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I am Dr. Mark Mozer. I am a clinical psychologist, in private practice in Helena, since 1974, specializing in forensic psychology.

In the abstract, assisted suicide seems compassionate. However, SB 167 doesn't legislate a *theory*; it seeks to establish, and regulate the *practice* of assisted suicide. As the practice has evolved elsewhere, there has been a vast difference between the good-hearted intentions, and the actual practices of those directly involved in the industry. I would be happy to describe those differences upon questioning; for brevity's sake, I will limit present comments to the difficulties involved in determining the competence of a decision to die, especially by depressed patients.

SB 167 seems to sidestep issues of patient rationality or competence, by simply requiring that the decision be "informed." The "informing" would be done by another party, presumably the physician. To propose just a couple of troubling possibilities, a severely learning disabled patient, or a markedly depressed one, could be "informed" by the doctor, yet be very questionably competent to make this, life's most paramount decision.

Let's address the issue of competence, as it clearly underlies the concept of assisted suicide. If I am lying on my deathbed, gravely ill and/or in pain, I might conceivably make a decision to die, quite possibly in my "right" mind, by some minimal standard, but this would hardly be my *best* mind. Issues of competence on assisted suicide might be addressed by a psychiatrist or psychologist. There is no way I would offer my services to evaluate the competence of a decision to die—not because I am inalterably opposed to assisted suicide, but because there is simply no established standard for evaluating such competence. Clearly such a decision is far too grievous, to allow the doctors to fly by the seat of their pants.

Let's assume some established standard of evaluation. We still have the serious problem of the reliability/consistency of mental health assessments. Those committee members who are lawyers need no description of the courtroom psychodrama, by which doctors hired by the opposing sides take the exact same set of facts, and arrive at polar opposite conclusions.

The issue becomes all the more muddled, when we factor in depression, and try to differentiate the extent to which a decision to die is rational, vs. a symptom of depression. Studies have shown that about forty percent of cancer patients are depressed. I have done thousands of forensic evaluations, and it is my concerted opinion that the ability of psychiatrists and psychologists to clearly and reliably separate rationality from depression is highly limited.

Thank you.



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