

10-1-2020

## Aid in Dying in Montana: Three Takeaways

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### Recommended Citation

James C. Nelson, Aid in Dying in Montana: Three Takeaways, 81 Mont. L. Rev. 355 (2020).

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# EPILOGUE

## AID IN DYING IN MONTANA EPILOGUE: THREE TAKEAWAYS\*

James C. Nelson\*\*

After the Symposium concluded, I was offered the opportunity to write an article for the summer issue of the *Montana Law Review*. This issue was going to be devoted to the topic of aid in dying. For personal reasons related solely to my own prior commitments and schedule, I respectfully declined that gracious invitation. For whatever their worth, I offered a copy of my foregoing, as-delivered keynote remarks, and those were accepted as a substitute. My thanks for that.

Since the invitation was offered, however, I felt I had some license to, at least, briefly put in writing my personal takeaways from the excellent Symposium panel presentations. I have three observations.

First, my congratulations to Kathryn Tucker, Mark Connell, and Professor Anthony Johnstone as well as to the various panelists. All did a thoroughly professional and commendable job. This Symposium represented an unparalleled opportunity to become informed about aid in dying in Montana and the *Baxter v. State*<sup>1</sup> opinion ten years post-decision—as seen through the eyes of the lawyers, physicians, legislators, and academics in the field. Most important, though, were the compelling and heartrending first-person experiences shared by those who have suffered with their loved ones through the maelstrom of an incurable final illness.

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\* Editors' Note: This Article is an epilogue containing Justice Nelson's personal takeaways on aid in dying following the *Montana Law Review*'s Honorable James R. Browning Symposium on Aid in Dying in Montana: A Decade of Practice Following *Baxter v. Montana*, held at the Alexander Blewett III School of Law on September 6, 2019.

\*\* James C. Nelson is a retired Justice of the Montana Supreme Court.

1. 224 P.3d 1211 (Mont. 2009).

Second, one comment during the Q and A following one of the panel discussions sent a chill up my spine. To paraphrase, it was along the lines of intuiting the Montana Supreme Court's supposed broader intentions in rendering its *Baxter* decision.

Based upon my nearly 20 years of serving on the Court, I can state that opinion writing, especially in important cases like *Baxter*, is a tedious, deliberative, complex, and often adversarial process—all of which, save for oral argument, is completed within the chambers of the Court and is not open to the public or to the attorneys involved. I participated in that entire process in *Baxter* and am probably as familiar with the intentions of the Court as anyone.

It is with this experience in mind I suggest the plain language of the Court's written opinion in *Baxter* should be taken at face value. It says what it says; no more, no less.

I mention this only to emphasize that the *Baxter* Court did not create some sort of right to aid in dying. Indeed, if the Court had intended to do that, it would not have done so by implication. The Court would have simply affirmed District Court Judge Dorothy McCarter's opinion holding there is a constitutional right to aid in dying grounded in Montana's rights of individual privacy (Article II, section 10) and inviolable human dignity (Article II, section 4).<sup>2</sup>

Rather, the Court's focus was on the assisting physician's conduct. The Court interpreted Montana statutes, extant at the time, in holding that consent could be raised as a defense by a physician charged with deliberate homicide or another felony resulting from prescribing for his or her incurably ill patient a life-ending medication to be taken (or not) by the patient at a time and place of the patient's choosing. To the extent it created anything—and that really is not an apt verb—*Baxter* simply affirmed there was a consent defense available to prescribing physicians charged with deliberate homicide. In short, *Baxter* was a statutory interpretation.

*Baxter*'s impact on affected patients was collateral—albeit, expected. Importantly, however, the direct consequence of *Baxter* was to allow prescribing physicians to raise a criminal defense to a criminal charge resulting from allegedly criminal conduct. The decision was physician-focused, not patient-focused.

Indeed, in its various attempts to legislatively overrule *Baxter*, that is how the Legislature read and understood the Court's opinion as well. Those attempts, including the one in the 2019 session (HB 284, sponsored by Representative Carl Glimm),<sup>3</sup> addressed and criminalized the conduct of the

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2. *Baxter v. State*, No. ADV-2007-787, 2008 WL 6627324 (Mont. Dist. Ct. Dec. 5, 2008).

3. H.R. 284, 66th Leg. (Mont. 2019), available at <https://perma.cc/YVA7-Y8Q3>.

prescribing physician or otherwise made the consent defense unavailable against criminal charges filed in assisted dying cases. The government, while very effectively frustrating the patient's most personal end-of-life decision, brought its full weight to bear against the involved doctors. Incurably ill patients would have been, unfortunately, the collateral damage from the government's intrusion into the practice of medicine. Thankfully, none of these legislative attempts to overrule *Baxter* were successful.

While panelist-legislator Representative Glimm and I are polar opposites on a "right" to and need for aid in dying, we are, at least, on the same page in understanding what the *Baxter* Court's decision was, and was not, about.

And that leads me to my third and probably most important take-away. It was clear from the forthright presentations of panelists-physicians, Drs. Colette Kirchoff, R.D. Marks, Deric Weiss, and Lonny Shavelson, that medical aid in dying *is actually the practice of medicine* at the end of a patient's life. This practice involves a very intimate, and often long-standing, physician-patient relationship. It involves much counseling and discussions with the patient and often with members of the family. It is not practiced willy-nilly or by happenstance, any more than medicine is generally practiced in that manner.

The physicians who engage in this medical practice are compassionate, principled, and provide aid in dying only when it is in the best interests of the patient and in accord with the patient's competently made and clearly articulated desire to end his or her personal suffering in the final stages of an incurable illness. Most of these patients are in or are involved with hospice or some palliative care program, and all want to address their situations proactively while still able to self-administer the life-ending medication. It is a serious matter, taken seriously by all concerned.

Physicians practicing medical aid in dying are not involved in assisting suicide or in any way encouraging suicides—much less the problems of depressed veterans, teenagers, or those suffering from mental disability or illness (all of which are factually and substantively different from the situations of aid in dying patients).

Suicide (a problem in which Montana is at the top of the charts) and medical assistance in dying are substantively two different things. Medical aid in dying produces a dignified, peaceful, and otherwise inevitable and natural death resulting from incurable illness. Medical aid in dying does not involve assisting those who would take their own lives in an untimely and unnatural manner because of physical or mental issues that various branches of medicine can address.

Too often, suicide (with all that term's pejorative baggage) and the medical practice of aid in dying are conflated so as to support political

attacks on the latter. In truth, however, to characterize medical aid in dying practice as assisting suicide is little more than ignorant and disingenuous fearmongering.

Moreover, these panelist-physicians highlighted access problems and barriers incurably ill patients face in learning about and requesting a medical aid in dying option. Problems and barriers in many cases are grounded in ignorance, misinformation, and misperception on the part of not only the public, but on the part of medical practitioners as well. Access and barrier issues also involve a dearth of physicians willing to perform this sort of practice and, often, difficulty in obtaining life-ending medications from pharmacological sources.

Importantly, medical aid in dying must be understood and accepted for the practice of medicine that it actually is and as a medical practice subject to medically informed standards of care—the same as any other medical practice. There needs to be much more public and professional education in this regard.

Moreover, the focus of the government efforts in this matter must be turned from punishing physicians for practicing medicine in the best interest of their competent, incurably ill patients and, rather, redirected to protecting and honoring patients' informed and considered determinations about ending their physical and mental suffering in a dignified manner.

Indeed, viewed through this lens, stress and anxiety are typically removed from the patient's shoulders when he or she obtains the life-ending medication. Just having it ensures the patient retains ultimate control over his or her destiny—even if the medication is never used (and often it is not).

To the contrary, when a medical aid in dying option is not available, it is clear that patients often consider, and some resort to, a more violent way of ending their own suffering and lives.

Finally, medical aid in dying provides a dignified and peaceful closure for not only the incurably ill patient, but, equally, for the patient's family and friends who are able to say their final good-byes and expressions of love and support to their loved one personally, timely, and in a deliberate and predetermined process.

Those are my three takeaways from this Symposium.

In closing, I note that the Symposium was recorded. I hope that this record will be preserved and made available for viewing by Continuing Legal Education groups, by legislators, by lawyers and judges, and by members of the public. I urge any legislator, member of the public, lawyer, academic, and student interested in this very important issue to watch the video.

I believe that it is absolutely imperative that Montanans retain the ability to take advantage of medical aid in dying a dignified and peaceful death

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in cases of final, incurable illness. Ultimately, aid in dying is a medical option; it is not a mandate. And as my keynote remarks and special concurrence in *Baxter* indicate, I firmly believe that aid in dying is a constitutional right under Montana's Constitution. However this ability is retained, whether under the present *Baxter* rationale or as a constitutional right, the medical practice of aid in dying must be preserved—indeed encouraged.

My thanks again to the *Montana Law Review* for devoting an issue to aid in dying and for allowing me to make these remarks.

