SENATE Judiciary
Exhibit No. 31
Date 2/10/13
Bill No. SB202

MEMORANDUM

TO: Senate Judiciary Committee

FROM: Margaret Dore, Esq.

RE: Vote No on SB 202. (No Assisted Suicide/Euthanasia)

HEARING: February 10, 2013 at 8 a.m.

DATE: February 8, 2013

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I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.[1] Our law is modeled on Oregon's law. Both laws are similar to the proposed bill, SB 202.[2]

SB 202 eliminates safeguards such as waiting periods that supposedly render the Oregon and Washington laws safe.[3] Doctor reporting is also eliminated.[4] The former Hemlock Society, Compassion & Choices, claims that this is because Oregon's reporting system has "demonstrated the safety of the practice."[5] To the contrary, Oregon's reports support that the claimed safety is speculative. The reported statistics are also consistent with elder abuse. No wonder Compassion & Choices wants the reporting system gone.

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[1] I have been licensed to practice law in Washington state since 1986. I am a former Law Clerk to the Washington State Supreme Court. I am a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. I am also President of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide. For more information, please see www.margaretdore.com, www.choiceillusion.org and www.margaretdore.org .

[2] A copy of SB 202 is attached hereto at A-1 through A-13.

[3] The Oregon and Washington laws have a 15 day waiting period and a 48 hour waiting period. *See* ORS 127.850 § 3.08 & RCW 70.245.110. SB 202 does not. Oregon's and Washington's laws require a second "consulting" doctor. *See* ORS 127.820 § 302 & RCW 70.245.050. SB 202 makes the second doctor "waivable," *i.e.*, not required. *See* SB 202 § 7. Oregon and Washington require two oral requests. See ORS 127.840 § 306 & RCW 70.425.090. SB 202 requires one oral request and a written request. *See* SB 202, § 4.

[4] The Oregon and Washington laws require doctor reporting to a health department entity. See ORS 127.865 § 3.11 & RCW 70.245.150. SB 202 does not.

[5] Compassion & Choices' Handout, "Montana Physicians Can Now Respect Dying Patients' Decisions, [etc]," passed out as part of a media packet, January 27, 2011.

II. FACTUAL AND LEGAL BACKGROUND

A. Compassion & Choices is a Successor Organization to the Hemlock Society

Compassion & Choices ("C & C") was formed in 2004 as the result of a merger/takeover of two other organizations.[6] One of these organizations was the former Hemlock Society, originally formed by Derek Humphry.[7]

In 2011, Humphry was in the news as a promoter of mail-order suicide kits.[8] Later that year, he was the keynote speaker at C & C's annual meeting.[9]

B. Physician-assisted Suicide, Assisted Suicide and Euthanasia.

The American Medical Association defines "physician-assisted suicide" as occurring when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."[10] "Assisted suicide" is a general term in which the aiding person is not necessarily a physician. "Euthanasia," by contrast, is the

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[6] *See* Ian Dowbiggin, A Concise History of Euthanasia 146 (2007)("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices") and Compassion & Choices Newsletter excerpt attached hereto at A-14.

[7] Id.

[8] Randi Bjornstad, "Suicide Kits Sell Death by Mail," *The Register-Guard*, March 20, 2011, at A-17 ("All roads lead to Derek Humphry").

[9] *See* Compassion & Choices newsletter at A-14.

[10] The AMA Code of Medical Ethics, Opinion 2.211 - Physician-Assisted Suicide. (Attached at A-18).

direct administration of a lethal agent with the intent to cause another person's death.[11] "Euthanasia" is also known as "mercy killing."[12]

The American Medical Association rejects physician-assisted suicide and euthanasia, stating they are:

> fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.[13]

C. Withholding or Withdrawing Treatment.

Withholding or withdrawing treatment ("pulling the plug") is not assisted suicide or euthanasia. The purpose is to remove treatment as opposed to an intent to kill the patient. More importantly, the patient does not necessarily die. Consider this quote from an article in Washington state regarding a man removed from a ventilator:

> [I]nstead of dying as expected, the man slowly began to get better.[14]

D. Most States Have Rejected Assisted Suicide and/or Euthanasia

The vast majority of states to consider legalizing assisted

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[11] Cf. AMA Code of Ethics, Opinion 2.21 - Euthanasia. (Attached at A-19).

[12] The American Heritage Dictionary of the English Language. Definition available at http://www.thefreedictionary.com/p/mercy%20killing

[13] AMA Code of Ethics, Opinions 2.211 and 2.21, supra at footnotes 10 & 11.

[14] Nina Shapiro, *Terminal Uncertainty – Washington's new 'Death with Dignity' law allows doctors to help people commit suicide – once they've determined that the patient has only six months to live. But what if they're wrong?*, Seattle Weekly, January 14, 2009. (Attached at A-20, quote at A-22).

suicide and/or euthanasia have rejected it.[15] Just last week, a bill similar to SB 202 was summarily defeated in Colorado, which is Compassion & Choices' home state.[16]

In the last four years, four states have strengthened their laws against assisted suicide. These states are: Arizona, Idaho, Georgia and Louisiana.[17]

III. THE BILL

A. "Eligible" Patients May Have Years, Even Decades, to Live.

SB 202 applies to "terminal" patients, meaning those predicted to have six months or less to live.[18] Such persons may, however, actually have years, even decades, to live, *i.e.*, unless this bill passes and they commit suicide or are euthanized thereunder. This is true for at least two reasons:

1. If Montana follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for persons with chronic conditions such as diabetes.

SB 202 states:

> "Terminal illness" means an incurable and irreversible illness that has been medically

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[15] *See* tabulation at http://epcdocuments.files.wordpress.com/2011/10/attempts_to_legalize_001.pdf

[16] See AP article at A-26.

[17] See articles at A-27 to A-30.

[18] SB 202, § 2(15). (Attached at A-2).

> confirmed and will, within reasonable medical judgment, produce death within 6 months.[19]

Oregon's law has a similar definition, as follows:

> "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.[20]

In Oregon, this similar definition is interpreted to include chronic conditions such as insulin dependent diabetes.[21] Oregon doctor, William Toffler, explains:

> Our law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions . . . . Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live.[22]

If Montana enacts SB 202 and follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for people with chronic conditions such as diabetes. Dr. Toffler states:

> Such persons, with treatment, could otherwise have years or even decades to live.[23]

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[19] SB 202, §2(15).

[20] Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-31.

[21] *See* Oregon's annual assisted suicide report for 2013, attached hereto at A-32 to A-38. "Chronic lower respiratory disease" and "diabetes" are listed at A-37 & A-38, respectively.

[22] Letter to the Editor, William Toffler MD, New Haven Register, February 24, 2014, ¶2. (Attached at A-39). (I verified the content with him).

[23] Id.

2. Predictions of life expectancy can be wrong.

Patients may also have years to live because predicting life expectancy is not an exact science.[24] Consider John Norton who was diagnosed with ALS. He was told that he would get progressively worse (be paralyzed) and die in three to five years. Instead, the disease progression stopped on its own. In a 2012 affidavit, at age 74, he states:

> If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.

Affidavit of John Norton, attached at A-41, ¶ 5.

B. If SB 202 Is Enacted, There Will be Pressure to Expand "Eligibility."

In Washington State, our law went into effect in 2009. Since then, we have had informal proposals to expand our law to non-terminal people. For example, there was a column in the *Seattle Times*, which is our largest paper, with a suggestion of euthanasia for people who didn't have enough money for their old age.[25] So, if you worked hard all your life, paid taxes and then

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[24] Shapiro, Nina, *Terminal Uncertainty – Washington's new 'Death with Dignity' law allows doctors to help people commit suicide – once they've determined that the patient has only six months to live. But what if they're wrong?*, Seattle Weekly, January 14, 2009. (Attached hereto at A-20).

[25] *See* Jerry Large, "Planning for old age at a premium," The Seattle Times, March 8, 2012 ("After Monday's column, . . . a few [readers] suggested that if you couldn't save enough money to see you through your old age, you shouldn't expect society to bail you out. At least a couple mentioned euthanasia as a solution.") (Emphasis added). (Attached at A-43).

your pension plan went broke, this is how society would pay you back, with non-voluntary or involuntary euthanasia?

Prior to passing our law, I never heard anyone talk like this.

C. How the Bill Works.

SB 202 has an application process to obtain the lethal dose, which includes a written lethal dose request form.[26]

Once the lethal dose is issued by the pharmacy, there is no oversight.[27] No doctor is required to be present.[28] The death is not required to be witnessed.[29]

D. Specific Problems.

Proponents claim that SB 202 will assure patient choice and control. This is untrue.

1. No witnesses at the death

As noted above, SB 202 does not require witnesses at the death. Without disinterested witnesses, the opportunity is created for a person to administer the lethal dose to the patient without his consent.[30] Even if he struggled, who would know?

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[26] The request form can be viewed at SB 202, § 11. (Attached at A-6 & A-8)

[27] *See* SB 202 in its entirety. (Attached at A-1 through A-13).

[28] Id.

[29] Id.

[30] The drugs used, Secobarbital and Pentobarbital (Nembutal), are water soluable, such that they can be injected without consent, for example, to a sleeping person. See "Secobarbital Sodium Capsules, Drugs.Com, at http://www.drugs.com/pro/seconal-sodium.html and http://www.drugs.com/pro/nembutal.html See also Oregon's report, attached at

Without witnesses, the patient's control over the time, place and manner of his death is not guaranteed.

2. Adding witnesses will not fix the problem.

Requiring disinterested witnesses at the death would protect against overt murder. Generally, however, witnesses are not much of a safeguard. Many wills are properly witnessed and nonetheless set aside for undue influence, fraud, etc.

3. Witnesses can be coercive.

Witnesses can also be coercive. Consider Oregon resident Lovelle Svart, who threw herself an "exit party," during which she danced the polka with George Eighmey of Compassion & Choices. The party was reported in the *Seattle Times*, which wrote an article implying that she was in control.[31] At the end of the party, however, when it was time for her to die, the paper also reported this exchange between her and Eighmey, which took place in front of ten people:

> "Is this what you want?"
>
> "Actually, I'd like to go on partying," Lovelle replied, laughing before turning serious. "But, yes."
>
> "If you do take it, you will die."

A-~~40~~ 37 (listing these drugs).

[31] *See* Don Colburn, "Last day of life all planned out, down to the polka," October 26, 2007, available at http://seattletimes.com/html/localnews/2003918100_suicide02.html

"Yes."[32]

The situation is similar to a wedding when it's time to take your vows. Everyone's watching and it's the thing to do. So even if you are having second thoughts or would rather "go on partying," you go forward to take the lethal dose. If Eighmey had wanted to give her an out, he could have said:

> "You are having so much fun, you don't have to do this today or even next week."

Instead, he proceeded according to the script that she would die at the end of the party. His role was to preside over her death. Her role was to comply. Once she was in this role, she no longer had control. The situation was inherently coercive.

4. Someone else is allowed to speak for the patient.

Under SB 202, patients signing the lethal dose request form are required to be "competent."[33] This is, however, a relaxed standard in which someone else is allowed to speak for the patient. SB 202 states:

> "Competent" means that . . . the patient has the ability to make and communicate an informed decision . . ., <u>including communication through persons familiar with the patient's manner of communicating</u> . . ."

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[32] Id.

[33] SB 202 § 2(12). (Attached at A-2).

(Emphasis added).[34]

There is no requirement that the person speaking for the patient be a designated agent such as an attorney in fact. The person could also be an heir or a new "best friend" who will benefit financially from the patient's death. The patient would not necessarily be in control of his fate.

5. Legal capacity for treatment decisions is not required when requesting the lethal dose.

Under SB 202's definition of "competent," there is no requirement that a patient signing the lethal dose request form have the ability to make "responsible" or "rational" decisions, which is the definition of legal capacity for treatment decisions in Montana.[35] Yet again, the patient would not necessarily be in

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[34] SB 202 § 2(3) states:

> "Competent" means that, in the opinion of a court or in the opinion of a patient's attending physician, consulting physician, psychiatrist, or psychologist, the patient has the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the patient's manner of communicating if that person is available.

Attached at A-1.

[35] Compare SB 202's definition of "competent" in § 2(3) and 72-5-101(1), MCA, which states:

> "Incapacitated person" means any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, except minority, *to the extent that the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the person or which cause has so impaired the person's judgment that the person is incapable of realizing and*

control.

6. Consent is not required when the lethal dose is administered

SB 202 does not require competency or even awareness when the lethal dose is administered.[36] SB 202 does not require the patient's consent when the lethal dose is administered.[37] Without the right of consent at the time of death, the patient's control over his death is an illusion.[38]

7. Euthanasia is not prohibited

SB 202 appears to prohibit "euthanasia," which is another name for mercy killing.[39] SB 202 states:

> *making a rational decision with respect to the person's need for treatment.* (Emphasis added).

[36] SB 202 requires that a determination of "competent" be made in conjunction with the lethal dose request, not later. *See* SB 202, §§ 2(3), (5) & (12); § 3(1)(a); § 4(2)(c)(i); § 6(1)(a)(iii) & (c). Optional determinations of competency are also made in conjunction with the lethal dose request, not later. *See e.g.* SB 202, §§ 7(1)(c)(i).

[37] SB 202 requires that a determination of "voluntariness" be made in conjunction with the lethal dose request, not later. *See e.g.* SB 202 §§ 3(1)(d); 4(2)(c)(ii) & (iii); and 6(1)(a)(iv). There is no requirement that the patient be acting on a voluntary basis at the time of administration. *See* SB 202 in its entirety. (Attached at A-1 through A-13).

[38] Proponents may counter that patients are nonetheless protected because they may rescind the request for the lethal dose "at any time." (SB 202 §5, attached at A-4). The fact that a patient may rescind is not the same thing as a right to give consent when the lethal dose is administered. Consider a patient who obtained the lethal dose on a "just-in-case" basis without consenting to taking it. If such person would later become incompetent, be sedated, or simply be asleep, he or she would not have the ability to rescind. Without the right to consent, someone else could, nonetheless, legally, administer the lethal dose to that person. Proponents may also argue that patients are protected due to provisions imposing civil and criminal liability. (SB 202 §17). None of these provisions penalize administration of the lethal dose without the patient's consent. (Id.).

[39] *See* http://medical-dictionary.thefreedictionary.com/mercy+killing (defining "mercy killing" as euthanasia).

> Nothing in [this act] may be construed to authorize a physician or any other person to end a patient's life by . . . mercy killing, or active euthanasia.[40]

This prohibition is, however, defined away in the next sentence. SB 202 states:

> Actions taken in accordance with [this act] may not, for any purposes constitute . . . mercy killing [also known as "euthanasia"] . . . ."[41]

8. The term, "self-administer," allows someone else to administer the lethal dose to the patient.

SB 202 defines "self-administer" as the patient's "act of ingesting" the lethal dose.[42] SB 202 does not define "ingest." Dictionary definitions include:

> [T]*o take* (food, drugs, etc.*) into the body, as by swallowing, inhaling, or absorbing."* (Emphasis added).[43]

With these definitions, someone else putting the lethal dose in the patient's mouth qualifies as proper administration because the patient will thereby be "swallowing" the lethal dose, *i.e.*, "ingesting" it. Someone else placing a medication patch on the patient's arm will also qualify because the patient will thereby

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[40] SB 202, § 20. (Attached at A-12).

[41] *Id.*

[42] SB 202 §2(14), states: *"Self-administer" means a qualified patient's act of ingesting* medication to end the qualified patient's life . . ." (Emphasis added).

[43] Webster's New World College Dictionary, ingest. (Attached at A-44).

be "absorbing" the dose, *i.e.*, "ingesting" it. Gas administration, similarly, qualifies because the patient will thereby be "inhaling" the dose, *i.e.*, "ingesting" it. With self-administer defined as mere ingesting, someone else is allowed to administer the lethal dose to the patient.

Once again, the patient would not necessarily be in control of her fate.

9. If Montana follows Washington State, all deaths under SB 202 will be treated as "Natural," *i.e.*, no matter what the facts; There will be no recourse for patients or their families.

SB 202 states:

> Actions taken in accordance with [sections 1 through 20] may not for any purposes constitute suicide, assisted suicide, mercy killing, or homicide under the law.[44]

In Washington State, similar language in our law is interpreted to require the death certificate to reflect a natural death if our law is "used." The Washington State Department of Health, "Instructions for Medical Examiners, Coroners and Prosecutors: Compliance with the Death with Dignity Act," states:

> If you know that the decedent used the Death with Dignity Act, you must comply with the strict requirements of the law when completing the death record: . . .
>
> 2. The manner of death must be marked as

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[44] SB 202, §20.

"Natural."[45]

With the death required to be reported as "Natural" simply because the act was used, there appears to be no recourse for a patient and/or his family in the case of overreaching. In other words, the death must be certified as Natural even if there is a lack of compliance with the act.

If Montana adopts a similar interpretation based on SB 202's similar language, there will be a similar situation.

8. Individual "opt outs" are not allowed.

SB 202 says that a provision in a will or contract that affects whether a patient may make or rescind a lethal dose request "is not valid."[46]

So if you are a person who gets talked into things, and you don't want to get talked into suicide (or facilitating your own homicide), you are not allowed to make legal arrangements to try and prevent it.

So much for your personal "control."

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[45] Attached hereto at A-45.

[46] SB 202 § 13(1) states:

> A provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end the person's life in a humane and dignified manner, is not valid.

IV. PUBLIC SAFETY AND WELFARE.

A. Legalization will Create New Paths of Elder Abuse

Abuse of the elderly is often difficult to detect. This is due in part to the unwillingness of victims to report. An article on KULR8.com, states: "often time the victimizer is a family member and the elderly victim doesn't want to get them into trouble."[47]

In Montana, preventing elder abuse is official state policy.[48] If assisted suicide is legalized, new paths of abuse will be created against the elderly, which is contrary to that policy. Alex Schadenberg, chair for the Euthanasia Prevention Coalition, International, states:

> With assisted suicide laws in Washington and Oregon [and with SB 202], perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. . . . [E]ven if a patient struggled, "who would know?"[49]

B. Any Study Claiming that Oregon's Law is Safe, is Invalid.

In the 2011 legislative session, the lack of oversight over

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[47] Nicole Grigg,

[48] *See* the "Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act," 52-3-801, MCA; the Protective Services Act for Aged Persons or Disabled Adults, 52-3-201, MCA; and the "Montana Older Americans Act," 52-3-501, et. al., MCA.

[49] Alex Schadenberg, Letter to the Editor, *Elder abuse a growing problem, The Advocate*, October 2010, page 14, available at http://www.margaretdore.com/info/October_Letters.pdf

administration in Oregon's law prompted Senator Essmann to make this observation: the Oregon studies are invalid. He stated:

> [All] the protections end after the prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is [taken on a voluntary basis].
>
> So frankly, any of the studies that come out of the state of Oregon's experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.[50]

C. Legal Assisted Suicide Allows Health Care Providers and Insurers to Steer Patients to Suicide.

If SB 202 is passed, health care providers and insurers in Montana will be able to follow Oregon's lead to steer patients to suicide. Consider the case of Oregon resident, Barbara Wagner. In 2008, the Oregon Health Plan offered to cover her assisted suicide instead of a drug to possibly cure her cancer.

> "It was horrible," Wagner told ABCNews.com. "I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won't give you the medication to live."[51]

With the Oregon Health Plan's letter, Wagner was steered to

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[50] See link to hearing transcript for SB 167, February 10, 2011, http://www.margaretdore.com/pdf/senator_essmann_sb_167_001.pdf

[51] Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (Excerpt attached at A-66)

suicide. The drug's manufacturer subsequently agreed to provide the drug.[52] She nonetheless died a short time later.

To learn more about steerage to suicide in Oregon, *See*: the affidavit of Kenneth Stevens, MD (attached hereto at A-49 to A-58, describing how the Oregon Health Plan works).

D. Oregon's Annual Report for 2013 is Consistent with Financial Elder Abuse and the "Barbara Wagner" Scenario

According to Oregon's most recent annual assisted suicide report for 2013, most of the people who died from a lethal dose were white, aged 65 or older, and well-educated.[53] People with these attributes are typically well off, *i.e.*, the middle class and above.

The report implies that these deaths were voluntary, stating that Oregon's act "allows" residents to obtain a lethal dose.[54] There is nothing in the report, however, that actually says that the deaths were voluntary. Older well-off people are also in a vulnerable demographic for abuse and exploitation. This includes murder. A 2009 MetLife Mature Market Institute Study states:

> Elders' vulnerabilities and larger net worth make them a prime target for financial abuse . . . Victims may even be murdered by perpetrators who just want their funds and

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[52] "Letter noting assisted suicide raises questions," KATU TV, July 30, 2008. (Attached at A-68)

[53] Report, page 2, attached hereto at A-33.

[54] Id., page 1, attached hereto at A-32.

See them as an easy mark.[55]

The Oregon report, in which most of the people dying under the act were older and well-off, is consistent with financial elder abuse. The report, which also describes patients on Medicaid, is consistent with the "Barbara Wagner" scenario.

E. In Oregon, Other (Regular) Suicides Have Increased with Legalization of Physician-Assisted Suicide; the Financial Cost is "Enormous."

Government reports from Oregon show a positive statistical correlation between the legalization of physician-assisted suicide and an increase in other (regular) suicides. Of course, a statistical correlation does not prove causation. The statistical correlation is, however, consistent with a suicide contagion in which legalizing and normalizing assisted suicide has encouraged other suicides. Please consider the following:

> Oregon's assisted suicide act went into effect "in late 1997."[56]
>
> By 2000, Oregon's regular suicide rate was "increasing significantly."[57]
>
> By 2007, Oregon's regular suicide rate was

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[55] The MetLife Study can be viewed at this link: https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

[56] Oregon's assisted suicide report for 2013, attached at A-32.

[57] *See* Oregon Health Authority News Release, September 9, 2010, at http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached at A-70)

> 35% above the national average.[58]
>
> By 2010, Oregon's regular suicide rate was 41% above the national average.[59]

The financial cost of these other suicides is huge. The 2010 report, page 3, elaborates:

> The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.[60]

Oregon is the only state where there has been legalization of assisted suicide long enough to have statistics over time. The enormous cost of increased (regular) suicides in Oregon, positively correlated to physician-assisted suicide legalization, is a significant factor for this body to consider regarding SB 202, which seeks to legalize physician-assisted suicide in Montana.

Montana already has one of the highest suicide rates in the nation.[61] It is also a state priority to reduce this rate for persons "of all ages."[62] Steering residents to kill themselves is

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[58] Attached at A-72

[59] Attached at A-75.

[60] Attached at A-76.

[61] Cindy Uken, "State of Dispair: High-Country Crisis, Montana's suicide rate leads the nation," Billings Gazetter, November 25, 2012, http://billingsgazette.com/news/state-and-regional/montana/montana-s-suicide-rate-leads-the-nation/article_b7b6f110-3e5c-5425-b7f6-792cc666008d.html?print=true&cid=print

[62] 53-21-1101, MCA (regarding a required suicide reduction plan, which is to address reducing suicides by Montanans "of all ages").

contrary to this policy.

F. Legal Assisted Suicide can be Traumatic for Family Members as well as Patients.

1. The Swiss study.

In 2012, a study was released in Switzerland, addressing trauma suffered by persons who witnessed an assisted suicide.[63] The study found that 1 out of 5 family members or friends present at an assisted suicide were traumatized.[64] These persons:

> [E]xperienced full or sub-threshold PTSD [Post Traumatic Stress Disorder] related to the loss of a close person through assisted suicide.[65]

2. My cases involving the Oregon and Washington assisted suicide laws.

I have had two clients whose fathers signed up for the lethal dose.[66] In the first case, one side of the family wanted the father to take the lethal dose, while the other did not. The father spent the last months of his life caught in the middle and traumatized over whether or not he should kill himself. My

---

[63] "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," B. Wagner, J. Muller, A. Maercker; European Psychiatry 27 (2012) 542-546, available at http://choiceisanillusion.files.wordpress.com/2012/10/family-members-traumatized-eur-psych-2012.pdf (First page attached at A-77).

[64] Id.

[65] Id.

[66] Cf. Margaret Dore, "Preventing Abuse and Exploitation: A Personal Shift in Focus" (An article about elder abuse, guardianship abuse and assisted suicide), The Voice of Experience, ABA Senior Lawyers Division Newsletter, Vol. 25, No. 4, Winter 2014, available at http://www.americanbar.org/publications/voice_of_experience/2014/winter/preventing_abuse_and_exploitationa_personal_shift_focus.html

client, his adult daughter, was also traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it's not clear that administration of the lethal dose was voluntary. A man who was present told my client that his father refused to take the lethal dose when it was delivered ("You're not killing me. I'm going to bed"), but then he took it the next night when he was high on alcohol. The man who told this to my client later recanted. My client did not want to pursue the matter further.

G. SB 202 lacks transparency and accountability.

1. No annual reporting.

As noted previously, SB 202 eliminates annual reporting, which is a part of the Oregon and Washington acts.

2. Record keeping is private.

SB 202 provides that a doctor's compliance with its provisions be tracked in the patient's medical record, which is a private document protected by HIPPA.[67]

3. The death certificate is required to be falsified.

As noted previously, SB 202 states:

> Actions taken in accordance with [sections 1 through 20] may not for any purposes constitute suicide, assisted suicide, mercy killing, or homicide under the law.[68]

---

[67] *See* SB 202, § 12, attached at ~~A-10~~. A-8

[68] SB 202, §20 at A-12.

With this language, a death by assisted suicide cannot be truthfully reported. The death certificate is required to be falsified.

H. Pain is Not the Issue.

The current Oregon assisted suicide report for 2013 lists "concerns" as to why the people who ingested the lethal dose signed up to do so.[69] Per the report, there were 20 patients who had a concern about: "inadequate pain control."[70] This is 20 people out of 32,475 total deaths in Oregon.[71] Regardless, there was no claim that any one of these 20 patients was actually in pain.[72] Pain is not the issue.

V. CONCLUSION

SB 202's promise of patient control is an illusion. SB SB 202 is instead a recipe for elder abuse, especially for those with money. The most obvious gap is the lack of witnesses at the death. Even if the patient struggled, who would know?

Don't make Washington's mistake. I urge you to reject SB 202.

---

69 Oregon Report, page 6, attached hereto at A-37.

70 Id.

71 Report, p.2, at A-33, fn 1 (total Oregon deaths in 2012 was 32,475)

72 *See* entire Oregon report at A-32 et seq.

Respectfully submitted February 10, 2015

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SENATE BILL NO. 202

INTRODUCED BY DICK BARRETT

A BILL FOR AN ACT ENTITLED: "AN ACT ALLOWING A TERMINALLY ILL PATIENT TO REQUEST MEDICATION TO END THE PATIENT'S LIFE; ESTABLISHING PROCEDURES; PROVIDING THE RIGHT TO RESCIND THE REQUEST; PROVIDING DEFINITIONS; PROVIDING IMMUNITY FOR PERSONS PARTICIPATING IN GOOD FAITH COMPLIANCE WITH THE PROCEDURES; PROVIDING RULEMAKING AUTHORITY; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Short title.** [Sections 1 through 20] may be cited as the "Montana Death With Dignity Act".

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 20], the following definitions apply:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of a patient and treatment of the patient's terminal illness.

(3) "Competent" means that, in the opinion of a court or in the opinion of a patient's attending physician, consulting physician, psychiatrist, or psychologist, the patient has the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the patient's manner of communicating if that person is available.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's illness.

(5) "Counseling" means one or more consultations as necessary between a patient and a psychiatrist or psychologist licensed in this state for the purpose of determining that the patient is competent and is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Department" means the department of public health and human services provided for in 2-15-2201.

(7) (a) "Health care provider" or "provider" means a person licensed, certified, or otherwise authorized

or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession.

(b) The term includes a health care facility as defined in 50-5-101.

(8) "Informed decision" means a decision by a patient to request and obtain a prescription for medication that the patient may self-administer to end the patient's life that is based on an understanding and acknowledgment of the relevant facts and that is made after being fully informed by the attending physician of:

(a) the patient's medical diagnosis and prognosis;

(b) the potential risks associated with taking the medication to be prescribed;

(c) the probable result of taking the medication to be prescribed; and

(d) the feasible alternatives or additional treatment opportunities, including but not limited to comfort care, hospice care, and pain control.

(9) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(10) "Patient" means a person who is under the care of a physician.

(11) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this state.

(12) "Qualified patient" means a competent adult who is a resident of Montana and has satisfied the requirements of [sections 1 through 20] in order to obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life.

(13) "Resident" means an individual who demonstrates residency in Montana by means that include but are not limited to:

(a) possession of a Montana driver's license;

(b) proof of registration to vote in Montana;

(c) proof that the individual owns or leases real property in Montana; or

(d) filing of a Montana tax return for the most recent tax year.

(14) "Self-administer" means a qualified patient's act of ingesting medication to end the qualified patient's life in a humane and dignified manner.

(15) "Terminal illness" means an incurable and irreversible illness that has been medically confirmed and will, within reasonable medical judgment, result in death within 6 months.

NEW SECTION. **Section 3. Right to request medication to end life.** (1) A patient may make a written

1 request for medication to be self-administered to end the patient's life if the patient:
2 (a) is a competent adult;
3 (b) is a resident of this state;
4 (c) has been determined by the patient's attending physician and, except as provided in [section 7], by
5 a consulting physician to be suffering from a terminal illness; and
6 (d) has voluntarily expressed the wish to receive medication to end the patient's life in a humane and
7 dignified manner.
8 (2) A person does not qualify under the provisions of [sections 1 through 20] solely because of age or
9 disability.
10
11 NEW SECTION. **Section 4. Request process -- witness requirements.** (1) A patient wishing to
12 receive a prescription for medication to end the patient's life shall submit an oral request and a written request
13 to the patient's attending physician.
14 (2) A valid written request for medication under [sections 1 through 20] must be:
15 (a) in substantially the form described in [section 11];
16 (b) signed and dated by the patient; and
17 (c) witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their
18 knowledge and belief the patient is:
19 (i) competent;
20 (ii) acting voluntarily; and
21 (iii) not being coerced to sign the request.
22 (3) One of the witnesses must be an individual who is not:
23 (a) related to the patient by blood, marriage, or adoption;
24 (b) at the time the request is signed, entitled to any portion of the patient's estate upon death of the
25 qualified patient under a will or any operation of law; or
26 (c) an owner, operator, or employee of a health care facility where the patient is receiving medical
27 treatment or where the patient resides.
28 (4) The patient's attending physician may not be a witness to the signing of the written request.
29 (5) If the patient is a patient in a long-term care facility, as defined in 50-5-1103, at the time the written
30 request is made, one of the witnesses must be an individual designated by the facility and who meets

1 qualifications established by the department by rule.
2
3 NEW SECTION. **Section 5. Right to rescind request -- requirement to offer opportunity to rescind.**
4 (1) A qualified patient may at any time rescind the qualified patient's request for medication to end the qualified
5 patient's life without regard to the qualified patient's mental state.
6 (2) A prescription for medication under [sections 1 through 20] may not be written without the attending
7 physician offering the patient an opportunity to rescind the request for medication.
8
9 NEW SECTION. **Section 6. Attending physician responsibilities.** (1) The attending physician shall:
10 (a) make the initial determination of whether an adult patient:
11 (i) is a resident of this state;
12 (ii) has a terminal illness;
13 (iii) is competent; and
14 (iv) has voluntarily made the request for medication pursuant to [sections 3 and 4];
15 (b) ensure that the patient is making an informed decision by discussing with the patient:
16 (i) the patient's medical diagnosis and prognosis;
17 (ii) the potential risks associated with taking the medication to be prescribed;
18 (iii) the probable result of taking the medication to be prescribed; and
19 (iv) the feasible alternatives or additional treatment opportunities, including but not limited to comfort care,
20 hospice care, and pain control;
21 (c) except as provided in [section 7], refer the patient to a consulting physician to medically confirm the
22 diagnosis and prognosis and for a determination that the patient is competent and acting voluntarily;
23 (d) if appropriate, refer the patient for counseling pursuant to [section 8];
24 (e) ensure that the patient's request does not arise from coercion or undue influence by another person;
25 (f) recommend that the patient notify the patient's next of kin;
26 (g) counsel the patient about the importance of:
27 (i) having another person present when the patient takes the medication prescribed pursuant to [sections
28 1 through 20]; and
29 (ii) not taking the medication in a public place;
30 (h) inform the patient that the patient may rescind the request for medication at any time and in any

manner;

(i) offer the patient an opportunity to rescind the request for medication before prescribing the medication;

(j) verify, immediately prior to writing the prescription for medication, that the patient is making an informed decision;

(k) fulfill the medical record documentation requirements of [section 12];

(l) ensure that all appropriate steps are carried out in accordance with [sections 1 through 20] before writing a prescription for medication to enable a qualified patient to end the qualified patient's life in a humane and dignified manner; and

(m) (i) dispense medications directly, including ancillary medication intended to minimize the qualified patient's discomfort, if the attending physician:

(A) is registered as a dispensing physician with the board of medical examiners provided for in 2-15-1731;

(B) has a current drug enforcement administration certificate; and

(C) complies with any applicable administrative rule; or

(ii) with the qualified patient's written consent, contact a pharmacist, inform the pharmacist of the prescription, and deliver the written prescription personally or by mail to the pharmacist, who shall dispense the medications to either the qualified patient, the attending physician, or a person expressly designated by the qualified patient.

(2) Unless otherwise prohibited by law, the attending physician may sign the qualified patient's death certificate.

NEW SECTION. **Section 7. Consulting physician confirmation -- waiver.** (1) Before a patient may be considered a qualified patient under [sections 1 through 20], a consulting physician shall:

(a) examine the patient and the patient's relevant medical records;

(b) confirm in writing the attending physician's diagnosis that the patient is suffering from a terminal illness; and

(c) verify that the patient:

(i) is competent;

(ii) is acting voluntarily; and

(iii) has made an informed decision.

1 (2) (a) The requirements of this section do not apply if in the attending physician's opinion the
2 requirements would result in an undue hardship for the patient because:
3 (i) the patient's terminal illness is sufficiently advanced that confirmation of the illness is not necessary;
4 or
5 (ii) an appointment with a consulting physician cannot be made within a reasonable amount of time or
6 with a physician who is within a reasonable distance of the patient's residence.
7 (b) An attending physician who waives the requirement for a confirmation by a consulting physician shall
8 document the reasons for the waiver in the medical documentation required pursuant to [section 12].
9
10 NEW SECTION. **Section 8. Counseling referral.** (1) An attending physician or a consulting physician
11 shall refer a patient who has requested medication under [sections 1 through 20] for counseling if in the opinion
12 of the attending physician or the consulting physician the patient may be suffering from a psychiatric or
13 psychological disorder or depression causing impaired judgment.
14 (2) Medication to end a patient's life in a humane and dignified manner may not be prescribed until the
15 person performing the counseling determines that the patient is not suffering from a psychiatric or psychological
16 disorder or depression causing impaired judgment.
17
18 NEW SECTION. **Section 9. Informed decision required.** A patient may not receive a prescription for
19 medication to end the person's life unless the patient has made an informed decision. Immediately before writing
20 a prescription for medication under [sections 1 through 20], the attending physician shall verify that the patient
21 is making an informed decision.
22
23 NEW SECTION. **Section 10. Family notification recommended -- not required.** The attending
24 physician shall recommend that a patient notify the patient's next of kin of the patient's request for medication
25 pursuant to [sections 1 through 20]. A request for medication under [sections 1 through 20] may not be denied
26 because a patient declines or is unable to notify the next of kin.
27
28 NEW SECTION. **Section 11. Form of request.** A request for medication as authorized by [sections 1
29 through 20] must be in substantially the following form:
30 REQUEST FOR MEDICATION TO END MY LIFE

IN A HUMANE AND DIGNIFIED MANNER

I,....., am an adult of sound mind.

I am suffering from ....., which my attending physician has determined is a terminal illness and which has been medically confirmed by a consulting physician, unless my attending physician has waived the confirmation requirement as provided in [section 7].

I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment opportunities, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner and authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

.....I have informed my family of my decision and taken their opinions into consideration.

.....I have decided not to inform my family of my decision.

.....I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request, and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within 3 hours, my death may take longer, and my attending physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed:.....

Dated:.....

DECLARATION OF WITNESSES

We declare that the person signing this request:

(1) is personally known to us or has provided proof of identity;

(2) signed this request in our presence;

(3) appears to be of sound mind and not under duress, fraud, or undue influence; and

(4) is not a patient for whom either of us is the attending physician.

.....Witness 1/Date

.....Witness 2/Date

1 NOTE: One witness may not be a relative (by blood, marriage, or adoption) of the person signing this
2 request, may not be entitled to any portion of the person's estate upon death, and may not own, operate, or be
3 employed at a health care facility where the person is a patient or where the person resides. If the patient is an
4 inpatient at a health care facility, one of the witnesses must be an individual designated by the facility.
5
6 NEW SECTION. **Section 12. Medical record documentation requirements.** The following items must
7 be documented or filed in the patient's medical record:
8 (1) the determination and the basis for determining that a patient requesting medication to end the
9 patient's life in a humane and dignified manner is a qualified patient;
10 (2) all oral requests by a patient for medication made pursuant to [section 4] to end the patient's life in
11 a humane and dignified manner;
12 (3) all written requests by a patient for medication made pursuant to [sections 3 and 4] to end the
13 patient's life in a humane and dignified manner;
14 (4) the attending physician's diagnosis, prognosis, and determination that the patient is competent, is
15 acting voluntarily, and has made an informed decision;
16 (5) unless waived as provided in [section 7], the consulting physician's diagnosis, prognosis, and
17 verification that the patient is competent, is acting voluntarily, and has made an informed decision;
18 (6) the reasons for waiver of confirmation by a consulting physician, if a waiver was made;
19 (7) a report of the outcome and determinations made during counseling, if performed;
20 (8) the attending physician's offer before prescribing the medication to allow the patient to rescind the
21 patient's request for the medication; and
22 (9) a note by the attending physician indicating:
23 (a) that all requirements under [sections 1 through 20] have been met; and
24 (b) the steps taken to carry out the request, including a notation of the medication prescribed.
25
26 NEW SECTION. **Section 13. Effect of contracts, wills, and agreements.** (1) A provision in a contract,
27 will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may
28 make or rescind a request for medication to end the person's life in a humane and dignified manner is not valid.
29 (2) An obligation owing under any currently existing contract may not be conditioned or affected by a
30 person making or rescinding a request for medication to end the person's life in a humane and dignified manner.

1

2 NEW SECTION. **Section 14. Insurance or annuity policies.** (1) The sale, procurement, or issuance
3 of a life, health, or accident insurance or annuity policy or the rate charged for a policy may not be conditioned
4 on or affected by a person making or rescinding a request for medication to end the person's life in a humane and
5 dignified manner.

6 (2) A qualified patient's act of ingesting medication to end the qualified patient's life in a humane and
7 dignified manner may not have an effect on a life, health, or accident insurance or annuity policy.

8

9 NEW SECTION. **Section 15. Immunities -- prohibitions on certain health care providers --**
10 **notification -- permissible sanctions.** (1) (a) A person is not subject to civil or criminal liability or professional
11 disciplinary action for participating in good faith compliance with [sections 1 through 20], including an individual
12 who is present when a qualified patient takes the prescribed medication to end the qualified patient's life in a
13 humane and dignified manner.

14 (b) The civil immunity provisions of this subsection (1) do not apply to a person employed by or an entity
15 operated by the state or a political subdivision of the state.

16 (2) A health care provider or professional organization or association may not subject an individual to
17 censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for
18 participating or refusing to participate in good faith compliance with [sections 1 through 20].

19 (3) A request by a patient for or provision by an attending physician of medication in good faith
20 compliance with the provisions of [sections 1 through 20] does not constitute neglect for any purpose of law or
21 provide the sole basis for the appointment of a guardian or conservator.

22 (4) (a) A health care provider may choose whether to participate in providing to a qualified patient any
23 medication to end the patient's life in a humane and dignified manner and is not under any duty, whether by
24 contract, by statute, or by any other legal requirement, to participate in providing a qualified patient with the
25 medication.

26 (b) If a health care provider is unable or unwilling to carry out a patient's request under [sections 1
27 through 20] and the patient transfers care to a new health care provider, the prior health care provider shall
28 transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

29 (5) (a) Unless otherwise required by law, a health care provider may prohibit another health care provider
30 from participating in activities under [sections 1 through 20] on the premises of the prohibiting provider if the

1 prohibiting provider has notified the health care provider in writing of the prohibiting provider's policy against
2 participating in activities under [sections 1 through 20]. Nothing in this subsection (5) prevents a health care
3 provider from providing a patient with health care services that do not constitute participation in activities under
4 [sections 1 through 20].
5 (b) Notwithstanding the provisions of subsections (1) through (4), a health care provider may subject
6 another health care provider to the following sanctions if the sanctioning health care provider has notified the
7 sanctioned provider prior to participation in activities under [sections 1 through 20] that the sanctioning provider
8 prohibits participation in activities under [sections 1 through 20]:
9 (i) loss of privileges, loss of membership, or any other sanction provided pursuant to the medical staff
10 bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned provider is a member
11 of the sanctioning provider's medical staff and is participating in activities under [sections 1 through 20] while on
12 the health care facility premises of the sanctioning health care provider, but not including the private medical
13 office of a physician or other provider;
14 (ii) termination of a lease or other property contract or other nonmonetary remedies provided by a lease
15 contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the
16 sanctioned provider participates in activities under [sections 1 through 20] while on the premises of the
17 sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning
18 health care provider; or
19 (iii) termination of a contract or other nonmonetary remedies provided by a contract if the sanctioned
20 provider participates in activities under [sections 1 through 20] while acting in the course and scope of the
21 sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider.
22 (c) The provisions of subsection (5)(b) may not be construed to prevent:
23 (i) a health care provider from participating in activities under [sections 1 through 20] while acting outside
24 the course and scope of the provider's capacity as an employee or independent contractor; or
25 (ii) a patient from contracting with the patient's attending physician and consulting physician to act
26 outside the course and scope of the provider's capacity as an employee or independent contractor of the
27 sanctioning health care provider.
28 (d) A health care provider that imposes sanctions pursuant to subsection (5)(b) shall follow all due
29 process and other established procedures of the sanctioning health care provider that are related to the
30 imposition of sanctions on any other health care provider.

(6) For purposes of this section, "participating in activities under [sections 1 through 20]" means to perform:

(a) the duties of an attending physician pursuant to [section 6];

(b) the duties of a consulting physician pursuant to [section 7]; or

(c) the counseling function pursuant to [section 8].

(7) Suspension or termination of staff membership or privileges under subsection (5) is not reportable to a licensing board provided for in Title 37. Action taken pursuant to [section 4, 6, 7, or 8] may not be the sole basis for a report of unprofessional conduct under 37-1-308.

(8) A provision of [sections 1 through 20] may not be construed to allow a lower standard of care for patients in the community where the patient is treated or in a similar community.

NEW SECTION. **Section 16. Nonsanctionable activities.** A health care provider may not be sanctioned under [section 15] for:

(1) making an initial determination that a patient has a terminal illness and informing the patient of the medical prognosis;

(2) providing information about the Montana Death With Dignity Act to a patient upon the request of the patient;

(3) providing a patient, upon the request of the patient, with a referral to another physician; or

(4) contracting with a patient to act outside the course and scope of the provider's capacity as an employee or independent contractor of a health care provider that prohibits activities under [sections 1 through 20].

NEW SECTION. **Section 17. Liabilities.** (1) Purposely or knowingly altering or forging a request for medication to end a patient's life without the authorization of the patient or concealing or destroying a rescission of a request for medication is punishable as a felony if the act is done with the intent or effect of causing the patient's death.

(2) Purposely or knowingly coercing or exerting undue influence on a patient to request medication for the purpose of ending the patient's life or to destroy a rescission of a request is punishable as a felony.

(3) Nothing in [sections 1 through 20] limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in [sections 1 through 20] do not preclude criminal penalties applicable under other law for conduct inconsistent with the provisions of [sections 1 through 20].

(5) For purposes of this section, "purposely" and "knowingly" have the meaning provided in 45-2-101.

NEW SECTION. **Section 18. Penalties.** (1) It is a felony for a person without the authorization of the patient to purposely or knowingly alter, forge, conceal, or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the patient's desires and interests with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration that hastens the death of the patient.

(2) Except as provided in subsection (1), it is a misdemeanor for a person without authorization of the patient to purposely or knowingly alter, forge, conceal, or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the patient's desires and interests with the intent or effect of affecting a health care decision.

(3) For purposes of this section, "purposely" and "knowingly" have the meaning provided in 45-2-101.

NEW SECTION. **Section 19. Claims by governmental entity for costs incurred**. A governmental entity that incurs costs resulting from a qualified patient terminating the qualified patient's life in a public place while acting pursuant to [sections 1 through 20] may submit a claim against the estate of the person to recover costs and reasonable attorney fees related to enforcing the claim.

NEW SECTION. **Section 20. Construction.** Nothing in [sections 1 through 20] may be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with [sections 1 through 20] may not for any purposes constitute suicide, assisted suicide, mercy killing, or homicide under the law.

NEW SECTION. **Section 21. Codification instruction.** [Sections 1 through 20] are intended to be codified as an integral part of Title 50, and the provisions of Title 50 apply to [sections 1 through 20].

NEW SECTION. **Section 22. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications,

1 the part remains in effect in all valid applications that are severable from the invalid applications.

2

3 NEW SECTION. **Section 23. Effective date.** [This act] is effective on passage and approval.

4 - END -

COMPASSION & CHOICES
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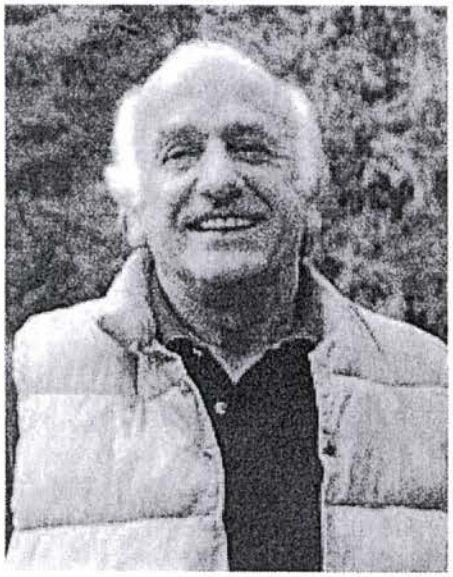
Derek Humphry to be Keynote Speaker at 2011 Annual Meeting



This year our keynote speaker will be Derek Humphry, the author of *Final Exit* and the founder of the Hemlock Society USA in 1980. Derek is generally considered to be the father of the modern movement for choice at the end of life in America.

Save the Date!
Sat., October 22, 2011, 1-3 p.m.
University Unitarian Church
6556 35th Ave NE
Seattle, WA 98115-7393

Derek is a British journalist and author who has lived in the United States since 1978, the same year he published the book *Jean's Way* describing his first wife's final years of suffering from cancer and his part in helping her to die peacefully. The public response to the book caused him to start the Hemlock Society USA in 1980 from his garage in Santa Monica. Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion In Dying to become Compassion & Choices.

In 1991 he published *Final Exit*. Much to his surprise, it became the national #1 bestseller within six months. Since then it has been translated into 12 languages and is now in its fourth edition.

Although not affiliated with – and sometimes even at odds with – Compassion & Choices, Derek is still actively involved in the movement. Always interesting and sometimes controversial, Derek will provide our supporters and their guests with his perspective about the evolution of the movement for choice at the end of life in America.

Advertisement

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SUICIDE KITS SELL DEATH BY MAIL

Legislation is being prepared to outlaw sale of helium hoods

By Randi Bjornstad

The Register-Guard

Appeared in print: Sunday, March 20, 2011, page A1

His mind was keen, his grin infectious. His passions were politics and sports. He read voraciously. His humor was prankish, his wit razor-sharp.

Born and raised in Eugene, he adored his parents and four brothers. He graduated from South Eugene High School and the University of Michigan.

For years, he struggled through bouts of pain and fatigue that defied medical diagnosis and left him depressed about his inability to carry on normal daily activities and fearful that he would never regain normal health.

He had dreams, ambitions, accomplishments and, say many who knew him, vast potential.

But three months ago, in the throes of a flu that upended a period of relatively good health, Nick Klonoski took his own life.

He had just turned 29.

Klonoski did not use any of the commonly known methods of suicide. Instead, he employed a "helium hood kit" that he ordered by mail from a two-person company in Southern California.

The small, white box, measuring 10 by 7 by 3 inches and decorated with a butterfly, holds a brown paper packet, its edges zigzagged with pinking shears and stitched shut on a sewing machine. Inside the packet is a clear plastic bag with an elasticized band sewn to the open end, to slip over the head and fit snugly around the neck. The box also contains clear plastic tubing, for hooking up tanks of lethal helium gas.

Manufactured and sold by The Gladd Group, the helium hood kit has no other use than to assist a person contemplating suicide. It costs $60, payable only by cash or check. According to Manta, an online business networking site where small-business owners can share information, The Gladd Group has two employees and estimated annual sales of $98,000 — equal to the price of 1,633 kits.

Selling a "suicide kit" — coupled with detailed instructions from another right-to-suicide organization on where to buy it and how to use it — raises complex legal, ethical and emotional questions about what constitutes helping another person to take his or her own life. Assisting another person's suicide violates the law in most states, including Oregon. But definitions of aiding, promoting, encouraging or assisting are not legally precise.

No one to date has been prosecuted for selling a helium hood kit in the United States. Many police agencies, medical examiners, district attorneys and legislators know little or nothing about the kits, although now that he is aware of them, state Sen. Floyd Prozanski, D-Eugene, says he's drafting a bill to outlaw their sale.

The right-to-suicide movement argues that disseminating how-to information about suicide and selling the kits that facilitate the act are protected by the free speech clause of the First Amendment in the U.S. Constitution.

On the afternoon he died, Klonoski drove to a party goods store not far from his family's Eugene home. A store receipt police found in his room shows that at 2:16 p.m., he signed for rental of a large tank of helium. Returning home, with the rest of his family out of the house for the afternoon — all five brothers had gathered at the family home for the holidays — he followed the instructions for using the helium hood kit as detailed in "Final Exit," a book written by longtime pro-suicide activist and longtime Lane County resident, Derek Humphry. He died in his bedroom before his family returned.

Jake Klonoski, at 30 the oldest of the Klonoski brothers, found his next-younger brother's body after Nick didn't respond to attempts to call him to dinner.

"I know Nick was vulnerable because of the health issues he had been dealing with for years, but he wasn't terminally ill, and he seemed to have been getting better until the flu thing happened," Jake Klonoski said. "He had family and many friends to help him through the bad times and then enjoy the good times with him. Now I know there also are people out there ready to persuade people like Nick to give up."

Nearly 1,000 people, including a former governor and a busload of colleagues from one of his many political projects, packed Temple Beth Israel's huge sanctuary — the only place large enough to accommodate the crowd on a cold sunny afternoon in early January — to honor Nick Klonoski's life. Although the family is

not Jewish, his brothers wore yarmulkes, bright yellow imprinted with the blue emblem of the University of Michigan, in his honor. Speakers laughed and cried as they chronicled his intellectual brilliance and mischievous nature, and mourned the loss of his immense possibilities.

Overwhelmed by his death, his mother, U.S. District Court Judge Ann Aiken, declines to speak publicly about it. His father, retired University of Oregon political science professor James Klonoski, died two years ago. But two of his brothers, Jake and Zach Klonoski, are determined to speak out, to stop what they consider illegal and immoral assisted suicide.

"The company that sells this kit obviously is purposely targeting a vulnerable group," said Jake Klononski, a law student at Stanford University. "They made money off my brother, they gave him the tools to take his own life without knowing him, without knowing anything about him. For $60, they blew his life apart. It breaks my heart."

When it comes to promoting an American's right to die by suicide, all roads lead to Derek Humphry. He describes himself in an online autobiography as "a journalist and author who has spent the last 30 years campaigning for lawful physician-assisted dying to be an option for the terminally and hopelessly ill."

His first book, "Jean's Way," tells of his first wife's suicide in 1975 — with his assistance, by his acknowledgement — when she was terminally ill with bone cancer. In 1980, he founded the Hemlock Society to help change laws prohibiting assisted suicide as well as share information about suicide methods.

More books followed. The royalties allowed the organization to provide substantial financial backing to initiative campaigns in favor of physician-assisted suicide — unsuccessful in California and Washington and successful in Oregon — in the late 1980s and early '90s. Since then, Washington and Montana voters have joined Oregon in allowing physician-assisted suicide.

In February 1991, Humphry published "Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying," his best-known book.

"It sold 500,000 copies in its first six weeks — I was staggered," Humphry said in a recent telephone interview. "It has been translated into 12 languages, and it has sold well over a million copies. It doesn't sell hugely now, but it is consistent. It has made me a living, and it has funded my organizations considerably."

In 1992, "temporarily burned out," British-born Humphry abandoned the Hemlock Society, but the next year he formed a new organization, ERGO — Euthanasia Research & Guidance Organization — to continue his quest. His goal expanded to making assisted suicide legal not only to the terminally or "hopelessly" ill, as he puts it, but to anyone who seeks it, except "the mentally disturbed, including the depressed, (or) for the disabled or the handicapped."

Humphry also formed NuTech — New Technology for Self-Deliverance Group — to find new ways to help "adults who do not qualify under (assisted suicide) law but their illness still justifies, to them, bringing life to an end." The group's mission, Humphry wrote, was "to explore methods of hastened death that dying persons could use to 'self-deliver' without breaking the law or with help from a physician."

The helium hood kit emerged as the group's "chief success," Humphry wrote, allowing "a peaceful, quick death in minutes."

The third edition of "Final Exit," and an addendum published in 2009, provide detailed instructions on how to use the helium hood kit for "self-deliverance," including how to rent helium tanks without exciting suspicion. Humphry also has made a DVD of the process, in which he demonstrates use of the kit. He makes

Opinion 2.211 - Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient tc perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandone once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

Issued June 1994 based on the reports "Decisions Near the End of Life ," adopted June 1991, and "Physician-Assisted Suicide ," adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.

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Opinion 2.21 - Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respec for patient autonomy, and good communication. (I, IV)

Issued June 1994 based on the report "Decisions Near the End of Life," adopted June 1991 (JAMA. 1992; 267: 2229-2233); Updated June 1996

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Terminal Uncertainty

Washington's new "Death With Dignity" law allows doctors to help people commit suicide—once they've determined that the patient has only six months to live. But what if they're wrong?

By Nina Shapiro
published: January 14, 2009

Nina Shapiro

Maryanne Clayton with her son, Eric, in the Fred Hutch waiting room: "I just kept going."

Details:

— Study: Why Now? Timing and Circumstances of Hastened Deaths

— Dilemmas by caretakers and other Oregon studies

— Stats on people who have used Oregon's Death with Dignity law.

— Harvard professor Nicholas Christakis looking at the accuracy of prognosis.

— JAMA study examining the accuracy of prognosis.

UPDATE: "It Felt Like the Big One"

She noticed the back pain first. Driving to the grocery store, Maryanne Clayton would have to pull over to the side of the road in tears. Then 62, a retired computer technician, she went to see a doctor in the Tri-Cities, where she lived. The diagnosis was grim. She already had Stage IV lung cancer, the most advanced form there is. Her tumor had metastasized up her spine. The doctor gave Clayton two to four months to live.

That was almost four years ago.

Prodded by a son who lives in Seattle, Clayton sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center. Too weak to endure the toxicity of chemotherapy, she started with radiation, which at first made her even weaker but eventually built her strength. Given dodgy prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called pemetrexate.

Her response was remarkable. The tumors shrunk, and although they eventually grew back, they shrunk again when she enrolled in a second clinical trial. (Pemetrexate has since been approved by the FDA for initial treatment in lung cancer cases.) She now comes to the Hutch every three weeks to see Martins, get CT scans, and undergo her drug regimen. The prognosis she was given has proved to be "quite wrong."

"I just kept going and going," says Clayton. "You kind of don't notice how long it's been." She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. "I had to have cancer to have nice hair," she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip to

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Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

"We almost lost her because she was having too much fun, not from cancer," Martins chuckles.

Her experience underscores the difficulty doctors have in forecasting how long patients have to live—a difficulty that is about to become even more pertinent as the Washington Death With Dignity Act takes effect March 4. The law, passed by initiative last November and modeled closely on a 14-year-old law in Oregon, makes Washington the only other state in the country to allow terminally ill patients to obtain lethal medication. As in Oregon, the law is tightly linked to a prognosis: Two doctors must say a patient has six months or less to live before such medication can be prescribed.

The law has deeply divided doctors, with some loath to help patients end their lives and others asserting it's the most humane thing to do. But there's one thing many on both sides can agree on. Dr. Stuart Farber, head of palliative care at the University of Washington Medical Center, puts it this way: "Our ability to predict what will happen to you in the next six months sucks."

In one sense, six months is an arbitrary figure. "Why not four months? Why not eight months?" asks Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, adding that medical literature does not define the term "terminally ill." The federal Medicare program, however, has determined that it will pay for hospice care for patients with a prognosis of six months or less. "That's why we chose six months," explains George Eighmey, executive director of Compassion & Choices of Oregon, the group that led the advocacy for the nation's first physician-assisted suicide law. He points out that doctors are already used to making that determination.

To do so, doctors fill out a detailed checklist derived from Medicare guidelines that are intended to ensure that patients truly are at death's door, and that the federal government won't be shelling out for hospice care indefinitely. The checklist covers a patient's ability to speak, walk, and smile, in addition to technical criteria specific to a person's medical condition, such as distant metastases in the case of cancer or a "CD4 count" of less than 25 cells in the case of AIDS.

No such detailed checklist is likely to be required for patients looking to end their lives in Washington, however. The state Department of Health, currently drafting regulations to comply with the new law, has released a preliminary version of the form that will go to doctors. Virtually identical to the one used in Oregon, it simply asks doctors to check a box indicating they have determined that "the patient has six months or less to live" without any additional questions about how that determination was made.

Even when applying the rigid criteria for hospice eligibility, doctors often get it wrong, according to Nicholas Christakis, a professor of medicine and sociology at Harvard University and a pioneer in research on this subject. As a child, his mother was diagnosed with Hodgkin's disease. "When I was six, she was given a 10 percent chance of living beyond three weeks," he writes in his 2000 book, *Death Foretold: Prophecy and Prognosis in Medical Care*. "She lived for nineteen remarkable years...I spent my boyhood always fearing that her lifelong chemotherapy would stop working, constantly wondering whether my mother would live or die, and both craving and detesting prognostic precision."

Sadly, Christakis' research has shown that his mother was an exception. In 2000, Christakis published a study in the *British Medical Journal* that followed 500 patients admitted to hospice programs in Chicago. He found that only 20 percent of the patients died approximately when their doctors had predicted. Unfortunately, most died *sooner*. "By and large, the physicians were overly optimistic," says Christakis.

In the world of hospice care, this finding is disturbing because it indicates that many patients aren't being referred early enough to take full advantage of services that might ease their final months. "That's what has frustrated hospices for decades," says Wayne McCormick, medical director of Providence Hospice of Seattle, explaining that hospice staff frequently don't get enough time with patients to do their best work.

Death With Dignity advocates, however, point to this finding to allay concerns that people might be killing themselves too soon based on an erroneous six-month prognosis. "Of course, there is the occasional person who outlives his or her prognosis," says Robb Miller, executive director of Compassion & Choices of Washington. Actually, 17 percent of patients did so in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13 percent of hospice patients around the country outlived their six-month prognoses.

It's not that prognostication is completely lacking in a scientific basis. There is a reason that you can pick up a textbook and find a life expectancy associated with most medical conditions: Studies have followed *populations* of people with these conditions. It's a statistical average. To be precise, it's a median, explains Martins. "That means 50 percent will do worse and 50 percent will do better."

Doctors also shade their prognoses according to their own biases and desires. Christakis' study found that the longer a doctor knew a patient, the more likely their prognosis was inaccurate, suggesting that doctors who get attached to their patients are reluctant to talk of their imminent demise. What's more, Christakis says, doctors see death "as a mark of failure."

Oncologists in particular tend to adopt a cheerleading attitude "right up to the end," says Brian Wicks, an orthopedic surgeon and past president of the Washington State Medical Association. Rather than talk about death, he says, their attitude is "Hey, one more round of chemo!"

But it is also true that one more round of chemo, or new drugs like the one that helped Clayton, or sometimes even just leaving patients alone, can help them in ways that are impossible to predict. J. Randall Curtis, a pulmonary disease specialist and director of an end-of-life research program at Harborview Medical Center, recalls treating an older man with severe emphysema a couple of years ago. "I didn't think I could get him off life support," Curtis says. The man was on a ventilator. Every day Randall tested whether the patient could breathe on his own, and every day the patient failed the test. He had previously made it clear that he did not want to be kept alive by machines, according to Curtis, and so the doctor and the man's family made the wrenching decision to pull the plug.

But instead of dying as expected, the man slowly began to get better. Curtis doesn't know exactly why, but guesses that for that patient, "being off the ventilator was probably better than being on it. He was more comfortable, less stressed." Curtis says the man lived for at least a year afterwards.

Curtis also once kept a patient on life support against his better judgment because her family insisted. "I thought she would live days to weeks," he says of the woman, who was suffering from septic shock and multiple organ failure. Instead she improved enough to eventually leave the hospital and come back for a visit some six or eight months later.

"It was humbling," he says. "It was not amazing. That's the kind of thing in medicine that happens frequently."

Every morning when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.

"There's always a little triumph," Bud chimes in. "I made it for another day."

It's been like this for years. A decade ago, after clearing a jungle of blackberries off a lot he had bought adjacent to his secluded ranch house south of Tacoma, Bud came down with a case of pneumonia. "Well, no wonder he's so sick," Heidi recalls the chief of medicine saying at the hospital where he was brought. "He's in congestive heart failure."

Then 75, "he became old almost overnight," Heidi says. Still, Bud was put on medications that kept him going—long enough to have a stroke five years later, kidney failure the year after that, and then the onset of severe chest pain known as angina. "It was scary," says Heidi, who found herself struggling at 3 a.m. to find Bud's veins so she could inject the morphine that the doctor had given Bud for the pain. Heidi is a petite blond nurse with a raucous laugh. She's 20 years younger than her husband, whom she met at a military hospital, and shares his cigar-smoking habit. Bud was a high-flying psychiatrist in the '80s when he became the U.S. Assistant Secretary of Defense, responsible for all Armed Forces health activities.

After his onslaught of illnesses, Bud says, his own prognosis for himself was grim. "Looking at a patient who had what I had, I would have been absolutely convinced that my chance of surviving more than a few months was very slim indeed."

Bud's doctor eventually agreed, referring him to hospice with a prognosis of six months. That was a year and a half ago. Bud, who receives visits from hospice staff at home, has since not gotten much worse or much better. Although he has trouble walking and freely speaks of himself as "dying," he looks like any elderly grandfather, sitting in a living room decorated with mounted animal heads, stuffing tobacco into his pipe and chatting about his renewed love of nature and the letter he plans to write to Barack Obama with his ideas for improving medical care. Despite his ill health, he says the past few years have been a wonderful, peaceful period for him—one that physician-assisted suicide, which he opposes, would have cut short.

A year after he first began getting visits from the Franciscan Hospice, the organization sent Dr. Bruce Brazina to Mayer's home to certify that he was still really dying. It's something Brazina says he does two to four times a week as patients outlive their six-month prognoses. Sometimes, Brazina says, patients have improved so much he can no longer forecast their imminent death. In those cases, "we take them off service"—a polite way of saying that patients are kicked off hospice care, a standard procedure at all hospices due to Medicare rules. But Brazina found that Mayer's heart condition was still severe enough to warrant another six-month prognosis, which the retired doctor has just about outlived again.

"It's getting to the point where I'm a little embarrassed," Mayer says.

What's going on with him is a little different than what happened to Randall Curtis' patients or to Maryanne Clayton. Rather than reviving from near death or surviving a disease that normally kills quickly, Mayer is suffering from chronic diseases that typically follow an unpredictable course. "People can be very sick but go along fine and stable," Brazina explains. "But then they'll have an acute attack." The problem for prognosis is that doctors have no way of knowing when those attacks will be or whether patients will be able to survive them.

When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the *Journal of the American Medical Association*.

Given these two studies, it's no surprise that in Oregon some people who got a prescription for lethal medication on the basis of a six-month prognosis have lived longer. Of the 341 people who put themselves to death as of 2007 (the latest statistics available), 17 did so between six months and two years after getting their prescription, according to state epidemiologist Katrina Hedberg. Of course, there's no telling how long any of the 341 would have lived had they not killed themselves. The Department of Health does not record how long people have lived after getting prescriptions they do not use, so there's no telling, either, whether those 200 people outlived their prognosis. Compassion & Choices of Oregon, which independently keeps data on the people whom it helps navigate the law, says some have lived as long as eight years after first inquiring about the process (although it doesn't track whether they ever received the medication and a six-month prognosis).

The medical field's spotty track record with prognosis is one reason Harborview's Curtis says he is not comfortable participating in physician-assisted suicide. It's one thing to make a six-month prognosis that will allow patients access to hospice services, he says, and quite another to do so for the purpose of enabling patients to kill themselves. "The consequences of being wrong are pretty different," he says.

Under the law, doctors and institutions are free to opt out, and several Catholic institutions like Providence Hospice of Seattle have already said they will do so. Medical director McCormick finds the idea of patients killing themselves particularly troubling because "you can't predict what's going to happen or who's going to show up near the end of your life." He says he has watched people make peace with loved ones or form wonderful new connections. He's preparing a speech in case patients ask about the new law: "I will stop at nothing to ensure that you're comfortable. I won't shorten your life, but I will make it as high-quality as possible."

Thomas Preston, a retired cardiologist who serves as medical director of Compassion & Choices of Washington, says he has in mind a different kind of speech: "You have to understand that this prognosis could be wrong. You may have more than six months to live. You may be cutting off some useful life."

He also says he will advise doctors to be more conservative than the law allows. "If you think it's going to be six months, hold off on it [writing a prescription]—just to be sure." Instead, he'll suggest that doctors wait until they think a patient has only one or two months to live.

The UW's Farber leans toward a different approach. While he says he hasn't yet decided whether he himself will write fatal prescriptions, he plans at least to refer patients to others who will. Given that prognostic precision is impossible, he says, "I personally just let go of the six months." Instead, he says he would try to meet what he sees as the "spirit of the law" by assessing that someone is "near" the end of their life, so that he could say to them, "You're really sick and you're not going to get better."

Knowing exactly when someone is going to die, he continues, is not as important as knowing when someone "has reached the point where their life is filled with so much suffering that they don't want to be alive."

Randy Niedzielski reached that point in the summer of 2006, according to his wife Nancy. Diagnosed with brain cancer in 2000, the onetime Lynnwood property manager had been through several rounds of chemotherapy and had lived years longer than the norm. But the cancer cells had come back in an even more virulent form and had spread to his muscle system. "He would have these bizarre muscle contractions," Nancy recalls. "His feet would go into a cone shape. His arms would twist in weird angles." Or his chest would of its own volition go into what Nancy calls a "tent position," rising up from his arms. "He'd just be screaming in pain."

Randy would have liked to move to Oregon to take advantage of the Death With Dignity Act there, according to Nancy. But he didn't have time to establish residency as required. That was about six weeks before his death.

Nancy, who has become an advocate for physician-assisted suicide, says that typically people are only weeks or days away from death when they want to kill themselves. Oregon's experience with people hanging onto their medicine for so long, rather than rushing to use it as soon as they get a six-month prognosis, bears this out, she says: "A patient will know when he's at the very end of his life. Doctors don't need to tell you."

Sometimes, though, patients are not so near the end of their life when they're ready to die. University of Washington bioethics professor Helene Starks and Anthony Back, director of palliative care at the Seattle Cancer Care Alliance, are two of several researchers who in 2005 published a study that looked at 26 patients who "hastened" their death. A few were in Oregon, but most were in Washington, and they brought about their own demise mostly either by refusing to eat or drink or by obtaining medication illegally, according to Back and Starks. Three of these patients had "well over six months" of remaining life, Starks says, perhaps even years.

The paper, published in the *Journal of Pain and Symptom Management*, quotes from an interview with one of these patients before she took her life. Suffering from a congenital malformation of the spine, she said it had reached the point that her spine or neck could be injured even while sitting. "I'm in an invisible prison," she continued. "Every move I make is an effort. I can't live like this because of the constant stress, unbearable pain, and the knowledge that it will never be any better."

Under the law, she would not be eligible for lethal medication. Her case was not considered "terminal," according to the paper. But for patients like her, the present is still unbearable. Former governor Booth Gardner, the state's most visible champion of physician-assisted suicide, would have preferred a law that applied to everyone who viewed their suffering this way, regardless of how long they were expected to live. He told *The New York Times Magazine*, for a December 2007 story, that the six-month rule was a compromise meant to help insure the passage of Initiative 1000. Gardner has Parkinson's disease, and now can talk only haltingly by phone. In an interview he explained that he has been housebound of late due to several accidents related to his lack of balance.

Researchers who have interviewed patients, their families, and their doctors have found, however, that pain is not the central issue. Fear of future suffering looms larger, as does people's desire to control their own end.

"It comes down to more existential issues," says Back. For his study of Washington and Oregon patients, he interviewed one woman who had been a successful business owner. "That's what gave her her zest for life," Back says, and without it she was ready to die.

Maryanne Clayton says she has never reached that point. Still, she voted for the Death With Dignity Act. "Why force me to suffer?" she asks, adding that if she were today in as much pain as she was when first diagnosed with lung cancer, she might consider taking advantage of the new law. But for now, she still enjoys life. Her 35-year-old son Eric shares a duplex with her in the Tri-Cities. They like different food. But every night he cooks dinner on his side, she cooks dinner on her side, and they eat together. And one more day passes that proves her prognosis wrong.

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Colorado rejects right-to-die legislation

Related

By IVAN MORENO

The Associated Press

DENVER — Colorado lawmakers rejected a proposal to give dying patients the option to seek doctors' help ending their lives, concluding a long day of emotional testimony from more than 100 people.

For one lawmaker who voted no, the issue was personal. Tearfully telling her colleagues she was a cancer survivor, Democratic Rep. Dianne Primavera recalled how a doctor told her she wouldn't live more than five years.

But she found a doctor who gave her a different opinion.

"And he took me in his care, and I am here today 28 years later," she said.

Doctors who opposed the measure told lawmakers earlier that allowing dying patients to seek life-ending medications from a physician closed off the possibility of a recovery when a prognosis can sometimes be wrong.

A House committee considering the bill voted 8-5 against it after dozens of people with serious illnesses and others who have seen relatives suffer packed the Colorado legislative hearing.

The vote comes as a handful of other states, including California and Pennsylvania, consider laws to allow the terminally ill get doctor-prescribed medication to die.

Five states allow patients to seek aid in dying: Oregon, Washington, Montana, Vermont and New Mexico.

"This bill represents a very personal freedom that for some is taken away in the final stages of their illness," said Democratic Rep. Joann Ginal, one of the bill sponsors. "Physicians give patients the best possible care. But there comes a time when a physician is no longer able to heal."

Religious organizations opposed the measure, saying it facilitated suicide. But supporters argued that terminally ill patients should control when they die.

The story of Brittany Maynard last year spotlighted the debate over whether doctors should be able to prescribe life-ending medication to patients. Maynard, 29, moved from California to Oregon after being diagnosed with terminal brain cancer so she could use that state's law. She died Nov. 1.

Colorado's bill was modeled after Oregon's. It would have required dying patients to get two doctors to sign off on their oral and written requests to end their lives. The patients also would have needed to be found to be mentally competent and be able to administer the life-ending medication themselves.

One of the opponents to the bill, Carrie Ann Lucas, spoke on behalf of Not Dead Yet, a New-York based disability rights group.

Lucas uses a wheelchair and ventilator because of a neuromuscular disease. She told lawmakers that she worries the proposal would make it easy for a disabled person who is depressed to get medication from a doctor. Without her ventilator, Lucas told lawmakers, she would have only hours to live. And, she said, if she were to get depressed, she thinks she could go to a doctor who doesn't know her well to get the drugs.

"And they probably would give me that lethal prescription instead of referring me to mental-health treatment that I would so desperately need," said Lucas, 43.

Boulder resident David Hibbard, 77, told lawmakers that as a hospice physician for the past 15 years, he knows what to expect once his Parkinson's disease and leukemia advance.

"I will be hunched over, either bed-bound or in a wheelchair," he said, his hands shaking as he spoke. He would be unable to talk and feed himself, Hibbard told lawmakers.

"I don't want to endure this scenario, and I certainly don't want to have my family, my wife and my three children, have to endure watching me go through this rapid deterioration," he said.

Lawmakers hearing the bill raised concerns about whether there are enough safeguards to prevent abuse, such a family member advocating for life-ending medications on behalf of a dying relative. Lawmakers also wondered what would happen if the medications are not used, and whether someone other than the patient could then take them.

One lawmaker, Rep. Jon Keyser, R-Morrison, said he worries Colorado could become a state known for "suicide tourism" if the bill passes.

The Colorado legislation was inspired by Charles Selsberg, 77, who urged legislators to take on the issue with an editorial published in The Denver Post shortly before his death a year ago. Selsberg died of ALS, or amyotrophic lateral sclerosis.

His daughter, Julie Selsberg, wiped away tears after the vote. She supported the bill.

—

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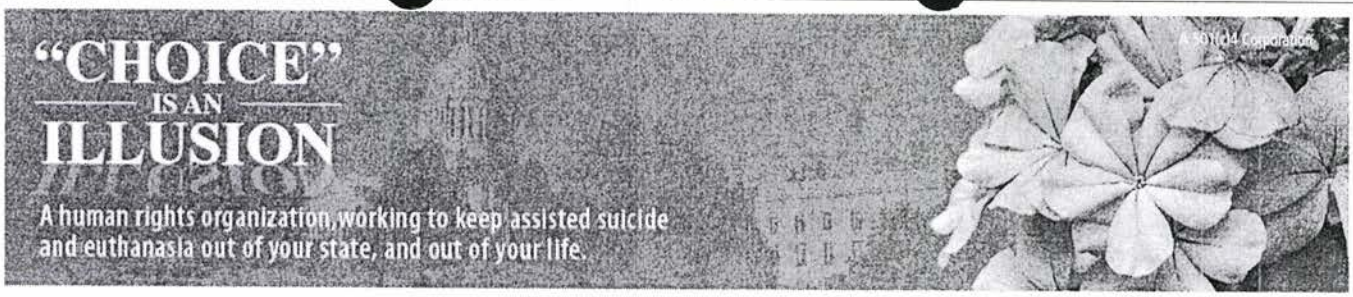

MONDAY, MAY 5, 2014

Arizona Strengthens its Law Against Assisted Suicide

http://www.kansascity.com/2014/04/30/4993778/brewer-signs-bill-targeting-assisted.html

PHOENIX — Arizona Gov. Jan Brewer has signed a bill that aims to make it easier to prosecute people who help someone commit suicide.

Republican Rep. Justin Pierce of Mesa says his bill will make it easier for attorneys to prosecute people for manslaughter for assisting in suicide by more clearly defining what it means to "assist."

House Bill 2565 defines assisting in suicide as providing the physical means used to commit suicide, such as a gun. The bill originally also defined assisted suicide as "offering" the means to commit suicide, but a Senate amendment omitted that word.

The proposal was prompted by a difficult prosecution stemming from a 2007 assisted suicide in Maricopa County.

Brewer signed the bill on Wednesday.

Labels: assisted suicide

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ASSISTED SUICIDE BATTLE IN COURT

Click on the photo to find out more about the battle to prevent assisted suicide from becoming legal in Montana

MY BLOG LIST

Margaret Dore
Compassion & Choices has a New Campaign to Reduce Patient Choice: Be Careful What you Sign.

VOICES AGAINST ASSISTED SUICIDE AND EUTHANASIA

- "I was afraid to leave my husband alone"
- "This is how society will pay you back? With non-voluntary or involuntary euthanasia?"
- "It wasn't the father saying that he wanted to die"
- "He made the mistake of asking for information about assisted suicide"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "Mild stroke led to mother's forced starvation"

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HELP US HELP YOU

Choice is an Illusion gives you a voice against assisted suicide, euthanasia and palliative care abuse. Please donate now.

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MARGARET DORE BLOG

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WELCOME

Assisted suicide proponents claim that legalization will give you "choice." But whose choice will it be?

In Oregon where assisted suicide is legal, that state's Medicaid program uses coverage incentives to steer patients to suicide. See here.

In Oregon and Washington State, where assisted suicide is legal, there is no oversight over administration of the lethal dose. Even if the patient struggled, who would

A-27

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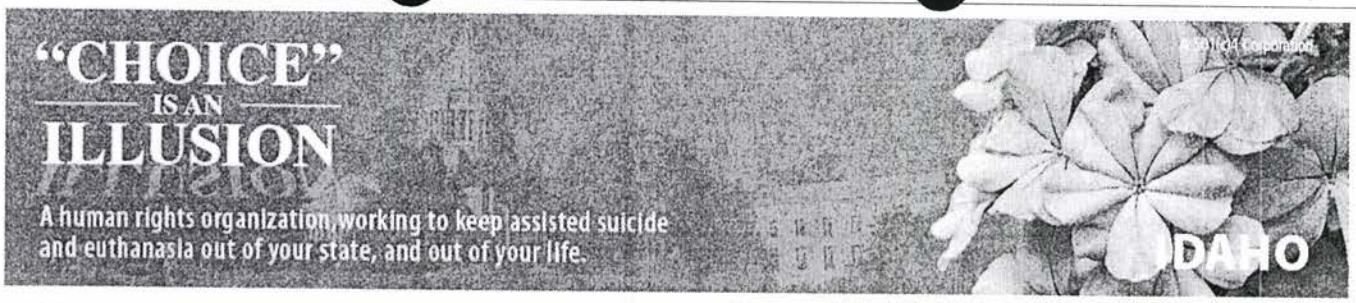

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VOICES AGAINST ASSISTED SUICIDE AND EUTHANASIA

- "I was afraid to leave my husband alone"
- "In Oregon, the only help my patient received was a lethal prescription, intended to kill him."
- "It wasn't the father saying that he wanted to die"
- "He made the mistake of asking for information about assisted suicide"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "Mild stroke led to mother's forced starvation"

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- What People Mean When They Say They Want to Die
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- Definitions

BAR ARTICLES

- Idaho: The Advocate

MONDAY, JULY 4, 2011

Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

On April 5, 2011, Idaho Governor Butch Otto signed Senate Bill 1070 into law.[1] The bill explicitly provides that causing or aiding a suicide is a felony.[2]

Senate bill 1070 supplements existing Idaho law, which already imposed civil and criminal liability on doctors and others who cause or aid a suicide.[3] The bill's "Statement of Purpose" says: "This legislation will supplement existing common law and statutory law by confirming that it is illegal to cause or assist in the suicide of another."[4]

The bill was introduced in response to efforts by Compassion & Choices to legalize physician-assisted suicide in Idaho. The issue came to a head after that organization's legal director wrote articles claiming that the practice, which she called "aid in dying, was already legal in Idaho. Compassion & Choices was formerly known as the Hemlock Society.[5]

The legal director's articles included "Aid in Dying: Law, Geography and Standard of Care in Idaho," published in *The Advocate*, the official publication of the Idaho State Bar.[6] Responding letters to the editor stated that the article was "a gross misunderstanding of Idaho law" and that "[f]alse claims about what the law of Idaho actually is, published in *The Advocate*, cannot possibly benefit public debate on this issue."

These letters and other letters can be viewed here, here and here. A direct rebuttal to the article can be viewed here.

The vote to pass the new bill was overwhelming: the Senate vote was 31 to 2; the house vote was 61 to 8.[7] The new law will be codified as Idaho Code Ann. Section 18-4017 and go into effect on July 1, 2011.[8]

* * *

[1] Bill Status S1070, entry for April 5, 2011.
[2] *See* here for bill text.
[3] Then existing civil law included *Cramer v. Slater*, 146 Idaho 868, 878, 204 P.3d 508 (2009), which states that doctors "can be held liable for [a] patient's suicide." Existing law also included a common law crime in which an "aider and abettor" of suicide is guilty of murder. Assisted suicide can also be statutorily charged as murder. *See* Margaret K. Dore, "Aid in Dying: Not Legal in Idaho; Not About Choice," *The Advocate*, official publication of the Idaho State Bar, Vol. 52, No. 9, pages 18-20, September 2010 (describing existing law prior to the new bill's enactment); and The Hon. Robert E. Bakes, Retired Chief Justice of the Idaho Supreme Court, Letter to the Editor, "Legislature rejected euthanasia," *The Advocate*, September 2010 ("in both the Idaho criminal statutes as well as I.C.6-1012, the Idaho legislature has rejected physician-assisted suicide"). Entire issue, available here:
http://www.isb.idaho.gov/pdf/advocate/issues/adv10sep.pdf
[4] Revised Statement of Purpose, RS20288.
[5] Ian Dowbiggin, A CONCISE HISTORY OF EUTHANASIA: LIFE, DEATH, GOD AND MEDICINE, Rowman & Littlefield Publishers,

LINKS

- Montana's Campaign Against Assisted Suicide (Following Idaho's Lead!)

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LABELS

- 18-4017 (1)
- assisted suicide (1)
- common law (1)
- Compassion and Choices (1)
- Hemlock Society (1)
- Kathryn Tucker (1)
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- Robert E. Bakes (1)
- S1070 (1)

IDAHO ARCHIVE

▼ 2011 (1)
▼ July (1)
Idaho Strengthens Law Against Assisted-Suicide

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Georgia General Assembly

2011-2012 Regular Session - HB 1114
Homicide; offering to assist in commission of suicide; repeal certain provisions

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Committees

HC: Judiciary Non-Civil

SC: Judiciary

First Reader Summary

A BILL to be entitled an Act to amend Article 1 of Chapter 5 of Title 16 of the O.C.G.A., relating to homicide, so as to repeal certain provisions regarding offering to assist in the commission of a suicide; to prohibit assisted suicide; to provide for definitions; to provide for criminal penalties; to provide for certain exceptions; to provide for certain reporting requirements with respect to being convicted of assisting in a suicide; to amend Title 51 of the O.C.G.A., relating to torts, so as to provide for civil liability for wrongful death caused by assisted suicide; to provide for definitions; to provide an effective date; to repeal conflicting laws; and for other purposes.

Status History

May/01/2012 - Effective Date
May/01/2012 - Act 639
May/01/2012 - House Date Signed by Governor
Apr/~~10/2012 - House Sent to Governor~~
Mar/29/2012 - Senate Agreed House Amend or Sub
Mar/29/2012 - House Agreed Senate Amend or Sub As Amended
Mar/27/2012 - Senate Passed/Adopted By Substitute
Mar/27/2012 - Senate Third Read
Mar/22/2012 - Senate Read Second Time
Mar/22/2012 - Senate Committee Favorably Reported By Substitute
Mar/07/2012 - Senate Read and Referred
Mar/07/2012 - House Immediately Transmitted to Senate
Mar/07/2012 - House Passed/Adopted By Substitute
Mar/07/2012 - House Third Readers
Feb/28/2012 - House Committee Favorably Reported By Substitute
Feb/23/2012 - House Second Readers
Feb/22/2012 - House First Readers
Feb/21/2012 - House Hopper

Footnotes

3/7/2012 Modified Structured Rule; 3/7/2012 Immediately transmitted to Senate; 3/29/2012 House agrees to the Senate Substitute as House amended; 3/29/2012 Senate agreed to House amendment to Senate substitute

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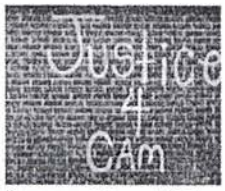

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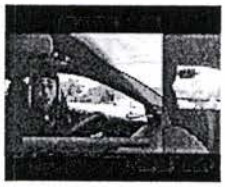
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La. assisted-suicide ban strengthened

The Associated Press

Published: Tuesday, April 24, 2012 at 8:37 a.m.

Last Modified: Tuesday, April 24, 2012 at 8:37 a.m.

BATON ROUGE -- The House unanimously backed a proposal Monday to strengthen Louisiana's ban on euthanasia and assisted suicide.

House Bill 1086 by Rep. Alan Seabaugh, R-Shreveport, would spell out that someone authorized to approve medical procedures for another person may not approve any procedure that would be considered assisted suicide. That prohibition also would be extended to include surgical or medical treatment for the developmentally disabled or nursing home residents who may be unable to make their own medical decisions.

Louisiana already has a prohibition in criminal law against euthanasia and assisted suicide. But Seabaugh said he wanted to make sure it was clear in the state's medical consent law.

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Oregon Revised Statute

Chapter 127

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

Please browse this page or **download the statute** for printing - (*or read the statute at* **https://www.oregonlegislature.gov**)

Contact Us

dwda.info@state.or.us

127.800 s.1.01. Definitions.

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.

(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

(c) The potential risks associated with taking the medication to be prescribed;

(d) The probable result of taking the medication to be prescribed; and

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

(Written Request for Medication to End One's Life in a Humane and Dignified Manner)

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and

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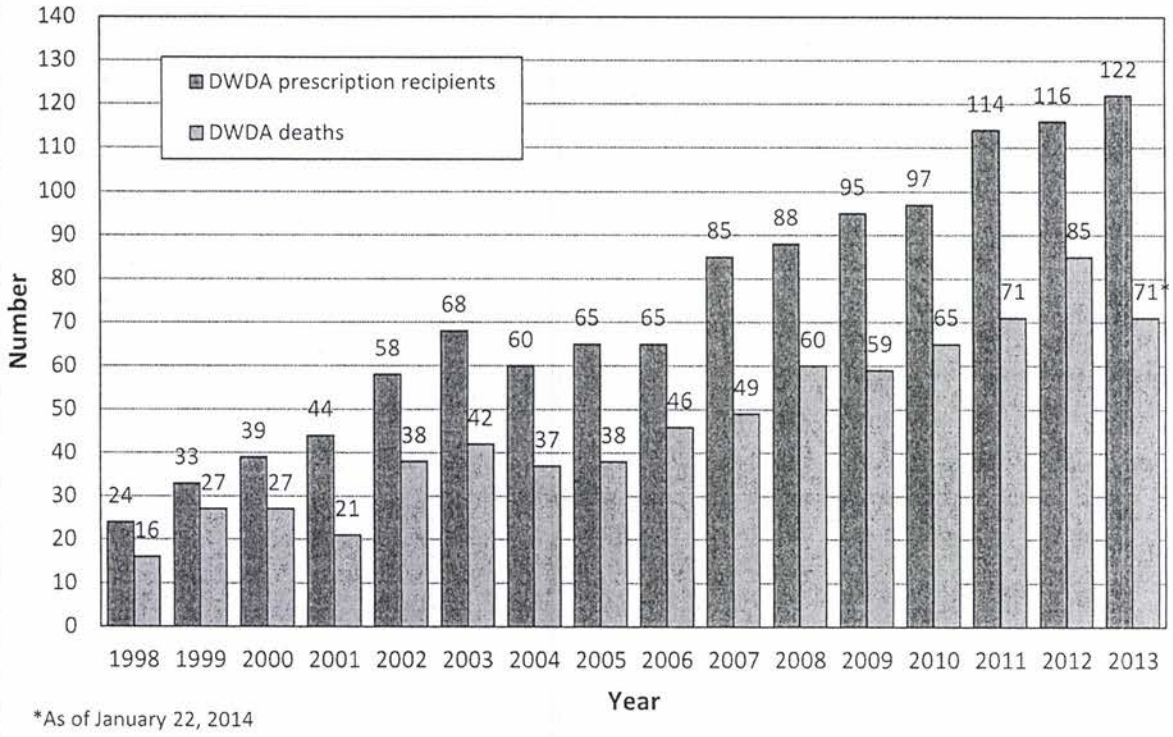
Oregon's Death with Dignity Act--2013

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2013 are listed below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and deaths that occurred as a result of ingesting prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of January 22, 2014. For more detail, please view the figures and tables on our web site: http://www.healthoregon.org/dwd.

Figure 1:
Oregon DWDA Prescription Recipients and Deaths*, 1998-2013



*As of January 22, 2014

- As of January 22, 2014, prescriptions for lethal medications were written for 122 people during 2013 under the provisions of the DWDA, compared to 116 during 2012 (Figure 1). At the time of this report, there were 71 known DWDA deaths during 2013. This corresponds to 21.9 DWDA deaths per 10,000 total deaths.[1]

- Since the law was passed in 1997, a total of 1,173 people have had DWDA prescriptions written and 752 patients have died from ingesting medications prescribed under the DWDA.

- Of the 122 patients for whom DWDA prescriptions were written during 2013, 63 (51.6%) ingested and died from the medication. Eight (8) patients with prescriptions written during the previous years (2011 and 2012) died after ingesting the medication during 2013, for a total of 71 DWDA deaths.

- Twenty-eight (28) of the 122 patients who received DWDA prescriptions during 2013 did not take the medications and subsequently died of other causes.

- Ingestion status is unknown for 31 patients who were prescribed DWDA medications in 2013. Seven (7) of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received. For the remaining 24 patients, both death and ingestion status are pending (Figure 2).

- Of the 71 DWDA deaths during 2013, most (69.0%) were aged 65 years or older; the median age was 71 years (42 years – 96 years). As in previous years, most were white (94.4%), well-educated (53.5% had a least a baccalaureate degree), and had cancer (64.8%). In 2013, fewer patients had cancer (64.8%) compared to previous years (80.4%), and more patients had chronic lower respiratory disease (9.9%), and other underlying illnesses (16.9%).

- Most (97.2%) DWDA patients died at home, and most (85.7%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, most (96.7%) had some form of

[1] The rate per 10,000 deaths is calculated using the total number of Oregon resident deaths in 2012 (32,475), the most recent year for which final death data are available.

health care insurance. The number of patients who had private insurance (43.5%) was lower in 2013 than in previous years (64.7%), and the number of patients who had only Medicare or Medicaid insurance was higher than in previous years (53.2% compared to 33.7%).

- As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (93.0%), decreasing ability to participate in activities that made life enjoyable (88.7%), and loss of dignity (73.2%).
- Two of the 71 DWDA patients who died during 2013 were referred for formal psychiatric or psychological evaluation.
- Prescribing physicians were present at the time of death for eight patients (11.4%) during 2013 compared to 16.5% in previous years.
- A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 11 of the 71 DWDA deaths during 2013. Among those 11 patients, time from ingestion until death ranged from 5 minutes to 5.6 hours.
- Sixty-two (62) physicians wrote the 122 prescriptions provided during 2013 (range 1-10 prescriptions per physician).
- During 2013, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

Figure 2: Summary of DWDA Prescriptions Written and Medications Ingested in 2013, as of January 22, 2014

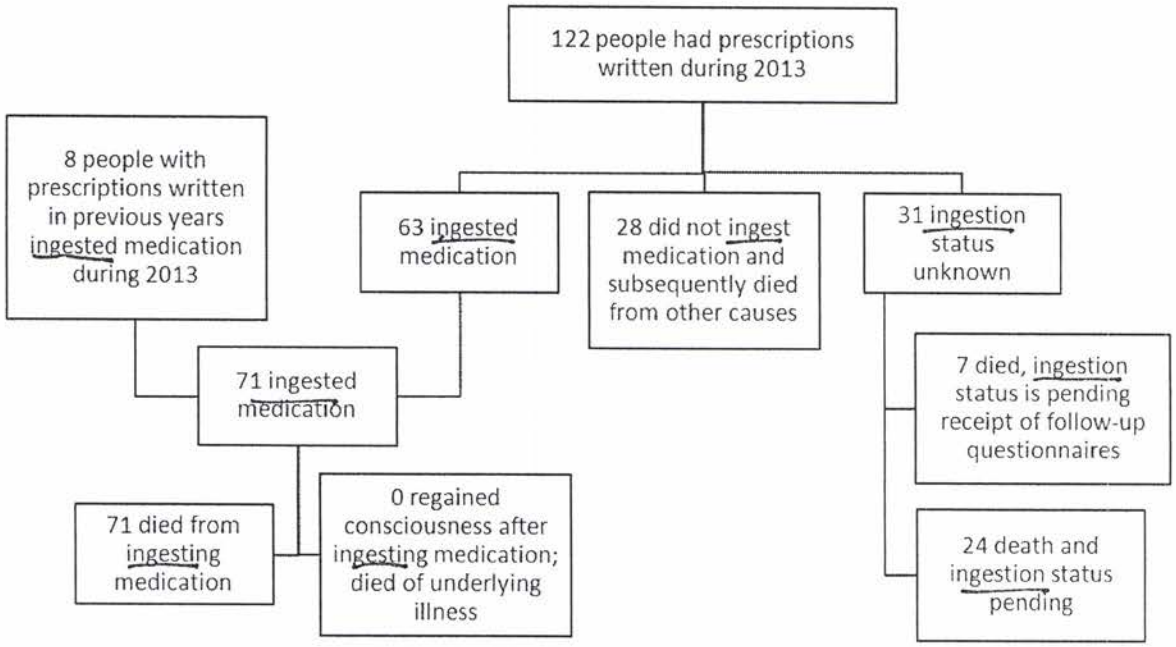


Table 1. Characteristics and End-of-life Care of 752 DWDA Patients who Died from Ingesting a Lethal Dose of Medication as of January 17, 2014, Oregon, 1998-2013

Characteristics	2013 (N=71)	1998-2012 (N=681)	Total (N=752)
Sex	N (%)[1]	N (%)[1]	N (%)[1]
Male (%)	44 (62.0)	352 (51.7)	396 (52.7)
Female (%)	27 (38.0)	329 (48.3)	356 (47.3)
Age			
18-34 (%)	0 (0.0)	6 (0.9)	6 (0.8)
35-44 (%)	1 (1.4)	15 (2.2)	16 (2.1)
45-54 (%)	6 (8.5)	52 (7.6)	58 (7.7)
55-64 (%)	15 (21.1)	141 (20.7)	156 (20.7)
65-74 (%)	23 (32.4)	194 (28.5)	217 (28.9)
75-84 (%)	17 (23.9)	189 (27.8)	206 (27.4)
85+ (%)	9 (12.7)	84 (12.3)	93 (12.4)
Median years (range)	71 (42-96)	71 (25-96)	71 (25-96)
Race			
White (%)	67 (94.4)	662 (97.6)	729 (97.3)
African American (%)	0 (0.0)	1 (0.1)	1 (0.1)
American Indian (%)	1 (1.4)	1 (0.1)	2 (0.3)
Asian (%)	0 (0.0)	8 (1.2)	8 (1.1)
Pacific Islander (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	1 (1.4)	0 (0.0)	1 (0.1)
Two or more races (%)	2 (2.8)	0 (0.0)	2 (0.3)
Hispanic (%)	0 (0.0)	5 (0.7)	5 (0.7)
Unknown	*0*	*3*	*3*
Marital Status			
Married (%)[2]	36 (50.7)	310 (45.7)	346 (46.2)
Widowed (%)	13 (18.3)	158 (23.3)	171 (22.8)
Never married (%)	8 (11.3)	55 (8.1)	63 (8.4)
Divorced (%)	14 (19.7)	155 (22.9)	169 (22.6)
Unknown	*0*	*3*	*3*
Education			
Less than high school (%)	2 (2.8)	42 (6.2)	44 (5.9)
High school graduate (%)	10 (14.1)	154 (22.8)	164 (22.0)
Some college (%)	21 (29.6)	177 (26.2)	198 (26.5)
Baccalaureate or higher (%)	38 (53.5)	303 (44.8)	341 (45.6)
Unknown	*0*	*5*	*5*
Residence			
Metro counties (%)[3]	25 (35.2)	289 (42.6)	314 (41.9)
Coastal counties (%)	5 (7.0)	51 (7.5)	56 (7.5)
Other western counties (%)	33 (46.5)	292 (43.1)	325 (43.4)
East of the Cascades (%)	8 (11.3)	46 (6.8)	54 (7.2)
Unknown	*0*	*3*	*3*
End of life care			
Hospice			
Enrolled (%)[4]	60 (85.7)	593 (90.5)	653 (90.1)
Not enrolled (%)	10 (14.3)	62 (9.5)	72 (9.9)
Unknown	*1*	*26*	*27*
Insurance			
Private (%)[5]	27 (43.5)	424 (64.7)	451 (62.9)
Medicare, Medicaid or Other Governmental (%)	33 (53.2)	221 (33.7)	254 (35.4)
None (%)	2 (3.2)	10 (1.5)	12 (1.7)
Unknown	*9*	*26*	*35*

Characteristics	2013 (N=71)	1998-2012 (N=681)	Total (N=752)
Underlying illness			
Malignant neoplasms (%)	**46 (64.8)**	**545 (80.4)**	**591 (78.9)**
Lung and bronchus (%)	10 (14.1)	129 (19.0)	139 (18.6)
Breast (%)	1 (1.4)	56 (8.3)	57 (7.6)
Colon (%)	6 (8.5)	43 (6.3)	49 (6.5)
Pancreas (%)	2 (2.8)	45 (6.6)	47 (6.3)
Prostate (%)	2 (2.8)	31 (4.6)	33 (4.4)
Ovary (%)	1 (1.4)	27 (4.0)	28 (3.7)
Other (%)	24 (33.8)	214 (31.6)	238 (31.8)
Amyotrophic lateral sclerosis (%)	**5 (7.0)**	**49 (7.2)**	**54 (7.2)**
Chronic lower respiratory disease (%)	**7 (9.9)**	**27 (4.0)**	**34 (4.5)**
Heart Disease (%)	**1 (1.4)**	**13 (1.9)**	**14 (1.9)**
HIV/AIDS (%)	**0 (0.0)**	**9 (1.3)**	**9 (1.2)**
Other illnesses (%)[6]	**12 (16.9)**	**35 (5.2)**	**47 (6.3)**
Unknown	*0*	*3*	*3*
DWDA process			
Referred for psychiatric evaluation (%)	2 (2.8)	42 (6.2)	44 (5.9)
Patient informed family of decision (%)[7]	62 (91.2)	570 (93.9)	632 (93.8)
Patient died at			
Home (patient, family or friend) (%)	69 (97.2)	645 (95.1)	714 (95.3)
Long term care, assisted living or foster care facility (%)	2 (2.8)	27 (4.0)	29 (3.9)
Hospital (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	0 (0.0)	5 (0.7)	5 (0.7)
Unknown	*0*	*3*	*3*
Lethal medication			
Secobarbital (%)	7 (9.9)	396 (58.1)	403 (53.6)
Pentobarbital (%)	64 (90.1)	278 (40.8)	342 (45.5)
Other (%)[8]	0 (0.0)	7 (1.0)	7 (0.9)
End of life concerns[9]	**(N=71)**	**(N=677)**	**(N=748)**
Losing autonomy (%)	66 (93.0)	618 (91.3)	684 (91.4)
Less able to engage in activities making life enjoyable (%)	63 (88.7)	602 (88.9)	665 (88.9)
Loss of dignity (%)[10]	52 (73.2)	452 (81.9)	504 (80.9)
Losing control of bodily functions (%)	26 (36.6)	350 (51.7)	376 (50.3)
Burden on family, friends/caregivers (%)	35 (49.3)	264 (39.0)	299 (40.0)
Inadequate pain control or concern about it (%)	20 (28.2)	157 (23.2)	177 (23.7)
Financial implications of treatment (%)	4 (5.6)	18 (2.7)	22 (2.9)
Health-care provider present[11]	**(N=71)**	**(N=611)**	**(N=682)**
When medication was ingested[12]			
Prescribing physician	8	111	119
Other provider, prescribing physician not present	3	235	238
No provider	3	73	76
Unknown	*57*	*192*	*249*
At time of death			
Prescribing physician (%)	8 (11.4)	99 (16.5)	107 (16.0)
Other provider, prescribing physician not present (%)	5 (7.1)	258 (43.1)	263 (39.3)
No provider (%)	57 (81.4)	242 (40.4)	299 (44.7)
Unknown	*1*	*12*	*13*
Complications[12]	**(N=71)**	**(N=681)**	**(N=752)**
Regurgitated	0	22	22
Seizures	0	0	0
Other	1	0	1
None	10	477	487
Unknown	*59*	*182*	*241*
Other outcomes			
Regained consciousness after ingesting DWDA medications[13]	0	6	6

Chronic conditions

includes diabetes see next page

drugs used are water and alcohol soluble - to be drank - Also injectable

20 people

Characteristics	2013 (N=71)	1998-2012 (N=681)	Total (N=752)
Timing of DWDA event			
Duration (weeks) of patient-physician relationship[14]			
Median	13	12	12
Range	1-719	0-1905	0-1905
Number of patients with information available	*71*	*679*	*750*
Number of patients with information unknown	*0*	*2*	*2*
Duration (days) between 1st request and death			
Median	52	46	47
Range	15-692	15-1009	15-1009
Number of patients with information available	*71*	*681*	*752*
Number of patients with information unknown	*0*	*0*	*0*
Minutes between ingestion and unconsciousness[11]			
Median	5	5	5
Range	2-25	1-38	1-38
Number of patients with information available	*11*	*476*	*487*
Number of patients with information unknown	*60*	*205*	*265*
Minutes between ingestion and death[11]			
Median	15	25	25
Range (minutes - hours)	5min-5.6hrs	1min-104hrs	1min-104hrs
Number of patients with information available	*11*	*481*	*492*
Number of patients with information unknown	*60*	*200*	*260*

1 Unknowns are excluded when calculating percentages.

2 Includes Oregon Registered Domestic Partnerships.

3 Clackamas, Multnomah, and Washington counties.

4 Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.

5 Private insurance category includes those with private insurance alone or in combination with other insurance.

6 Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.

7 First recorded beginning in 2001. Since then, 31 patients (4.6%) have chosen not to inform their families, and 12 patients (1.8%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and three in 2013.

8 Other includes combinations of secobarbital, pentobarbital, and/or morphine.

9 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

10 First asked in 2003. Data available for all 71 patients in 2013, 552 patients between 1998-2012, and 623 patients for all years.

11 The data shown are for 2001-2013 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.

12 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

13 There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.

14 Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.

Margaret K. Dore

Margaret Dore <margaretdore@margaretdore.com>

Letter to editor, New Haven Register

1 message

William Toffler <toffler@ohsu.edu> Sun, Feb 23, 2014 at 7:23 PM
To: "letters@nhregister.com" <letters@nhregister.com>

Dear Editor,

I am a professor of Family Medicine and a practicing physician in Oregon for over 30 years. I write to provide some insight on the issue of assisted suicide, which is legal in Oregon, and which has been proposed for legalization in Connecticut. (Raised Bill No. 5326)

Our law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions such as "chronic lower respiratory disease" and "diabetes". Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live. They are unlikely die in less than six months unless they don't receive their medications. Such persons, with treatment, could otherwise have years or even decades to live.

This illustrates a great problem with our law--it encourages people with years to live, to throw away their lives. I am also concerned, that by starting to label people with chronic conditions "terminal," there will be an excuse to deny such persons appropriate medical treatment to allow them to continue to live healthy and productive lives.

These factors are something for your legislators to consider. Do you want this to happen to you or your family?

Furthermore, in my practice I have had many patients ask about assisted-suicide. In each case, I have offered care and treatment but declined to provide assisted suicide. In one case, the man's response was "Thank you."

To read a commentary on the most recent Oregon government assisted-suicide report, which lists chronic conditions as the "underlying illness" justifying assisted suicide, please go here: http://www.noassistedsuicideconnecticut.org/2014/02/oregons-new-assisted-suicide-report.html

To read about some of my cases in Oregon, please go here: http://www.choiceillusion.org/p/what-people-mean_25.html

I hope that Connecticut does not repeat Oregon's mistake.

William L. Toffler MD
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I verified the content with Dr. Toffler.

A-39

CANADA

COUR SUPÉRIEURE

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO ASSISTED SUICIDE AND EUTHANASIA

THE UNDERSIGNED, being first duly sworn on oath, STATES:

1. I live in Florence Massachusetts USA. When I was eighteen years old and in my first year of college, I was diagnosed with Amyotrophic Lateral Sclerosis (ALS) by the University of Iowa Medical School. ALS is commonly referred to as Lou Gehrig's disease. I was told that I would get progressively worse (be paralyzed) and die in three to five years.

2. I was a very physical person. The diagnosis was devastating to me. I had played football in high school and was extremely active riding bicycles. I also performed heavy labor including road construction and farm work. I prided myself for my physical strength, especially in my hands.

3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the

time. By then, I had twitching in both hands, which were also getting weaker. At some point, I lost the ability to grip in my hands. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor's prescription and support, I would have taken that opportunity.

4. Six years after my initial diagnosis, the disease progression stopped. Today, my condition is about the same. I still can't grip with my hands. Sometimes I need special help. But, I have a wonderful life. I am married to Susan. We have three children and one grandchild. I have a degree in Psychology and one year of graduate school. I am a retired bus driver (no gripping required). Prior to driving bus, I worked as a parole and probation officer. When I was much younger, I drove a school bus. We have wonderful friends. I enjoy singing tenor in amateur choruses. I help other people by working as a volunteer driver.

5. I will be 75 years old this coming September. If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come. I hope that Canada does not legalize these practices.

SWORN BEFORE ME at
MASSACHUSETTS, USA
on, August 15th, 2012

NAME: Heidi Pruzynski

A notary in and for the
State of ~~Washington~~ Massachusetts

ADDRESS: 85 Main ST
Florence MA 01062

EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

HEIDI PRUZYNSKI
MY COMMISSION EXPIRES JUNE 22, 2018
COMMONWEALTH OF MASSACHUSETTS
NOTARY PUBLIC

JOHN NORTON

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A.42

The Seattle Times
Winner of Nine Pulitzer Prizes

our largest paper

Three years after our assisted law went into effect here in Washington state, this article came out in our largest paper, with a suggestion of euthanasia for people without enough money for their old age.

Columnists

Originally published Wednesday, March 7, 2012 at 6:46 PM

Planning for old age at a premium

Preparing for longterm care is difficult — even for those who can afford insurance plans.

Jerry Large

Seattle Times staff columnist

Monday, I suggested exploring long-term health insurance as a way to deal with the cost of assisted living.

Like almost everything about managing when you can no longer live on your own, insurance can be complicated, frustrating and inadequate. Lots of readers shared stories about their experiences.

It was an email from a reader that led to the column. Roslyn Duffy wrote about her mother, who ran out of money and had to turn to Medicaid. She was told she'll have to move because the assisted-living facility where she lives no longer accepts Medicaid.

— So if you work hard all your life, pay taxes & then your pension plan goes broke, this is how society pays you back?

Care is expensive. I had no idea how costly until my wife and I began to deal with parents who needed it.

We didn't know about the paperwork and bureaucracy, or the difficult hunt for quality care that was accessible to people who hadn't managed to get rich. It's like college hunting — but with no joy attached to it.

There are good places out there, but they're harder to get into and usually cost more. Some of the most desirable places take Medicaid clients, but placements are limited.

The only certainty is that nothing is universally true.

The problem of what to do with old people who need help is a creation of modern society that we haven't committed ourselves to solving. It's almost like a monster that you don't believe exists until you answer its knock at your door.

X After Monday's column, some readers were unsympathetic, a few suggested that if you couldn't save enough money to see you through your old age, you shouldn't expect society to bail you out.

X At least a couple mentioned euthanasia as a solution.

But most readers were glad the topic was raised. Out of sight, out of mind is no way to deal with something so important.

So here's the deal. If you are rich, it's not a problem. If you are poor, Medicaid will pick up the tab for a nursing home.

If you are somewhere in the middle, you may want what the rich have, but be able to afford only what the poor get — and only until your money runs out, and then Medicaid will step in.

Insurance for long-term care is supposed to provide some security for people who are not quite

Non-voluntary/involuntary euthanasia? A.K.

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- Sentence Examples

ingest definition

in·gest (in jest′)

transitive verb

to take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing

Origin: < L *ingestus*, pp. of *ingerere*, to carry, put into < *in-*, into + *gerere*, to carry

Related Forms:

- **ingestion in·ges′·tion** ***noun***
- **ingestive in·ges′·tive** ***adjective***

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in·gest (ĭn-jĕst′)

transitive verb **in·gest·ed, in·gest·ing, in·gests**

1. To take into the body by the mouth for digestion or absorption. See Synonyms at eat.
2. To take in and absorb as food: *"Marine ciliates ... can be observed ... ingesting other single-celled creatures and harvesting their chloroplasts" (Carol Kaesuk Yoon).*

Origin: Latin *ingerere, ingest-* : *in-, in*; see **in-** [2] + *gerere, to carry*.

Related Forms:

- **in·gest′i·ble** ***adjective***
- **ingestion in·ges′tion** ***noun***
- **ingestive in·ges′tive** ***adjective***

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A.4Y

~~A-12~~

Washington State Department of Health

Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with the Death with Dignity Act

Washington's Death with Dignity Act (RCW 70.245) states that "...the patient's death certificate...shall list the underlying terminal disease as the cause of death." The act also states that, "Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law."

If you know the decedent used the Death with Dignity Act, you must comply with the strict requirements of the law when completing the death record:

not "complied" with the act

1. The underlying terminal disease must be listed as the cause of death.
2. The manner of death must be marked as "Natural."
3. The cause of death section may not contain any language that indicates that the Death with Dignity Act was used, such as:
    a. Suicide
    b. Assisted suicide
    c. Physician-assisted suicide
    d. Death with Dignity
    e. I-1000
    f. Mercy killing
    g. Euthanasia
    h. Secobarbital or Seconal
    i. Pentobarbital or Nembutal

The Washington State Registrar will reject any death certificate that does not properly adhere to the requirements of the Death with Dignity Act.[1] If a death certificate contains any reference to actions that might indicate use of the act, the Local Registrar and Funeral Director will be instructed, under RCW 70.58.030, to obtain a correction from the medical certifier before a permit to proceed with disposition will be issued.

Call the Department of Health's Center for Health Statistics (360-236-4307) for guidance on how to proceed if you have any questions regarding compliance with cause of death reporting under the Death with Dignity Act.

[1] Under state law, the State Registrar of Vital Statistics "shall prepare and issue such detailed instruction as may be required to secure the uniform observance of its provisions and the maintenance of a perfect system of registration. ... The State Registrar shall carefully examine the certificates received monthly from the local registrars, county auditors, and clerks of the court and, if any are incomplete or unsatisfactory, the State Registrar shall require such further information to be furnished as may be necessary to make the record complete and satisfactory." RCW 43.70.160.

CANADA

COUR SUPÉRIEURE

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

1. I am a doctor in Oregon USA where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have treated thousands of patients with cancer.

2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify for the court that this does not necessarily mean that patients are dying.

3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for cancer. I understand that he had referred her to me.

4. At our first meeting, Jeanette told me plainly that she did not want to be treated and that was going to "do" our law, *i.e.*, kill herself with a lethal dose of barbiturates. It was very much a settled decision.

5. I, personally, did not and do not believe in assisted suicide. I also believed that her cancer was treatable and that her prospects were good. She was not, however, interested in treatment. She had made up her mind, but she continued to see me.

6. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated and she is still alive today. Indeed, she is thrilled to be alive. It's been twelve years.

7. For Jeanette, the mere presence of legal assisted suicide had steered her to suicide.

8. Today, for patients under the Oregon Health Plan (Medicaid), there is also a financial incentive to commit suicide: The Plan covers the cost. The Plan's "Statements of Intent for the April 1, 2012 Prioritized List of Health Services," states:

> It is the intent of the [Oregon Health Services] Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services.

Attached hereto at page SI-1.

9. Under the Oregon Health Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient's treatment. For example, patients with cancer are denied treatment if they have a "less than 24 months median survival with treatment" and fit other criteria. This is the Plan's "Guideline Note 12." (Attached hereto at page GN-4).

10. The term, "less than 24 months median survival with treatment," means that statistically half the patients receiving treatment will live less than 24 months (two years) and the other half will live longer than two years.

11. Some of the patients living longer than two years will likely live far longer than two years, as much as five, ten or twenty years depending on the type of cancer. This is because there are always some people who beat the odds.

12. All such persons who fit within "Guideline Note 12" will nonetheless be denied treatment. Their suicides under Oregon's assisted suicide act will be covered.

13. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.

14. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Canada, your government health plan could follow a similar pattern. If so, the plan will pay for a patient to die, but not to live.

SWORN BEFORE ME at Sherwood
Oregon, USA
on, September 18, 2012

NAME: Jessica Borgo

A notary in and for the
State of Oregon

ADDRESS: 16100 SW Tualatin-Sherwood Rd

EXPIRY OF COMMISSION: Aug, 30, 2015

PLACE SEAL HERE: Jessica Borgo

Ken Stevens MD
Ken Stevens, MD

OFFICIAL SEAL
JESSICA R BORGO
NOTARY PUBLIC - OREGON
COMMISSION NO. 461438
MY COMMISSION EXPIRES AUGUST 30, 2015

STATEMENT OF INTENT 1: PALLIATIVE CARE

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the goals for medical treatment and with services available according to the patient's expected length of life (see examples below).

Palliative care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services that should be available to patients with a life-threatening/limiting illness,

A) without regard to a patient's expected length of life:
   - Inpatient palliative care consultation; and,
   - Outpatient palliative care consultation, office visits.

B) with an expected median survival of less than one year, as supported by the best available published evidence:
   - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.

C) with an expected median survival of six months or less, as supported by peer-reviewed literature:
   - Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

It is the intent of the Commission that certain palliative care treatments be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Some examples of covered palliative care treatments include:

A) Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.
B) Surgical decompression for malignant bowel obstruction.
C) Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.
D) Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.
E) Acupuncture with intent to relieve nausea.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. See Guideline Note 12: TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE.

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

It is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.

GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

b) Suspected Crohn's disease: upper and lower endoscopy, small bowel follow through
2) Radiological evidence of lack of stricture
3) Only covered once during any episode of illness
4) FDA approved devices must be used
5) Patency capsule should not be used prior to procedure

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

Central serous retinopathy (362.41) is included on this line only for treatment when the condition has been present for 3 months or longer. Pars planitis (363.21) should only be treated in patients with 20/40 or worse vision..

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

Lines 79,102,103,105,123-125,131,144,159,165,166,168,170,181,197,198,206-208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,314,320,339-341,356,459,622

A) CSF are not indicated for primary prophylaxis of febrile neutropenia unless the primary chemotherapeutic regimen is known to produce febrile neutropenia at least 20% of the time. CSF should be considered when the primary chemotherapeutic regimen is known to produce febrile neutropenia 10-20% of the time; however, if the risk is due to the chemotherapy regimen, other alternatives such as the use of less myelosuppressive chemotherapy or dose reduction should be explored in this situation.
B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.
C) CSF are not indicated in patients who are acutely neutropenic but afebrile.
D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <100/mcl, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.
E) CSF are not indicated to increase chemotherapy dose-intensity or schedule, except in cases where improved outcome from such increased intensity has been documented in a clinical trial.
F) CSF (other than pegfilgrastrim) are indicated in the setting of autologous progenitor cell transplantation, to mobilize peripheral blood progenitor cells, and after their infusion.
G) CSF are NOT indicated in patients receiving concomitant chemotherapy and radiation therapy.
H) There is no evidence of clinical benefit in the routine, continuous use of CSF in myelodysplastic syndromes. CSF may be indicated for some patients with severe neutropenia and recurrent infections, but should be used only if significant response is documented.
I) CSF is indicated for treatment of cyclic, congenital and idiopathic neutropenia.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE

Lines 102,103,123-125,144,159,165,166,170,181,197,198,207,208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,320,339-341,356,459,586,622

This guideline only applies to patients with advanced cancer who have less than 24 months median survival with treatment.

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.

Unpublished evidence may be taken into consideration in the case of rare cancers which are universally fatal within six months without treatment.

The Health Evidence Review Commission is reluctant to place a strict $/QALY (quality adjusted life-year) or $/LYS (life-year saved) requirement on end-of-life treatments, as such measurements are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend $100,000 in public resources to increase an individual's expected survival by three months when hundreds of thousands of Oregonians are without any form of health insurance.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE (CONT'D)

Treatment with the goal to palliate is addressed in Statement of Intent 1, Palliative Care.

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

Minimally invasive coronary artery bypass surgery indicated only for single vessel disease.

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

Lines 79,103,105,125,131,166,170,198,206,231,280,314

Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

Radiation treatment is indicated only in those at high risk of heterotopic bone formation: those with a history of prior heterotopic bone formation, ankylosing spondylitis or hypertrophic osteoarthritis.

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

Cystic fibrosis carrier testing is covered for 1) non-pregnant adults if indicated in the genetic testing algorithm or 2) pregnant women.

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

Dental cleaning and fluoride treatments are limited to once per 12 months for adults and twice per 12 months for children up to age 19 (D1110, D1120, D1203, D1204, D1206). More frequent dental cleanings and/or fluoride treatments may be required for certain higher risk populations.

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

A) as a bridge to cardiac transplant;
B) as treatment for pulmonary hypertension when pulmonary hypertension is the only contraindication to cardiac transplant and the anticipated outcome is cardiac transplant; or,
C) as a bridge to recovery.

Ventricular assist devices are not covered for destination therapy.

Ventricular assist devices are covered for cardiomyopathy only when the intention is bridge to cardiac transplant.

GUIDELINE NOTE 19, PET SCAN GUIDELINES

Lines 125,144,165,166,170,182,207,208,220,221,243,276,278,292,312,339

PET Scans are covered for diagnosis of the following cancers only:

- Solitary pulmonary nodules and non-small cell lung cancer
- Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

PET scans are covered for the initial staging of the following cancers:

- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal

Learn more

Death Drugs Cause Uproar in Oregon

Aug. 6, 2008

By SUSAN DONALDSON JAMES

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The news from Barbara Wagner's doctor was bad, but the rejection letter from her insurance company was crushing.

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ed the disease hat her doctor

What the Oregon Health Plan did agree to cover, however, were drugs for a physician-assisted death. Those drugs would cost about $50.

"It was horrible," Wagner told ABCNews.com. "I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won't give you the medication to live."

Critics of Oregon's decade-old Death With Dignity Law -- the only one of its kind in the nation -- have been up in arms over the indignity of her unsigned rejection letter. Even those who support Oregon's liberal law were upset.

The incident has spilled over the state border into Washington, where advocacy groups are pushing for enactment of Initiative 1000 in November, legalizing a similar assisted-death law.

Opponents say the law presents all involved with an "unacceptable conflict" and the impression that insurance companies see dying as a cost-saving measure. They say it steers those with limited finances toward assisted death.

"News of payment denial is tough enough for a terminally ill person to bear," said Steve Hopcraft, a spokesman for Compassion and Choices, a group that supports coverage of physician-assisted death.

Letter's Impact 'Devastating'

"Imagine if the recipient had pinned his hope for survival on an unproven treatment, or if this were the first time he understood the disease had entered the terminal phase. The impact of such a letter would be devastating," he told ABCNews.com.

Wagner, who had worked as a home health care worker, a waitress and a school bus driver, is divorced and lives in a low-income apartment. She said she could not afford to pay for the medication herself.

"I'm not too good today," said Wagner, a Springfield great-grandmother. "But I'm opposed to the [assisted suicide] law. I haven't considered it, even at my lowest point."

A lifelong smoker, she was diagnosed with lung cancer in 2005 and quit. The state-run Oregon Health Plan generously paid for thousands of dollars worth of chemotherapy, radiation, a special bed and a wheelchair, according to Wagner.

The cancer went into remission, but in May, Wagner found it had returned. Her oncologist prescribed the drug Tarceva to slow its growth, giving her another four to six months to live.

But under the insurance plan, she can the only receive "palliative" or comfort care, because the drug does not meet the "five-year, 5 percent rule" -- that is, a 5 percent survival rate after five years.

A 2005 New England Journal of Medicine study found the drug erlotinib, marketed as Tarceva,

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does marginally improve survival for patients w dvanced non-small cell lung cancer who had completed standard chemotherapy.

The median survival among patients who took erlotinib was 6.7 months compared to 4.7 months for those on placebo. At one year, 31 percent of the patients taking erlotinib were still alive compared to 22 percent of those taking the placebo.

"It's been tough," said her daughter, Susie May, who burst into tears while talking to ABCNews.com.

"I was the first person my mom called when she got the letter," said May, 42. "While I was telling her, 'Mom, it will be ok,' I was crying, but trying to stay brave for her."

"I've talked to so many people who have gone through the same problems with the Oregon Health Plan," she said.

Indeed, Randy Stroup, a 53-year-old Dexter resident with terminal prostate cancer, learned recently that his doctor's request for the drug mitoxantrone had been rejected. The treatment, while not a cure, could ease Stroup's pain and extend his life by six months.

Playing With 'My Life'

"What is six months of life worth?" he asked in a report in the Eugene Register-Guard. "To me it's worth a lot. This is my life they're playing with."

The Oregon Health Plan was established in 1994 and the physician-assisted death law was enacted in 1997. The state was recently hailed by a University of Wisconsin study as having one of the nation's top pain-management policies.

The health plan, for those whose incomes fall under the poverty level, prioritizes coverage -- from prevention first, to chronic disease management, treatment of mental health, heart and cancer treatment.

"It's challenging because health care is very expensive, but that's not the real essence of our priority list," said Dr. Jeanene Smith, administrator for the Office of for Oregon's Health Policy and Research staff.

"We need evidence to say it is a good use of taxpayer's dollars," she said. "It may be expensive, but if it does wonders, we cover it."

The state also regularly evaluates and updates approvals for cancer treatments. "We look as exhaustively as we can with good peer review evidence," she said.

The health plan takes "no position" on the physician-assisted suicide law, according to spokesman Jim Sellers.

The terminally ill who qualify can receive pain medication, comfort and hospice care, "no matter what the cost," he said.

But Sellers acknowledged the letter to Wagner was a public relations blunder and something the state is "working on."

"Now we have to review to ensure sensitivity and clarity," Sellers told ABCNews.com "Not only is the patient receiving had news, but insensitivity on top of that. This is something that requires the human touch."

Sellers said that from now on insurance officials will likely "pick up the phone and have a conversation," he said.

But a 1998 study from Georgetown University's Center for Clinical Bioethics found a strong link between cost-cutting pressures on physicians and their willingness to prescribe lethal drugs to patients -- were it legal to do so.

The study warns that there must be "a sobering degree of caution in legalizing [assisted death] in a medical care environment that is characterized by increasing pressure on physicians to control the cost of care."

Cancer drugs can cost anywhere from $3,000 to $6,000 a month. The cost of lethal medication, on the other hand, is about $35 to $50.

Advocates for the proposed Washington law say that while offering death benefits but not health care can be perceived as a cost-cutting, "respectable studies" say otherwise.

PHOTO GALLERIES

View: Remembering Veterans Who Served Proudly

US

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Tomas Young, Iraq War veteran and Antiwar Activist, Dead at 34

Courtesy Claudia Cuellar Young

Sharks Swarm, Reporter Kicks and Cameras Roll

ABC News

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A-67

Letter noting assisted suicide raises questions

By *Susan Harding and KATU Web Staff* | Published: Jul 30, 2008 at 5:30 PM PST (2008-07-31T1:30:0Z) | Last Updated: Oct 30, 2013 at 6:35 AM PST (2013-10-30T14:35:0Z)

Barbara Wagner

SPRINGFIELD, Ore. - Barbara Wagner has one wish - for more time.

"I'm not ready, I'm not ready to die," the Springfield woman said. "I've got things I'd still like to do."

Her doctor offered hope in the new chemotherapy drug Tarceva, but the Oregon Health Plan sent her a letter telling her the cancer treatment was not approved.

Instead, the letter said, the plan would pay for comfort care, including "physician aid in dying," better known as assisted suicide.

"I told them, I said, 'Who do you guys think you are?' You know, to say that you'll pay for my dying, but you won't pay to help me possibly live longer?' " Wagner said.

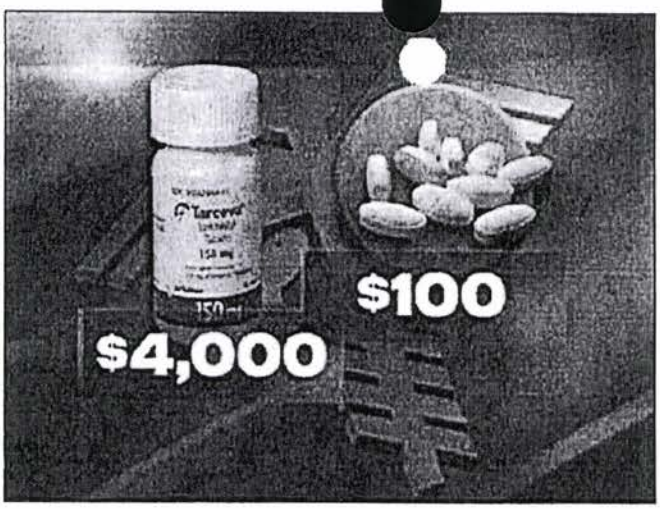
An unfortunate interpretation?

Dr. Som Saha, chairman of the commission that sets policy for the Oregon Health Plan, said Wagner is making an "unfortunate interpretation" of the letter and that no one is telling her the health plan will only pay for her to die.

But one critic of assisted suicide calls the message disturbing nonetheless.

"People deserve relief of their suffering, not giving them an overdose," said Dr. William Toffler.

He said the state has a financial incentive to offer death instead of life: Chemotherapy drugs such as Tarceva cost $4,000 a month while drugs for assisted suicide cost less than $100.



Saha said state health officials do not consider whether it is cheaper for someone in the health plan to die than live. But he admitted they must consider the state's limited dollars when dealing with a case such as Wagner's.

"If we invest thousands and thousands of dollars in one person's days to weeks, we are taking away those dollars from someone," Saha said.

But the medical director at the cancer center where Wagner gets her care said some people may have incredible responses to treatment.

Health plan hasn't evolved?

The Oregon Health Plan simply hasn't kept up with dramatic changes in chemotherapy, said Dr. David Fryefield of the Willamette Valley Cancer Center.

Even for those with advanced cancer, new chemotherapy drugs can extend life.

Yet the Oregon Health Plan only offers coverage for chemo that cures cancer - not if it can prolong a patient's life.

"We are looking at today's ... 2008 treatment, but we're using 1993 standards," Fryefield said. "When the Oregon Health Plan was created, it was 15 years ago, and there were not all the chemotherapy drugs that there are today."

Patients like Wagner can appeal a decision if they are denied coverage. Wagner appealed twice but lost both times.

However, her doctors contacted the pharmaceutical company, Genentech, which agreed to give her the medication without charging her. But doctors told us, that is unusual for a company to give away such an expensive medication.

OREGON HEALTH AUTHORITY

NEWS RELEASE

Date: Sept. 9, 2010

Contact: Christine Stone, Oregon Public Health Information Officer; 971-673-1282, desk; 503-602-8027, cell; christine.l.stone@state.or.us.

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

Oregon's suicide rate is 35 percent higher than the national average. The rate is 15.2 suicides per 100,000 people compared to the national rate of 11.3 per 100,000. (for 2007)

After decreasing in the 1990s, suicide rates have been increasing significantly since 2000, according to a new report, "Suicides in Oregon: Trends and Risk Factors," from Oregon Public Health. The report also details recommendations to prevent the number of suicides in Oregon.

"Suicide is one of the most persistent yet preventable public health problems. It is the leading cause of death from injuries – more than even from car crashes. Each year 550 people in Oregon die from suicide and 1,800 people are hospitalized for non-fatal attempts," said Lisa Millet, MPH, principal investigator, and manager of the Injury Prevention and Epidemiology Section, Oregon Public Health.

There are likely many reasons for the state's rising suicide rate, according to Millet. The single most identifiable risk factor associated with suicide is depression. Many people can manage their depression; however, stress and crisis can overwhelm their ability to cope successfully.

Stresses such as from job loss, loss of home, loss of family and friends, life transitions and also the stress veterans can experience returning home from deployment – all increase the likelihood of suicide among those who are already at risk.

"Many people often keep their depression a secret for fear of discrimination. Unfortunately, families, communities, businesses, schools and other institutions often discriminate against people with depression or other mental illness. These people will continue to die needlessly unless they have support and effective community-based mental health care," said Millet.

The report also included the following findings:

- There was a marked increase in suicides among middle-aged women. The number of women between 45 and 64 years of age who died from suicide rose 55 percent between 2000 and 2006 — from 8.2 per 100,000 to 12.8 per 100,000 respectively.
-

9/2010

O[illegible]N DEPARTMENT OF HUMAN SERVIC[illegible]

Public Health Division (PHD)

Suicides in Oregon
Trends and Risk Factors

Oregon Violent Death Reporting System
Injury and Violence Prevention Program
Office of Disease Prevention and Epidemiology

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Oregon suicide report, issued in September 2010. Data through 2007. Excerpts attached.

Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the leading cause of injury death – there are more deaths due to suicide in Oregon than due to car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all Oregonians. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data of Oregon Violent Death Reporting System (ORVDRS). This report presents main findings of suicide trends and risk factors in Oregon.

Key Findings

In 2007, the age-adjusted suicide rate among Oregonians of 15.2 per 100,000 was 35 percent higher than the national average.

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among women ages 45-64 rose 55 percent from 8.2 per 100,000 in 2000 to 12.8 per 100,000 in 2007.

Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (78.4 per 100,000). White males had the highest suicide rate among all races / ethnicity (25.6 per 100,000). Firearms were the dominant mechanism of suicide among men (62%).

Approximately 27 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (45.7 vs. 27.4 per 100,000). Significantly higher suicide rates were identified among male veterans ages 18-24, 35-44 and 45-54 when compared to non-veteran males. Veteran suicide victims were reported to have more physical health problems than non-veteran males.

Over 70 percent of suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, less than one third of male victims and just about half of female victims were receiving treatment for mental health problems at the time of death.

Investigators suspect that 30 percent of suicide victims had used alcohol in the hours preceding their death.

The number of suicides in each month varies. But there was not a clear seasonal pattern.

Introduction

Suicide is an important public health problem in Oregon. Each year there are more than 550 Oregonians who died by suicide and more than 1800 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon with more deaths due to suicide among Oregonians than car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all ages in Oregon [1]. The cost of suicide is enormous. In 2006 alone, self-inflicted hospitalization charges exceeded 24 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 570 million dollars [1, 2]. The loss to families and communities broadens the impact of each death.

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors"[3]. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Methods, data sources and limitations

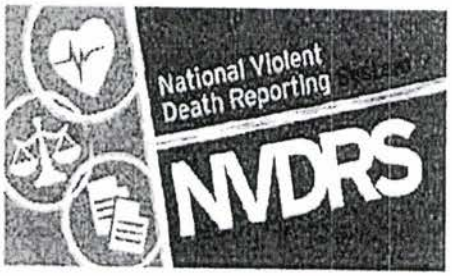
Suicide is a death resulting from the intentional use of force against oneself. In this report, suicide deaths are identified according to International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of deaths on death certificates. Suicide was considered with code of X60-84 and Y87.0.[4] Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore are excluded from this report.

[1] Injury in Oregon, 2008 Annual Report. http://www.oregon.gov/DHS/ph/ipe/docs/report2008v2_2.pdf. Accessed on March. 26, 2010.

[2] Phaedra S. Corso, James A. Mercy, Thomas R. Simon et al, Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States. Am J Prev Med. 2007;32(6):474–482.

[3] Ronald W Maris, Alan L. Berman, Aorton M. Silverman. (2000). Comprehensive Textbook of suicidology. New York: The Guilford Press. (p378)

[4] Paulozzi LJ, Mercy J, Frazier Jr L, et al. CDC's National Violent Death Reporting System: Background and Methodology. Injury Prevention, 2004;10:47-52.



OREGON

Public Health Division

Suicides in Oregon: Trends and Risk Factors

-2012 Report-

Oregon Violent Death Reporting System

Injury and Violence Prevention Program

Center for Prevention and Health Promotion

Excerpt
Printed
2/9/14

Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all Oregonians in 2010. The financial and emotional impacts of suicide on family members and the broader community are devastating and long lasting. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data of the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Key Findings

In 2010, the age-adjusted suicide rate among Oregonians of 17.1 per 100,000 was 41 percent higher than the national average.

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among adults ages 45-64 rose approximately 50 percent from 18.1 per 100,000 in 2000 to 27.1 per 100,000 in 2010. The rate increased more among women ages 45-64 than among men of the same age during the past 10 years.

Suicide rates among men ages 65 and older decreased approximately 15 percent from nearly 50 per 100,000 in 2000 to 43 per 100,000 in 2010.

Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (76.1 per 100,000). Non-Hispanic white males had the highest suicide rate among all races / ethnicity (27.1 per 100,000). Firearms were the dominant mechanism of injury among men who died by suicide (62%).

Approximately 26 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (44.6 vs. 31.5 per 100,000). Significantly higher suicide rates were identified among male veterans ages 18-24, 35-44 and 45-54 when compared to non-veteran males. Veteran suicide victims were reported to have more physical health problems than non-veteran males.

Psychological, behavioral, and health problems co-occur and are known to increase suicide risk. Approximately 70 percent of suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, less than one third of male victims and about 60 percent of female victims were receiving treatment for mental health problems at the time of death.

Eviction/loss of home was a factor associated with 75 deaths by suicide in 2009-2010.

Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year[1,2]. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts[3,4]. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon[3]. The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars [3,4,5]. The loss to families and communities broadens the impact of each death.

The cost $

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors"[6]. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

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[1] Oregon Healthy Teens 2009 -11th Grade Results.
http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2009/11/Documents/mental11.pdf

[2] Crosby A.E., Han B., Ortega L.A.G., Park S.E., et al, Suicidal Thoughts and Behaviors Among Adults aged >= 18 Years – United States, 2008-2009. MMWR. 2011;60:13.

[3] Oregon Vital Statistics Annual Report, Vol. 2, 2010. Oregon Heath Authority.

[4] Wright D., Millet L., et al, Oregon Injury and Violence Prevention Program Report for 2011 Data year. Oregon Heath Authority.

[5] Corso P.S., Mercy J.A., Simon T.R., et al, Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States.
Am J Prev Med. 2007;32(6):474–482.

[6] Maris R.W., Berman A.L., Silverman A.M. (2000). Comprehensive Textbook of suicidology. New York: The Guilford Press.
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Original article

Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

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ABSTRACT

Background: Despite continuing political, legal and moral debate on the subject, assisted suicide is permitted in only a few countries worldwide. However, few studies have examined the impact that witnessing assisted suicide has on the mental health of family members or close friends.
Methods: A cross-sectional survey of 85 family members or close friends who were present at an assisted suicide was conducted in December 2007. Full or partial Post-Traumatic Distress Disorder (PTSD; Impact of Event Scale–Revised), depression and anxiety symptoms (Brief Symptom Inventory) and complicated grief (Inventory of Complicated Grief) were assessed at 14 to 24 months post-loss.
Results: Of the 85 participants, 13% met the criteria for full PTSD (cut-off $\geq$ 35), 6.5% met the criteria for subthreshold PTSD (cut-off $\geq$ 25), and 4.9% met the criteria for complicated grief. The prevalence of depression was 16%; the prevalence of anxiety was 6%.
Conclusion: A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although there seemed to be no complications in the grief process, about 20% of respondents experienced full or subthreshold PTSD related to the loss of a close person through assisted suicide.

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1. Introduction

Assisted suicide and euthanasia for terminally ill patients are punishable by law almost everywhere except Switzerland, the Netherlands, Belgium and the U.S. states of Oregon and Washington. Assisted suicide is generally defined as the prescribing or supplying of drugs with the explicit intention of enabling the patient to end his or her own life. In euthanasia, in contrast, it is the physician who administers the lethal drug. In the Netherlands and Belgium, physician-assisted euthanasia is legally permitted, meaning that physicians are allowed to administer drugs to end a patient's life at his or her request. In Switzerland, in contrast, euthanasia is punishable by imprisonment (Article 114 of the Swiss penal code). It is only in the absence of self-serving motives that assisting another person's suicide is permissible. Physicians in Switzerland are therefore allowed to prescribe or supply a lethal dose of barbiturates with the explicit intention of enabling a patient they have examined to end his or her own life. However, most assisted suicides in Switzerland are conducted with the assistance of non-profit organisations [23]. These right-to-die organisations offer personal guidance to members suffering diseases with "poor outcome" or experiencing "unbearable suffering" who wish to die.

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient's home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient's home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.

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