more specifically the act of a physician assisting in the suicide of another human being (despite terminal illness), is a declaration that this is how we believe all physicians should behave and a value that all physicians should share. This is how physicians should be in the world; assistants of suicide.

### **IS PAS A LEGITIMATE ROLE FOR PHYSICIANS?**

Appropriately, great reservations have been expressed as to the inappropriateness of the physician playing a role in assisted suicide of the terminally ill. The reservations and in fact dramatic opposition, stem from such basic medical doctrines as the Hippocratic Oath as well as multiple guidelines produced by physician organizations stating rather emphatically that it is unethical for physicians to participate in PAS or euthanasia (e.g. the American Medical Association Ethics Guidelines). Ethicists, and I am not one, often argue about the ethical distinctions between a physician stopping a futile treatment (e.g. hemodialysis, ventilator support), utilizing

opioids aggressively for pain control, or sedation for symptom control in the terminally ill, and PAS. Most ethicists argue that there are in fact ethical distinctions among these different situations, citing the nature of intent, the "double effect" and other classic medical ethics concepts. Let us, for argument sake, capitulate the point that there is an ethical distinction, and that as some claim, all of the above mentioned acts are ethically and morally equivalent to PAS or euthanasia because the physician's actions have a similar outcome: a dead patient. Thus we would be conceding that stopping or not starting dialysis or a ventilator is the equivalent to PAS or euthanasia; that giving opioids to control pain with the possibility that respiratory depression may occur is the equivalent of PAS or euthanasia; that the use of sedation to control symptoms may lead to a cessation of eating and drinking and thus hasten death (despite recent studies suggestion that both the aggressive use of opioids and sedation do not in fact shorten survival in terminally ill patients compared to those who do not receive such symptom control-Connor, et al., 2007). Even if we concede the argument over the ethical distinctions between these various scenarios, we cannot ignore the fact that hemodialysis, use of a ventilator, use of opioids for pain control, and light sedation for symptom control are all well recognized, long-standing, and accepted medical treatments and practices that have proven benefit for millions of patients. Prescribing medications for the sole purpose of providing the patient the means to kill themselves is not a medical treatment. It is a means of killing. The purpose is clear. Interestingly, some patients hold onto these prescriptions and never use them to commit suicide. Some are content to have the "possibility of suicide" as an option. But the physician never knows who that patient will be when they agree to prescribe a specific cocktail of short acting barbiturates and anti-emetics whose sole purpose at the time of prescribing is for use as an effective cocktail for suicide. Many patients are routinely prescribed opioids, benzodiazepines, anti-depressants, etc. for the control of symptoms. They have the means to commit suicide on their night tables and many feel some sense of relief and control that if they can no longer tolerate their suffering they have a way out. Yet a cohort of patients, with the same medications in their possession, ask the physician for a specific set of prescribed drugs to assure suicide when they ask for PAS. They are not asking for a medical treatment and we are not providing a medical treatment.

It is interesting to note that in many of the 37 or so U.S. states in which capital punishment (the death penalty- now enacted thru the use of a lethal injection composed of a cocktail of drugs similar to those

used in PAS and euthanasia), physicians are not allowed to participate in any aspect of the execution except to be present to pronounce death. Physicians are often prohibited from designing protocols of lethal injection regimens, or to insert cannulas or inject the lethal drugs. There is a recognition that this is not an appropriate role for the physician in our society. A recognition that physicians should not concurrently be responsible for preserving life as well as taking life or being active participants in procedures that only have the purpose of intentionally inducing death.

Many proponents of PAS suggest that if PAS is legalized, then physicians can choose to take part in PAS or choose not to, without coercion. They point to the abortion situation and say that doctors can choose not to perform abortions, and if legalized doctors can choose not to perform PAS. Well, this argument is problematic to me. The abortion analogy to PAS can be readily challenged, but I won't do that here (i.e. a fetus being equivalent to an adult, competent terminally ill human being). There are many problems. Look at the situation now with abortion providers. They are being assassinated, bombed, and forced to hire protection. There are areas of the U.S. where abortion providers just do not exist and women have to cross state lines to obtain a service that is federally legal. In addition, a huge problem lies in the fact that when something, like abortion, is the law of the land, there is great pressure to comply with a legal request of a patient. Take the recent uproars which occurred when pharmacists refused to dispense legal prescriptions for the "morning after" pill. I don't believe there was great sentiment for pharmacists' right not to participate in a treatment they considered the equivalent of abortion. If PAS is legal, how can physicians legitimately deny the legal rights of their patients? So the solution is not to conclude that only those physicians who wish to provide PAS will do so, and all others can refuse. While surveys suggest that there are physicians who are willing to perform PAS, it is clear that the vast majority of physicians with palliative care expertise do not see PAS as a palliative care intervention and would not participate. I can envision entire departments of palliative medicine in large academic centers where not a single palliative care practitioner will choose to participate in a PAS. Who then would be the physician providers of PAS? Those with the least expertise in palliative care? Is that what we want for the care of the dying?

George Annas (1994) saw the problem of PAS as follows: "Society and physicians in the United States remain unable to accept death and thus unable to deal with the physical, psychological, and spiritual approach of death. The hour of death itself is

commonly tranquil, but the serenity is bought at a fearful price- and the price is the process by which we reach that point". Thus the ethicist George Annas is telling us that we have such a fear of the process of dying, and such a lack of confidence that palliative care can ameliorate suffering during the dying process, that patients and even doctors see suicide as a reasonable choice rather than spending the time and expense and energy to provide excellent physical, psychological and existential/spiritual interventions in the care of the dying. In other words we would rather provide "Aid in dying" than "Care for the dying".

### **AID IN DYING VERSUS CARE FOR THE DYING**

An essential question regarding the legalization of PAS and its legitimization as an appropriate medical option in the care of the terminally ill is the following: Is PAS a physician intervention whose purpose is to provide aid in dying or care of the dying? We have learned a great deal in the last several decades on how to optimize the care of the terminally ill and dying. Great advances have been made in pain and physical symptom control, the organization and delivery of palliative care, the use of multidisciplinary teams, and, most pertinent to PAS, the development of effective interventions to manage the emotional despair and the existential suffering not rarely encountered in the dying process (e.g., Breitbart et al., 2009; Chochinov et al., 2005; Steinhauser et al., 2009). These interventions focusing on enhancing meaning, conserving dignity and engaging in life completion tasks, all represent cutting edge efforts to humanely and effectively provide care for the dying that is consistent with the palliative care goals of preserving life (not prolonging it and not hastening death) and protecting patients from harm. Ganzini and colleagues (2009) have recently published on the mental health outcomes of family members of Oregonians who request physician aid in dying. They report that there were limited benefits to PAS in Oregon as they pertain to bereavement outcomes in family members. There seem to be no differences in rates of depression and grief difficulties between those family members who had a family member request PAS versus those who did not. Some Family members of patients requesting PAS felt more prepared for the death and had less guilt about the suicide compared to norms of relatives who experienced suicide of a family member under more typical circumstances (e.g. sudden, unexpected suicides). The study is preliminary but quite interesting. It suggests PAS deaths may not have a profoundly negative impact on families. But let me

note several points related to the paper; some subtle and other not so subtle. The authors choice not to refer to the practice they were studying as PAS, but rather as “Aid in Dying”. Perhaps intentionally or not, they have put their finger on the exact dilemma and the most accurate description of what PAS is. PAS is a method to aid a patient in dying; it is not a method of care for the dying. Certainly, while extolling the lack of negative mental health outcomes, and the limited benefits in the grieving process of relatives, the authors are not suggesting that PAS be adopted as a method to care for the terminally ill that has superior mental health and grief outcomes for family members. The study points out clearly that death by suicide generally has negative mental health outcomes for family members. By comparison, when a terminally ill cancer patient commits suicide family members feel less shame and guilt and also seem to be able to comprehend the suicide in more rational and acceptable terms: “They were suffering so, at least now they are at peace”. Additionally families of the terminally ill have time to prepare for the death of a terminally ill family member, and even individually directed suicide or PAS come after some process of anticipatory bereavement. The finding of less shame and guilt in some families whose members participated in PAS seems to be a real example of how PAS is different in many ways than a patient suicide done under their own control without involving others in the decision.

### **A REQUEST FOR ASSISTED SUICIDE IS A VERY COMPLEX COMMUNICATION**

A request for PAS by a terminally ill patient is a very complex psychological, psychiatric, existential, spiritual, social and financial communication. We as a society make a grave error in taking the request as a minimally examined, simple request of a competent terminally ill adult. Research over the past two decades has taught us that the request for PAS, expressions of desire for hastened death, expressions of suicidal intent are complex phenomenon that have multiple contributing factors including poorly controlled depression, unrecognized and untreated depression, loss of meaning, hopelessness, loss of dignity, concerns regarding being an emotional and financial burden, as well as a desire for control (e.g. Olden, et al, 2008). What is apparent is that patients have a right and often have the means to commit suicide on their own with involving others. We also know that suicide is by definition an ambivalent process and act. What must be made very clear here, is that patients who are suffering during the dying process, and contemplate PAS because they feel they have lost all meaning, dignity and purpose in life,

are asking physicians, “Do you agree that my life is worthless because I am dying? They are searching in our responses for a way to resolve the ambivalence. An response affirming the value of one’s life even during the dying process is as powerful and influential as out agreeing that “yes, your life no longer has value and I agree with your decision to die”. Our participation in PAS as physicians chooses a side of the patients’ ambivalence and moves them towards death, when in fact there are very valid reasons to take the other side of the ambivalence towards death and support the meaning, value and dignity of the patient even during the dying process. To assuage concerns of burden, loss of meaning, hopelessness, worthlessness, and loss of dignity. We need to understand this intense complexity of the request for PAS and not feel content to have it go relatively unexplored and feel satisfied that we have a nice set of guidelines for its performance (guidelines that do not require psychiatric assessment or expert palliative care assessment, but rather suggest them). We are a culture that sees things in black and white rather than shades of grey complexity, and we are pacified by guidelines and algorithms. This is a terrible mistake and an injustice to the very vulnerable population of the dying terminally ill.

### **THE SOLUTION**

The ideal solution regarding legalizing PAS versus decriminalizing it; creating guidelines versus no guidelines; returning the practice to the private domain of longstanding doctor patient relationships is beyond my expertise. My expertise tells me to be very wary of the practice of PAS and to emphasize the complexity of the request for PAS, and the true nature of PAS and the damage such practice can bring to the profession of medicine and to the care of the terminally ill. May we have the wisdom to proceed with compassion and reason, as we debate PAS in the future. I have expressed my opinions and hope that readers of palliative and Supportive Care feel free to submit guest editorials that either disagree or agree with the points I have made. We need an ongoing debate and exchange of views.

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