IN THE SUPREME COURT OF THE STATE OF MONTANA

Case No. DA 09-0051

STATE OF MONTANA, *et al*.

Appellants,

vs.

ROBERT BAXTER, *et al.*,

Appellees.

On Appeal from the Montana First Judicial
District Court, Lewis and Clark County
The Honorable Dorothy McCarter, Presiding

BRIEF OF *AMICI CURIAE* FAMILY RESEARCH COUNCIL, AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS AND GYNECOLOGISTS, CATHOLIC MEDICAL ASSOCIATION, DR. DONALD BERDEAUX, DR. RICHARD D. BLEVINS, DR. PAUL L. GORUSCH, JR., DR. KIRSTEN L. MORISSETTE, DR. CARLEY C. ROBERTSON, DR. D. PERRIN ROTEN, JR., DR. RONALD P. SKIPPER, DR. STEPHEN R. SHAUB, DR. CRAIG TREPTOW, DR. JAMES THREATT, DR. THOMAS A. WARR, and MS. BROOKE E. CANTU, IN SUPPORT OF APPELLANTS

Duane T. Schmidt, Esq.
(Counsel of Record)
MT Bar. No. 3779
ALLIANCE DEFENSE FUND
15100 N. 90th St.
Scottsdale, Arizona 85260
Tel: 480-388-8045
Fax: 480-444-0025
Email: dschmidt@telladf.org

Steven H. Aden, Esq. (Of Counsel)
Matthew S. Bowman, Esq. (Of Counsel)
ALLIANCE DEFENSE FUND
801 G Street NW, Suite 509
Washington, DC 20001
Tel: (202) 637-4610
Fax: (202) 347-3622
Email: saden@telladf.org,
mbowman@telladf.org

TABLE OF CONTENTS

Page

TABLE OF CONTENTS-continued

TABLE OF AUTHORITIES

CASES

OTHER AUTHORITIES

AMICI CURIAE **HAVE COMPLIED WITH RULES 2 AND 12 OF THE MONTANA RULES OF APPELLATE PROCEDURE**

The Court has granted the motion of *amici curiae* ("Concerned Physicians") to file this brief, and none of the parties objected. Accordingly, Concerned Physicians have complied with the Montana Rules of Appellate Procedure.

INTEREST OF *AMICI CURIAE* CONCERNED PHYSICIANS

Concerned Physicians are various individual physicians in Montana along with national physician and public policy organizations who are deeply troubled about the impact of judicially imposed assisted suicide on vulnerable patients, on their own practices, and on the State of Montana in general. Concerned Physicians described the interests of their doctors, nurse and organizations in their motion for leave to file. The description of their individual interests is attached again here for ease of reference as Appendix A.

STATEMENT OF THE ISSUES

Legalizing assisted suicide would have drastic public policy implications. The question whether some citizens (doctors) should be allowed to kill other citizens (patients) is a decision with profound ramifications for the safety and well-being of the whole community, not least its most vulnerable members. Interpreting the Montana Constitution's protections of dignity and privacy to require legalization of assisted suicide threatens rather than protects the individual dignity of vulnerable patients. Therefore, this Court should reverse the district court and

hold that the Montana Constitution does not require the legalization of assisted suicide.

SUMMARY OF THE ARGUMENT

Judicially mandating assisted suicide is a drastic and unwarranted step under the Montana Constitution. Experience in the Netherlands shows that even a "regulated" assisted suicide regime engenders monumental abuses. Assisted suicide undermines patient autonomy, logically and practically. Nearly all requests for it are attributable to depression and are withdrawn upon proper treatment. Legalizing assisted suicide diminishes compassionate treatment of pain because while palliative care is available, assisted suicide encourages the elimination of patients themselves rather than of their suffering.

ARGUMENT

I. EXPERIENCE IN THE NETHERLANDS SHOWS THAT EVEN A "REGULATED" ASSISTED SUICIDE REGIME ENGENDERS MONUMENTAL ABUSES.

The experience of the Netherlands shows widespread abuse of legalized killing. The Netherlands was the first nation to lift legal penalties for euthanasia and assisted suicide in 1984, by a decision of the Dutch Supreme Court which was quickly followed by guidelines of the Royal Dutch Medical Association.[1] The

[1] *Schoonheim*, Sup. Ct., Alkmaar, 27 november 1984, NJ 106:451; Central Committee of the Royal Dutch Medical Association, *Vision on Euthanasia* (Utrecht: KNMG, 1986); cited and discussed in John Keown, *Euthanasia, Ethics*

Dutch practice purported to allow euthanasia and assisted suicide only at the "explicit request" of the patient to put an end to "unbearable suffering." But evidence shows that the Dutch guidelines and limitations have been widely flouted, and that the Dutch have slid down the slippery slope with remarkable rapidity.

A. Even With Guidelines That Require Reporting, Those Rules Have Failed Miserably and Have Therefore Opened the Door to Widespread Abuse.

Government surveys have shown that in literally thousands of cases, doctors have broken the legal and professional guidelines regulating euthanasia and assisted suicide. The regime requires that the doctor in a euthanasia or assisted suicide case to first consult with an independent doctor, and afterwards to call in the local medical examiner and file a report. A 1990 government-sponsored survey (the first of four)[2] showed that over 80 percent of cases went unreported and

---

and Public Policy: An Argument Against Legalisation 83 n.2 and accompanying text (Cambridge U. Press, 2002).

[2] The first two surveys are P.J. van der Maas, J.M.M. van Delden, L. Pijnenborg, *Medische beslissingen rond het levenseinde. Het onderzoek voor de Commissie onderzoek medische praktijk inzake euthanasia* (The Hague, SDU Uitgeverij Plantijnstraat 1991) ("1990 Survey"); and G. van der Wal, P.J. van der Maas, *Euthanasie en andere medische beslissingen rond het levenseinde. De praktijk en de meldingsprocedure* (The Hague, SDU Uitgevers 1996) ("1995 Survey"). For an analysis of the first two surveys, see *Euthanasia, Ethics and Public Policy*, *supra* note 1, chs. 9-12. The third survey is G. van der Wal, A. van der Heide, B.D. Onwuteaka-Philipsen and P.J. van der Maas, *Medische besluitvorming aan het einde van het leven: De praktijk en de toetsingprocedure euthanasiae* (Utrecht, De Tijdstroom 2003) ("2001 Survey"). For a summary of the third survey, see Richard Fenigsen, "Dutch Euthanasia: the New Government Ordered Survey," 20 ISSUES IN LAW AND MEDICINE 73 (2004). For a summary of the fourth survey, see

were instead illegally certified by doctors as deaths from "natural causes." The latest survey, from 2005, shows that 20 percent of cases were still illegally certified as death from "natural causes."[3]

B. Non-Voluntary Killings Quickly Commenced Despite the Alleged Requirement That Patients Give an "Express Request."

More shocking is the widespread incidence of non-voluntary euthanasia. In 1990, no fewer than 1000 patients (0.7% of deaths from all causes that year) were given a lethal injection without having made an explicit request. And still in 2005 this happened to 500 patients (0.4% of all deaths).[4] Moreover, authorities responded by condoning the non-voluntary killings when they had previously condemned them. Dutch defenders of euthanasia had previously stressed that killings not made by explicit request would be prosecuted as murder.[5] However, in 1990 the government survey committee condoned those 1000 non-voluntary killings, describing them not as cases of "murder" but of "care for the dying." Moreover, leading authors of the surveys have since declared that it is now the

---

A. van der Heide, et al, "End-of-Life Practices in the Netherlands under the Euthanasia Act," 356 NEW ENGLAND JOURNAL OF MEDICINE 1957 (2007) ("2005 Survey").

[3] *See* 2005 Survey, *supra* note 2.

[4] *Id.* at Table 1

[5] H. J. J. Leenen, "Dying with Dignity: Developments in the Field of Euthanasia in the Netherlands," 8 MEDICINE & LAW 517, 520 (1989); quoted in *Euthanasia, Ethics and Public Policy*, *supra* note 1, at 123; Board of the Dutch Society for Voluntary Euthanasia, *Letter*, 19(1) HASTINGS CENTER REPORT 31, 49 (1989); Director of the Dutch National Hospital Association, *Letter by Herman H. van der Kloot Meijberg*, *id.* at 48.

responsibility of *patients* to make it clear, when competent, orally and in writing, if they do *not* want to be given a lethal injection upon becoming incompetent.[6]

Dutch courts later held that doctors who had given lethal injections to disabled babies had acted lawfully, and pediatricians and prosecutors have drawn up guidelines to regularize this infanticide.[7] Legal authorities began to propose accepting the "voluntary" killing of people with the beginnings of dementia.[8] The lead government-survey authors have aptly observed: "once one accepts [voluntary] euthanasia and assisted suicide, the principle of 'universalizability' forces one to accept termination of life without explicit request."[9]

C. Killing Expanded Far Outside Situations of "Unbearable Suffering."

The Dutch experience also illustrates the elasticity of the requirement of "unbearable suffering." Dutch law has expanded to encompass mental suffering, and authorities have proposed to accept "tired of life" as an indication for

---

[6] John Keown, *Considering Physician-Assisted Suicide: An Evaluation of Lord Joffe's Assisted Dying for the Terminally Ill Bill* 6 (Care Not Killing Alliance 2006), *available at* http://www.carenotkilling.org.uk/pdf/Keown_report.pdf (last accessed Apr. 21, 2009).

[7] Edouard Verhagen and Pieter Sauer, "The Groningen Protocol—Euthanasia in Severely Ill Newborns," 352 NEW ENGLAND JOURNAL OF MEDICINE 959 (2005).

[8] House of Lords Select Committee, *Report of the Select Committee on Medical Ethics*, para. 5, 1993–94 HL Paper 21-I.

[9] Quoted in *Euthanasia, Ethics and Public Policy*, *supra* note 1, at 123.

euthanasia.[10] The Dutch Supreme Court declared that a woman's suffering from grief at the death of her two sons qualified her for euthanasia or assisted suicide.[11]

Dutch doctors have noted that their regime—permitting not just assisted suicide but also euthanasia—is necessary if assisted suicide itself is allowed. They observe that assisted suicide alone often does not ensure a quick and painless death. Almost 20 percent of Dutch cases in which the doctor intended to assist suicide ended up with the doctor administering a lethal injection to overcome complications such as failure to die or patient difficulty in self-administration.[12]

The experience of the Netherlands is instructive. It is reasonable to conclude that Montana would suffer similar abuses if this court held that the state constitution required the legalization of assisted suicide.

---

[10] Quoted in *Considering Physician-Assisted Suicide*, *supra* note 6, at 8–9; *see also* Tony Sheldon, "Dutch Euthanasia Law Should Apply to Patients 'Suffering through Living' Report Says" 330 BRITISH MEDICAL JOURNAL 61 (2005).

[11] Discussed in *Euthanasia, Ethics and Public Policy*, *supra* note 1, at 87, 109, 131.

[12] Johanna H. Groenewoud, *et al.*, "Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands," 342 NEW ENGLAND JOURNAL OF MEDICINE 551, 554–55 (2000); *see also* Gerrit K. Kimsma, *Euthanasia Drugs in the Netherlands*, *in* David C. Thomas, *et al.* (eds.), *Asking to Die: Inside the Dutch Debate about Euthanasia* 135, 142–43 (Kluwer 1998) (it "is a fantasy" to think that that physician-assisted suicide without euthanasia is adequate to serve the desired patient goal); *and* "Euthanasia and Euthanizing Drugs in The Netherlands," in M. P. Battin and A. G. Lipman (eds.), *Drug Use in Assisted Suicide and Euthanasia* 200, 207 (Pharm. Prods. Press 1996) (laws permitting only physician-assisted suicide are "headed for disaster").

II. CONSTITUTIONALIZING ASSISTED SUICIDE WOULD UNDERMINE CHOICE AND COMPASSION.

In addition to assisted suicide's harmful consequences as evident from the Dutch experience, two primary arguments urged to justify legalizing assisted suicide actually militate against its legalization: autonomy and compassion.

A. The Argument Based on Patient "Choice" Fails; Most Patients Would Withdraw Their Requests if Given Proper Psychological Treatment.

1. Choice is Not an Absolute Value.

Our capacity to make choices is indeed important. But the mere fact that I have chosen something cannot *justify* what I have chosen. For example, laws prohibit a range of choices to harm others, from murder to assault. Does the fact that the murderer or mugger *wants* to commit these crimes afford them any shred of justification? And even if the victim consented would that justify the conduct? Would it be right, for example, for a person to kill someone who volunteered to be the victim in a "snuff" movie?

Laws sometimes also prohibit choices to harm or risk harming ourselves, such as by snorting cocaine or driving without a seatbelt, as well as conduct which may arguably be consensual, such as incest and bestiality. Are these acts justified by the mere desire to commit them? If individual choice were to be the touchstone of constitutional protection of dignity and privacy in Montana, the Court would need to repeal many more laws beyond those affecting suicide.

The laws against assisted suicide reflect the historical principle of the sanctity/inviolability of innocent human life, a principle which has been enshrined for centuries in Western criminal law and for over two thousand years (since the Hippocratic Oath) in Western medical ethics. Our laws and medical ethics have long held that it is a grave wrong for doctors intentionally to kill patients, even at their request. Assisted suicide has long been rejected by the World Medical Association, and just this year the Montana Medical Association promoted palliative care rather than assisted suicide and declared that compassion, autonomy, and dignity can all exist without assisted suicide.[13] No one is in a better position to determine whether assisted suicide is necessary than are the doctors of the State of Montana, and if assisted suicide is not necessary for patient dignity then historically-justified laws against the practice cannot be unconstitutional.

The health care professions rightly fear that decriminalization would presage an erosion of trust between the patient, on the one hand, and the doctor and nurse on the other. As the United States Supreme Court observed in 1997, the policies of multiple medical organizations confirmed the view that assisted suicide threatens

[13] World Medical Association, *Statement on Physician-Assisted Suicide*, adopted by the 44th World Medical Assembly, Marbella, Spain, Sept. 1992, *available at* http://www.wma.net/e/policy/p13.htm (last viewed Apr. 21, 2009); "Policy, Montana Medical Association Upon Physician Assisted Suicide," 20090221, MMABoT, 54th IM (Feb. 21, 2009), attached here as Appendix B.

to undermine the fundamental ethical healing directive of the medical profession itself.[14]

Life is a basic good, with intrinsic and ineradicable value. The value of the patient's life does not depend on the patient's subjective appreciation of it. The fact that a patient may have lost sight of the value of his or her life, through depression or other cause, is no warrant for endorsing that tragically misguided judgment and for assisting that patient to end his or her life. Doctors should no more grant patients' requests for a lethal dose than they should help them jump off a bridge.

2. Assisted Suicide Assumes "Lives Not Worth Living."

Autonomy-based arguments actually distract from an unavoidable underlying assumption, namely, that some lives are no longer worth living and some people would be better off dead. Even if it *were* only the patient who was making that judgment, it would still be a false judgment, a reflection that the patient had lost sight of his or her worth.

Although we never lose our inherent human dignity, we can lose sight of it. This is especially so when those around us tell us, directly or indirectly, by unfeeling word or cold indifference, that our life is no longer worth living. How we

[14] *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997). On the incompatibility between killing and healing, see also Leon R. Kass, *'I Will Give No Deadly Drug': Why Doctors Must Not Kill*, *in* Kathleen Foley and Herbert Hendin (eds.), *The Case Against Assisted Suicide: For the Right to End-of-Life Care* 38 (Baltimore: John Hopkins U. Press 2002).

see ourselves is influenced, often greatly, by how others see us. And by legalizing assisted suicide, society would be telling patients who "qualified" for it that their lives were indeed no longer worth living—that they would be better off dead. Assisted suicide corrodes the bonds of human solidarity.

Western law and medical ethics have historically rejected the view that patients can be divided into two categories: those with lives "worth living" and those with lives "not worth living." And rightly so: the lives of *all* patients are worthwhile. Although terminal illnesses such as cancer can reduce a person to experiencing undignified circumstances (such as incontinence), this does not mean that the person loses their inherent dignity or worth. The person of color enslaved and set to work on a plantation; the woman regularly battered in an abusive relationship; the baby born of a crack-addicted mother into abject poverty; the tourist thrown into a foul, violent jail—have they lost their dignity because of the undignified circumstances in which they find themselves? Indeed, it is precisely because they retain their human dignity that we have a moral duty to do what we reasonably can to put an end not to them but to their undignified circumstances.

3. Absolutized Autonomy is a Slippery Slope to Euthanasia.

The logic of a constitutional argument from autonomy would require euthanasia and assisted suicide in a *much* wider range of circumstances than initially proposed by the lower court. If respect for autonomy is overriding, why

should assisted suicide not be available to *anyone* who autonomously requested it? Why deny assisted suicide to a patient who was terminally ill but who was not suffering at all, or to a patient who was suffering but who was not terminally ill? Why deny assisted suicide to people who were not sick but who wanted to die for other reasons, such as the loss of a beloved spouse, or animal, or because of long-term unemployment? And why should death be denied to patients who cannot ask for it but who are suffering from the same maladies justifying the request of patients who can ask? In ordinary medical practice doctors do not deny beneficial treatments to patients simply because they cannot request them. Why should it be any different with euthanasia?

4. Assisted Suicide Threatens the Easily-Influenced and Vulnerable.

How autonomous would requests for assisted suicide be? How many patients would be in a position to make a balanced and informed decision? Illness, particularly terminal illness, renders us not only physically but also psychologically vulnerable. In a statement on assisted suicide in 2006, the Royal College of Psychiatrists in England observed that systematic studies have "clearly shown" that the wish for assisted suicide among terminally ill patients is "strongly associated" with depression.[15] This same depression and pain "can generally be

[15] Royal College of Psychiatrists, *Statement on Physician-Assisted Suicide* para. 2.4 (Apr. 24, 2006), *available at*

relieved" by medical and psychological treatments, and once such treatment occurs, "98–99 [percent] will subsequently change their minds about wanting to die."[16] More troublingly, many doctors are not equipped to recognize or treat depression among the terminally ill, and they often improperly dismiss it or consider it untreatable.[17] Patients are not exercising "choice" when 99% of their requests for assisted suicide are attributable to untreated clinical depression.[18]

B. Assisted Suicide Diminishes Compassion for Patients.

1. Death is Not a "Benefit."

Dignity and privacy do not necessitate legalizing assisted suicide in the name of compassion for those who are suffering.

Compassion for the sick no more justifies killing them than compassion for the poor justifies robbing banks to redistribute wealth. How often might our compassion for the terminally ill turn out, on closer analysis, to be counterfeit: a

---

http://www.rcpsych.ac.uk/pressparliament/collegeresponses/physicianassistedsuicide.aspx (last accessed Apr. 21, 2009).

[16] *Id.*

[17] *Id.*

[18] Evidence that has been reported in Oregon shows that only 13 percent of patients have been referred for psychiatric evaluation, and 38 percent of patients expressed a concern about being a burden on family, friends or caregivers. Oregon Department of Human Services, *Annual Report 2006*, Table 1, *available at* http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf (last accessed Apr. 21, 2009). And, far from assisted suicide being used to put an end to unbearable suffering, the three most common reasons for seeking a lethal prescription have been loss of autonomy (87 percent), a decreasing ability "to engage in activities making life enjoyable" (87 percent) and "loss of dignity" (80 percent). *Id.*

desire not to put them out of *their* misery but to put them out of *our* misery? True compassion respects the equality-in-dignity of all patients and seeks to alleviate their suffering in ways that respect their dignity and, where suffering cannot be further alleviated, to show solidarity with them by standing by them and furnishing what support we can. We do not respect the dignity of the sick by eliminating them. Killing is the ultimate abandonment.[19]

2. Compassion, Too, is a Slippery Slope to Euthanasia.

The argument that we have a duty to benefit the terminally ill, and express our compassion, by granting them assisted suicide tempts us, just like the argument from autonomy, onto a steep "slippery slope." Many people suffer who are not terminally ill. If it is right to give lethal injections to those dying from cancer, why is it not right to do likewise to those suffering from illnesses which are not terminal? Indeed, is the duty to relieve suffering not all the greater when the suffering is likely to be protracted rather than brief, when it may last years rather than days? Why should our compassion be rationed?

3. Palliative Care is the Real, Compassionate Alternative.

It is ironic that the campaign for assisted suicide should be pressed so hard when never before has palliative care been so able to do so much for so many. The birth of the "hospice movement" in the United Kingdom, and its growth

[19] *See* Edmund D. Pellegrino, *Compassion is Not Enough*, in Foley and Hendin, *supra* note 14, at 41.

internationally, has been one of the most striking success stories in modern medicine and nursing. The evidence from palliative care experts—those who devote their professional lives to the care of the terminally ill and whose expert opinion must surely carry great weight in this debate—is that patients can die with dignity, their passage eased by palliative care, without assisted suicide. Assisted suicide is therefore not only unethical, it is unnecessary.

Doctors agree. The undersigned *amici curiae* doctors and nurse from Montana oppose the legalization of assisted suicide in part because of the availability and effectiveness of palliative care. For illustrative purposes, declarations are provided in Appendix C from two of those doctors: internist Dr. Richard D. Blevins, and oncologist and palliative care expert Dr. Thomas A. Warr. Combined, these doctors have decades of experience attending the deaths of thousands of patients in Montana. They affirm that palliative care is a fully effective and ethical alternative to assisted suicide.

Consider also the consensus of doctors around the world who have considered this issue. In 2006, over 70 percent of members of the Royal College of Physicians (and over 90 percent of those in the specialty of palliative medicine) agreed with the following statement:

> [We] believe that with improvements in palliative care, good clinical care can be provided within existing legislation and that patients can die with dignity. A change in legislation [to legalize assisted suicide] is not needed.[20]

It is true that more can be done to make quality palliative care available to all. However, given the necessary political will, this is an attainable goal. Further, there is a real risk that decriminalizing assisted suicide would distract from this urgent goal. Why fund palliative care, it would surely be asked, if there were a quicker, cheaper "fix"?

Assisted suicide advocates argue that assisted suicide is a necessary extension of the right to receive pain relieving drugs or to refuse treatment because either might hasten a person's death. But administering palliative drugs like morphine need not involve active killing. Palliative drugs do not, if properly titrated, accelerate death; if anything, they prolong life by making the patient more comfortable.[21] Yet even if a patient's hastened death is foreseen, either by pain relievers or by refusing a sustaining treatment, such an action would not morally be

---

[20] Royal College of Physicians, "RCP cannot support legal change on assisted dying—survey results" (May 9, 2006), *available at* http://www.rcplondon.ac.uk/news/news.asp?PR_id=310 (last accessed Apr. 21, 2009). In another survey in England, only 2.6 percent of doctors replied that a relaxed law would have facilitated the management of their patients. Clive Seale, "National Survey of end-of-life decisions made by UK medical practitioners," 20 PALLIATIVE MEDICINE 3, 6–8 (2006).

[21] Robert G. Twycross, *Where There is Hope, There is Life: A View from the Hospice, in* John Keown, ed., *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* 141, 162 (Cambridge U. Press 1995)

the same as assisted suicide, which involves the intentional, not merely foreseen, causing of death by a doctor's assistance.

A doctor administering morphine or disconnecting a patient's life-support machine need have no intention to hasten death. He may simply have the purpose of relieving pain or stopping an unwanted or unduly burdensome treatment. The patient's death can in fact be attributable solely to the patient's underlying pathology. Assisted suicide and voluntary euthanasia cause death in a more direct and intervening, and therefore distinguishable, way.[22]

Though it is wrong intentionally to kill the innocent, there is no requirement that we preserve life at all costs. Patients have every right to refuse medical treatment, even life-prolonging treatment, if it would be futile or would prove too burdensome. But that does not justify intentional or direct killing.

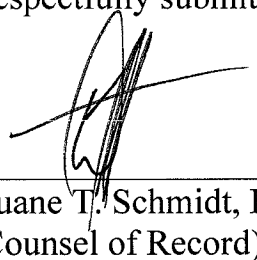
CONCLUSION

Hard cases really do make bad law. The Montana Constitution does not require that laws against assisted suicide be struck down to the blind detriment of patient dignity on a statewide scale. Montana doctors have verified that pain relief and psychological treatment are available to patients and nearly always moot requests for suicide. The dignity and privacy rights of vulnerable patients require

[22] On the importance of intention and causation in distinguishing physician-assisted suicide from lawful and ethical medical conduct, see the judgment of Chief Justice Rehnquist in *Glucksberg*, 521 U.S. at 725–26; *see also Vacco v. Quill*, 521 U.S. 793, 800–02 (1997)

that they *not* be propelled into a society where they can be successfully pressured to die. Their lives are valuable and protectable by law. The Dutch experience conclusively demonstrates that abuses will occur and respect for the dignity of patients will diminish if euthanasia or physician assisted suicide is legalized.

Respectfully submitted this 27th day of April, 2009,



Duane T. Schmidt, Esq.
(Counsel of Record)
MT Bar. No. 3779
ALLIANCE DEFENSE FUND
15100 N. 90th St.
Scottsdale, Arizona 85260
Tel: 480-388-8045
Fax: 480-444-0025
Email: dschmidt@telladf.org

Steven H. Aden, Esq. (Of Counsel)
Matthew S. Bowman, Esq. (Of Counsel)
ALLIANCE DEFENSE FUND
801 G Street NW, Suite 509
Washington, DC 20001
Tel: (202) 637-4610
Fax: (202) 347-3622
Email: saden@telladf.org,
mbowman@telladf.org

APPENDIX A

INTEREST OF *AMICI CURIAE* "CONCERNED PHYSICIANS"

Dr. Donald Berdeaux is a medical oncologist in Great Falls, Montana, and has practiced there since 1993. As an oncologist he has many terminally ill patients.

Dr. Richard D. Blevins is a medical doctor who has practiced in Great Falls since 1982. He is board certified in pulmonary disease and internal medicine, and has directed critical services at a hospital for 15 of those years. He has cared for hundreds of patients in the final stages of their lives, and has dealt with many issues of relief of suffering, both physical and emotional, through palliative care or hospice programs.

Dr. Paul L. Gorsuch, Jr., is a neurosurgeon in Great Falls. He has practiced since 1987 and has extensive training and experience in conditions such as stroke, spinal cord injuries, brain tumors with no reasonable expectation of cure, degenerative diseases of the nervous system, brain trauma, and pain. He frequently engages in end-of-life, palliative care, and hospice discussions and decisions with his patients and their whole team of specialists.

Dr. Kirsten L. Morissette is a family physician in Hardin, Montana. She practices the full scope of family medicine, including at the end of patients' lives, and in hospice care and nursing homes. Palliative care was an integral part of her training.

Dr. Carley C. Robertson is a medical doctor in Havre, Montana. She is a general practitioner who has practiced medicine in rural Montana for over 25 years. She practices in an emergency room in Havre, and she supervises three rural ambulance services in Blaine County as well as three physician assistants in Chouteau County.

Dr. D. Perrin Roten, Jr., is a general surgeon in Great Falls. He treats many acutely ill patients and helps families with many "end of life decisions," such as those involving patients receiving life-sustaining medical treatment for extended periods or time, or patients with head injuries, and/or those who will not recover from their conditions.[1]

Dr. Ronald Patrick Skipper is a general surgeon in Lewistown, Montana. He graduated from medical school in 1986 and from his general surgery residency program in 1991. He is a fellow of the American College of Surgeons and is certified by the American Board of Surgery.

Dr. Stephen R. Shaub, D.O., practices in Billings, Montana. He is a board certified physician with thirty years of experience in family medicine, and has knowledge of pain management, compassionate treatment, and hospice care for those near death.

[1] Dr. Roten's description of interest was inadvertently omitted from *amici curiae*'s motion for leave to file, but his name was included as a party requesting leave, and was included in the Court's order granting the motion.

Dr. Craig Treptow is a family practice physician in Great Falls, treating patients from birth through the natural end of their life. These include patients with heart problems, cancer, disabilities, progressive neurological problems, and depression. He has been asked by a patient's family member about assisted suicide.

Dr. James Threatt is an ophthalmologist in Billings. He received his M.D. from Emory University in 1973, was a flight surgeon for the United States Air Force, did a residency in ophthalmology and has been in private medical practice in Billings since 1980. He sees about 3,500 patient-visits per year, and 75% of his patients receive Medicare. Many of his patients suffer significant medical problems, and often his patients' last office visit is within a few years or months of their death.

Dr. Thomas Warr is a medical doctor in Great Falls who is board certified in medical oncology, hematology, internal medicine, and hospice and palliative medicine. His practice is oncology, and he often cares for patients at the end of life. He was medical director of Peace Hospice of Montana for 15 years, during which time he supervised the deaths of over 3000 patients.

Ms. Brooke E. Cantu is a registered nurse in Kalispell, Montana. As a nurse at a medical center she has encountered multiple opportunities to care for patients in end-of-life and hospice situations.

Catholic Medical Association is a non-profit corporation incorporated in the State of Virginia and comprised of doctors in various fields of medicine from around the country, including from Montana. CMA's members are deeply committed to the ethical principles intrinsic to the medical profession (including those ethical principles expressed in the Hippocratic Oath), and believe that patients are in danger of becoming victims when society begins to define killing as an acceptable legal, and constitutional interest, and attempts to require members of the medical profession to participate in advancing this interest.

The American Association of Pro-Life Obstetricians and Gynecologists is a non-profit organization comprised of obstetricians and gynecologists from around the country, including from Montana. AAPLOG's members are deeply concerned about the ethics of the medical profession and are opposed to defining acts of killing as medical care. Many of AAPLOG's members encounter terminal illnesses in their patients.

Family Research Council is a non-profit organization located in Washington, D.C. that exists to develop and analyze governmental policies that affect the family. FRC is committed to strengthening traditional families in America and advocates continuously on behalf of policies designed to accomplish that goal.

APPENDIX B

POLICY
MONTANA MEDICAL ASSOCIATION
UPON
PHYSICIAN ASSISTED SUICIDE
Adopted February 21, 2009

The Montana Medical Association does not condone the deliberate act of precipitating the death of a patient. This does not imply, however, that a physician using his or her best judgment should not allow a patient to die with dignity.

MMA supports and advocates for compassionate and competent palliative care at the end of life and, furthermore, acknowledges that medical efforts to eliminate irreversible and extreme pain and suffering at the end of life are an appropriate medical response that may result in hastening the patient's death. MMA acknowledges the patient's legitimate right to autonomy at the end of life, but does not accept the proposition that death with dignity may be achieved only through physician assisted suicide.
(20090221, MMABoT, 54th IM)

APPENDIX C

DECLARATION OF DR. RICHARD D. BLEVINS

I, Richard D. Blevins, M.D., do hereby declare:

1. That if called upon, I could and would testify truthfully, as to my own personal knowledge as follows.

2. I am over the age of eighteen years and am competent to testify.

3. I graduated from the University of Colorado School of Medicine in 1974. I served in an internal medicine residency from 1974 to 1978 at the Naval Regional Medical Center in Oakland, California, and then in a fellowship in pulmonary diseases at the Naval Regional Medical Center in San Diego, California from 1978 to 1980. I am board certified in pulmonary disease and internal medicine.

4. I have practiced critical care and pulmonary medicine in Great Falls, Montana since 1982, and I was the Medical Director of Critical Services at Montana Deaconess Hospital and Benefis Healthcare for 15 of those years.

5. I have had the privilege of caring for hundreds of patients in the final stage of their lives, and have seen many of them make the transition from life to death. I have dealt with many issues of their care relating to the relief of suffering, both physical and emotional, through palliative care or hospice programs.

Appendix C

6. In my experience, compassionate medical care dictates that the physician provide relief of suffering, which includes physical and emotional distress. This is best done through a well-planned palliative care or hospice program, using appropriate medications and psycho-social interactions to minimize symptoms and allow natural death to occur. State of the art palliative care and psychological treatment are effective methods of relieving suffering.

7. One of the basic tenets of medical education is "first, do no harm." Palliative care and other treatment make this tenet possible and immensely preferable to assisted suicide. Another guiding principle for the ethical care of patients is to use medications in palliative care or hospice situations with the intent of relieving symptoms and allowing death to come. Such care is far different than giving medications with the express intent of causing a patient's death, which is a violation of the Hippocratic oath that many of us took at medical school graduation.

8. Legalizing, expecting, or demanding the physician to actively aid a patient's death would forever alter the relationship of trust historically established and maintained between physician and patient, because it would violate the physician's primary ethical tenet and it would make patients wonder whether their doctors might function to kill instead of heal them.

The foregoing is true and correct and is of my own personal knowledge, and I indicate such below by my signature executed on this 24th day of April, 2009, in Great Falls, Montana.

Richard D Blevins MD

Richard D. Blevins, M.D.

DECLARATION OF DR. THOMAS A. WARR

I, Thomas A. Warr, M.D., do hereby declare:

1. That if called upon, I could and would testify truthfully, as to my own personal knowledge as follows.

2. I am over the age of eighteen years and am competent to testify.

3. I am board certified in medical oncology, hematology, internal medicine, and hospice and palliative medicine. I graduated from Vanderbilt School of Medicine in Tennessee in 1981. I served in an internship and residency in internal medicine, and a fellowship in hematology and oncology, at the University of California San Diego.

4. I practice oncology in Montana, and throughout my practice I have often cared for patients at the end of life. Furthermore, I was medical director of a Peace Hospice of Montana in Great Falls between 1991 and 2006. During that time I attended the deaths of over 5000 patients. In my experience, a request for assisted suicide was extremely rare, and in each case, the suffering was relieved without resorting to that drastic measure.

5. In my opinion and experience, assisted suicide is unnecessary, unethical, and counterproductive, whereas state-of-the-art palliative and hospice treatments are effective. Assisted suicide is unnecessary because ordinary palliative and hospice care will obviate any "need" for suicide in the vast majority of

Appendix C

patients suffering from terminal illness, and will maximize their quality of life until a natural death ensues. In all other rare and exceptional situations of unrelenting suffering, a well-established and accepted technique known as palliative sedation can be used effectively.

6. Notably, the intent of palliative sedation is to relieve suffering, not to kill the patient. In fact, death is not a requirement, nor is it a necessary result. On several occasions I have used palliative sedation and was able to relieve intense suffering while the patient and family were able to enjoy several more days or weeks of life with a decent, meaningful quality of life. In contrast, because the intent and goal of assisted suicide is to kill the patient, my opinion is that assisted suicide violates medical ethics and is immoral.

7. Assisted suicide is counterproductive because it is too "easy," too "cost effective," too single-minded and selfish. It substantially distracts from what can and should be done to actually care for this vulnerable population of patients. If in a particular situation hospice care is not adequate, then it should be and can be improved. Offering true care for patients instead of assisted suicide is a better and indeed an obligatory option for the medical profession and for society.

The foregoing is true and correct and is of my own personal knowledge, and I indicate such below by my signature executed on this 24th day of April, 2009, in Great Falls, Montana.

Thomas A. Warr, M.D.