IN THE SUPREME COURT OF THE STATE OF MONTANA
No. DA 09-0051

ROBERT BAXTER, STEVEN STOELB, STEPHEN SPECKART, M.D., C. PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D., and COMPASSION & CHOICES,

Plaintiffs,

v.

STATE OF MONTANA and MIKE McGRATH,

Defendants.

BRIEF FOR CHRISTIAN MEDICAL ASSOCIATION AND CHRISTIAN LEGAL SOCIETY AS *AMICI CURIAE* SUPPORTING APPELLANTS

On appeal from the District Court of
the First Judicial District Court,
in and for the county of Lewis and Clark,
Judge Dorothy McCarter presiding

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INTRODUCTION AND SUMMARY OF ARGUMENT

Amici Christian Medical Association (CMA) and Christian Legal Society (CLS) are professional organizations that advocate for religious freedom and the sanctity of human life. CMA's membership includes over 15,000 physicians, nurses, physician assistants, and pharmacists. CLS has over 3,000 member attorneys, law students, and judges. In this case, *amici* seek to protect the right of healthcare professionals to provide patient care according to their consciences.

Amici agree with the State that the Court should reverse the district court's judgment because a right to physician-assisted suicide finds no support in the Montana Constitution. *Amici* categorically oppose physician-assisted suicide as inconsistent with time-honored principles of medical ethics (discussed below), with the role of medical professionals as healers, and with the interest of society in protecting human life.

In this brief, however, *amici* wish to focus on the particular threat that creating a new constitutional right to physician-assisted suicide would pose to the conscience rights of healthcare providers. If this Court were to hold that terminally ill patients have a constitutional right to "die with dignity" under circumstances that "require the assistance of [a] medical professional" (Decision and Order ("Decision") 18-19), would a healthcare professional who conscientiously objects

to helping a patient commit suicide be obligated to write a prescription for lethal medication? To counsel the patient on how and when to take the medication? To fill the prescription?

The district court announced a previously-unrecognized constitutional right on a matter fraught with moral complexity and with ramifications for the rights of others. It leaves the protection of providers' rights of conscience, at best, unclear. Indeed, the court's remark that the State *may choose* to protect the rights of objecting physicians suggests that, without statutory protection, physicians *would* be obligated to help patients exercise the new right. Decision 21-23.

This is unacceptable. Many healthcare professionals have profound moral objections to facilitating suicide. Additionally, most medical professional organizations require the exercise of personal conscience in providing healthcare. The law must protect a physician's right of conscience—especially on matters of life and death.

If Montana chooses to create a right to physician-assisted suicide, it should do so through the democratic process, as Oregon and Washington have done. The legislature is better able than the courts to address such controversial issues of public policy and, if it decides to enact a law, to ensure that it safeguards physicians' conscience rights.

If this Court nonetheless recognizes a constitutional right to physician-assisted suicide, it should declare unequivocally that the right extends only to assistance from a *willing* provider. A patient's autonomy interest in making end-of-life decisions cannot trump a physician's own conscience rights.

ARGUMENT

I. A RIGHT TO PHYSICIAN-ASSISTED SUICIDE COULD CONFLICT WITH HEALTHCARE PROFESSIONALS' CONSCIENCE RIGHTS

The district court announced a new individual right under the Montana Constitution's dignity clause, Article II, § 4, and privacy clause, Article II, § 10, to "obtain assistance from a medical care provider in the form of obtaining a prescription for lethal drugs." Decision 17. The court's opinion provides no protection for physicians who object to facilitating such a request. To the contrary—the opinion suggests that, absent statutory protection that has not yet been provided, unwilling healthcare professionals *would* be obligated to facilitate a patient's exercise of the new right.

First, the district court acknowledged the State's interest in protecting unwilling providers, but declined to provide such protection or to stay enforcement of its decision until the legislature could act. Rather, it mused that the State "can provide an express provision that excludes physicians who do not wish to participate." Decision 21-22. The district court failed to acknowledge that if the

right to physician-assisted suicide is of constitutional dimension, conscientious providers may face challenges to their ability to rely on any statutory protection. *See National Family Planning & Reprod. Health Ass'n v. Gonzales*, 468 F.3d 826 (2006) (constitutional challenge to federal conscience statute in abortion context); *California v. United States*, 2008 WL 744840 (N.D. Cal. 2008) (same); *Taylor v. St. Vincent's Hosp.*, 523 F.2d 75 (9th Cir. 1975) (same in sterilization context).

Second, in the absence of effective protection, government-run healthcare institutions, and perhaps even their employees, may be obligated to comply with a patient's request for suicide assistance. *See Parham v. J.R.*, 442 U.S. 584 (1979) (state-operated hospital subject to constitutional requirements). Private institutions that accept government funding could likewise face efforts to compel assistance. *See Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959 (4th Cir. 1963) (en banc) (finding state action by non-profit hospitals receiving federal funds); *but see Blum v. Yaretsky*, 457 U.S. 991 (1982) (state official not responsible for decisions of private nursing home); *Rendell-Baker v. Kohn*, 457 U.S. 830 (1982) (private school did not act under color of state law even though it received at least 90% of its funds from government). Although *amici* believe such a claim would be meritless, healthcare professionals should not be forced to litigate their conscience rights simply because they work for an institution receiving government funds. Moreover, if a court concluded that such institutions *were* obligated to honor a

patient's request for lethal medication, many Montana providers would be forced to violate their consciences, violate the constitution, or leave their profession or the State.

Third, no statute now clearly protects healthcare professionals in this context. The district court, despite acknowledging "a substantial state interest in protecting the integrity of the medical profession" (Decision 21), denied the State's motion to stay enforcement pending legislative consideration, and the sixty-first legislature concluded without adopting any protective statute. Unlike in the contexts of abortion, sterilization, and capital punishment, no federal statute protects healthcare professionals from forced participation in physician-assisted suicide. *Compare, e.g.*, 42 U.S.C. §§ 300a-7 *et seq.* (federally-funded institutions cannot require individuals to assist in sterilizations or abortions);[1] Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, § 508(d), 121 Stat. 1844, 2209 (2004) (prohibits discrimination against healthcare organizations that do not offer abortion); 18 U.S.C. § 3597(b) (prohibits requiring employees to participate in capital punishment in violation of "moral or religious convictions").

[1] Two provisions, §§ 300a-7(c)(2) and 300a-7(d), are not limited to abortion and sterilization, but are limited to certain types of funding and programs, and would provide little, if any, protection to medical professionals objecting to physician-assisted suicide.

The ambiguity of the district court's opinion and the lack of statutory protection leaves healthcare professionals' rights of conscience very much at risk. Employees of government-associated institutions, and perhaps all healthcare providers, could be required to violate either their consciences or a patient's new constitutional right. At a minimum, a constitutional right to physician-assisted suicide would engender litigation over the precise scope of the right and who, if anyone, is obliged to participate. This result would disregard the ethical convictions of many healthcare professionals and undermine the vital role of conscience in the provision of healthcare services to the detriment of Montana's healthcare system.

II. MONTANA MUST PERMIT HEALTHCARE PROFESSIONALS TO FOLLOW THEIR CONSCIENCES ON PHYSICIAN-ASSISTED SUICIDE

A. Many healthcare professionals hold profound moral convictions against facilitating a patient's suicide

Medical ethics, heavily influenced by the Hippocratic Oath, has historically forbidden physician-assisted suicide. "[A]t least since the [second century AD], the Hippocratic Oath has been elevated to premier status among physicians as the summary of their sense of ethical obligation." Veatch, *Medical Ethics: An Introduction*, in *Medical Ethics* 8 (2d ed. 1997). A physician taking the Oath promises to "neither give a deadly drug to anybody if asked for it, nor ... make

such a suggestion to this effect." Carrick, *Medical Ethics in the Ancient World* 84 (2001).

Many medical associations maintain the Oath's prohibition on physician-assisted suicide. Less than twenty years ago, the American Medical Association (AMA) asserted that "[p]hysicians must not perform euthanasia or participate in assisted suicide." AMA Council on Ethical and Judicial Affairs, *Decisions Near the End of Life* 10 (June 1991). The AMA has reaffirmed that "[p]hysician assisted suicide is fundamentally inconsistent with the physician's professional role," AMA Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide* 4 (Dec. 1993), which is "to affirm life, not to hasten its demise," *id.* at 2. Likewise, the Montana Medical Association (MMA) has adopted a policy that "'does not condone the deliberate act of precipitating the death of a patient'" and "'does not accept the proposition that death with dignity may be achieved only through physician-assisted suicide.'" A.P., *Terminally Ill Montana Woman: Doctors Won't Help with Suicide*, Flathead Beacon, Apr. 4, 2009 (quoting MMA policy).

Many physicians also hold religious beliefs that forbid helping another commit suicide. The Catholic Church teaches that "to help in . . . so-called 'assisted suicide' means to cooperate in, and at times to be the actual perpetrator of, an injustice which can never be excused, even if it is requested." *See* Pope John

Paul II, *The Gospel of Life* 120 (1995); *see also* United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Service*, Directive 60 (June 15, 2001) ("Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way."); Second Vatican Counsel, *Gaudium et Spes* 27 (Dec. 7, 1965) (condemning suicide generally).

A number of Protestant Christian groups, including the National Association of Evangelicals (NEA), the pastors of the Southern Baptist Convention, the Evangelical Lutheran Church in America (ELCA), and the United Methodist Church (UMC), have also concluded that physician-assisted suicide is morally impermissible. *See* NEA, *Physician Assisted Suicide* (1997); Roach, *SBC Pastors, Average Americans View National Issues Differently* (May 28, 2008); ELCA, *End of Life Decisions* (1992); The Book of Discipline of the UMC (2004).

Likewise, The Church of Jesus Christ of Latter-day Saints and the Union of Orthodox Jewish Congregations of America both believe that physician-assisted suicide is unacceptable. LDS Newsroom: Public Issues, *Euthanasia and Prolonging Life*; Diament, *Judaism Values Life* (Dec. 8, 1999). Many Muslims interpret the Qur'an's prohibition on taking innocent life to preclude participation in physician-assisted suicide. *See* BBC: Islam Ethics, *Euthanasia and Suicide*

("Suicide and euthanasia are explicitly forbidden."); Islamic Medical Association of North America, *The Oath of a Muslim Physician* (1977) ("Whoever killeth a human being, not in lieu of another human being nor because of mischief on earth, it is as if he hath killed all mankind." (quoting Qur'an 5:32)); *see also* Qur'an 17:33 (prohibiting the taking of human life "other than in the course of justice").

In fact, about 90% of Montanans espouse a Christian tradition that opposes physician-assisted suicide. *See* Jones, *Gallup: Tracking Religious Affiliation State by State* (June 22, 2004).

Religious convictions are not the sole source of conscientious objections to physician-assisted suicide. Many advocates for women, disadvantaged minorities, and persons with disabilities worry that physicians are culturally conditioned not to accord equal value to the lives of all patients. *See Gender, Feminism, and Death*, in *Feminism & Bioethics* 282, 291-293 (Wolf ed., 1996); King & Wolf, *Physician Assisted Suicide From the African American Experience*, in *Physician Assisted Suicide* 91, 96 (Battin et al. eds., 1998); *Testimony: Hearing Before Judiciary Comm. of the New Hampshire H. Rep.* 3 (Feb. 19, 2009) (statement by Tom Cagle & Dianne Coleman of Not Dead Yet); *see generally* Bergner, *Death in the Family*, New York Times Magazine, Dec. 7, 2007 (interviewing opponents of Washington Death with Dignity Act). Some healthcare professionals therefore object to

participating in physician-assisted suicide for fear the practice would unfairly affect the historically marginalized members of society. *See* N.Y. State Task Force on Life and the Law, *When Death is Sought*, vi-vii (May 1994) ("[The risks of assisted suicide] would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized group.").

B. The healthcare profession values the exercise of conscience in the provision of services

Most medical professional organizations require the exercise of conscience in healthcare services. For instance, the World Medical Association (WMA) holds that "[a physician shall] be dedicated to providing competent medical service in *full professional and moral independence.*" *WMA International Code of Medical Ethics* (1949, amended 2006) (emphasis added). The Association believes that a "physician should be free to make clinical and ethical judgements without inappropriate outside interference," noting that "[p]rofessional autonomy and the duty to engage in vigilant self-regulation are essential requirements for high quality care." WMA, *Statement on Professional Responsibility for Standards of Medical Care* (2006). Likewise, the AMA's *Principles of Medical Ethics*, provides that "[a] physician shall, in the provision of appropriate patient care, except in medical emergencies, *be free to choose* whom to serve," and "[a]s a member of [the

medical] profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, *and to self*." AMA, *Code of Medical Ethics* (2005) (emphasis added). Also, graduates of the University of Washington School of Medicine, the only medical school specifically charged with serving Montana, promise to "practice [the] profession with conscience and dignity." UW Medicine, *Physician's Oath* (2009).

Pharmacists, who could be required to fill a prescription for a lethal dose of medication, also prize the exercise of conscience. The American Pharmaceutical Association (APhA) holds that pharmacists have a duty to "act with conviction of conscience." APhA, *Code of Ethics for Pharmacists* (adopted 1994). Further, APhA "recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patients' access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal." APhA, *Pharmacist Conscience Clause, in 2004 Action of the APhA House of Delegates* 6 (2004). The American Society of Health-System Pharmacists (ASHP) likewise recognizes "the right of pharmacists ... to decline to participate in therapies they consider to be morally, religiously, or ethically troubling." ASHP, *Pharmacist's Right of Conscience and Patient's Right of Access to Therapy.*

C. *Any right to physician-assisted suicide would undermine patient-doctor trust*

Perhaps the greatest benefit of the obligation of medical professionals to exercise their consciences in healthcare is the trust it engenders: patients trust that a physician will not do something that the physician believes is harmful. Any right to physician-assisted suicide would fundamentally alter that trust relationship. Although patients understand that a doctor can misdiagnose an illness, or at worst, provide negligent care, they trust their physician would never *intentionally* harm them. Permitting physicians to prescribe lethal medication would revolutionize this relationship; suddenly the person patients believed to be the least likely to harm them is entitled to help cause their death. This would inject confusion, doubt, and cynicism into the doctor-patient relationship, eroding trust and erecting psychological barriers to effective healthcare.

D. *Requiring healthcare professionals to participate over their conscientious objections would harm Montana's healthcare system by eroding the role of conscience and encouraging healthcare professionals to practice elsewhere*

If Montana chooses to create a right to physician-assisted suicide, requiring physicians to participate could jeopardize Montana's healthcare system. Crispin Sartwell, a philosopher and "pro-choice atheist," recently raised the following questions in defense of medical professionals' conscience rights:

> What are some of the bad things that have happened because people refused, on conscientious grounds, to do what the institutions in which they were embedded demanded? Now ask yourself: What are some of the bad things that have happened because people overcame serious qualms and did what they were ordered to do?

Sartwell, *The Fundamental Right to Refuse*, L.A. Times, Sept. 2, 2008.

Faced with the requirement to facilitate suicide, some professionals might dare to follow their consciences, risking personal liability and professional discipline. Others, unwilling to risk sanction or to violate their consciences, might relocate their practices. After all, Montana would be the only state to force healthcare professionals to facilitate suicide. Indeed, over 90% of medical professionals who belong to a faith-based professional organization "would rather stop practicing medicine altogether than be forced to violate [their] conscience[s]." Christian Medical Association, *Memorandum to Office of Public Health and Science on Proposed HHS Regulation Rescission* 5 (Apr. 9, 2009) (based on a 2009 survey of nearly 3,000 medical professionals). Many new professionals likely would elect to start their careers in a state more hospitable to moral independence. The cumulative effects, particularly in fields dedicated to end-of-life care, would threaten the availability of healthcare for Montana's most vulnerable residents.

A law interfering with the exercise of conscience would also operate in subtler ways, as professionals choose between healing the sick and complying with

the legal obligation to assist suicide. Personal conviction in healthcare services would erode by degrees, and a right intended to promote the autonomy of the terminally ill would leave Montanans' healthcare in the hands of moral automatons. *See* Smith, *Taking Requests, Doing Harm*, National Review Online, July 23, 2003 ("[P]atients rightly view the Hippocratic Oath as one of their primary defenses against the overwhelming power over our vulnerable lives that we, of necessity, place in the hands of our doctors.").

The dangers listed above could mount into a crisis for Montana's healthcare system, especially as the baby-boomer population ages. Not only would there be fewer physicians, nurses, and pharmacists to care for the elderly, there would be a simultaneous decline in conscientiousness and an increase in institutional pressure to help patients shorten their lives. Institute of Medicine, *Retooling for an Aging America: Fact Sheet* (Apr. 2008) ("As the nation's baby boomers turn 65 and older, fundamental changes in the health care system must take place and greater financial resources must be committed to ensure they can receive the high-quality care they need."); Glendon, President's Council on Bioethics, *Challenges Posed by the Changing Age Structure and Dependency Ratio in the United States* (Sept. 2004) ("[T]he United States is unprepared to meet the needs of the large and expanding number of people facing a lengthy period of disability before death.").

E. Healthcare professionals' conscience rights deserve protection at least equal to plaintiffs' claimed right to physician-assisted suicide

The great irony of the district court's decision is that it would grant a dignity and privacy right to patients while imposing an intolerable burden on the "personal dignity and autonomy" of physicians to define their own moral parameters and abide by them. Decision 15. Surely one of "the most fundamental questions of life" for a physician is whether assisting a patient's suicide is consistent with his or her ethical beliefs. *Id.* at 17 (quoting *Armstrong v. State*, 1999 MT 261, ¶ 72).

As this Court concluded in *Armstrong v. State*, 1999 MT 261, 296 Mont. 361, 989 P.2d 364 (1999), the right of privacy under the Montana Constitution is "as broad as are the State's ever innovative attempts to dictate in matters of conscience, to define individual values, and to condemn those found to be socially repugnant or politically unpopular." *Armstrong* ¶ 38. That right must include a physician's freedom to form and follow his or her own conscience, especially out of respect for human life.

> The fundamental right to personal and procreative autonomy and, in the broader sense, to individual privacy, *prohibits the government from dictating, approving or condemning values, beliefs and matters ultimately involving individual conscience*, where opinions about the nature of such values and beliefs are seriously divided; where, at their core, such values and beliefs reflect essentially religious convictions that are fundamental to moral personality; and where the government's decision has a greatly disparate impact on the persons whose individual beliefs and personal commitments are displaced by the State's legislated values.

Armstrong ¶ 68 (emphases added).

Indeed, there is perhaps no right more "'deeply rooted in this Nation's history and tradition,' ... and 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if [it was] sacrificed.'" *Washington v. Glucksberg*, 521 U.S. at 721 (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977), and *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)); *see, e.g.*, Sartwell, *The Fundamental Right to Refuse* ("[A] decent society would not require extraordinary moral heroism; it would respect people's fundamental moral commitments."); Thoreau, *Civil Disobedience*, in *Walden and Other Writings* 280-281 (1992) ("Must the citizen ever for a moment, or in the least degree, resign his conscience to the legislator?"); Jefferson, *Notes on the State of Virginia* 170 (J.W. Randolph, 1853) (1787) ("The rights of conscience we never submitted [to rulers], we could not submit. We are answerable for them to our God.").

The First Amendment to the United States Constitution and Article II, section 5 of the Montana Constitution further protect the rights of healthcare professionals to object to participating in suicide on religious grounds. Although the Supreme Court of the United States has never squarely addressed the issue, in *Doe v. Bolton*, it let stand a state statutory provision allowing objecting physicians to not participate in abortion, stating that this was an "appropriate protection to the

individual [healthcare professional] and to the denominational hospital." 410 U.S. 179 (1973). The Ninth Circuit has characterized this decision as protecting the "freedom of religion of those with religious or moral scruples." *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308, 311-312 (9th Cir. 1974); *see also Taylor*, 523 F.2d at 77 ("If the hospital's refusal to perform [an abortion] infringes upon any constitutionally cognizable right to privacy, such infringement is outweighed by the need to protect the freedom of religion of denominational hospitals 'with religious or moral scruples against sterilizations and abortions.'") (quoting *Chrisman*). The fundamental right of healthcare providers to abide by their sincerely held religious beliefs complements their rights of conscience under the dignity and privacy clauses of the Montana Constitution.

III. BY HOLDING THAT THE MONTANA CONSTITUTION DOES NOT GRANT A RIGHT TO PHYSICIAN-ASSISTED SUICIDE, THE COURT WOULD AVOID BURDENING THE CONSCIENCE RIGHTS OF HEALTHCARE PROFESSIONALS AND ALLOW THE LEGISLATURE TO PROTECT THEM SHOULD IT CHOOSE TO GRANT A STATUTORY RIGHT TO PHYSICIAN-ASSISTED SUICIDE

The district court declined to address all of the State's compelling interests, including its interest in protecting healthcare professionals' conscience rights. *See* Decision 23 ("the implementation of [the right] to effect the compelling state interests as discussed herein is properly left to the legislature"). It concluded that "the Court is simply the first in line to deal with the issue, followed by the legislature to implement the right. Thus, both the courts and the legislature are

involved either way." *Id.* The court got it backwards. It should have taken a cue from Oregon and Washington, which left this complex and controversial issue to the people, adopting physician-assisted suicide statutes only by popular referendum. The Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.001 *et seq.*; The Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800 *et seq.*

The Oregon and Washington statutes, which are almost identical, expressly protect the conscience rights of healthcare providers and institutions. They exempt from liability all "health care providers" who choose not to participate in physician-assisted suicide. Wash. Rev. Code § 70.245.190(1)(d); Or. Rev. Stat. § 127.885(4). They also provide that no "professional organization or association, or heath care provider" may "subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating *or refusing to participate*" in a physician-assisted suicide. Wash. Rev. Code § 70.245.190(1)(b); Or. Rev. Stat. § 127.885(2). The statutes also protect objecting healthcare facilities. *See* Wash. Rev. Code § 70.245.010(6); Or. Rev. Stat. § 127.800(6). The experience of those states demonstrates that granting patients access to lethal medication does not require infringing the conscience rights of healthcare professionals.

This Court should defer to Montana's democratic process, allowing it to determine whether to create a right of physician-assisted suicide. Unlike the courts, the legislature can inquire into experiences elsewhere, listen to all affected parties, and make decisions that ultimately reflect a democratic judgment on this controversial matter. If it chooses to enact legislation, it can take care to do so in a way that seeks to protect the rights of conscience. If there is to be a new right to physician-assisted suicide, a statutory right would at least be more precise and adaptable to new or unforeseen concerns, instead of grounded in overly-broad judicial formulae and bound to the slow progress of future litigation. Indeed,

> [l]egislatures . . . have superior opportunities to obtain the facts necessary for a judgment about the present controversy. Not only do they have more flexible mechanisms for fact finding than the Judiciary, but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions.

Glucksberg, 521 U.S. at 788 (Souter, J., concurring); *see also Krischer v. McIver*, 697 So. 2d 97, 104 (Fla. 1997) (concluding that issue is best left to state legislature). As in Oregon and Washington, the legislature could task an agency with overseeing a statute's implementation, providing accountability and transparency. *See* Wash. Rev. Code § 70.245.150 (requiring physicians to file records of requests and prescriptions with department of health, which must review and report annually); Or. Rev. Stat. § 127.865 § 3.11 (same).

Deferring to the legislature on the issue would also avoid an unnecessary extension of Montana constitutional law. The district court's ruling substantially extends the rationale of the holding in *Armstrong* (Decision 17-18), where this Court held that prohibiting medical professionals other than doctors from participating in an abortion violates a woman's right to terminate her pregnancy, *Armstrong* ¶ 75. The court's opinion was thus in line with the Supreme Court of the United States' long-standing holding that a woman's right overrides a State's interest in protecting life before viability. *See Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (affirming *Roe v. Wade*, 410 U.S. 113 (1973)).

By contrast, the district court's conclusion here is novel and ignores the State's interest in protecting Montana citizens. Every court of final jurisdiction to consider the constitutionality of physician-assisted suicide has agreed that a State's interest in preserving the lives of its citizens justifies its prohibition. *See Glucksberg*, 521 U.S. at 738; *Sampson v. State*, 31 P.3d 88, 96 (Alaska 2001); *Krischer*, 697 So. 2d at 104. In fact, the district court's own holding tacitly acknowledges that the State's interest here is in protecting the lives of "competent" individuals, capable of free, rational judgment. *See* Decision 16 ("[T]he right of personal autonomy . . . includes 'the right of each individual to make medical judgments . . . free from the interference of the government." (quoting *Armstrong* ¶ 39)). Thus, to affirm the district court, this Court would have to extend the

Montana Constitution beyond a principled limit recognized by every other American court to consider the issue. The Court should instead defer to the political process to decide the appropriate public policy in this area, and to safeguard the conscience rights of healthcare professionals in the event Montana chooses to grant a statutory right to physician-assisted suicide.

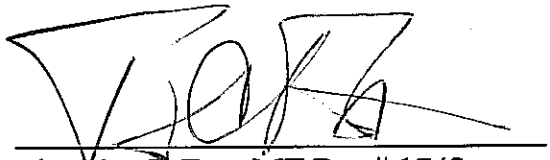
IV. ALTERNATIVELY, THE COURT SHOULD HOLD THAT THE MONTANA CONSTITUTION PROVIDES A RIGHT OF CONSCIENTIOUS OBJECTION TO HEALTHCARE PROFESSIONALS

In any event, this Court should not affirm a constitutional right to physician-assisted suicide without expressly holding that healthcare professionals, too, have an inviolable right of personal autonomy under the dignity and privacy clauses of the Montana Constitution, and have a complementary right of free exercise of religion and conscience under the religion clauses of the United States and Montana Constitutions. Holding that patients are entitled to assistance with suicide only from *willing* professionals would protect healthcare professionals who have promised to practice conscientiously and patients who trust that their physicians would never intentionally harm them. Alternatively, this Court should stay enforcement of a constitutional right to physician-assisted suicide until the legislature enacts a statute that defines that right *and* protects the conscience rights of objecting healthcare providers. The Court must not tolerate a result that eliminates the exercise of conscience by physicians on a matter of life and death.

CONCLUSION

Amici respectfully request that this Court reverse the district court's decision.

Submitted this 30th day of April, 2009



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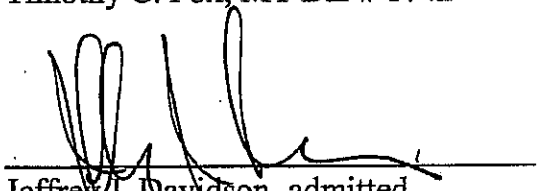

Jeffrey J. Davidson, admitted
pro hac vice April 8, 2009

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing Brief of Christian Medical Association and Christian Legal Society as *Amici Curiae* in Support of Appellants complies with Rule 14(d) of the Montana Rules of Appellate Procedure: it is double-spaced, has a proportionately-spaced 14-point Times New Roman typeface, and is 4,640 words in length.

DATED this 30th day of April, 2009

Timothy C. Fox, MT Bar # 1742

Jeffrey J. Davidson, admitted
pro hac vice April 8, 2009

CERTIFICATE OF SERVICE

I hereby certify that I served true and accurate copies of the foregoing Brief of Christian Medical Association and Christian Legal Society as *Amici Curiae* in Support of Appellants by depositing said copies into the U.S. mail, postage prepaid, addressed to the following:

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