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, Mont., 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 regarded as a 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 their 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." 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." ■

POLICY & PRACTICE

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Zyprexa Among Stolen Drugs

Thieves broke into an Eli Lilly & Co. warehouse in Enfield, Conn., in mid-March and stole some $75 million worth of pharmaceuticals. The company is working with the Food and Drug Administration (FDA) to recover the products, which included Zyprexa, Cymbalta, Prozac, and Strattera. According to a story in the Wall Street Journal, the theft might have been the biggest ever recorded for pharmaceuticals. Lilly has stopped distributing all of the affected lots. A full listing of the products and the stolen lots can be found on the FDA's Cargo Theft Web site and on Lilly's Web site.

Seeking Parity for Medicare

Sen. John Kerry (D-Mass.) has introduced a bill that would eliminate the 190-day cap on inpatient psychiatric days for Medicare patients. The Medicare Mental Health Inpatient Equity Act (S. 3028) would make coverage for Medicare enrollees on par with that received by people who have private health insurance. There is no lifetime limit on any other Medicare inpatient specialty care. "This arcane and outdated policy runs counter to every battle we've fought to equalize mental health care in this country," said Sen. Kerry in a statement. The bill is cosponsored by Sen. Olympia Snowe (R-Maine) and supported by 48 national organizations, including the American Association for Geriatric Psychiatry and the American Psychiatric Association.

Psych Drugs for Psych Conditions

The Substance Abuse and Mental Health Administration (SAMHSA) says that a new study indicates that most psychiatric medications are being prescribed for psychiatric conditions. The agency aimed to look into whether antipsychotics, antidepressants, and antianxiety drugs were being used in an appropriate manner. Antipsychotics were prescribed for psychiatric conditions 99% of the time, with the majority for mood disorders and schizophrenia or other psychotic disorders. Antidepressants were prescribed for psychiatric conditions 93% of the time; the nonpsychiatric conditions included headaches, connective tissue disease, and back problems. Antianxiety drugs only were used 72% of the time for psychiatric conditions. They also were prescribed for allergic reactions, back problems, and anxiety related to medical interventions. The study analyzed data from the 2005 National Disease and Therapeutic Index, a survey of 4,000 office-based physicians conducted by IMS Health. It appears in the March issue of CNS Drugs.

HHS Extends Medicaid Relief

The Department of Health and Human Services is giving states a $4.3 billion break on prescription drugs for people who qualify for both Medicare and Medicaid. That's how much less the federal government will charge states through this year for Medicare coverage of drugs for "dual eligibles." "We believe [this] action will help states as they struggle to maintain Medicaid and other budget priorities in these difficult economic times," HHS Secretary Kathleen Sebelius said in a statement. The relief comes from the American Recovery and Reinvestment Act, which granted a temporary increase in the amount states receive from the federal government for Medicaid. The new action applies the funding adjustment to the period Oct. 1, 2008, through Dec. 31, 2010. In his proposed budget for 2011, President Obama called for again extending the funding break, through June 30, 2011.

PhRMA Urges Web-Ad Standards

The Pharmaceutical Research and Manufacturers of America urged the FDA to work with drug companies to develop standards for them to communicate online about products. The industry group submitted lengthy comments to the FDA, which has been seeking public input on ways it might regulate advertising and other communication appearing on Web sites and social media. PhRMA said the agency could develop an icon for use on "space-constrained media" to take users directly to FDA-regulated risk and benefit information. Such constrained spaces might include company-sponsored links that come up on search engines.

More Quality Reporting Woes

Medical practice leaders continued to cite multiple administrative challenges with Medicare's Physician Quality Reporting Initiative, according to a survey from the Medical Group Management Association. Specifically, the 429 medical practices surveyed said the process for accessing PQRI feedback reports was "unnecessarily arduous" and that the reports themselves were not satisfactory. According to the MGMA, less than half of the medical practices that attempted to participate in the 2008 PQRI were able to access their 2008 feedback reports. For those that did get the data, it took an average of 9 hours to download the report. Sixty percent of practices that got the reports said they were dissatisfied or very dissatisfied with the presentation of the information, and two-thirds said they were dissatisfied or very dissatisfied with the report's ability to guide them in improving patient care outcomes.

—Alicia Ault