Montana Court Rules in Favor of Aid in Dying

BY JOYCE FRIEDEN

Physicians in Montana may legally assist terminally ill patients in hastening death, according to a ruling by the Montana Supreme Court.

The decision in the case of *Baxter v. State of Montana* concerned Robert Baxter, a retired truck driver from Billings, who was terminally ill with lymphocytic leukemia with diffuse lymphadenopathy. As a result of the disease and its treatment, Mr. Baxter suffered from symptoms including "infections, chronic fatigue and weakness, anemia, night sweats, nausea, massively swollen glands, significant ongoing digestive problems, and generalized pain and discomfort," according to the decision.

The court said further, "The symptoms were expected to increase in frequency and intensity as the chemotherapy lost its effectiveness. There was no cure for Mr. Baxter's disease and no prospect of recovery. Mr. Baxter wanted the option of ingesting a lethal dose of medication prescribed by his physician and self-administered at the time of Mr. Baxter's own choosing."

Mr. Baxter, along with four physicians and Compassion & Choices, a pro-aid-in-dying group, filed suit in Montana's district court for the first judicial district, challenging the constitutionality of Montana homicide statutes' being applied to physicians who provide aid in dying to mentally competent, terminally ill patients. Mr. Baxter's attorneys contended that the right to die with dignity was constitutional under Montana law.

The district court ruled in favor of Mr. Baxter, but the state appealed the ruling to the Montana Supreme Court. On Dec. 31, 2009, that court also ruled in favor of Mr. Baxter, by a vote of 5-2, although it declined to comment on whether aid in dying complied with the Montana constitution. Mr. Baxter had died in December 2008.

"This court is guided by the judicial principle that we should decline to rule on the constitutionality of a legislative act if we are able to decide the case without reaching constitutional questions," wrote Justice W. William Leaphart. "We find nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy. … Furthermore, the Montana Rights of the Terminally Ill Act indicates legislative respect for a patient's autonomous right to decide if and how he will receive medical treatment at the end of his life. … We therefore hold that under [Montana law], a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply."

Justice James Rice, one of the two dissenting judges, argued that under current Montana law, a physician can be prosecuted for helping a patient commit suicide—if the patient survives, the crime falls under the category of aiding suicide; if the patient dies, the crime is homicide.

"Importantly, it is also very clear that a patient's consent to the physician's efforts is of no consequence whatsoever under these statutes," he wrote. "[The majority] ignores expressed intent, parses statutes, and churns reasons to avoid the clear policy of the State and reach an untenable conclusion: that it is against public policy for a physician to assist in a suicide if the patient happens to live after taking the medication; but that the very same act, with the very same intent, is not against public policy if the patient dies. In my view, the Court's conclusion is without support, without clear reason, and without moral force."

In the wake of the court ruling, which cannot be appealed, opinions vary as to whether more Montana physicians will now provide aid in dying to terminally ill patients. Chicago health care attorney Miles J. Zaremski, who wrote a "friend of the court" brief in support of Mr. Baxter in the Montana case, said that even though the decision came out in favor of the plaintiff, physicians in Montana will be reluctant to aid terminally ill patients in dying until legal protocols for the procedure have been established.

"In Montana, if the patient gives the doctor consent to provide aid in dying, the physician can escape homicide laws," said Mr. Zaremski, who is also a former president of the American College of Legal Medicine. "Well, how was that consent given? Were there witnesses to it? Did you wait 10 days? I think you need protocols and standards in place."

Oregon and Washington, the only states with aid-in-dying statutes, have protocols written into their laws, he noted. As to who would write the Montana protocols, "I think the legislature should, with input from the medical community," he said.

Kathryn Tucker, legal director of Compassion & Choices, noted that another aid-in-dying case with which her group is involved is being litigated in Connecticut. Ms. Tucker disagreed with the idea that Montana physicians would not immediately feel freer to provide aid in dying to terminally ill patients in the wake of the state supreme court decision.

"Montana physicians can feel safe that in providing aid in dying, they don't run risk of criminal prosecution," she said. "We know aid in dying happens in every state, even where the legality is unclear. In Montana, this [decision] brings clarity to this issue."

Ms. Tucker added that most medical care "is not governed by statute; it's governed by the standard of care and best practices. So most physicians will approach aid in dying in Montana as something regulated by the standard of care. I think what's going to happen with Montana [is that this case] will move aid in dying into normal medical practice that's governed by the standard of care, and we'll get away from the notion that there need to be elaborate statutes." ■

How Much Do RA Patients Suffer?

Most rheumatologic disorders do not meet the standard of terminal diseases. However, they can involve a level of intractable suffering that leaves them on the ethical edge of consideration of assisted suicide.

A case presented by the University of Washington's Ethics in Medicine Web site discusses a recently divorced 55-year-old man with severe rheumatoid arthritis who comes in for a routine visit, complaining of insomnia. "He requests a specific barbiturate, Seconal, as a sleep aid, asking for a month's supply. On further questioning, he states that he wakes up every morning at four, tired but unable to go back to sleep. He admits that he rarely leaves his house during the day, stating that he has no interest in the activities he used to find enjoyable."

The Web site ((http://depts.washington.edu/bioethx/topics/pasc1.html) poses the question whether the patient is a candidate for assisted suicide.

It then states that he falls outside the qualifying diseases: "The request for a specific quantity of a specific barbiturate suggests that this patient is contemplating suicide. This concern should be addressed explicitly with the patient. His sleep pattern (early morning awakening) and lack of interest in previously enjoyable pastimes (anhedonia) suggest major depression. This should be fully evaluated and treated. In addition, pain management and long-term care options should be fully revisited in a patient with complaints such as his.

"Even if the patient were fully competent, most proponents of [physician-assisted suicide] would object to aiding his suicide as he is not terminally ill. This said, rheumatoid arthritis can be a painful and debilitating chronic condition and it is unclear whether there is any relevant ethical or legal distinction between such a patient and one who is terminally ill."

—Sally Koch Kubetin

Former CDC Chief Gerberding to Run Vaccines at Merck

BY ED SILVERMAN

Dr. Julie Gerberding, a former director of the Centers for Disease Control and Prevention, has joined Merck & Co. as president of its vaccines division.

The Dec. 21 announcement comes just 5 months after the drug maker unexpectedly announced that the previous head of its vaccines unit, Margie McGlynn, planned to retire. She left in November, after running the vaccines divisions since 2005 and spending 26 years in different positions at Merck.

By hiring Dr. Gerberding, who headed the CDC from 2002 to 2009, Merck is getting a high-profile physician with a public health pedigree at a time when drug makers are increasingly pressed to justify the costs of their vaccines and find politically digestable ways to extend these products to developing nations.

During her tenure, she shepherded CDC through anthrax attacks, the avian flu outbreak, and SARS.

DR. GERBERDING

During her tenure, Dr. Gerberding shepherded the agency through dozens of emergency response initiatives for several closely watched health crises, including the investigation into anthrax attacks that killed five people in 2001; the H5N1 avian influenza; the global outbreak of severe acute respiratory syndrome (SARS); and various episodes of food poisoning.

"As a pre-eminent authority in public health, infectious diseases and vaccines, Dr. Gerberding is the ideal choice to lead Merck's engagement with organizations around the world that share our commitment to the use of vaccines to prevent disease and save lives," said Richard Clark, Merck's chief executive, in a statement.

By contrast, Ms. McGlynn's background was largely in sales and marketing. A pharmacist by training, she joined the drug maker in 1983 as a sales representative, later becoming a product manager and a senior vice president at Merck-Medco, the pharmacy benefits manager that the drug maker eventually spun off, before she took over the vaccines division in 2005.

Two years later, she oversaw the launch of the quadrivalent human papillomavirus vaccine, Gardasil, which the drug maker hoped would reinvigorate a corporate image sullied by accusations that Merck failed to fully acknowledge links between its painkiller Vioxx (rofecoxib) and heart attacks and strokes. Vioxx was withdrawn from the market in 2004. ■