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Attorneys for Plaintiffs

MONTANA FIRST JUDICIAL DISTRICT COURT,
LEWIS AND CLARK COUNTY

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| 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,<br><br>Plaintiffs,<br>v.<br><br>STATE OF MONTANA and MIKE MCGRATH, ATTORNEY GENERAL,<br><br>Defendants. | Judge: Dorothy McCarter<br>Cause No. DV 2007-787<br><br>AFFIDAVIT OF<br>STEPHEN F. SPECKART, M.D. |

STATE OF MONTANA )
ss:
COUNTY OF MISSOULA )

I, Stephen F. Speckart, M.D. being first duly sworn upon oath, depose and state as follows:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. I am a medical doctor and received my medical education at the Tulane University School of Medicine in New Orleans, Louisiana, graduating in 1970.

3. After obtaining my medical degree I completed an internship at George Washington University Hospital in Washington, D.C., followed by a residency at Oschner Foundation Hospital in New Orleans, Louisiana.

4. I completed a Fellowship in hematology and oncology at Oschner Foundation Hospital in New Orleans, Louisiana in 1974.

5. I completed a Fellowship in hematology and oncology at Walter Reed Army Medical Center in 1975.

6. I served as an attending physician at Walter Reed Army Medical Center from 1975 to 1977.

7. I have served as an instructor in the Department of Medicine of the University of Washington in Seattle, Washington, since 1977.

8. From 1977 to 2007, I was in private practice specializing in the treatment of cancer and hematology in Missoula, Montana. I hold staff privileges at St. Patrick Hospital.

9. I am certified by the American Board of Internal Medicine, with a subspecialty certification in Hematology and board eligibility in Oncology.

10. I am licensed to practice medicine in the State of Montana.

11. I have served as a board member of Missoula Community Medical Center in Missoula, Montana.

12. I helped develop Hospice of Missoula, in Missoula, Montana, and served as a board member and as Medical Director of that organization.

13. I developed the Physicians for Social Responsibility chapter in Missoula,

Montana.

14. I am a past board member of the Missoula Institute of Medicine and Humanities.

15. I am a past board member and the Medical Director of Chalice of Repose Project, Inc., formerly at St. Patrick Hospital.

16. I have published numerous articles and papers in medical journals. My full curriculum vitae is attached hereto as Attachment 1.

17. Two of the fundamental bioethical principles that guide a physicians's interactions with patients are: (1) respect for the patients' fundamental right of self-determination; and (2) respect for the patients' interests. Respect for the patients' interests is a fundamental guide throughout their care to include the dying process.

18. A substantial portion of my private practice involved treatment and care of persons with cancer, and I regularly treated patients dying from cancer.

19. Death from cancer can often be a very slow process, dragging out for months. Many cancer patients lose appetite, weight, and independence, while at the same time they are faced with growing pain and fatigue. Moreover, cancer patients are also faced with numerous other symptoms, depending on the location of the cancer. For example, patients with brain cancer often suffer excruciating headaches, seizures and progressive loss of brain function. A patient with lung cancer, on the other hand, usually suffers from terrible coughing and shortness of breath. As cancer usually progresses slowly and steadily, it means that the patient who is dying of cancer is fully aware of his or her present suffering while also worrying about future suffering. A patient dying of cancer is confronted with a future that can be terrifying. Near the end, the cancer patient can anticipate being bedridden, subject to a rapid loss of physical functions, and in relentless,

excruciating pain. The cancer patient at this stage is often forced to choose between suffering through unrelenting pain or sacrificing an alert mental state, because the dosage of medication required to ease the pain is so high that it impairs normal conscious activity. A very occasional patient seeks an alternative to ending his or her days either consumed with pain or comatose in a drug-induced stupor. Moreover, for some patients pain cannot be managed even with aggressive use of drugs, such as when side effects from the drugs exacerbate other symptoms of the patient's illness.

20. Physicians have an ethical obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even when it may sometimes hasten death. For example, morphine may be required at such a high dosage in order to relieve pain that it depresses respiration and heart function to the point of death. This is a common practice in the treatment of dying patients in the United States. This practice has a long tradition of acceptance in medicine and is sometimes referred to the dual effect rule or double effect doctrine.

21. In the course of my medical career, the issue of a terminally ill and suffering patient asking for help in hastening death has occurred in a very small number of patients. I sometimes encounter patients dying of cancer, for example, who have no chance of recovery whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who want to hasten their death and avoid prolonged suffering. These patients lack the knowledge or ability to hasten death on their own without assistance, or can do so only through violent or other means that risk an unsuccessful or further disabling outcome and extreme

trauma for their families.

22. Often patients simply want to know that they have a choice so that they can decide to end their suffering if they reach a point where it becomes unbearable. The comfort this brings to their last days can be an enormous contribution to easing their extreme fears.

23. It is my professional judgment that the decision of such a patient to shorten the period of suffering before his or her inevitable death can be rational, and my professional obligation is to be sympathetic and understanding of their terminal circumstances and try, within the law, to be present and maximally supportive of the dying patient.

24. Under Montana's statutes, it is my understanding that fulfillment of this professional responsibility to provide aid in dying to my terminal patients could expose me to criminal prosecution for homicide. The existence and potential enforcement of the statutes deter me from treating a small number of patients as comprehensively and effectively as their illness would require under my best of care application of ethics and good medical judgment.

25. The deterrent effect of Montana's homicide statutes as applied to physicians treating terminally ill patients has resulted in patients of mine dying tortured deaths.

26. I was recently contacted by the very loving and concerned family of a terminally ill middle-aged colon cancer patient of another physician. The patient had chronic unrelenting nausea and vomiting, could not eat, felt completely horrible, had intractable pain unresponsive to medications, and had recently had comprehensive evaluations in the hospital to see if any of this could be corrected, but to no avail.

He was then referred for hospice care. The family member, acting at the patient's request, asked me if anything further could be done to terminate the patient's suffering and I responded that I was sorry but there was only best of hospice care.

27. One patient whom I have encountered in my career is patient Smith (a fictitious name). Patient Smith had no chance of recovery, and understood this. Patient Smith was suffering terribly, and the suffering could not be relieved. It was my professional opinion as his treating physician that patient Smith was mentally competent when he asked me to assist in shortening his period of suffering before inevitable death. I felt sympathetic and somewhat professionally incomplete to accommodate his request. Montana's statutes kept this patient from making fundamental decisions about his own medical care, his life, his suffering, and his dignity. The statutes deterred me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

DATED this 24 day of June, 2008.

STEPHEN F. SPECKART, M.D.

STATE OF MONTANA )
ss:
COUNTY OF MISSOULA )

Signed and sworn to before me this 24 day of June, 2008 by Stephen F. Speckart, M.D.

(Notarial Seal)

Printed Name: Mark S. Connell
Notary Public for the State of Montana
Residing at: Missoula, Montana
My Commission Expires: May 15, 2011

Mark S. Connell
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Attorneys for Plaintiffs

MONTANA FIRST JUDICIAL DISTRICT COURT,
LEWIS AND CLARK COUNTY

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| 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,<br><br>Plaintiffs,<br>v.<br><br>STATE OF MONTANA and MIKE MCGRATH, ATTORNEY GENERAL,<br><br>Defendants. | Judge: Dorothy McCarter<br>Cause No. DV 2007-787<br><br>AFFIDAVIT OF LAR AUTIO, MD |

STATE OF MONTANA )
ss:
COUNTY OF MISSOULA )

I, Lar Autio, being first duly sworn upon oath, depose and state as follows:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. I am a medical doctor and received my medical degree from the University of Washington in 1992.

3. After obtaining my medical degree I completed a residency in family medicine in Spokane, Washington.

4. Since 1995, I have been in private practice specializing in family medicine in Missoula, Montana. I hold staff privileges at St. Patrick Hospital and Community Medical Center.

5. I am a member of the American Academy of Family Physician.

6. I am certified by the American Board of Family Practice and am licensed to practice medicine in the State of Montana.

7. I served as the Family Practice Department Chair at St. Patrick Hospital in Missoula, Montana, from 2002 to 2004.

8. I served as the Medical Director of Riverside Nursing Home in Missoula, Montana, from 1998 to 2006.

9. I have served as the Medical Director of Evergreen Nursing Home in Missoula, Montana since 1997.

10. I served as a member of the Executive Committee of the Western Montana Clinic in Missoula, Montana from 2005 to 2007.

11. My complete curriculum vitae is attached hereto as Attachment 1.

12. A substantial portion of my private practice involves treatment and care of persons with chronic medical illnesses such as diabetes, heart disease, hypertension, depression, dementia, cancer, and stroke. I follow several patients with progressive neurological disease.

13. In my medical practice, I regularly treat patients dying from cancer or stroke.

Some of my terminally ill patients have spent their last days or months in hospice care.

14. The pain, discomfort, and loss of dignity often involved in the dying process can be relieved in many cases by appropriate medication. Yet sometimes the pain and discomfort are so severe that only a high dose of extremely powerful medication is sufficient. Unfortunately such medication often results in unconsciousness or diminished awareness, and thus robs the patient of the ability to be alert and aware during the end stage of life. I have treated patients who have suffered terribly over how long the dying process takes, and the degree of pain, discomfort, and humiliation they must bear. Some of these patients have repeatedly requested assistance in hastening the process.

15. I occasionally encounter terminally ill patients who have no chance of recovery whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis, who desire to hasten their death and avoid prolonged and extreme suffering. These patients cannot hasten their death without assistance, or could do so but only at the risk of increased anguish and pain to themselves and their families.

16. It is my professional judgment that the decision of such a patient to shorten the period of suffering before death can be entirely rational, and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

17. Under Montana's homicide statutes, fulfillment of this professional responsibility may expose me to criminal prosecution. The statutes deter me from treating these patients as I believe I should.

18. Montana's statutes have resulted in patients of mine dying tortured deaths.

DATED this 30th day of June, 2008.

Lar Autio MD
LAR AUTIO, M.D.

STATE OF MONTANA )
ss:
COUNTY OF MISSOULA )

Signed and sworn to before me this 30 day of June, 2008 by Lar Autio, MD.

(Notarial Seal)

NOTARY PUBLIC for the State of Montana
Residing at Missoula, Montana
My Commission Expires June 12, 2012

PATRISHA L. CRISP
Printed Name: Patrisha L. Crisp
Notary Public for the State of Montana
Residing at: Missoula
My Commission Expires: June 12, 2012

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Attorneys for Plaintiffs

MONTANA FIRST JUDICIAL DISTRICT COURT,
LEWIS AND CLARK COUNTY

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| 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,<br><br>Plaintiffs,<br>v.<br><br>STATE OF MONTANA and MIKE MCGRATH, ATTORNEY GENERAL,<br><br>Defendants. | Judge: Dorothy McCarter<br>Cause No. DV 2007-787<br><br>AFFIDAVIT OF GEORGE FRANKLIN RISI, JR., M.D. |

STATE OF MONTANA )
ss:
COUNTY OF MISSOULA )

I, George Franklin Risi, Jr., M.D., being first duly sworn upon oath, depose and state as follows:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. I am a medical doctor and received my medical education at Jefferson Medical College, Thomas Jefferson University, in Philadelphia, Pennsylvania, graduating in 1980.

3. After obtaining my medical degree I completed an internship and a residency in internal medicine at Louisiana State University Medical Center in New Orleans, Louisiana.

4. I completed a Fellowship in infectious diseases at Louisiana State University Medical Center in New Orleans, Louisiana, in 1987.

5. I served as Project Medical Director at the Delta Region AIDS Education and Training Center from 1988 to 1990.

6. I served as Clinical Program Director for LSU in the Tulane/LSU AIDS Clinical Trial Unit from 1987 to 1990.

7. I was an Assistant Professor of Medicine, in the Division of Infectious Diseases, at Louisiana State University Medical Center in New Orleans, Louisiana, from 1987 to 1990.

8. Since 1991, I have been a member of the clinical faculty of the University of Montana School of Pharmacy, in Missoula, Montana.

9. Since 1991, I have been a Clinical Assistant Professor of Medicine of the University of Washington School of Medicine, Seattle, Washington.

10. From 1990 to 1993, I was the Director of the Infection Control Program at Community Medical Center, in Missoula, Montana.

11. I served as Assistant Professor of Medicine in the Division of Infectious Diseases, at University of Utah Health Sciences Center, in Salt Lake City, Utah, from 1993 to 1994.

12. From 1991 to 1993, and from 1995 to the present, I have served as the Director of the Infection Control Program at St. Patrick Hospital, in Missoula, Montana.

13. Since 2006, I have served as Infectious Disease Advisor to the St. Patrick Hospital Regional Referral Hospital/Patient Isolation Facility of Rocky Mountain Laboratories (NIH/NIAID).

14. Since 2003, I have served as Infectious Diseases Clinical consultant to Rocky Mountain Laboratories (NIH/NIAID), in Hamilton Montana.

15. Since 1990, I have been in private practice specializing in research and treatment of infectious diseases in Missoula, Montana. I held staff privileges at both St. Patrick Hospital and Community Medical Center until 2005. Since that time I have held staff privileges at St. Patrick Hospital only.

16. I am currently licensed to practice medicine in the State of Montana.

17. I am board certified in the specialties of internal medicine and infectious disease, and am a fellow of the Infectious Disease Society of America, the American College of Physicians, and the Society for Healthcare Epidemiology of America. Additionally, I am a member of the American Society for Microbiology, the Association for Professionals in Infection Control, and the Rocky Mountain Pus Club.

18. I am on the editorial review board of *Contagion*, as well as a manuscript reviewer for *Emerging Infectious Diseases* and for the *American Journal of Infection Control*.

19. I have published numerous articles and papers in medical journals, in addition to chapters in various texts. I have also participated extensively in conducting clinical research studies. My full curriculum vitae is attached hereto as

Attachment 1.

20. A substantial portion of my private practice involves treatment and care of persons infected with the Human Immunodeficiency Virus (HIV) and suffering from the Acquired Immune Deficiency Syndrome (AIDS).

21. HIV infection causes progressive destruction of the immune system, which eventually leads to AIDS. AIDS patients are susceptible to unusual infections and cancers, as well as conditions such as peripheral neuropathy (nerve damage causing burning or shooting pain in the limbs), wasting (chronic diarrhea and weight loss), and dementia (progressive loss of cognitive function). AIDS patients often die after suffering an extended period of severe illness.

22. Many AIDS patients die from Kaposi's Sarcoma; this common AIDS-related cancer can involve the lungs, which makes breathing increasingly difficult until the patient eventually dies by suffocation. Many AIDS patients die of pneumonia, which also causes the patient to essentially suffocate. Many AIDS patients who have wasting or dementia die of starvation and dehydration, an excruciatingly slow process. Others die from massive infection that resists treatment.

23. Before death is caused by one of the conditions described above, many AIDS patients are in misery from additional non-fatal conditions that can cause intense pain and suffering. These conditions include Kaposi's Sarcoma of the skin, which can result in severe pain and disfigurement from swollen tissues and open, weeping skin lesions; neuropathy, with pain so agonizing that it requires such a high dosage of narcotics that consciousness is impaired; and cytomegalovirus (CMV) retinitis, with resulting vision loss and eventual blindness.

24. Medication can often ease the suffering of the dying patient. In these cases, it can

lessen the severity of symptoms so that the patient can be relatively free from pain and discomfort during the dying process. In other cases, however, the pain, suffering, and loss of dignity can be relieved only through medication that renders the patient unconscious. I have had patients express their overwhelming frustration at how long the process takes, given their lack of control over their bodies and what is happening to them. In the face of the excruciating pain and intense humiliation that they feel, some of these patients have repeatedly requested help in ending their suffering.

25. Physicians have an ethical obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even when it may sometimes accelerate death. For example, morphine may be required at such a high dose in order to relieve pain that it results in hastening death by depressing respiration and heart function. This is a common practice in the treatment of dying patients in the United States. This concept has a long tradition of acceptance in medicine and is sometimes referred to the dual effect rule or double effect doctrine.

26. I occasionally encounter dying patients with no chance of recovery whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis, who desire to accelerate their death and avoid prolonged suffering. These patients cannot accomplish this without assistance, or can do so only through violent or other means that risk an unsuccessful or further disabling outcome and extreme trauma for their families. On several occasions I have had patients relate to me that they have been hoarding sleeping pills in order that they can make their own determination of when they die. Two patients I can recall told

me point blank that they had purchased handguns specifically so they could commit suicide when they wanted to put an end to their lives. Both attempted drug overdoses and attempted shootings are notorious for failures, which lead to further impairment and to an even lower quality of life in the final months.

27. It is my professional judgment that the decision of such a patient to shorten the period of suffering before his or her inevitable death can be rational and medically appropriate, and my professional obligation to relieve suffering may often dictate under such circumstances that I provide aid in dying for that individual.

28. Under Montana's homicide statutes, however, fulfillment of this professional responsibility may expose me to criminal prosecution. The existence and potential enforcement of the statutes deter me from treating these patients as I believe I should, based on proper medical judgment and ethics.

29. The deterrent effect of Montana's homicide statutes as applied to physicians treating terminally ill patients has resulted in patients of mine dying tortured deaths.

30. The following example is illustrative of situations I have experienced in my career. Patient Jones (a fictitious name) had no chance of recovery, and understood this. He was suffering terribly, and the suffering could not be relieved. It was my professional opinion as his treating doctor that Mr. Jones was mentally competent when he told me that for the past several months he had been filling prescriptions from all of his doctors for either sleeping pills, pain pills, or muscle relaxants, and had developed a hoard of these pills that he kept in a freezer at his home. The patient never did ask me to directly assist in ending his life because he knew that it was something that I could not acquiesce to given the current statutes,

but I am sure that he would have wanted to take advantage of a controlled and dignified end to his suffering if that had been an option. Instead he took the responsibility upon himself, even though he knew that attempts at overdosing could prove disastrous. The statutes kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

DATED this 30 day of June, 2008.

GEORGE FRANKLIN RISI, JR., M.D.

STATE OF MONTANA )
ss:
COUNTY OF MISSOULA )

Signed and sworn to before me this 30th day of June, 2008 by George Franklin Risi, Jr., M.D.

(Notarial Seal)

DEBRA THATCHER GILCREST NOTARIAL SEAL STATE OF MONTANA

Printed Name: DEBRA THATCHER GILCREST
Notary Public for the State of Montana
Residing at: MISSOULA, MONTANA
My Commission Expires: MAY 23, 2012