Senate Judiciary
2/10/15
#32
SB202

Philip Tummarello
[redacted]
Stevensville, Montana 59870
[redacted]
[redacted]

Education: Indiana University, Bloomington: French Horn & Comparative Religious Studies
B.S. 1977 Music Performance Scholarship Award
St. Mary's College; Moraga, Ca. Management B.A. 1995

Professional History: Henry Mancini Orchestra 1974-77 Barry White Orchestra 1975
San Francisco Chamber Orchestra 1979 Oakland East Bay Symphony 1980
San Francisco Pocket Opera 1980 Positions Offered: Jerusalem Symphony Israel ; Kassel Opera Germany; Stockholm Brass Quintet Sweden

New York Public Interest Research Group 1981-82 Canvass Supervisor

San Francisco Police Department 1982-2004
Patrol Division Mission Station 1982-1986
Narcotics Division 1987-1989 Organized Crime Drug Enforcement Task Force U.S. Attorney's Office
Bureau of Investigations 1989-2004 Sergeant/Inspector
Narcotics Division
Financial Crimes Section
Elder Abuse Task Force Inspector in Charge*
Homicide Section Elder Abuse Crimes
Child Abuse Section
Supervisor- Cargo Theft Task Force San Francisco Airport
Sexual Assault Section

P.O.S.T Certifications: Basic, Intermediary, Advanced, Supervisory
Narcotics Investigation
Financial Crimes Investigation
Homicide Investigation
Child Abuse Investigation
Sexual Assault Investigation

*Co-designed & Implemented Multi-Disciplinary Protocol for SFPD, Adult Protective Service, Public Guardians Office, District Attorney's Office response to Elder Abuse Allegations

AWARDS:

San Francisco Police Department:

Medal of Valor

Meritorious Conduct Award

Police Commission Commendations (4)

Captain's Complimentary Reports (42)

Honolulu Police Department:

Service award

California Attorney General:

Excellence in Investigations Performance Award

Citizen Awards:

American Institute of Architects Citation for Outstanding Service

Justice for Murder Victims Appreciation Certificate

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JAN GOLDSMITH

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CARL WASHINGTON

Assembly
California Legislature

Committee on Public Safety

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JUDITH M. GARVEY

COUNSELS
DAWN KUSUMOTO
JEROME McGUIRE

CONSULTANT
JAMES TOMA

COMMITTEE SECRETARY
SUE HIGHLAND

October 16, 1997

John Willett, Deputy Chief
San Francisco Police Department
Hall of Justice
850 Bryant Street
San Francisco, CA 94103

Dear Deputy Chief Willett:

The Assembly Committee on Public Safety will conduct an interim hearing relating to elder abuse at the State Capitol, Room 4202, Sacramento, on Tuesday, November 18, 1997, beginning at 9:30 a.m. This hearing will explore both financial and physical elder abuse.

As my staff has prepared for hearing, there is a strong statewide consensus that Inspector Phillip Tummarello be invited to participate on our panels. As you may know, Inspector Tummarello was very helpful to me this year securing the enactment of AB 870 (elder abuse training for law enforcement).

Your consideration of this request is appreciated.

Sincerely,

ROBERT M. HERTZBERG
Chair

RMH/jt/jg:slh

cc: Inspector Tummarello

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COUNSELS
DAWN KUSUMOTO
JEROME McGUIRE

CONSULTANT
JAMES TOMA

COMMITTEE SECRETARY
SUE HIGHLAND

November 24, 1997

Philip Tummarello, Inspector
Department of Justice
2720 Taylor Street, #300
San Francisco, CA 94133

Dear Inspector Tummarello:

Thank you for your valuable participation at our hearing, "Invisible Crimes: What Can the Legislature Do to Prevent the Physical or Financial Abuse of the Elderly."

Our Committee members and staff felt the hearing was extremely informative and educational, and provided the Committee with many ideas about ways in which to combat the problem of elder abuse. We believe were successful in creating significant awareness of the problem and in educating Assembly members and staff regarding the complexities of the issue.

I hope that you continue to work with us on solving problems in this very important area of public policy. If you have a legislative idea (or ideas), I urge you to submit them in writing to the Assembly Committee on Public Safety (P.O. box 942849, Sacramento, CA 94249-0001).

I hope you will stay in touch with Committee staff and keep us informed. I look forward to working with you in the future.

Sincerely,

ROBERT M. HERTZBERG
Chair

RMH/JT:slh

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California Legislature

ROBERT M. HERTZBERG
ASSEMBLYMEMBER, FORTIETH DISTRICT

COMMITTEES
CHAIR, PUBLIC SAFETY
MEMBER, GOVERNMENTAL ORGANIZATION
MEMBER, HEALTH
MEMBER, INTERNATIONAL TRADE & DEVELOPMENT
MEMBER, LOCAL GOVERNMENT

March 14, 1997

Deputy Chief John Willett
Chief of Inspectors
Hall of Justice
850 Bryant Street Room 400
San Francisco, CA 94102

Dear Mr. Willett:

I wish to request the testimony of Sergeant Inspector Phillip Tummarello Star # 803 before the Assembly Public Safety Committee on Tuesday April 8, 1997. I am chair of the Committee and will be presenting AB 870, a measure to help prevent the increasing incidence of white collar crimes committed against the elderly. Attached is a copy of the bill and a brief summary of the legislation.

Mr. Tummarello's testimony would greatly contribute to the committee's understanding of the breadth of scams which are committed against the elderly in the San Francisco Bay Area and throughout California. Please inform Elise Thurau (916) 445-7644 of your decision concerning Mr. Tummarello's attendance and testimony at this upcoming hearing.

Thank you for your consideration.

Kindest regards,

Robert M. Hertzberg
Chairman, Assembly Public Safety Committee
Assemblymember, 40th District

RMH:et

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Francisco Examiner
SINCE 1887 · MONARCH OF THE DAILIES
[★★]
Friday afternoon
NOVEMBER 7, 1997
HOME DELIVERY EDITION
TWENTY-FIVE CENTS NEWSSTAND PRICE

'Mad City'

Hoffman, Travolta star in remake by Costa-Gavras [C-1]

8 accused of plotting poison murders

FOXGLOVE from A-1

ght indicted in eath conspiracy

n arrested as of late Thursday. Department sources said investors and prosecutors had debated for years whether they could r convince a jury that any of the tims were actually murdered. ile traces of digitalis were found he bodies of five alleged victims, y all were originally determined have died of natural causes, according to law enforcement irces.

Coroner reports on all the vicns have been sealed at the request of investigators for more an three years.

The five alleged victims were all friended not long before their aths by members of a group that cluded Angela Tene, also known Angela Bufford; her mother, ary Tene Steiner; her brother, anny Tene; and Angela's boyend, George Lama, police said.

Jail officials said George Lama, , and Angela Bufford, 37, were ch arrested on six counts of conpiracy to commit murder and ore than a dozen counts of stealg from a dependent adult. Mary ene Steiner, 57, was booked on vo charges of conspiracy to comit murder and two counts of cruty to a dependent adult.

Danny Tene, 35, was arrested n nine counts of stealing from a ependent adult and one count of rand theft of property.

Teddy Tene, 27, was booked on single count of stealing from a ependent adult. His involvement n the group and the alleged crimes vas not clear late Thursday.

Police arrested Lama and Buford at 10:25 a.m. at their home at 9th Avenue and Moraga Street. Mary Tene Steiner, Danny Tene nd Teddy Tene were all taken into ustody just after noon at 22nd Avenue and Taraval Street.

All five were being held at the County Jail. No bail was set for Lama, Bufford and Steiner; Danny and Teddy Tene were each being held on $1 million bail.

Bufford's attorney, Robert Sheridan, said she is innocent.

"The poison murder story is fascinating but it's missing couple of things, like poison and murder," Sheridan said. "The booking sheet says that she is charged with conspiracy to commit murder — not murder. That shows they don't have a case. If they had a case, why didn't they prosecute her four years ago? Three years ago? Two years ago? Last year? Why now? ... This is completely political."

The attorneys for the others could not be reached for comment.

Because copies of the indictments were not made public, the identities of the other three people who were indicted were not known.

Law enforcement officials say all four Tenes are members of the Tene Bimbo clan, which gained notoriety in Peter Maas' best-selling slowly poisoned using the drug digitalis in a plot to acquire their estates, investigators said. Digitalis, a heart drug that can be fatal in higher doses, is derived from the foxglove plant.

The defendants allegedly won the confidence of their targets, getting access to each man's assets. The defendants decided not to wait for their elderly victims to die of natural causes and instead sped up the process, investigators believe.

The bodies of four men — Philip H. Steiner Jr., 93; Konstantin K. Liotweizen, 92; Nicholas C. Bufford, 87; and Stephen Storvick, 91 — were exhumed in 1994 for autopsies.

An autopsy also was conducted on a fifth man, Harry Glover Hughes, 94, when he died in March 1994. Police have not released the autopsy results.

The five San Francisco men died between 1984 and 1994. Two of the suspected victims were married shortly before they died, one to

bers of the clan also shared estates of three other elderly they had befriended, investi said.

The suspected ring has all acquired more than $1 mill cash, investments, real estat elry and automobiles, by eitl friending or marrying victir cording to private detectives ing on behalf of family mem the deceased.

The Foxglove investigati been very controversial witl Police Department. The investigators were pulled case and later accused of i misconduct charges for al violating police procedural lines. For several years, th glove investigation was refe as the "Case from Hell" b who were close to it.

The two original insp Greg Ovanessian and Dani czak, were taken off the 1994 and now face interna misconduct charges. They

FOXGLOVE CHRONOLOGY

The alleged murder-for-profit scam in San Francisco goes back at least 14 years.
The following is based on court records and interviews with law enforcement agents:

▶ **APRIL 1983:** Mary Tene, 42, marries Philip H. Steiner Jr., 89, a former hotel maintenance employee, and becomes a joint tenant on the deed to Steiner's 33rd Avenue home.

▶ **MAY 1984:** Angela Tene, Mary Tene's daughter, goes with Nicholas Bufford to the county courthouse, where she registers as his granddaughter on the deed of trust for his 14th Avenue home. Three months later, Angela Tene, then 24, marries Bufford, 87, and is designated his sole beneficiary and executor of his estate. In November, Bufford dies of uremia, complicated by heart disease. Angela Tene inherits his entire estate, including savings of $125,000.

▶ **1986:** While still married to Steiner, investigators believe that Mary Tene moved in with Konstantin Liotweizen, an 89-year-old retired deli owner with a broken hip. She becomes a joint tenant on the deed to Liotweizen's Funston Avenue apartment complex, later valued at $937,000.

▶ **1987:** Steiner dies of cardiopulmonary arrest, brought on by pneumonia. Mary Tene inherits his Sunset District house, his stock investments and half of his bank accounts. George Lama, who has been called Angela's boyfriend by investigators, begins buying digitalis, a heart drug, from the West Portal Pharmacy, according to police records.

▶ **1989:** Liotweizen dies of heart failure, according to coroner's records. As the surviving joint tenant, Mary Tene inherits the building. Some $77,000 in other assets is split between Mary Tene and Liotweizen's son, Michael. Angela Tene and Lama meet Stephen Storvick, 88, and begin to bring him food in his apartment above the deli. Storvick receives numerous anonymous telephone threats and agrees to Angela Tene's suggestion to make her his heir.

▶ **MARCH 1991:** Storvick tells police he suspects that Angela Tene and Lama are trying to kill him by drugging his food. Later, suspecting he is being manipulated, Storvick alters his will again, designating his relatives in Norway as beneficiaries.

▶ **1992:** Storvick dies of respiratory failure brought on by pneumonia.

▶ **1993:** Lama and Angela Tene meet and befriend Harry Glover Hughes, 94, and begin bringing him food. Lama's name later appears on the title to Hughes' Mercedes. By March 1994, Lama and Angela Tene's names are discovered on at least three of Hughes' bank accounts. That year, police inspectors Gregory Ovanessian and Daniel Yawczak begin investigating, based on tips from informants and private investigators.

▶ **MARCH 1994:** Hughes' nephew David Payne wins conservatorship of his uncle and his $1.2 million estate. In court documents, Payne's attorney asserts Hughes "was being manipulated and controlled, and his assets stolen and converted by a young couple who were preying on him due to his age and infirmities." Two weeks later, Hughes dies of a cerebral hemorrhage. His death certificate lists the cause of death as "pending further investigation and/or testing."

▶ **JUNE 1994:** San Francisco police confirm the bodies of Liotweizen, Bufford, Storvick and Steiner have been exhumed for autopsies and toxicological tests. Steiner was exhumed in Oakland. A new autopsy is also arranged for Hughes, who had not yet been buried.

▶ **JULY 1994:** The Foxglove investigation is transferred to the homicide detail from the fraud unit. Ovanessian and Yawczak are taken off the case and soon are investigated for wrongdoing themselves by the department's internal affairs unit. Inspector Phil Tummarello joins the team, then headed by homicide Inspector Jim Bergstrom.

▶ **1995:** Tummarello takes over the case, working in the homicide office.

▶ **1996:** Police Department accuses Ovanessian and Yawczak of wrongdoing. They are later accused of jeopardizing the safety of a witness, failing to warn potential victims of danger and leaking a sealed request for a search warrant to private investigators. Both investigators have denied wrongdoing. Tummarello is transferred out of Hall of Justice, working alone to prevent leaks about the investigation.

▶ **JULY 1997:** District attorney's office begins presenting the case to the grand jury.

▶ **NOVEMBER 1997:** Grand jury indicts eight people on charges ranging from conspiracy to commit murder to fraud, theft and elder financial abuse.

–EXAMINER

ARREST from D-1

..A. cop allegedly ilked S.F. woman

ad Palladino's money.

"Price did admit to me that he elt she wasn't in a position to nake these sorts of decisions. He aid that he was not surprised she ad been diagnosed with Alzhei-ner's," Tummarello said.

The probe is led by Tummarello ut also includes police from Irvine nd Los Angeles as well as the state Department of Corporations. It ook so long to break because of the victim's poor health and the difficulty of tracking down financial records without tipping off the suspects. But Palladino's plight inspired San Francisco to form a unit dedicated to investigating the swindling of senior citizens.

The investigation began in December 1993, when Wright escorted Palladino to Paine Webber's San Francisco offices and tried to cash out her entire $140,000 account.

Her broker, Peter Keating, grew suspicious because Palladino, a 20-year client, seemed disoriented and Wright, whom they had never seen before, was doing the talking, Tummarello said.

At that meeting, Wright represented himself first as Palladino's investment advisor, then her attorney and then, when Paine Webber employees became suspicious, "He pulled out his LAPD shield and identified himself as an LAPD officer," Tummarello said. "Then he quickly hustled her into an elevator" and left.

Palladino returned to Paine Webber a few days later again escorted by Wright, Tummarello said, but Wright waited in the lobby. At that time she withdrew $5,000 from her account and then signed it over to Liberty International. She also wrote a check to Liberty for $25,000 — her entire account — from American Savings Bank, Tummarello said.

The money was almost immediately withdrawn from Liberty International's account by Wright, Tummarello said, and hasn't been seen since.

In January of last year, Paine Webber received a letter, signed by Palladino, demanding that her account be immediately closed.

"Paine Webber was suspicious," Tummarello said, because the letter was postmarked Santa Ana, and their client lives in San Francisco. "It was typed — when she didn't own a typewriter," said Tummarello.

But until April, Palladino continued to receive calls and visits from Wright and Price. The two took her out to lunch at the Cliff House while winning her trust.

"They found the mother lode and they were up here to drain it," Tummarello said. "She was totally helpless and these guys got wind of it and took advantage of it like sharks at a feeding frenzy."

L.A. cop held in bilking of S.F. woman

Officer allegedly swindled 79-year-old with Alzheimer's out of $70,000 in savings

By Jim Herron Zamora
OF THE EXAMINER STAFF

A Los Angeles police officer has been arrested for allegedly bilking $70,000 from an 80-year-old San Francisco woman with Alzheimer's disease by promising to invest her money in lucrative securities, investigators said.

After a 15-month investigation, Thomas Wright, 30, of Orange County, was arrested Friday in Irvine at the office where several of his allegedly bogus investment companies are based, said San Francisco police Fraud Inspector Phil Tummarello.

Wright and his partner, Anthony Price, 26, allegedly defrauded Mary Palladino (who has since died) of nearly half her life savings. The scam allegedly took place between December 1993 and last April.

Palladino, a childless widow with Alzheimer's dementia, lived in San Francisco's Ingleside District until her death in October.

"It's disgusting that they were preying on her," said her niece, Denise Meschi, of Fairfield. "The poor thing — they just took advantage of her when she was helpless and confused. These guys make me sick."

Wright and Price are being held in connection with only the Palladino case, but investigators say their work is continuing. Officials from several agencies are reviewing their records taken in a raid Friday in an office park in Irvine.

"It looks like they had contacts with potential investors all over the state," Tummarello said Saturday. "It looks like they were targeting retired people."

The suspects are accused of defrauding people with promises of safe investments with 11¾ percent returns, Tummarello said. Police said the two men ran three companies: Liberty International Acquisitions, Woodbury Financial and Consolidated Energy — none of which is registered with the state Department of Corporations, Tummarello said.

"Neither is licensed to sell securities in California," Tummarello said. "They acknowledge that she (Palladino) invested $70,000 with them and Price acknowledged that she has never been paid anything."

Wright served for nearly two years as a reserve or part-time police officer in the LAPD's Rampart station near downtown Los Angeles before he resigned Friday after his arrest, Tummarello said.

It is unclear if he used his police status to further the conspiracy, other than mentioning it to gain Palladino's trust, Tummarello said.

Wright and Price are being held at the Orange County Jail in lieu of $150,000 bail on charges of elder abuse, grand theft and conspiracy, Tummarello said. Price is on federal probation for mail fraud in Arizona, Tummarello said, and he had been ordered not to sell securities.

Since their arrest, both Wright and Price told police they no longer

[See ARREST, D-8]

Lonely widow bilked of savings

Homeless junkie swindled her out of $30,000, cops say

By Jim Herron Zamora
OF THE EXAMINER STAFF

An 81-year-old widow, who was tired of crying alone in her studio apartment every holiday, took in a homeless drug user she met on the street to keep her company and ended up being swindled out of her life savings, police said.

"This is a sweet, vulnerable woman who was terribly lonely, and she lost everything to this guy," San Francisco police Inspector Phil Tummarello said Wednesday. After the suspect was jailed in the case, he even called the woman asking for bail money, Tummarello said.

The woman was allegedly cajoled into withdrawing about $30,000 — virtually her entire life savings — from her bank over an eight-month period and giving it all to Monte Forgue, 43, whom she met while he was panhandling near her home on Van Ness Avenue in February, police said.

"He befriended her, and she appreciated the attention because she is all alone," Tummarello said. "She had only met him once, and she offered him a place to stay.

"She told us she got tired of crying all by herself on all the holidays."

Forgue pleaded not guilty Wednesday in San Francisco Municipal Court to charges of elder abuse, grand theft and burglary. Forgue, who allegedly spent much of the money to feed a heroin habit, is being held in City Jail in lieu of $10,000 bail.

"He denies doing anything wrong," Tummarello said. Forgue told police "he was just keeping her company."

Judge Donna Little ordered him not to contact the alleged victim. Forgue, who was arrested Friday, had phoned the woman twice from jail asking her to bail him out, Tummarello said.

She had gone to visit him in jail twice and both times gave him $20 but declined to bail him out because she could not afford it, Tummarello said.

Police were alerted to the case by tellers at the Wells Fargo Bank branch at 1560 Van Ness Ave. who noticed that the woman, accompanied by Forgue, was withdrawing large amounts of money almost daily.

On Sept. 12, Officer Ed Garcia was at the bank taking a report in a unrelated case, and a teller told him about the woman.

After questioning, "she indicated that she was being intimidated by this man," Tummarello said. "He would ask her to withdraw money almost every day."

The woman also told police that Forgue encouraged her to drink alcoholic beverages, Tummarello said.

"She would ask (him) later what happened to all of the money, and he would say, 'You had a lot to drink, and you must have lost it,'" Tummarello said.

After interviewing her, police arrested Forgue on the sidewalk near her home.

compassion & choices
Montana

Support. Educate. Advocate. Choice & Care at the End of Life.

June 5, 2012

Dear Montana Physician,

Montanans are independent. Montanans are thoughtful. They believe in privacy. That's why the Montana constitution is written to guarantee personal privacy and dignity. Terminally ill Montanans are guaranteed the right to choice, privacy and dignity at the end of life. On December 31, 2009, the Montana Supreme Court ruled terminally ill Montanans have the right to choose aid in dying under state law. The court's decision set clear boundaries for this intervention: the patient must be terminally ill and mentally competent, and the physician may provide, but not administer, a prescription for life-ending medication. Only the patient may administer this medication. Physicians can provide prescriptions to such patients without fear that doing so could give rise to criminal or disciplinary sanction.

Compassion & Choices Montana has been working tirelessly with medical professionals and citizen activists to educate the public, implement the practice with appropriate safeguards and protect the right of Montanans to die with dignity. Recently, the Montana Board of Medical Examiners (BME) adopted a new policy further establishing aid in dying as a medical intervention to be governed, as with all other medical interventions, by professional practice standards. Specifically the BME Policy states:

> *"The Montana Board of Medical Examiners has been asked if it will discipline physicians for participating in aid-in-dying. This statement reflects the Board's position on this controversial question.*
>
> *The Board recognizes that its mission is to protect the citizens of Montana against the unprofessional, improper, unauthorized and unqualified practice of medicine by ensuring that its licensees are competent professionals. 37-3-101, MCA. In all matters of medical practice, including end-of-life matters, physicians are held to professional standards. If the Board receives a complaint related to physician aid-in-dying, it will evaluate the complaint on its individual merits and will consider, as it would any other medical procedure or intervention, whether the physician engaged in unprofessional conduct as defined by the laws and rules pertinent to the Board."*
>
> *(http://bsd.dli.mt.gov/license/bsd_boards/med_board/board_page.asp)*

Physician Advisory Council for Aid in Dying

Helping physicians empower terminally ill patients in Montana with the ability to control their suffering and choose their manner of death

End-of-Life Care in Montana

The State of Montana authorizes a range of end-of-life care options, including but not limited to:

- Discontinuing life-prolonging modalities such as dialysis, pacemakers, antibiotics, or other medication;
- Providing palliative support to a patient who elects to stop eating and drinking;
- Administering palliative sedation upon the request of the patient;
- Providing medication to provide peace of mind that peaceful dying is achievable.

The medical practice of aid in dying for terminally ill patients is becoming more established, as evidenced by the increasing number of states where aid in dying is openly available and by the growin number of professional medical organizations that support open access to aid in dying: the American College of Legal Medicine (ACLM), the American Medical Women's Association (AMWA), the America Medical Student Association (AMSA); the American Academy of Hospice and Palliative Medicine (AAHPM) has shifted its stand from oppositional to neutral.

Montana Physicians Are Authorized to Provide Aid In Dying Subject to Professional Best-Practice Standards

The *Baxter* decision, handed down by the Montana Supreme Court on December 31, 2009, affirmed that aid in dying is legal in Montana. The Court's decision specified that a patient must: (1) have a terminal illness; (2) be within six months of death; and (3) be of sound mind.

In response to the Baxter decision, the Board of Medical Examiners (BOME) issued a formal statement on January 20, 2012 clarifying the Board will treat aid in dying as it would any other medical procedur or intervention when evaluating physician conduct. The BOME statement entrusts physicians in Montar to set the standard of care for aid in dying as they have with other end-of-life practices.

Physician Advisory Council for Aid in Dying

The primary goal of the Montana Physician Advisory Council for Aid in Dying (PACAID) is to help physicians empower terminally ill patients to control their suffering and choose the manner and timing of death. To accomplish this goal, members of Montana PACAID will:

1. Adopt best-practice guidelines for aid-in-dying medical practice in Montana. Montana law entrusts physicians to set the standard of care for aid in dying as they have with other end-of-life practices. Physicians have established standards of practice in Oregon and Washington. Members of the Montana PACAID will help physicians adopt these standards and integrate aid in dying into end-of-life care in Montana.

2. Advise physicians, hospices and requesting patients. As the medical practice of aid in dying matures in Montana, physicians will receive increased requests. Hospices and individual hospice workers will benefit from information, guidance and emotional support from knowledgeable and supportive colleagues. All will need reassurance that what they are doing conforms to a medical best-practice standard, which shields them from criminal conviction and professional discipline.

3. Serve as a prescribing physician. Patients will need support and direction to talk with their physicians about aid in dying. Members of the PAC with current licenses and prescribing privileges for controlled substances can serve a consulting role as a prescribing physician.

4. Shepherd affirmative policies through local medical organizations. Members of PACAID will work with the Montana medical organizations to encourage adoption of affirmative policies and documented support of the medical practice of aid in dying.

5. Develop, grow and lead the Physician Coalition for Aid in Dying. The Physician Coalition for Aid in Dying will be a network of supportive physicians that will:

a. Lend their names and reputations to this effort by helping the public and medical community understand aid in dying as an available option in the palliative continuum at the end of life;

b. Inform physicians of Compassion & Choices' End-of-Life Consultation program for support and information, for their patients and themselves;

c. Educate medical providers and answer their concerns about prescribing or referring patients to prescribing physicians;

d. Serve as a prescribing physician;

e. Develop relationships with pharmacists so prescriptions can be filled locally; and

f. Provide professional education through grand rounds.

Please Join the Montana Physician Advisory Council for Aid in Dying

To learn more, please call Patrick Johnson at 406.552.2916 or email at PJohnson@compassionandchoices.org

Oregon's Death With Dignity Act – How well is it REALLY working?

"Death with Dignity" supporters in Vermont would like to convince us that physician-assisted suicide is safe from abuses or exploitations because it is supposedly going well in Oregon. But, consider the following:

- In commenting on the reported data, the Oregon Health Division says on its website, "The Oregon Health Divison is charged with collecting information under the Death With Dignity Act but also obligated to report any cases of noncompliance with the law to the Oregon Board of Medical Examiners. Our responsibility to report noncompliance makes it difficult, if not impossible, to detect accurately and comment on underreporting. … **We cannot determine whether physician-assisted suicide is being practiced outside the framework of the Death With Dignity Act."** (emphasis added)

- The Oregon Health Divison can only report data that is reported voluntarily to them. They have no authority or resources to look for abuses. The reports originate from physicians who have written the lethal prescriptions; they are not likely to report cases that do not comply with the law or do not go well.

Newspapers have reported cases of abuse. Read about the Michael Freeland story on the reverse side.

Dr. Robert Orr, President
Vermont Alliance for Ethical Health Care
P.O. Box 2145, South Burlington, VT 05407-2145
website: www.vaeh.org
e-mail: info@vaeh.org

> were not imminently dying or suffering intractable pain; they were suffering from depression and despair.) Those patients who are truly at the end-of-life need access to excellent palliative and hospice care, not a lethal overdose.[55]

Other research supports Greene's conclusion that most patients requesting death do so not based on physical symptoms such as pain or nausea, but rather based on depression and other forms of psychological distress.[56]

Ignoring What Lies Beneath: The Abandonment of the Patient

Addressing the situation of the individual patient, Hendin stated in Congressional testimony:

> a request for assisted suicide is ... usually made with as much ambivalence as are most suicide attempts. If the doctor does not recognize that ambivalence as well as the anxiety and depression that underlie the patient's request for death, the patient may become trapped by that request and die in a state of unrecognized terror.[57]

As Hendin and Foley wrote in 2008, when patients requesting a doctor's assistance to die "are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears."[58] Yet primary care physicians are generally not experts in diagnosing depression. Where assisted suicide is legal, the depression remains undiagnosed, and the only treatment consists of a lethal prescription.

The danger assisted suicide raises for people with depression and psychiatric disabilities has been very real in Oregon, and this is a key way that assisted suicide harms people with disabilities. N. Gregory Hamilton, M.D., Distinguished Fellow of the American Psychiatric Association and co-founder of Physicians for Compassionate Care, has demonstrated how Oregon's flimsy safeguards do not protect people with psychiatric and other mental health disabilities. In his 2004 testimony to a British delegation considering a law similar to Oregon's, Hamilton documented the case of Michael Freeland, a man with "a long history of serious depression and previous suicide attempts" who nonetheless received lethal drugs under the Oregon law.[59] A recent study in the *British Medical Journal* confirmed that that some of the reported Oregon cases were patients who were, in fact, depressed.[60]

People with depression can receive lethal drugs in Oregon and Washington legally, because they are still technically eligible as long as they are deemed legally competent, that is, "competent and not suffering from a psychiatric or psychological disorder or depression *causing impaired judgment.*"[61] [emphasis added] Yet the notion that patients with depression may be considered legally competent to decide to end their lives merely because the depression doesn't impair their legal competency—Orwellian at best—is also at variance with the majority of clinical and forensic psychiatrists who believe "that the presence of major depressive disorder should result in an automatic finding of incompetence" to make decisions about assisted suicide.[62] And as Hendin and Foley pointed out, "Reducing the psychiatric consultation to the issue of competency ignores all the other psychological factors

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Oregon doctor could not save patient from assisted suicide

JANUARY 27, 2013 12:00 AM

I am a doctor in Oregon, where assisted suicide is legal. A few years ago, I was caring for a 76-year-old man who presented to my office a sore on his arm, eventually diagnosed as melanoma. I referred him to specialists for evaluation and therapy.

I had known this patient and his wife for more than a decade. He was an avid hiker, a popular hobby here in Oregon. As his disease progressed, he was less able to do this activity, becoming depressed, which was documented in his chart.

During this time, my patient expressed a wish for assisted suicide to one of the specialists. Rather than take the time to address his depression, or ask me as his primary care physician to talk with him, she called me and asked me to be the "second opinion" for his suicide. She told me that barbiturate overdoses "work very well" for patients like this, and that she had done this many times before.

I told her that assisted suicide was not appropriate for this patient and that I did not concur. I was very concerned about my patient's mental state, and told her that addressing his underlying issues would be better than simply giving him a lethal prescription. Unfortunately, my concerns were ignored, and two weeks later my depressed patient was dead from an overdose prescribed by this doctor.

Under Oregon's law, I was not able to protect my depressed patient. If assisted suicide becomes legal in Montana, you may not be able to protect your friends or family members.

I urge you to contact your legislators to tell them to keep assisted suicide out of Montana. Don't make Oregon's mistake.

Dr. Charles J. Bentz

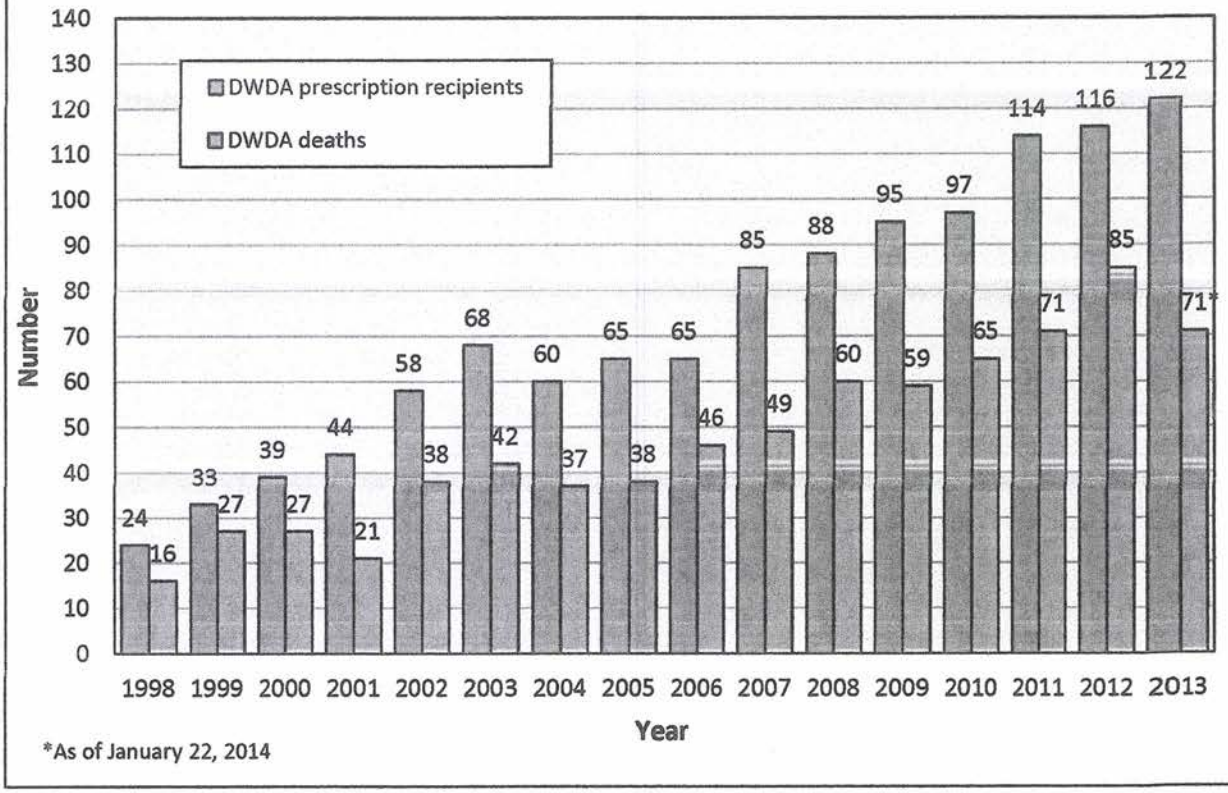
2400 SW Vermont St.

Portland, Ore.

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

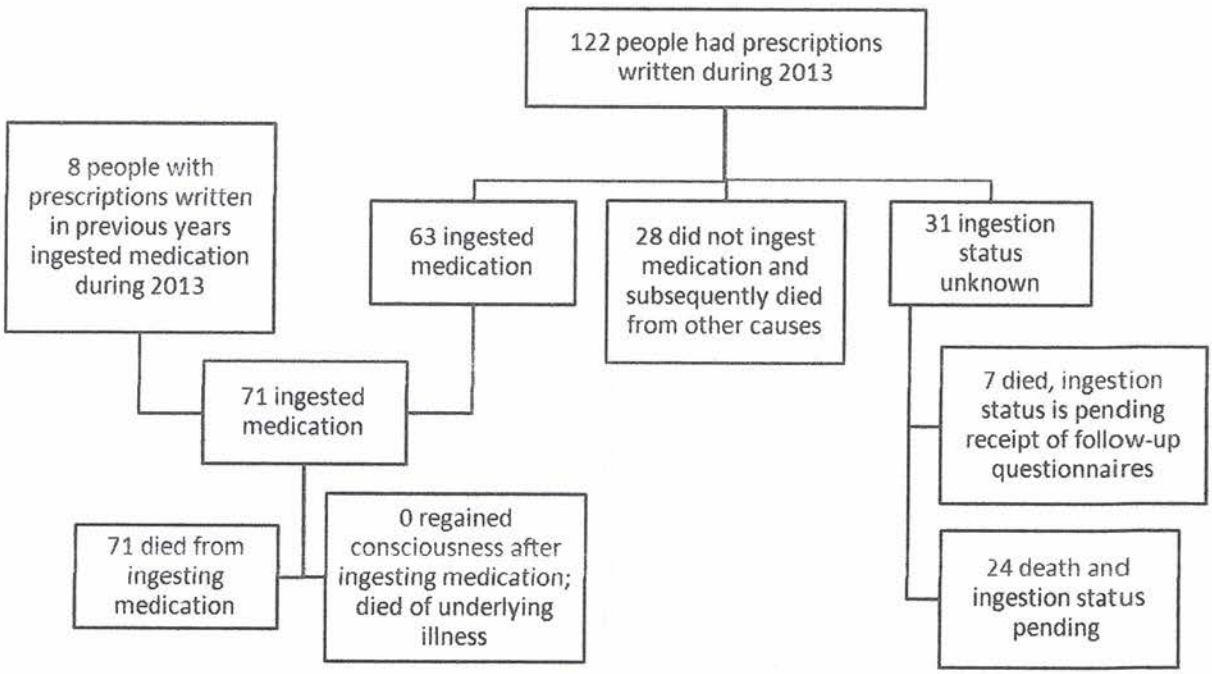


Table 1. Characteristics and End-of-life Care of 752 DWDA Patients who Died from Ingesting a Lethal Dose of Medication as of January 17, 2014, Oregon, 1998-2013

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

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.

Oregon's Physician-Assisted Suicide Law - Abused and Exploited

Case in Point: Kate Cheney

Kate Cheney, 85, had terminal cancer and told her doctor she wanted assisted suicide. Concerned that she didn't meet the required criteria for mental competence because of dementia, he declined to write the requested prescription and instead referred her to a psychiatrist as required by law. She was accompanied to the psychiatric consultation by her daughter. The psychiatrist found that Kate had a loss of short-term memory. It also appeared that her daughter had more interest in Cheney's assisted suicide than did the patient herself. The psychiatrist wrote in his report that while the assisted suicide seemed consistent with Kate's values, "she does not seem to be explicitly pushing for this." He also determined that Kate did not have the "very high capacity required to weigh options about assisted suicide," and he declined to authorize the lethal prescription.

Kate seemed to accept the psychiatrist's verdict, but her daughter did not. Her daughter viewed the guidelines protecting her mother's life as obstacles, and in a press interview called the guidelines a "roadblock" to Kate's right to die and demanded that Kate's HMO, Kaiser Permanente, provide a second opinion. This was provided by a clinical psychologist (rather than a MD-psychiatrist) who also found Kate had memory problems. The psychologist also worried about familial pressure, writing that Kate's decision to die "may be influenced by her family's wishes." Still, despite these reservations, the psychologist determined that Kate was competent to kill herself and approved the writing of the lethal prescription. Sometime later, Kate went into a nursing home for a week so that her family could have some respite from care giving. After she returned home, she declared her desire to take the pills.

The safeguards failed Kate Cheney:

- It is possible to circumvent the safeguards by "shopping" for an agreeable professional to write the lethal prescription.
- By giving the interview, the patient's daughter unintentionally revealed that the law does not adequately protect patients with diminished capacity from family coercion.
- Did financial considerations influence the HMO director to write the prescription?

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Oregon's Physician-Assisted Suicide Law - Abused and Exploited
Case in Point: Michael Freeland

Mr. Freeland requested and received a lethal prescription from Dr. Peter Reagan, a suicide advocate, a few months after being diagnosed with lung cancer. Dr. Reagan offered to refill it when he outlived his 6 month limit.

Over a year after receiving the first prescription, he was admitted to a psychiatric treatment facility with depression and suicidal intent. He was treated and improved. His professional caregivers ensured that his 32 guns and all his ammunition were removed from his home before he was allowed to return, but they knowingly allowed him to keep his lethal prescription. His treating psychiatrist wrote a letter to the court the day after his discharge saying he was not competent and needed a guardian.

Mr. Freeland called Physicians for Compassionate Care (he called them accidentally; he was actually trying to contact the suicide advocacy organization Compassion in Dying). Physicians for Compassionate Care volunteers helped him through his last several months of life, saw that his depression and his symptoms were treated aggressively, and assisted him in reconciling with his estranged daughter. He died naturally and comfortably nearly 2 years after receiving his first lethal prescription. Before he died, he signed an authorization releasing his medical records for public review.

The safeguards failed to protect Michael Freeland:

- Incorrect prognosis – Michael Freeland was not within six months of dying
- The prescribing doctor offered a lethal prescription to a depressed patient
- Even after courts determined that Michael Freeland was not competent and in need of a guardian, he was allowed to keep his lethal prescription

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Oregon's Physician-Assisted Suicide Law - Abused and Exploited
Case in Point: Patrick Matheny

Patrick Matheny, 43, had Lou Gehrig's disease (ALS). For several months, he struggled with a decision to end his life using a lethal prescription. He would set arbitrary deadlines, then, when the time came, would set new deadlines. At first, it was to be after his 15-year-old son came to visit last Thanksgiving. Then it was to be when he could no longer dress and wash himself. As an article in the Oregonian put it, "Pat felt he would rather be dead than accept help to bathe and dress." But when the time came, he was able to handle having his mother and hospice nurses help him-so he set new deadlines.

On 3/10/99, Matheny tried to swallow the barbiturates mixed into a chocolate nutrition drink, sweetened with a boxful of sugar substitute. Reportedly, he experienced difficulty swallowing the concoction. The only person Matheny had asked to be with him in his trailer was his brother-in-law, Joe Hayes. Hayes told the *Oregonian* that he had to "help" Matheny to die, but would not say how. According to Hayes, it was too personal. "It doesn't go smoothly for everyone," Hayes explained. "For Pat it was a huge problem. It would have not worked without help," he added.

The safeguards failed in the Patrick Matheny case:

- Patients are required by law to self-administer the lethal drug in order to protect people from coercion and foul play.
- No investigation was done in the Matheny case, even though the deviation from the law was reported in the newspapers, sending the signal that Oregon's Death with Dignity Act can be violated with impunity.

References: Oregonian, 10/27/99, 1/17/99, 3/17/99
Register-Guard, 3/16/99

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Oregon's Physician-Assisted Suicide Law - Abused and Exploited
Case in Point: John Doe

In December, 1999, during a lecture at Portland Community College, elder-law attorney Cynthia Barrett discussed a failed attempt at PAS. An unnamed man who had completed the paperwork for PAS, took the "lethal" prescription, then developed some (unspecified) physical symptoms that were hard for his wife to handle, so she called 911. The paramedics took him to a Portland hospital and he was resuscitated. He died of his disease at "some period of time after that time." This case of failed PAS was not included in the year-end data report. Students in the class were told not to use this information and not to "go to the media."[1]

The safeguards failed to protect Michael Freeland:

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[1] Hamilton, Catherine. "The Oregon Report: What's hiding behind the numbers?"

Oregon's Physician-Assisted Suicide Law - Abused and Exploited
Case in Point: David Pruitt

David Pruitt, also a man from Oregon with lung cancer, obtained from a physician the standard lethal prescription, and when he felt it was time, he took the entire amount. He went to sleep for 65 hours and woke up saying "What the hell happened? Why am I not dead?" He was so unnerved by the experience that he didn't want to go through it again. He died naturally nearly two weeks later.

Repeated data from the Netherlands shows that 18-25% of Dutch people who take the same dose of the same drug as is used in Oregon do *not* die. They are then given a lethal injection by their doctor; that's legal there. The Oregon law does not allow lethal injection, and we don't know what happens to those who do not die. Deaths from physician-assisted suicide are not investigated in Oregon, and the state government says they have no way of knowing how often assisted suicide happens outside the framework of the law. Mr. Pruitt's case is the first to come to public attention.

Abuses, expansions and complications. Physician-assisted suicide is not the right answer for Vermonters who are approaching death. The right answer is excellent hospice and palliative care.

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Oregon's Physician-Assisted Suicide Law - Abused and Exploited

Case in Point: The Patient of Dr. Charles Bentz

Dr. Charles Bentz, an internist in Portland, Oregon, diagnosed a malignant melanoma in a 76 year old man who had been under his care for over 10 years. Unfortunately, the cancer had already spread to his shoulder at the time of diagnosis, so it was not curable. Dr. Bentz referred this active man to both radiation oncology and medical oncology, using two methods to slow the cancer and prolong the man's life.

When the patient finished the radiation therapy, the radiation oncologist informed Dr. Bentz that the patient was depressed due to his diminished physical stamina. At almost the same time, he finished his chemotherapy and asked his medical oncologist for a prescription so he could take his own life by suicide. The medical oncologist called Dr. Bentz asking him to act as the required second physician to confirm the diagnosis and prognosis before he wrote the prescription, saying secobarbital "works very well" and indicating he had used it many times. Dr. Bentz responded that he could not do this; the man had a documented depression and needed therapy for this. The oncologist then found another physician to render the required "second opinion" and did not refer the man back to his primary physician. Two weeks later the patient was dead from a lethal prescription.

Dr. Bentz obtained permission from the man's family and obtained a copy of the death certificate which said death was from malignant melanoma.

The safeguards failed this patient:

- His well-documented depression was not evaluated by a mental health specialist, nor was it treated.
- His primary physician was excluded from helping him with his end-of-life concerns.
- His oncologist falsified a public document by lying about the cause of death.

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Oregon's Physician-Assisted Suicide Law - Abused and Exploited
Case in Point: Helen X

Helen X:

Supporters of physician-assisted suicide (PAS) say vulnerable patients are protected from inappropriate use of lethal prescriptions because the law has adequate safeguards.

Soon after the Oregon law went into effect allowing a physician to write a lethal prescription for a patient, Helen asked her physician for one. She had a history of breast cancer and was enrolled in hospice. She had been using a wheelchair for 2 weeks and had some shortness of breath for which she used oxygen. However, she had no pain and she was still doing aerobic exercises regularly. Her physician declined. Helen saw a second physician, and he too declined because he felt she was depressed. Her husband called Compassion in Dying (now called Compassion and Choice) and they found a willing physician. Dr. Peter Regan, an advocate for PAS, wrote the prescription, though he admitted he was shaken by Helen's eagerness to die.

- Physician refusal to write a lethal prescription because the requesting patient does not meet the legal criteria need not deter a patient who is eager to die. All she needs to do is keep asking until she finds someone willing.
- This is not "protection."

For More Information:
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Oregon's Physician-Assisted Suicide Law - Abused and Exploited

Case in Point: Clarietta Day

Clarietta Day:

After passage of the Oregon law allowing physician-assisted suicide, but before it went into effect, Clarietta Day, age 78, had a severe stroke. She had told her longstanding physician, Dr. James Gallant (Corvallis, OR), that she did not want heroic measures and did not want to be kept alive on machines. Based on this understanding of the patient's wishes, Dr. Gallant (1) took her off life support, (2) gave her frequent large doses of painkillers, and (3) attempted to stop her cardiac pacemaker by placing a magnet over it. She continued to breathe. He then ordered an intravenous injection of a paralyzing drug and Mrs. Day died in 15 minutes. Dr. Gallant wrote on her death certificate that the cause of death was "stroke due to subarachnoid hemorrhage."

The Oregon Board of Medical Examiners investigated and called this active euthanasia, an action they felt was both unethical and illegal. They suspended his license to practice for 60 days. The Lane County district attorney decided not to file criminal charges.

- Dr. Gallant's lethal injection was clearly illegal.
- Was he motivated to do this by pending new legislation that would allow doctors to hasten death?
- Would this incident have been reported in the official PAS statistics had it happened a few months later?

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Oregon's Physician-Assisted Suicide Law - Abused and Exploited

Case in Point: Mrs. S.

Mrs. S. from Oregon had been struggling with a malignant lymphoma for 3 years. In spite of the best efforts of her several physicians, it had spread from her lymph nodes to her bones, brain and spinal cord. She had vigorous chemotherapy and radiation therapy. She had considerable pain, but this was kept under adequate control with medication. She was repeatedly discouraged, and this was helped somewhat by use of an antidepressant.

In a final visit with her primary physician, he gently confronted the fact that there was nothing more that could be done for the disease, though comfort measures could be continued. At the end of the visit, he said, "Well, I could write a prescription for an extra large amount of pain medication for you." She declined the offer and left the office. Mrs. S. and her husband were devastated. She kept saying, "He wants me to kill myself!" They interpreted his offer as saying "Your life is no longer worth living. You would be better off dead." Their longstanding good relationship with this seemingly caring physician was shattered by this new understanding of his values. Mrs. S. died comfortably at home several days later.

Lessons learned:

- Such an offer by a physician is illegal under the Oregon law which has a section entitled "Who may initiate a written request for medication."
- H-44 has no such "protection." It merely states that the request from the patient must be "voluntary." This could be interpreted to mean "not coerced" rather than patient-initiated.

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Oregon's Physician-Assisted Suicide Law - Abused and Exploited

Case in Point: Heather MacAllister

The *San Francisco Chronicle* reported in March 2007 on a memorial service in SF for Ms. MacAllister, a local promoter of fat burlesque:

"On what would have been MacAllister's 38th birthday, members of the gay, lesbian, bisexual and transgender community gathered to say goodbye to the performer and activist who ended her life Feb. 13 in Portland, Ore., through assisted suicide after a battle with ovarian cancer...MacAllister, a Michigan native, moved to San Francisco in 2005 to create the Big Burlesque and Fat Bottom Revue, featuring and celebrating large women."

There was no indication that she had moved to Oregon. The Oregon "Death With Dignity" Act states that physician-assisted suicide is only legal for Oregon residents.

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Oregon's Physician-Assisted Suicide Law - Abused and Exploited

Research in Oregon by a British physician:

In September and October of 2006, Dr. Richard Jeffrey, FRCPE, a palliative care physician from England, traveled to Portland, OR and Seattle, WA to learn first-hand about end-of-life options by interviewing individuals involved in palliative care and physician-assisted suicide. His extensive report included the following anonymous case vignettes*:

- Physician: "A young man moved specifically here because Oregon had the law. He had a strong belief in an after life. He decided the day, took the medication and died peacefully. The hospice nurse knew the day but was not involved. She came to the house after his death and supported the family."
  - a non-resident takes up "residence" so he can receive PAS

- Physician: "A patient with cancer had a friend who was a doctor. This friend told him that it was going to be a painful way to die and advised him to take advantage of the PAS law. The hospice staff felt he was not ready to die and were concerned that he may have bypassed some of the legal hoops. The family were not happy and everybody involved was uneasy. After taking the lethal prescription the patient didn't die quickly. The family were upset... why hasn't he died? The wife said she had to leave, she could not cope with the situation. The volunteers from a pro PAS organization found two men who knew nothing about nursing care to sit with the patient until he died the next morning. The wife became profoundly depressed and attempted to commit suicide herself."
  - a patient acts on bad advice and skirts the legal requirements
  - prolonged dying
  - adverse effect on survivor

- Physician: "One patient with motor neuron disease (ALS) was given the diagnosis and at the same time was informed by the doctor of the availability of PAS. 'You have ALS... this is awful... you should consider PAS.' The patient was devastated."
  - professional promotion of PAS as a first line option, not as a "last resort"

- Hospice staff: "At one meeting which I attended there was a ... pause as a nurse excused herself to attend a patient, whom she had never met, who was going to commit suicide at 2PM."
  - attendance at PAS by stranger

- Compassion & Choices Oregon: "The death certificate in a case of PAS certifies natural causes as the cause of death and does not mention PAS."
  - false information makes data analysis meaningless

- Physician: "I had a patient with lung cancer. She went to another physician and got a prescription. I found out later from the family that she had done PAS."
  - avoidance of involvement of the primary physician
  - PAS from a stranger

- Family member: "It's possible to get a lethal prescription without the hospice knowing about it... They wouldn't want to offend the hospice nurse."
  - the process is not open and transparent as proponents suggest

* Full report available at www.wcmt.org.uk/reports

Oregon's Physician-Assisted Suicide Law - Abused and Exploited

Case in Point: Wendy Melcher

The *Portland Tribune* reports (July 6, 2007) that Wendy Melcher, a cancer patient, died August 23, 2005, four days after two nurses, Rebecca Cain and Diana Corson, administered high doses of morphine and phenobarbital in what is being called a patient-directed suicide plan. Deviations from the Oregon's Death With Dignity Act include:

- no physician involvement
- no waiting period
- no documentation
- no self-administration
- no report to the Oregon Health Division.

Their actions were reported to the OR State Board of Nursing, and the Board reported (one year later) that the nurses admitted participating in a suicide plan, stating that the patient was having intolerable and uncontrollable pain. The Board suspended Corson's license for 30 days and placed Cain on probation for two years. The Board did not report this to any law enforcement agency. The state has recently (July 2007) learned of the case and is investigating it as a criminal case.

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

William Charney

ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES

Daniel R. Levinson
Inspector General

November 2010
OEI-06-09-00090

EXECUTIVE SUMMARY

OBJECTIVES

To estimate the national incidence of adverse events for hospitalized Medicare beneficiaries, assess the preventability of such events, and estimate associated costs to Medicare.

BACKGROUND

The term "adverse event" describes harm to a patient as a result of medical care, such as infection associated with use of a catheter. The term "never events" refers to a specific list of serious events, such as surgery on the wrong patient, that the National Quality Forum (NQF) deemed "should never occur in a health care setting." The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of never events among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

We selected a nationally representative random sample of 780 Medicare beneficiaries from all beneficiaries discharged during October 2008. Physician reviewers determined (1) whether an adverse event occurred, (2) whether the event was on the NQF list of Serious Reportable Events or the Medicare list of hospital-acquired conditions (HAC), (3) what the level of harm was to the patient, and (4) whether the event was preventable. To establish an estimated adverse event incidence rate, we included events on the NQF and the HAC lists and events resulting in the most serious harm as defined by a patient harm index (prolonged hospital stay, permanent harm, life-sustaining intervention, or death). We also determined the cost to Medicare for hospital care resulting from the events. Lastly, we identified additional events that resulted in temporary patient harm but were not comparable to the more serious events in our overall rate and assessed their preventability and cost.

FINDINGS

An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays. Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about 1 in 7 experienced an adverse event that met at least 1 of our criteria (13.5 percent). This rate projects to an estimated

134,000 Medicare beneficiaries experiencing at least 1 adverse event in hospitals during the 1-month study period. We calculated incidence rates for adverse events that met our three criteria: 0.6 percent of beneficiaries had an NQF Serious Reportable Event, 1.0 percent had a Medicare HAC event, and 13.1 percent experienced an adverse event resulting in the four most serious categories of patient harm. An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month.

An additional 13.5 percent of Medicare beneficiaries experienced events during their hospital stays that resulted in temporary harm. Temporary harm events are those that require intervention but do not cause lasting harm. Although many cases represent fairly minor occurrences, such as hypoglycemia, others were classified as temporary harm only because the patients were in the hospital for lengthy periods as a result of other, more serious, diagnoses, allowing hospitals enough time to address the harm prior to discharge. Additionally, 28 percent of beneficiaries who experienced adverse events also had temporary harm events during the same stay.

Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable. Physicians determined that 44 percent of all events were preventable and 51 percent were not preventable. (For the remaining 5 percent of events, physicians were unable to make determinations.) Events related to surgery or procedures were less likely to be preventable than other types of events, such as hospital-acquired infections. Preventable events were linked most commonly to medical errors, substandard care, and lack of patient monitoring and assessment. Physician reviewers assessed events as not preventable when they occurred despite proper assessment and care or when the patients were highly susceptible to the events due to health status. Nearly all events on the NQF and Medicare lists were assessed as preventable, a key criterion of both lists.

Hospital care associated with adverse and temporary harm events cost Medicare an estimated $324 million in October 2008. Sixteen percent of sample beneficiaries in the Medicare Inpatient Prospective Payment System who experienced events incurred additional Medicare costs as a result. The added costs equate to an estimated 3.5 percent of Medicare's expenditure for inpatient care during October 2008. To give these figures an annual context,

treatment. Table 8 provides physician preventability rationales for events within each assessment category.

Table 8: Events by Physician Preventability Rationales

Preventability Rationale	Percentage of Events*
Preventable Events (n=133)	
Error was related to medical judgment, skill, or patient management	58%
Appropriate treatment was provided in a substandard way	46%
The patient's progress was not adequately monitored	38%
The patient's health status was not adequately assessed	23%
Necessary treatment was not provided	17%
Event rarely happens when proper precautions and procedures are followed**	14%
Communication between caregivers was poor**	8%
Facility's patient safety systems and policies were inadequate or flawed**	3%
Breakdown in hospital environment occurred (equipment failure, etc.)**	2%
Nonpreventable Events (n=155)	
Event occurred despite proper assessment and procedures followed	62%
Patient was highly susceptible to event because of health status	50%
Care provider could not have anticipated event given information available	35%
Patient's diagnosis was unusual or complex, making care difficult	29%
Harm was anticipated but risk considered acceptable given alternatives**	14%

See Appendix F for confidence intervals.

*Percentages do not add to 100 because physician reviewers often selected more than 1 rationale.

**Given the small percentages, confidence intervals for projected numbers exceed 50-percent relative precision.

Source: OIG analysis of hospital stays for 780 Medicare beneficiaries discharged in October 2008.

Other common factors associated with preventable events were inadequate monitoring of patients (38 percent) and inadequate assessment of patients (23 percent). These factors often led to delays in treatment and worsening of patient conditions. In several of these cases, patients displayed symptoms of infection but were not given antibiotics until they reached the point of sepsis. In one case, the patient exhibited signs of shock upon arrival at the hospital, but clinical staff did not monitor the patient's blood pressure for the first 8 hours and did not provide related treatment for another 16 hours. This delay caused the patient to experience severe hypotension, requiring life-sustaining intervention.

TAG ARCHIVES: SUICIDAL IDEATION

Suicidal Ideation Raises Concern Among American Surgeons

Posted on January 22, 2011 by Ben Kazie MD

A recent study has raised great concern about the rate of suicidal thought among practicing surgeons in the United States. Suicide is a higher cause of mortality for physicians in general compared with other professions as well as the general public. It would appear that a combination of general work related stress, job burnout, depression and pressures brought about by medical or surgical errors takes it toll. The constant threat of litigation over imagined or real malpractice seems to be a major issue, particularly among surgeons for whom the risk of such actions is the greatest. It also appears that surgeons are less likely to seek professional help for their depression than the general public and that the rate of suicidal thought is significantly higher among surgeons than the general public.

One in 16 surgeons reported suicidal ideation in the preceding year according to data reported in the Archives of Surgery. The study was based on a questionnaire sent to members of the American College of Surgeons. Nearly 8,000 surgeons responded. Among surgeons 45 and older, the rate was 1.5 to

3 times higher than the general US population. Persons who are highly educated, employed and married have lower rates of suicidal thoughts. This makes these findings more startling as surgeons in the study were mostly married (88%), clearly highly educated, and essentially fully employed. Also of interest was the finding that suicidal thoughts were higher in surgeons in the 45-54 age group than in younger individuals, the exact reverse of the usual findings in the general population where 45-54 year olds have lower rates of suicidal ideation than younger persons. Historically, the suicide risk rate among physicians has been reported as higher in female physicians, but the results of this study found no differences between the sexes in the risk of suicidal thought. Depression has long been associated with suicidal thoughts and actions. However, burn out has only recently begun to be recognized as a major factor leading to depression, suicidal thought and action. Previous studies in medical students had demonstrated the impact of burnout as well.

It is of concern that highly trained physicians and surgeons would not seek mental health services to deal with burnout, depression and suicidal thought. The most common reason given for this is that there appears to be great concern about licensing and loss of one's professional career. Licensing boards are generally focused on physician impairment as opposed to physician illness and treatment, so that the fact of a diagnosis of depression would generally not be sufficient to warrant any action in most cases, especially if treatment is ongoing. Still, many physicians, surgeons in particular, have great distrust of medical licensing boards as well as other professional monitoring organizations. This may well stem from the very nature of surgical training, practice and art, where a surgeon is solely responsible for his/her actions in the operative theater, as well as the outcome, be it positive or negative.

Health reform actions at the federal and state level will no doubt only add to the burden as more and more persons are brought into the mainstream of the medical care system. Additionally, the rapidly expanding ranks of the elderly, due to the aging of the baby boomers is having an impact on the numbers of patients needing treatment and surgical interventions. All of this is occurring amidst an environment

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CENTRAL OREGON'S NEWS LEADER

Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

By News sources
POSTED: 11:35 PM PDT September 7, 2011 UPDATED: 4:36 AM PDT July 14, 2011
BEND, Ore. -

Former Bend real estate broker Tami Sawyer was arraigned Thursday on state charges of criminal mistreatment and aggravated theft, four days after her arrest at Portland International Airport.

Sawyer was taken into custody by Port of Portland police after arriving on a flight back from Mexico, where she was allowed to go and check on rental property.

She appeared before Deschutes County Circuit Judge Wells Ashby, who continued her bond at $50,000 but set no travel restrictions, prosecutors said.

Ashby said she can travel outside of Oregon but has to sign and submit a waiver of extradition, should that be needed.

Sawyer faces charges of first-degree criminal mistreatment and aggravated theft., accused of selling Thomas Middleton's home and pocketing the proceeds.

The judge set her next court appearance for Sept. 6 at 8:30 a.m., when she is scheduled to enter a plea.

Sawyer and husband Kevin are scheduled for trial in December on federal fraud and money-laundering charges.

Former Bend real estate broker Tami Sawyer was arrested Sunday night at Portland International Airport on a Deschutes County warrant issued late last week after her indictment on felony charges of criminal mistreatment and aggravated theft.

Sawyer, 48, was booked into the Multnomah County Jail around 9 p.m. Sunday, about a half-hour after her arrest, reportedly having just flown back to Oregon after a judge agreed to let her go check on rental property that she and husband Kevin own in Cabo San Lucas, Mexico.

Deschutes County Circuit Judge Alta Brady signed an arrest warrant with $50,000 bail last Thursday, two days after she was indicted on a first-degree criminal mistreatment charge that alleges she took custody of Thomas Middleton, ?a dependent or elderly person,? for the purpose of fraud.

The first-degree aggravated theft charge alleges that in October 2008, Sawyer stole more than $50,000 from the Thomas Middleton Revocable Trust.

State and court documents show Middleton, who suffered from Lou Gehrig?s disease, moved into Sawyer?s home in July 2008, months after naming her trustee of his estate, The Bulletin reported Saturday. Middleton deeded his home to the trust and directed her to make it a rental until the real estate market improved.

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than $200,000, the documents show, and it was deposited into an account for one of Sawyer?s businesses, Starboard LLC, and $90,000 of that was transfered to two other Sawyer companies, Genesis Futures and Tami Sawyer PC.

Sawyer and her husband, a former Bend police captain, face trial scheduled for December in Eugene on federal charges of money laundering, wire fraud and conspiracy to commit wire fraud. They are accused of using investor money to pay for personal property, causing investors to lose $4.4 million.

A federal judge twice gave permission for her to travel to Mexico, once in May and again last month.

First-degree aggravated theft is a Class B felony, punishable by up to 10 years in prison. First-degree criminal mistreatment is a Class C felony, punishable by up to five years in prison.

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Suicide Risk and Pain in Cancer and AIDS Patients

William Breitbart

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Jerzy Kosinski, the Polish novelist and holocaust survivor, committed suicide in May 1991. Like other individuals suffering with chronic medical illnesses, he chose suicide as a means of controlling the course of his disease and the circumstances of his death. ``I am not a suicide freak, but I want to be free,'' Kosinski told an interviewer in 1979. ``If I ever have an accident or a terminal disease that would affect my mind or body, I will end it.'' These sentiments are shared by a significant segment of our society. The movement advocating ``death with dignity'' and autonomy for patients regarding how they die has been growing in this country. While Kosinski suffered with a cardiac condition, these issues are particularly compelling for those individuals with life-threatening illnesses such as cancer or AIDS. Perhaps of all medical conditions, cancer and AIDS are associated with the highest rates of suicide and of requests for hastened death (5,23,33,39,40). The movement to legalize euthanasia and the debate over physician-assisted suicide sparked by Derek Humphry's *Final Exit* (29a), have both centered on the plight of dying patients with cancer or acquired immunodeficiency syndrome (AIDS). Information that can shed light on our understanding of the factors that contribute to suicidal ideation, requests for hastened death, or suicide in cancer and AIDS patients will contribute greatly not only to the societal debate over these issues, but directly to humane patient care.

Uncontrolled pain has been recognized as an important contributing factor to suicide in cancer and AIDS patients (5,6,8,21,22). Persistent pain and terminal illness are the most common reasons for requests for euthanasia or physician-assisted suicide (28,63). Clinicians who specialize in pain management in cancer or AIDS settings will be confronted with these issues. The goal of this chapter is to provide the clinician with a factual framework on which to base an approach to managing cancer or AIDS patients with pain who are at risk of suicide or who request a hastened death. What follows is a review of the current research data on suicide, suicidal ideation, and suicide risk factors in cancer and AIDS patients, with particular focus on the roles of pain and psychiatric comorbidity. Additionally, a discussion of the ethical dilemmas presented by euthanasia and physician-assisted suicide is followed by an outline of principles in the management of suicidal cancer or AIDS patients.

The information presented in this chapter suggests that danger lies in the premature assumption that suicidal ideation or a request to hasten death in a cancer or AIDS patient represents a ``rational act'' unencumbered by physical symptom distress or psychiatric comorbidity. Clearly, there are suicides that occur in this population that many would view as rational expressions of personal autonomy; however, they represent only a small minority of suicides in cancer or AIDS patients. The vast majority of cancer or AIDS patients, particularly those with advanced disease, who express suicidal ideation or request a hastened death do so while suffering with unrecognized and untreated psychiatric disturbances (depression, confusional states), and poorly controlled physical symptoms (pain).

SUICIDE AND CANCER

Cancer patients are at increased risk of suicide relative to the general population. Recent studies (5,23,39) suggest that although only small numbers of cancer patients commit suicide, their relative risk of suicide is

Paul A. Glare, MD

Chief, Pain and Palliative Care Service

I came to Memorial Sloan-Kettering in August 2008 from Sydney, Australia, where I had spent ten years as chief of a large academic palliative medicine program. I trained in internal medicine, palliative medicine, and pain medicine; and also served as a Fellow in palliative medicine at the Cleveland Clinic. My research interests include prognostication and the cancer cachexia (loss of body weight and muscle mass) syndrome. I am the associate editor of the new *Palliative Medicine* textbook published by Elsevier, and as well am editor of books on prognostication and on opioid pharmacology. I am co-chair of the Palliative Care section of the Multinational Association of Supportive Care in Cancer.

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See My Colleagues in:
Department of Medicine › Pain and Palliative Care Service

Publications by Paul A. Glare
Visit PubMed for full listing of Paul A. Glare journal articles

Oregon's Physician-Assisted Suicide Law - Abused and Exploited

Case in Point: Barbara Wagner

This 64 year old woman had a recurrence of her lung cancer in May 2008, 2 years after initial treatment had produced a remission. Her oncologist prescribed Tarceva (erlotinib), a once daily tablet, to slow the growth of the cancer and extend her life. Studies had shown it resulted in a 30-45% increase in life expectancy in advanced lung cancer. She was on the Oregon Health Plan (Medicaid) and was notified in May that the Plan would not cover the beneficial chemotherapy treatment, "but that it would cover palliative, or comfort, care, including, if she chose, doctor-assisted suicide".

Case in Point: Randy Stroup

Randy Stroup, age 53, had advanced prostate cancer with a life expectancy of several months. He was given a prescription for mitoxantrone. This chemotherapy drug was not expected to produce a major extension of his life ("small, but measurable"), but studies had shown that it causes an increased quality of life, primarily by reducing pain. Coverage for this drug was denied by the Oregon Health Plan, but OHP told Randy that he could have coverage for "palliative, or comfort, care, including, if he chose, doctor-assisted suicide."

Coverage by the OHP for specific services are established by its Health Services Commission. Their guideline states that they will not pay for diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness which are intended to prolong life or alter disease progression for patients with <5% expected 5 year survival. Neither Barbara's nor Randy's prognosis fit into this guideline. But physician-assisted suicide did.

Both of these cases made headlines in Oregon, and the OHP admitted that telling them of coverage for PAS was a "public relations blunder."

For More Information:
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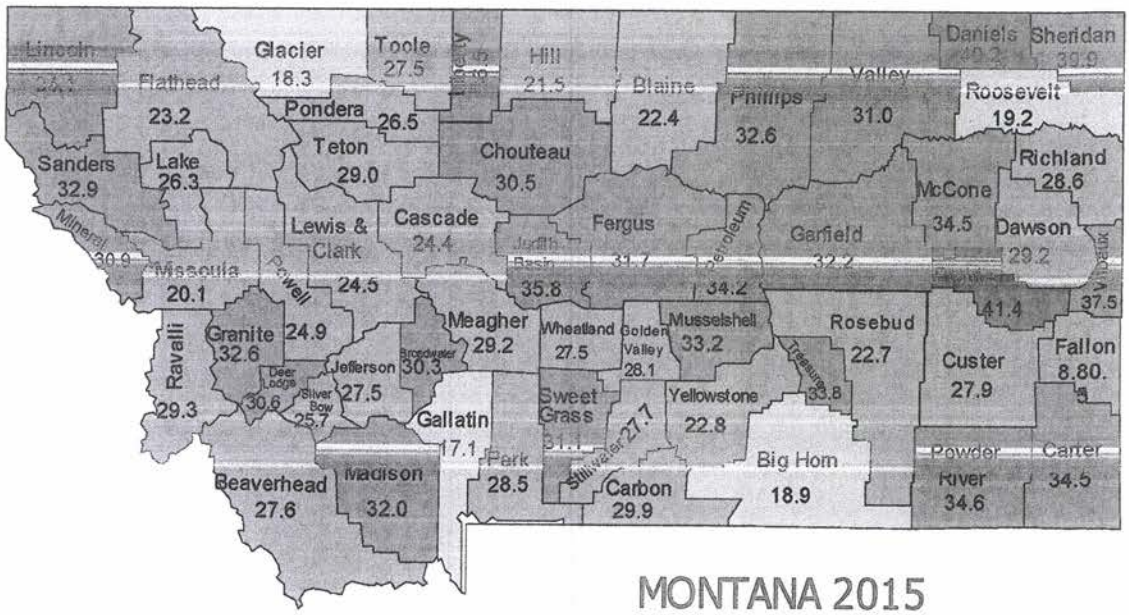
MONTANA

STATE PLAN ON AGING



MONTANA 2015

60+ population = 256,661
Range = 17.1% to 41.4%
St average = 24.1%
Median = 29.3%

PERCENT OF COUNTY POPULATION 60+

- 0.0 to 9.9
- 10.0 to19.9 (4)
- 20.0 to 29.9 (27)
- 30.0 to 39.9 (23)
- 40.0 to 49.9 (2)

FOR THE PERIOD

OCTOBER 1, 2011 TO SEPTEMBER 30, 2015

During this same time period (2010 to 2025), many of our more rural and frontier communities will be facing some critical changes as they see their 60 and older populations increase from 20% currently to as high as 70% . There are currently 137 communities in Montana whose 60 and older populations make up 20% to 49.7% of their total population. And by 2025, Montana could have 150 communites with 60 and older populations between 39% and 70% of their community's total population.

Here is a list of some of the communities in Montana whose 60 and older populations are currently over 30% of their total community population: Augusta (32.4%), Bainville (30.1%), Big Fork (35.7%), Big Sandy (31.4%), Chester (32.6%), Choteau (30.9%), Dayton (33.7%), DeBorgia (39.1%), Ekalaka (33.7%), Fallon (30.4%), Flaxville (34.5%), Hamilton (32.8%), Kings Point (43.2%), Nashua (36.7%), Neihart (41.8%), Opheim (36.9%), Plentywood (30.8%), Richey (30.2%), St. Marie (49.7%), Scobey (35.2%), Sheridan (36.3%), Terry (37.5%), Westby (31.4%) and Wibaux (30.2%).

As Montana ages over the next 15 to 20 years, we will be faced with major challenges regarding the quality and quantity of services, support and care offered to our elders, their families and caregivers. Some of these challenges will involve transportation issues, nutrition education and services, home and community based services, health related issues, advocacy issues (both legal and long term care), keeping people independent and in the least restrictive settings, and the need to provide information and education to help people do long term care planning.

This four year State Plan will begin to address some of the issues and challenges Montana will face not only in the next 4 years but in the next 10, to 15 to 20 years.

The U.S. Administration on Aging (AOA) has begun to address some of the issues our state as well as the country will be facing in the near future in their Strategic Action Plan for 2007 - 2012. The Strategic Action Plan covers five main goals and objectives which AOA will focus on over the next four to five years. These goals and objectives are:

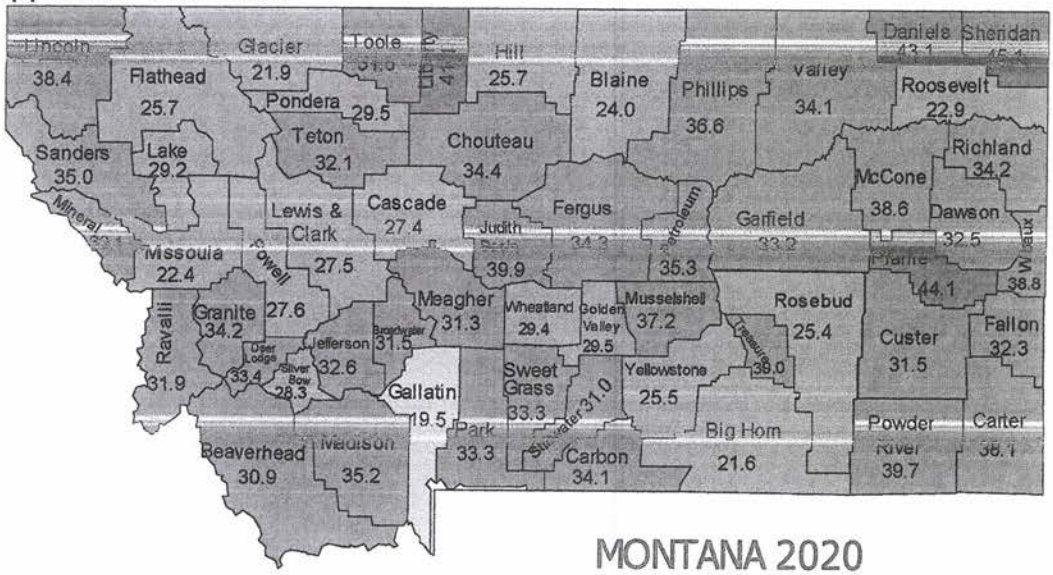
Goal 1: **Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access existing health and long Term Care options**

- Provide streamlined access to health and long term care through Aging and Disability Resource Center programs

- Empower individuals, including middle-aged individuals, to plan for future long term care needs

Goal 2: **Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers**

Ten years from now, 34 counties will exceed the 30% range and 4 counties will have topped the 40% mark.



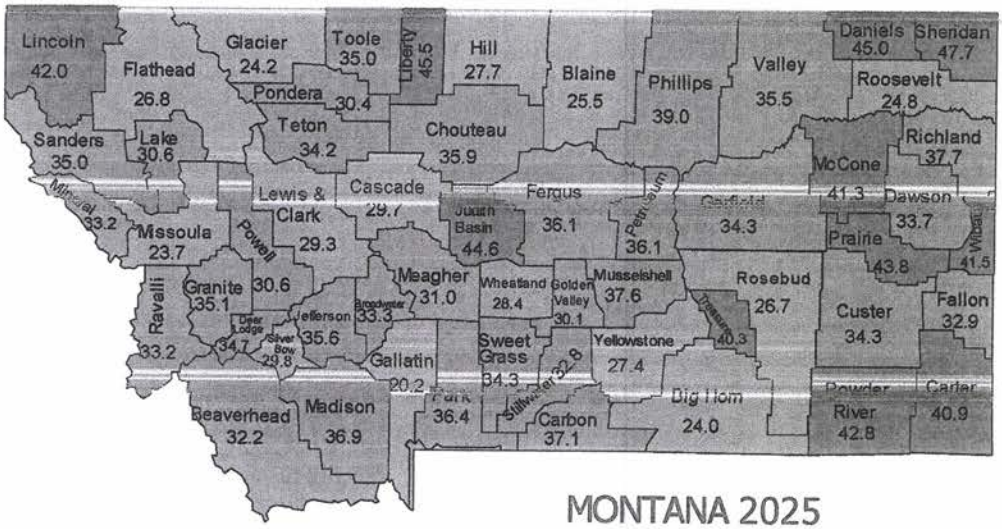
MONTANA 2020

60+ population = 305,096
Range = 19.5% to 45.1%
St average = 26.9%
Median = 32.6%

PERCENT OF COUNTY POPULATION 60+

- 0.0 to 9.9
- 10.0 to19.9 (1)
- 20.0 to 29.9 (17)
- 30.0 to 39.9 (34)
- 40.0 to 49.9 (4)

By the year 2025, there will be only 14 counties in Montana whose 60 and older populations are under 30% of their total population. And the number of counties whose 60 and older population has grown to over 40% will be 11. Those counties with less than 30% have either reservations or larger cities.



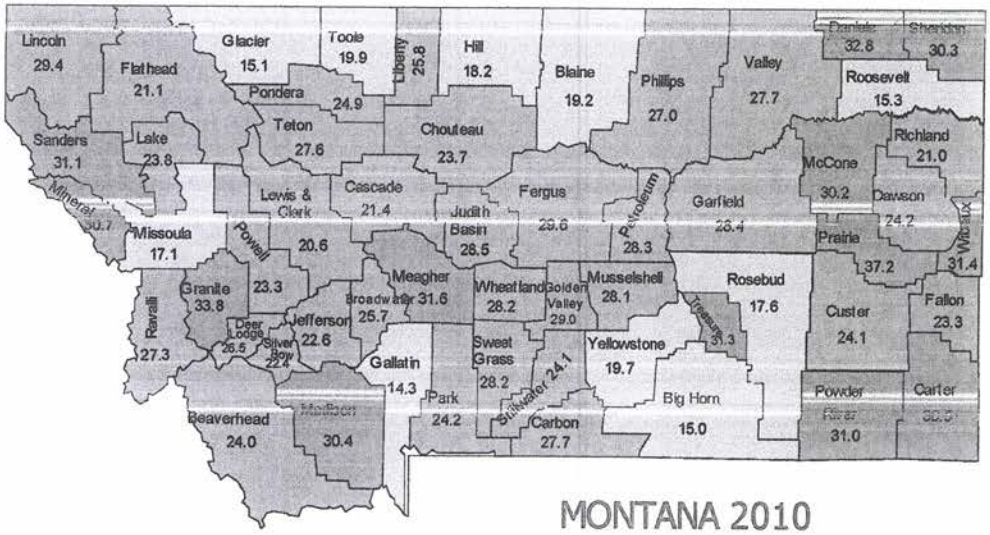
MONTANA 2025

60+ population = 342,295
Range = 20.2% to 47.7%
St average = 28.4%
Median = 34.4%

PERCENT OF COUNTY POPULATION 60+

- 0.0 to 9.9
- 10.0 to19.9
- 20.0 to 29.9 (14)
- 30.0 to 39.9 (31)
- 40.0 to 49.9 (11)

By 2010, thirteen counties had 60 and older populations that exceeded 30% of their total county populations which was an increase of six more counties since 2009.



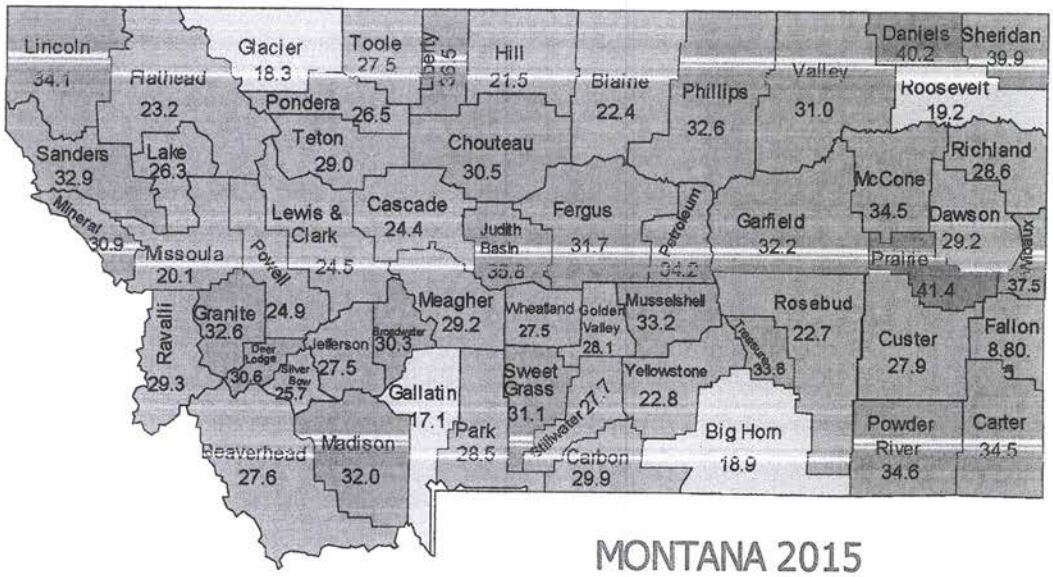
MONTANA 2010

60+ population = 209,865
Range = 14.3% to 37.2%
St average = 21.2%
Median = 26.5%

PERCENT OF COUNTY POPULATION 60+

- 0.0 to 9.9
- 10.0 to19.9 (10)
- 20.0 to 29.9 (33)
- 30.0 to 39.9 (13)
- 40.0 to 49.9

By 2015, we can expect this number to grow to 23 counties whose 60 and older populations exceed 30% of their total county population and 2 counties to pass the 40% mark.



MONTANA 2015

60+ population = 256,661
Range = 17.1% to 41.4%
St average = 24.1%
Median = 29.3%

PERCENT OF COUNTY POPULATION 60+

- 0.0 to 9.9
- 10.0 to19.9 (4)
- 20.0 to 29.9 (27)
- 30.0 to 39.9 (23)
- 40.0 to 49.9 (2)

INTRODUCTION

The Aging tsunami has begun. The number of elderly is increasing in Montana as well as nationally. We are an aging society and that fact is even more evident as the first of the Baby Boomers, the Aging tsunami, turn 65 years of age in 2011. And for the next 25 to 30 years, we will continue to see the rapid growth of the 65 and older age group.

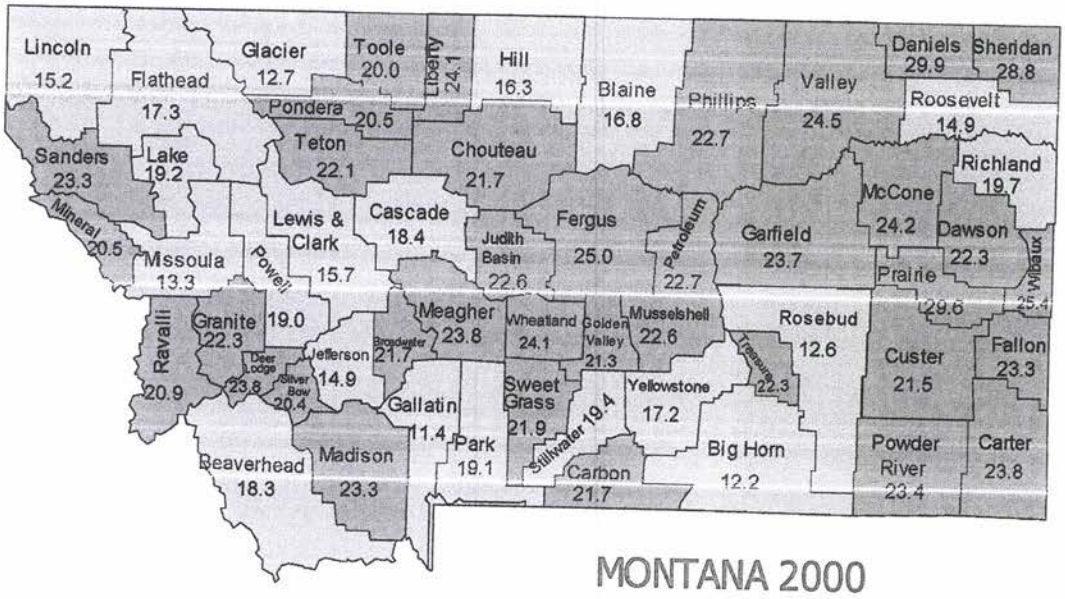
In 2000, Montana ranked 14th in the nation in percentage of our elderly population to total population. By 2025, just 14 short years away, Montana is projected to rank no less than 5th and could be as high as 3rd in the nation in the percent of those over the age of 65. This means that at least 25% or 1 in 4 people in Montana will be over the age of 65 by the year 2025.

Let's look at this in a different way. Starting now and every year for the next 15 to 20 years Montana will have an increase in our 65 and older population equal to or greater than the population of Havre, Montana.

Under Title III of the Older Americans Act, the Aging Network provides services to people 60 and older. As we look to the future, and see the changes in Montana's population, we need to take into account where some of the most critical needs will be over not just the next four years, but the next ten to twenty years.

Based on the 2000 Census, Montana's 60 and older population was 14% of our total population. In 2000, 36 of our counties had 60 and older populations at 20% or more of their populations over the age of 60. (see maps below)

MONTANA 60+ POPULATION DATA



to maintain an independent lifestyle, avoid unnecessary institutional care, and live in dignity; and

(4) It is the intent of the legislature that available federal, state, regional, and local resources be used to strengthen the economic, social, and general well-being of older Montanans and that the state:

(a) develop appropriate programs for older Montanans;
(b) coordinate and integrate all levels of service, with emphasis on the whole person; and
(c) promote alternative forms of service that will create options for older Montanans.

Based on the Federal Older Americans Act (OAA) as well as Montana's Older Americans Act, the mission of the State Office on Aging (Aging Services Bureau) is to help elderly individuals maintain their dignity and independence in their homes and communities through comprehensive, coordinated, and cost effective systems of long term care. The Senior and Long Term Care Division's Aging Service Bureau does this by serving as the state agency responsible for advancing the concerns and interests of older people and their caregivers, and by working with and through the Aging Services Network to promote the development of a comprehensive and coordinated system of home and community-based long term care that is responsive to the needs and preferences of older people and their family caregivers.

The primary strategies for accomplishing this mission include:

1) advocacy, which encompasses the Office on Aging's responsibility to represent the needs and concerns of older people in the policy, program and budget development processes at the State level;

2) the dissemination of consumer information and the conduct of public education activities;

3) the allocation of formula grants to Montana's ten Area Agencies on Aging (AAA);

4) the provision of technical assistance to state and community–based entities and other stakeholder organizations that affect aging services policies and programs;

5) research, data analysis, and program development which improves the quality of life and the delivery of health and human services to Montana's elderly; and,

6) oversight of Montana's Aging Network's programmatic and fiscal responsibilities.

OUR VISION FOR OLDER PEOPLE

Our vision for older Montanans is embodied in the Older Americans Act and Montana's Older Americans Act and is based on the American value that dignity is inherent to all individuals in our society, and the belief that older people should have the opportunity to fully participate in all aspects of society and community life, be able to maintain their

- Advocacy
- Caregiving Support
- Long Term Care
- Resource Development

Focused activity in these areas is integral to the successful implementation of our leadership charge as well as critical in laying the foundation for developing and providing comprehensive in-home and community-based systems of service. It will also assist DPHHS in addressing its goal to re-balance the long term care system.

During these next four to five years, the elderly population in several of Montana's frontier counties and communities will experience the first tsunami wave as their 60 and older population begins to increase to over 30% of their total populations.

This plan is designed to help educate Montanans on the tsunami of elderly coming and set some direction for the Aging Network to successfully meet the wave of service needs as well as provide the information, education and assistance framework so people can make appropriate choices in developing a long term care plan to meet their current and future needs. Also based on the fact that Montana is a minimally funded under the Older Americans Act, program growth and sustainability will be critical to providing even core services to an increasing client population over the next fifteen to twenty years.

OUR MISSION

The Montana Legislature addressed four key issues related to Montana's elderly when they passed Montana's Older Americans Act. In section 52-3-503 of the Montana Code Annotated, it states that the Legislature found:

(1) that older Montanans constitute a valuable resource of this state and that their competence, experience, and wisdom must be used more effectively for the benefit of all Montanans;

(2) that a complete range of services is not available in all areas of the state and that many Montanans lack access to the services that are available;

(3) The legislature declares that it is the policy of this state, subject to available funding, to provide a wide range of coordinated services to enable older Montanans

Currently the Aging Services Network in Montana provides an array of core services under Titles III, VI and VII of the Older Americans Act. Some of the services provided include information and assistance, congregate meals, home delivered meals (also know as meals on wheels), long term care Ombudsman services, legal assistance, homemaker, transportation, respite care, care management and a variety of services, information, health education and activities through senior centers.

Montana submits the following goal, which ties to the Administration on Aging's goals #1 and #2, for this plan period.

Goal 1: To strengthen the core services provided by Montana's Aging Services Network, especially in our frontier areas of Montana.

The core services under Titles III, VI and VII of the Older Americans Act are the foundation stones for building a continuum of long term care services for the elderly as our population continues to age over the next 20 to 30 years. Being able to provide basic core services in frontier areas of Montana is pivotal in developing and building the service capacity to meet the needs of an ever increasing clientele.

The demographic changes that are coming to Montana require the Aging Services Network to review our current delivery system to determine which services are necessary to aging individuals to support their health, dignity and independence as they age. Making sure the core services remain in place in frontier Montana as well as developing other long term care services may require a paradigm shift and may require the Aging Network to choose what services can be provided as well as how services are delivered especially in our frontier communities.

As the current economic crisis continues, rising costs and reduced income are putting stress on service delivery budgets. In a state that covers about the same distance as it is from Chicago to Washington, DC and facing stagnate or reduced resources, the service delivery system is important especially for core services. In an effort to reduce costs and maintain services to an ever increasing aging population, some Area Agencies on Aging and local providers have revised or are considering revising their delivery systems around consumer choice, utilizing vouchers for meals and transportation services, and developing or expanding cost sharing alternatives. Also, coordination of services will become an important part of our effort to meet the needs of our aging population especially at the local and area levels. The Aging Network will need to look for opportunities to develop new relationships with other agencies that provide services to the elderly such as Indian Health Services (IHS) especially as it relates to long term care, choice and self management.

NEW RULE IN
"If you drive 50 mi/
you better reac

Elderly Abuse Statistics

Statistic Verification
Source: National Center on Elder Abuse, Bureau of Justice Statistics
Research Date: 7.7.2014

Elderly Abuse Statistics	**Data**
Average number of elderly abuse cases each year	2,150,000
Percent of elderly population that will experience some type of abuse	9.5 %
Demographics of Elderly Abuse Victims	**Percent**
Percent of female elder abuse victims	67.3 %
Median age of elder abuse victims	77.9
Percent of white victims	66.4 %
Percent of black victims	18.7 %
Percent of hispanic victims	10.4 %
Breakdown of Reported Elder Abuse Cases	
Neglect	58.5 %
Physical Abuse	15.7 %
Financial Exploitation	12.3 %
Emotional Abuse	7.3 %
Sexual Abuse	0.04 %
All other types	5.1 %
Unknown	0.06 %
Family Perpetrated Elderly Abuse	

Percent of Adult Protective Service cases that involve elderly abuse	68 %
Percent of elderly abuse perpetrated by adult children or spouses	66 %
Percent of murder victims over 60 who were killed by their own offspring	42 %
Percent of murder victims over 60 who were killed by their spouses	24 %
Nursing Home Abuse	
Percent of nursing homes that lack adequate staff to properly care for patients	91 %
Percent of nursing homes that have been in violation of elderly abuse laws	36 %
Elderly defined as 60 years of age and older	

Tags:

statistics on elderly abuse ? prevalence of elderly abuse ? what is the main demographic of an elderly abuse victim ? what percent of the elderly population is abused each year ? total number of abused elderly each year ?

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Related Statistics:

Juvenile Violent Crime Statistics

School Shooting Statistics

BRAIN HOSTING

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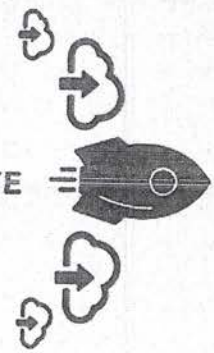

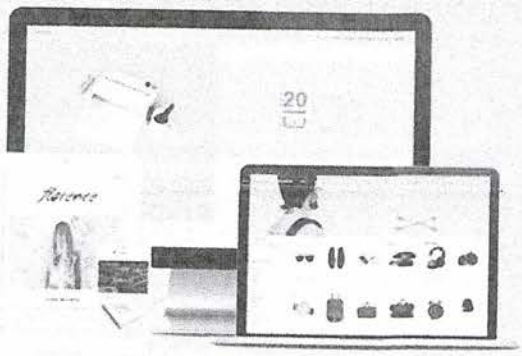

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VIDEO OF THE DAY

Brazilian doctor charged with 7 murders, may have killed 300: investigator

March 27, 2013 | Anthony Boadle | Reuters

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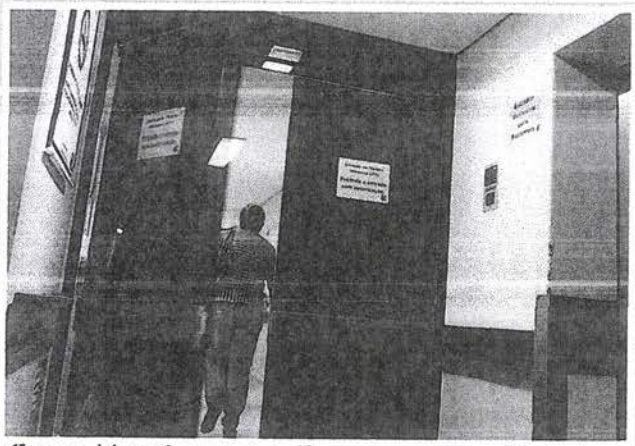

(http://snsimages.tribune.com/media/ph...
(STRINGERBRAZIL, REUTERS) 08/75073464.jpg)

BRASILIA (Reuters) - A Brazilian doctor who was charged with killing seven patients to free up beds at a hospital intensive care unit may have been responsible for as many as 300 deaths, according to a Health Ministry investigator.

Prosecutors said Dr. Virginia Soares de Souza and her medical team administered muscle relaxing drugs to patients, then reduced their oxygen supply, causing them to die of asphyxia at the Evangelical Hospital in the southern city of Curitiba.

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De Souza, a 56-year-old widow, was arrested last month and charged with seven counts of aggravated first degree murder. Three other doctors, three nurses and a physiotherapist who worked under De Souza have also been charged with murder.

Prosecutors for the state of Parana said wiretaps of De Souza's phone conversations revealed that her motive was to free up hospital beds for other patients.

"I want to clear the intensive care unit. It's making me itch," she said in one recording released to Brazilian media. "Unfortunately, our mission is to be go-betweens on the springboard to the next life," she added in the same phone call.

De Souza's lawyer, Elias Mattar Assad, said investigators had misunderstood how an intensive care unit works and she would prove her innocence.

More cases are expected to emerge as investigators comb through 1,700 medical records of patients who died in the last seven years at the hospital, where De Souza headed the intensive care unit.

"We already have more than 20 cases established, and there are nearly 300 more that we are looking into," the chief investigator assigned by Brazil's Health Ministry, Dr. Mario Lobato, said on Globo TV's Fantastico program on Sunday.

If prosecutors prove that De Souza killed 300 patients, this could be one of the world's worst serial killings, rivaling the notorious case of Harold Shipman, the English doctor who was found to have killed at least 215 patients.

Lobato said the deaths he reviewed occurred under similar circumstances: a muscle relaxant such as Pancuronium (trademark Pavulon) was administered, increasing the patients' dependence on artificial respiration; then the oxygen supply was reduced, causing death by asphyxia.

Some of the patients were conscious moments before they died, he said.

Prosecutors said De Souza felt "all powerful" running the intensive care unit homicide, to the point where she "had the power to decree the moment when a victim would die."

In some cases, De Souza was absent from the hospital and gave instructions to end the life of a patient by telephone to members of her medical team, according to documents detailing the charges.

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Last week, a Curitiba judge ordered the release of De Souza and her medical team. Prosecutors sought on Monday to have her returned to custody because she was the leader of the team and witnesses had reported being intimidated.

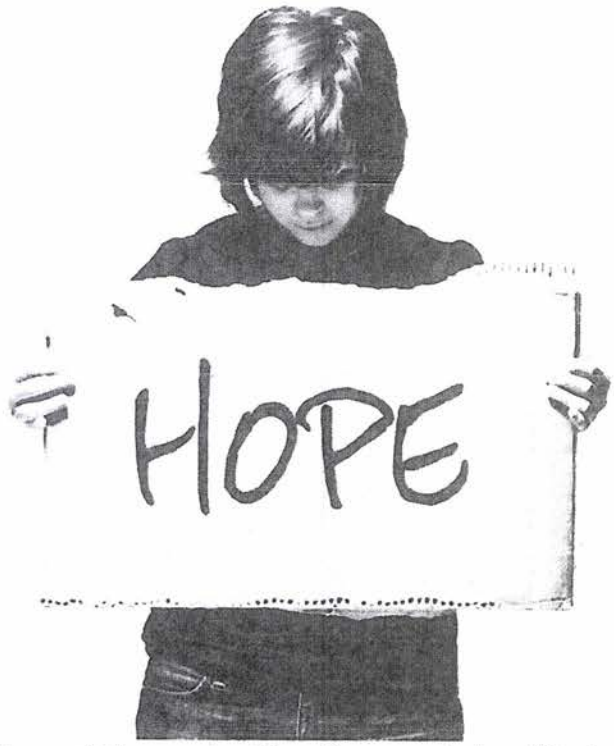
MONTANA
DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

SUICIDE IN MONTANA

Facts, Figures, and Formulas for Prevention

Karl Rosston, LCSW
Suicide Prevention Coordinator
406-444-3349
krosston@mt.gov
www.prc.mt.gov/suicideprevention

Updated: October, 2012



"Suicide is a particularly awful way to die: the mental suffering leading up to it is usually prolonged, intense, and unpalliated. There is no morphine equivalent to ease the acute pain, and death not uncommonly is violent and grisly. The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description."

Kay Redfield Jamison, Ph.D.
Professor of Psychiatry
Johns Hopkins University
"Night Falls Fast: understanding suicide", pg. 24

Suicide Fact Sheet

Source: Center for Disease Control – WISQARS website, http://www.cdc.gov/injury/wisqars/index.html, (September, 2012), 2009 National Vital Statistics Reports (March, 2012)

- For the first time, suicide has surpassed car accidents as the No. 1 cause of injury-related death in the United States. There has been a 15% increase in the number of suicides in the United States between 2000-2009. (American Journal of Public Health, November, 2012)
- In 2010 there were **38,364 suicides in the U.S.** (105 suicides per day; 1 suicide every 13.7 minutes). This translates to an annual suicide rate of 12.43 per 100,000.
- Suicide is the tenth leading cause of death.
- Males complete suicide at a rate four times that of females. However, females attempt suicide three times more often than males.
- Firearms remain the most commonly used suicide method, accounting for 50% of all completed suicides.
- Up to 45% of individuals who die by suicide visit their primary care provider within a month of their death.
- 20% of those who die by suicide visited their primary care provider within 24 hours of their death

Suicide among Children

- In 2010, **274 children ages 5 to 14 completed suicide in the U.S. (increase from 265 in 2008)**
- Suicide rates for those between the **ages of 5-14 increased 60%** between 1981 and 2010.

Suicide among the Young

- Suicide is the 3rd leading cause of death among young (15-24) Americans; only accidents and homicides occur more frequently. In **2010, there were 4,600 suicides by people 15-24 years old** (increase from 4,371 in 2009)
- Youth (ages 15-24) suicide rates increased more than 200% from the 1950's to the mid 1990's. The rates dropped in the 1990's but went up again in the early 2000's.
- Research has shown that most adolescent suicides occur after school hours and in the teen's home.
- Within a typical high school classroom, it is likely that three students (one boy and two girls) have made a suicide attempt in the past year.
- *Most* adolescent suicide attempts are precipitated by interpersonal conflicts. The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.
- The biggest factor associated with adolescent suicidal ideations is parental disconnect (not feeling validated or accepted by their parents)

Suicide among our Veterans

Source: Losing the Battle: The Challenge of Military Suicide (Oct. 2011). Center for a New American Security

- The VA estimates the suicide rate for young veteran men between the ages 18-29 is around 56 per 100,000 (compared to 20 for non-vet males 18-29)
- In the US, a veteran dies by suicide every 80 minutes, 18 a day, or 6,500 suicides a year.
- The suicide rate for the Army is 20 per 100,000, compared to 12 for the nation.
- In Montana, between 2002 and 2011, there were 460 suicides by Montana veterans of all ages, giving us a rate of approximately 53 per 100,000. (Montana Office of Vital Statistics, Aug, 2012)

Suicide among College Students

- It is estimated that there are more than **1,100 suicides on college campuses per year.**
- **1 in 12** college students has made a suicide plan (**2nd leading cause of death**)
- In 2000, the American College Health Association surveyed 16,000 college students from 28 college campuses.
  - **9.5% of students had seriously contemplated suicide.**
  - An estimated **24,000 suicide attempts** occur annually among US college students age 18-24 (JAMA).

***Source:** American Association of Suicidology webpage. http://www.suicidology.org/web/guest/stats-and-tools/statistics , May 24, 2010, Journal of the American Medical Association (2006), Vol. 296, No. 5*

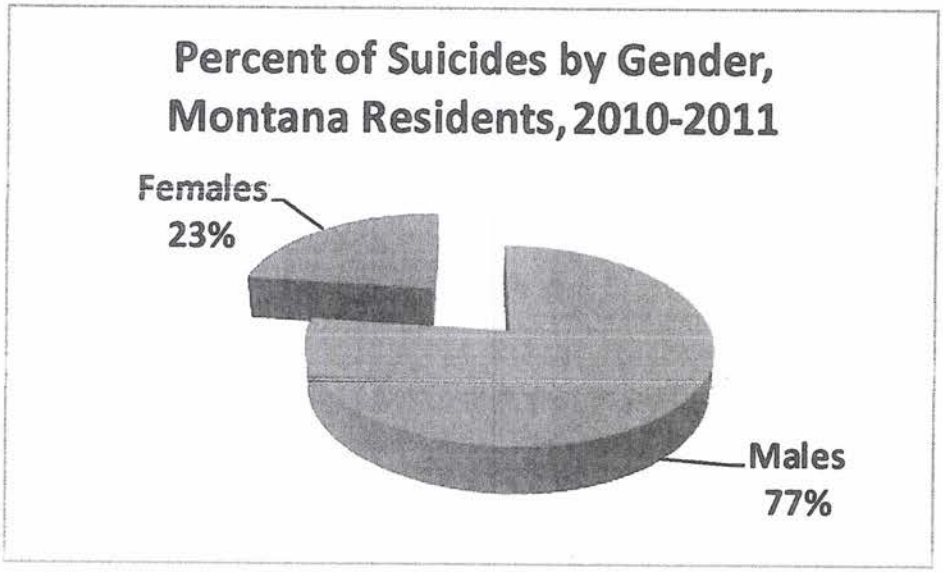
Suicide among the Elderly

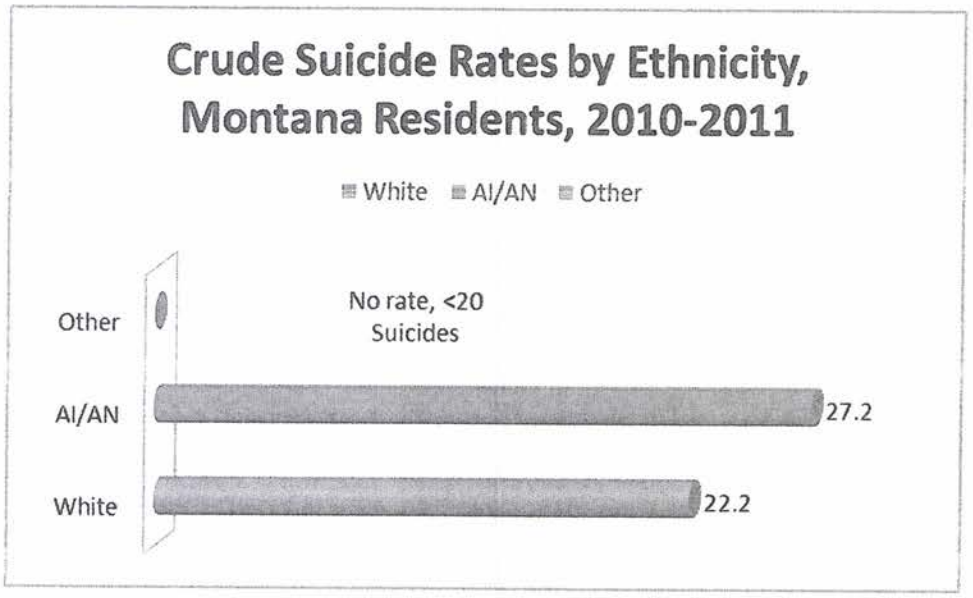
- In 2010, 5,994 Americans over the age of 65 died by suicide for a rate of 14.9 per 100,000
- The rate of suicide for women typically declines after age 60 (after peaking in middle adulthood, ages 45-49)
- 85% of elderly suicides were male; the rate of male suicides in late life was 7 times greater than for female suicides.
- White men over the age of 85, who are labeled "old-old", were at the greatest risk of all age-gender-race groups. In 2010, the suicide rate for these men was 50.2 per 100,000.
- Elders who complete suicide:
  - 73% have contact with primary care physician within a month of their suicide. Nearly half of those people visited with their primary care physician within **two weeks** of their suicide.

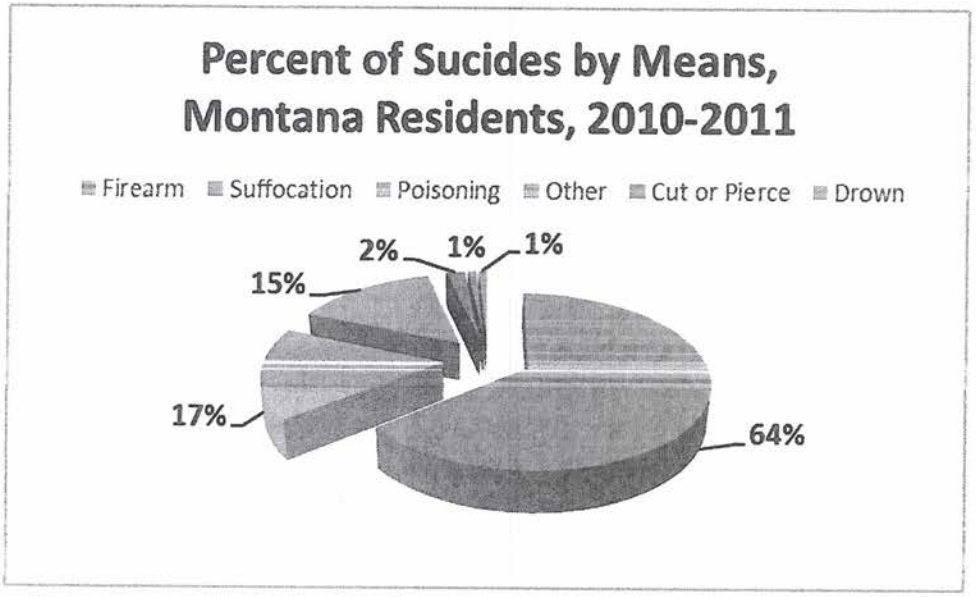
Suicide in Montana

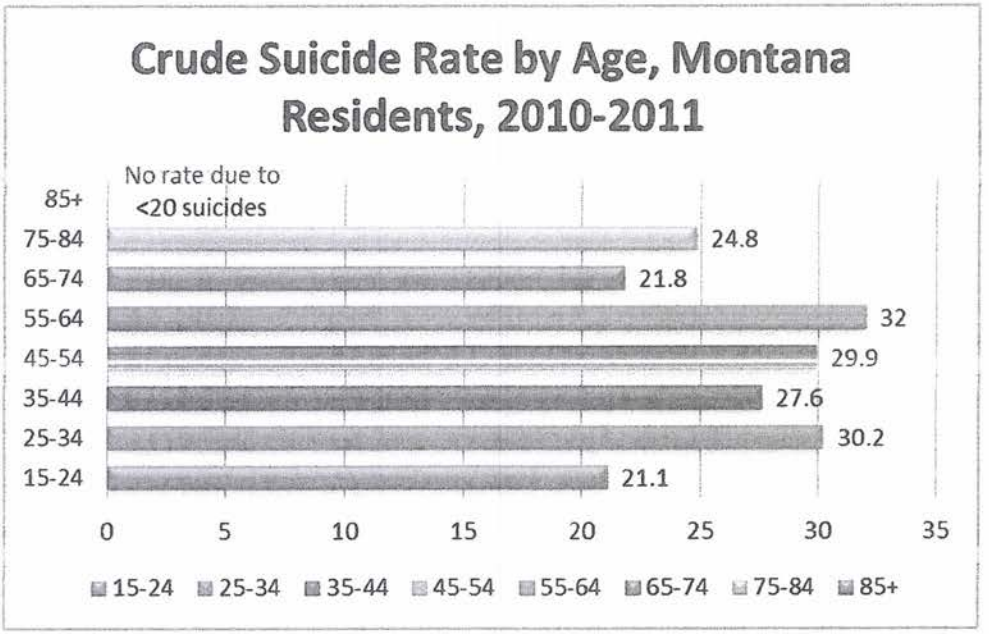
Data Source: 2009 National Vital Statistics Reports (April, 2012), American Association of Suicidology web site (www.suicidology.org), Montana Office of Epidemiology and Scientific Support (August, 2012)

- For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past thirty years. In a report for 2009 data released in the National Vital Statistics Report, Montana has the highest rate of suicide in the nation (219 suicides for a rate of 22.5 compared to a national rate of 12)
- Suicide has ranked as the 7th or 8th leading cause of death for Montanans for more than two decades. Gender differences are similar with national statistics, with males at greater risk.
- In Montana, the highest rate of suicide is among American Indians (27.2 per 100,000) although they only constitute 6% of the state's population. Caucasians are second at 22.2 per 100,000.
- Firearms (64%), suffocation (17%), and poisoning (15%) are the most common means of suicide in Montana. Other means include carbon monoxide, overdose, motor vehicles accidents, and jumping from heights.
- In Montana in 2010 there were 29 youth suicides (ages 15-24) for a rate of 21.66. This compares to the national rate for the same age group of 10.54.
- According to the 2011 Youth Risk Behavior Survey, during the 12 months before the survey, 6.5% of all Montanan students in grades 9 through 12 had made a suicide attempt. For American Indian students on reservations, 16.2% had attempted suicide one or more times in the twelve months before the survey.
- Suicide is the number **one** cause of preventable death in Montana for children ages 10-14
- Over the past ten years (2000-2009), suicide is the number **two** cause of death for children ages 10-14, adolescents ages 15-24 and adults ages 25-34.
- For 2010 and 2011, there were **74** suicides for Montanans over the age 65, for an **average of 37 per year**. This gives Montana a rate of approximately **24.74 per 100,000**.
- Studies show that for every completed suicide, there are 6 survivors. Given there are approximately180-200 suicides in Montana every year, that means there are 1,080-1,200 new survivors every year in Montana.




Crude Suicide Rates by Ethnicity, Montana Residents, 2010-2011
White
AI/AN
Other
Other
No rate, <20 Suicides
AI/AN
27.2
White
22.2


Percent of Sucides by Means, Montana Residents, 2010-2011
Firearm
Suffocation
Poisoning
Other
Cut or Pierce
Drown
2%
1%
1%
15%
17%
64%



FREQUENCY AND RATE OF SUICIDE BY COUNTY OF RESIDENCE

MONTANA RESIDENTS, 1997 - 2011

Montana counties with the highest rate of suicide between 1997 and 2011

Data is only provided for counties that had 20 or more suicides. Numbers below 20 are statistically unreliable, especially when we presenting 15 years of data. Counties with fewer than 5 suicides are only identified with a <5 indication.

The population is the total number of people who lived in the county for each year between 1997 and 2011.

County	Suicides	Population	Rate
BEAVERHEAD	29	135,458	21.4
BIG HORN	26	191,937	13.5
BLAINE	20	100,489	19.9
BROADWATER	16		
CARBON	22	144,985	15.2
CARTER	<5		
CASCADE	224	1,216,092	18.4
CHOUTEAU	13		

County	Suicides	Population	Rate
MADISON	25	106,453	23.5
MEAGHER	<5		
MINERAL	11		
MISSOULA	263	1,522,942	17.3
MUSSELSHELL	15		
PARK	56	235,902	23.7
PETROLEUM	<5		
PHILLIPS	9		
PONDERA	13		
POWDER RIVER	<5		

CUSTER	45	171,987	26.2
DANIELS	<5		
DAWSON	19		
DEER LODGE	40	137,661	29.1
FALLON	6		
FERGUS	33	173,821	19
FLATHEAD	230	1,222,514	18.8
GALLATIN	179	1,171,236	15.3
GARFIELD	<5		
GLACIER	33	199,749	16.5
GOLDEN VALLEY	<5		
GRANITE	10		
HILL	38	247,398	15.4
JEFFERSON	24	158,531	15.1
JUDITH BASIN	8		
LAKE	83	410,940	20.2
LEWIS & CLARK	141	875,249	16.1
LIBERTY	<5		
LINCOLN	64	281,890	22.7
MCCONE	<5		

Social Factors Associated With Suicide

Suicidal behavior is associated with a wide variety of social factors, but correlates most highly with:

- Social Isolation (isolation from peers or social relationships that are troubled)
- Social Disorganization (society lacks the regulatory constraints necessary to control the behavior of its members.)
- Downward Social Mobility (socioeconomic)
- Rural Residency

Approximately 90% of those who complete suicide suffer from mental illness.

- The most frequent diagnosis is Major Depression
- The 2nd most frequent diagnosis is Alcoholism

REMEMBER: *Depression is Treatable!*

Depression is one of the most treatable of all psychiatric disorders in young people.

- 86% treatment success rate with a combination of antidepressants and therapy*
- Only 40-70% with either by themselves.

* Source: The TADS Team. The Treatment for Adolescents with Depression Study (TADS): Long-term Effectiveness and Safety Outcomes. Archives of General Psychiatry. Oct 2007; VOL 64(10).

Rebound Effect – This is a very important effect to watch for. People do not recover overnight unless there is a very important reason. People tend to come out of wanting to commit suicide slowly. Some times people who have decided to kill themselves may appear quite happy. This is because they have finally made up their minds and see an end to their pain and anguish. They aren't really happy. They are simply relieved of their burden or stress or pain. Also, sometimes people who are severely depressed and contemplating suicide don't have enough energy to carry it out. But, as the disease begins to "lift" they may regain some of their energy but will still have feelings of hopelessness.

You can't tell the difference by looking at them. Studies of people who have been institutionalized for depression who later killed themselves all indicate that the period of greatest suicidal risk is not when the people are in the depths of depression, but during the first 90 days after the depression begins to lift.

Warning Signs of Suicide

Here's an Easy-to-Remember Mnemonic for the Warning Signs of Suicide: **IS PATH WARM?**

Ideation	Expressed or communicated ideation threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or talking or writing about death, dying or suicide, when these actions are out of the ordinary.
Substance Abuse	Increased alcohol or drug use
Purposelessness	No reason for living; no sense of purpose in life, start giving things away because there's no purpose in keeping anything, no reason to maintain their hygiene
Anxiety	Anxiety, agitation, unable to sleep or sleeping all the time, difficulty concentrating
Trapped	Feeling trapped (like there's no way out and things will never get better)
Hopelessness	Hopelessness, no future orientation
Withdrawal	Withdrawal from friends, isolating from family and society
Anger	Rage, uncontrolled anger, seeking revenge, irritable
Recklessness	Acting reckless or engaging in high risk activities, seemingly without thinking, impulsive behavior (especially in younger people)
Mood Change	Dramatic mood changes, flat affect, depressed mood, acting out of character

VERY IMPORTANT - All suicidal ideations are serious and every precaution needs to be taken, even if you believe the action is purely to gain attention. NEVER PUT A PERSON IN THE POSITION OF NEEDING TO PROVE THAT THEY ARE SERIOUS. Suicidal ideations are a cry for help. **DON'T AVOID THE TOPIC, TALK ABOUT THE FEELINGS AND DON'T BE AFRAID TO MENTION THE WORD "SUICIDE."** Most people will respond honestly. Many people are hesitant to bring up the subject of suicide for fear that they will be planting the idea in the mind of the person. This is a serious mistake! If the person is suicidal, asking them might lead to a conversation that could prevent the suicide.

Assessing the Degree of Risk – Mental health professionals should be used whenever possible, but once you suspect potential suicide, the best procedure is to approach the person in a **warm, accepting, non-judgmental manner** and ask a question similar to:

"Have you had thoughts of killing yourself?" or "Are you suicidal?"

Be careful with how you word your questions. Avoid asking questions that start with "why...". This elicits a defensive response and may cause the youth to close down. For example, don't ask a youth, "Why would you want to do something like that?" Instead ask, ***"How would you harm yourself?"*** This will let you quickly know if the youth has a **suicide plan.**

If the youth does have a suicide plan, remember the four factors that help you determine the seriousness of the risk.

- **Specificity** – How specific are the details of the plan of attack. The greater the amount of detail, the higher the risk.
- **Lethality** – What is the level of lethality of the proposed method of self-attack? The higher the lethality, the higher the risk.
- **Availability** – What is the availability of the proposed method? The more readily available the proposed method is the higher the risk.
- **Proximity** – What is the proximity of helping resources? The greater the distance the youth is from those you could help him, the higher the risk.

Four factors to use to access the current level of risk (given an attempt)

The strongest behavioral warning is an attempted suicide.

- **Dangerousness** – The greater the dangerousness of the attempt, the higher the current level of risk. *e.g. Did the youth take five pills or twenty five?*
- **Intent** – Did the youth believe that taking five pills was going to actually kill him?
- **Rescue** – Did the youth tell anyone that they made the attempt? Did the youth leave any signs (notes, give away possessions), or just acted normally?
- **Timing** – The more recent the attempt, the higher the current level of risk.

Talking with a Suicidal Person using QPR

QPR is not therapy, it is a way of offering hope.

Question, Persuade, Refer

Do	Don't
• Voice concern	• Leave the person alone
• Ask if they have a plan	• Be sworn to secrecy
• Tell someone else	• Act shocked
	• Challenge or dare
	• Argue or debate

QPR

Tips for Asking the Suicide Question

- ❖ If in doubt, don't wait, ask the question
- ❖ If the person is reluctant, be persistent
- ❖ Talk to the person alone in a private setting
- ❖ Allow the person to talk freely
- ❖ Give yourself plenty of time
- ❖ Have your resources handy; phone numbers, counselor's name and any other information that might help

Remember: How you ask the question is less important than that you ask it

QUESTION

Direct Approach:

- ❖ "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too?"
- ❖ "You look pretty miserable, I wonder if you're thinking about suicide?"
- ❖ "Are you thinking about killing yourself?"

NOTE: If you cannot ask the question, find someone who can.

How NOT to ask the suicide question

- ❖ "You're not thinking of killing yourself, are you?"
- ❖ "You wouldn't do anything stupid would you?"
- ❖ "Suicide is a dumb idea. Surely you're not thinking about suicide?"
- ❖ Never start with "why". It elicits a defensive response.

PERSUADE

HOW TO PERSUADE SOMEONE TO STAY ALIVE

- Listen to the problem and give them your full attention.
- Encourage them to talk about their reasons for dying without challenging them or telling them they "shouldn't feel that way." Validate their experience.
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

Then Ask:

- "I don't want you to kill yourself, I want to help"
- "Will you go with me to get help?"
- "Will you let me get you some help?"
- "Will you promise me not to kill yourself until we've found some help?"

YOUR WILLINGNESS TO LISTEN AND TO HELP CAN REKINDLE HOPE, AND MAKE ALL THE DIFFERENCE.

REFER

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help (therapist, emergency room, pastor, police).
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- The third best referral is to give referral information and try to get a good faith commitment not to complete or attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

HELP REDUCE THE MEANS OF ATTEMPTING SUICIDE BY REMOVING OR LOCKING UP ALL FIREARMS AND MEDICATIONS.

Other Evidenced-Based Suicide Prevention Programs

- **ASIST** - A two-day workshop designed to provide participants with gatekeeping knowledge and skills. Gatekeepers are taught to recognize the warning signs and to intervene with appropriate assistance.
- **SOS: Signs of Suicide** - School-based program which combines a curriculum that aims to raise awareness of suicide and reduce stigma of depression. There is also a brief screening for depression and other factors associated with suicidal behavior.
- **Teen Screen** - Identifies youth, through a screening instrument, who are at-risk for suicide and potentially suffering from mental illness and then ensure they receive a complete evaluation.
- **Parents as Partners** – A 9 page booklet that helps parents recognize the symptoms of depression and the warning signs of suicide in their children and how to intervene.
- **Crisis Intervention Training** - CIT came out of the Memphis Police Dept. and is a training for law enforcement officers to help them manage mental health issues when they respond to a call.

Other Potential Resources

(go to www.prc.mt.gov/suicideprevention to download these programs)

- **Suicide Prevention Toolkit for Rural Primary Care Physicians** – Assessment and intervention material for physicians in rural communities.
- **Suicide Prevention Toolkit for Senior Living Communities** – Assessment and intervention material for assisted living programs and nursing home.
- **Good Behavior Game** -The classroom management strategy is designed to improve aggressive/disruptive classroom behavior. It is implemented when children are in 1st or 2nd grade in order to provide students with the skills they need to respond to later, possibly negative,

life experiences and societal influences. Studies have suggested that implementing the "Good Behavior Game" may delay or prevent onset of suicidal ideations and attempts in early adulthood. **(Wilcox, H.C, Sheppard, K., Hendricks, B., Jeanne, M, Poduska, N.S., Ialongo, W.W., Anthony, J.C. (June, 2008). The impact of two universal randomized first- and second-grade classroom interventions on young adult suicide ideation and attempts. Drug and Alcohol Dependence, 95(1), S60-S73.)**

For additional information about these programs or other evidenced-based practices, go to http://www.sprc.org/featured_resources/bpr//ebpp.asp or http://www.nrepp.samhsa.gov/index.htm

Suicide Prevention Resources

Montana Suicide Prevention Website at www.prc.mt.gov/suicideprevention

In the event of an immediate crisis, **Call 911**, law enforcement, or take the person to the **nearest hospital emergency room or clinic**.

Montana Statewide Suicide Hotline - 1-800-273-TALK, TTY: 1-800-799-4TTY (4889). *National number then routed regionally to either Voices of Hope or the Help Center depending on prefix of phone number.*

Helpline Mental Health Center, Billings (406) 252-5658
The Community Crisis Center, Billings, 704 N 30th, MT 59102, 259-8800
Voices of Hope, Great Falls, North Central and North East Montana, 406-268-1330
The Help Center, Bozeman, South Central and South East Montana, 406-586-3333
District XI Human Resource Council, Missoula, South West Montana, 406-728-3710
United Way of NW Montana, North West Montana, 406-752-7266
Center for Mental Health, Helena, 443-5353
Hays Morris House Crisis Line, Butte, 1-800-221-0106
Shodair Children's Hospital (Acute Crisis Unit), Helena, 800-447-6614

American Association of Suicidology (202) 237-2280
Call for written material on suicide and suicide prevention or visit www.suicidology.org

American Foundation for Suicide Prevention (888) 333-AFSP (2377)
For more information on suicide prevention, call toll free or visit www.afsp.org

Depression and Bipolar Support Alliance (800) 826-3632
Call national organization for local chapters and written information on depression or visit www.dbsalliance.org

National Alliance for the Mentally Ill (800) 950-NAMI (6264)
Call Help Line for local support group and/or additional materials on depression, or visit www.nami.org

National Suicide Prevention Lifeline 800-273-TALK (8255)
Provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider www.suicidepreventionlifeline.org

Planting Seeds of Hope, 406-252-2550, 222 North 32nd Street - Suite 401, Billings, MT 59101. *Suicide prevention program for Native Americans. The PSOH program includes Montana's Blackfeet, Crow, Northern Cheyenne, Fort Peck and Fort Belknap, and Wyoming's Wind River Indian populations.*

Suicide Prevention Resource Center (SPRC) 877-GET-SPRC (438-7772)
Provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the National Strategy for Suicide Prevention. Includes materials for students, parents, school staff, and others. Includes state suicide data on state pages www.sprc.org.

Depression Is Treatable Suicide Is Preventable

If you are in crisis and want help, call the Montana Suicide Prevention Lifeline, 24/7, at

1-800-273-TALK

(1-800-273-8255)

QPR Training Exit Survey

Location of training: _____ Date of training: _____

Please take the 50 seconds that it requires to complete this short survey. It provides us with valuable data to improve future trainings. Thank you.

Which item is **not** a warning sign of suicide?

- ☐Ideation
- ☐Substance abuse
- ☐Purposelessness
- ☐Anxiety
- ☐Trapped
- ☐Hopelessness
- ☐Buying life insurance
- ☐Withdrawal
- ☐Anger
- ☐Recklessness
- ☐Mood change

Which item is **not** part of how to intervene with a suicidal person

☐Question ☐Persuade ☐Secret ☐Refer

Which item is **not** a suicide prevention resource in our state.

☐ 1-800-273-TALK	☐ Toolkit for senior living comm.	☐ ASIST
☐ SOS for schools	☐ Teen Screen	☐ QPR
☐ Toolkit for physicians	☐ Ignoring the warning signs	☐ Crisis Intervention Training

On a scale of 1-10, please rate how effective this training was in increasing your awareness of the warning signs of suicide and how to intervene.

(not effective) 1 2 3 4 5 6 7 8 9 10 (very effective)

On a scale of 1-10, please rate the facilitator's knowledge of the subject matter and ability to present the material in a manner in which you can apply what you learned.

(not effective) 1 2 3 4 5 6 7 8 9 10 (very effective)

How can we improve this training?

_____

_____

Thank you for your feedback

DREDF

DISABILITY RIGHTS EDUCATION & DEFENSE FUND

Why Assisted Suicide Must Not Be Legalized

Introduction

I. Few Helped, Many Harmed: Disability Prejudice and the Damage to Society

A. *Legal Alternatives Avoid A Great Harm*
B. *Fear, Bias, and Prejudice against Disability*
C. *A Deadly Mix: Managed Health Care and Assisted Suicide*

1. *An Ailing System Made Worse*
2. *Deteriorating Health Care in Oregon*
3. *The Broad Indirect Impacts on Health Care*

II. The Failure of Safeguards and the Case of Oregon

A. *The Myth of Free Choice and Self-Determination*
B. *The Fundamental Loophole of Terminal Illness Prognosis*
C. *Safeguards in Name Only*

1. *Doctor Shopping: All Roads Lead to Rome*
2. *Alternatives: Presented But Not Provided*
3. *Good Faith: A Safeguard for Doctors, Not Patients*

D. *The Danger to People with Depression and Psychiatric Disabilities*

1. *Depression and the Wish to Die*
2. *Ignoring What Lies Beneath: The Abandonment of the Patient*
3. *One Visit, Rarely: The Impact on the Individual*

E. *Minimal Data and Fatally Flawed Oversight*
F. *The Questionable Circumstances of Oregon Deaths*

III. So-called "Narrow" Proposals Can Easily Expand

A. *The Netherlands: Pandora's Box*
B. *Other Factors Driving Toward Expansion*

Conclusion
Endnotes

INTRODUCTION

While many people know that Oregon, Washington State, and Vermont have legalized assisted suicide, it is less well known that approximately half the states in the U.S. have either defeated bills to legalize it, or have passed laws explicitly banning it.[1]

In many cases, the bills or referenda were defeated due to the efforts of an opposition coalition spanning the political spectrum from left to right. These coalitions typically represent doctors and other health care workers, disability rights organizations, hospice organizations, and Catholics and other right-to-life organizations. In some cases, they also include organizations representing the Latino community, poor people, and workers.

The opposition to the legalization of assisted suicide is often mischaracterized as driven exclusively by religious conservatives, but most current opposition coalitions include many people and organizations whose opposition is based on their progressive politics. Among those are disability rights groups; many nationally prominent disability rights organizations oppose the legalization of assisted suicide.[2]

Other key opponents include the World Health Organization, the American Medical Association and its state affiliates, the American College of Physicians, the National Hospice and Palliative Care Organization, the American Cancer Society, many other medical organizations, and the League of United Latin American Citizens (LULAC). Many prominent Democrats and liberals also oppose legalization, including Bill Clinton, Ralph Nader, and noted civil liberties journalist Nat Hentoff.

Assisted suicide strikes many people as a cause to support, when they first hear about it. But upon closer inspection, there are many reasons why legalization is a serious mistake. Supporters focus on superficial issues of choice and self-determination. It is crucial to look deeper. Legalizing assisted suicide would not increase choice and self-determination, despite the assertions of its proponents. It would actually augment real dangers that negate genuine choice and control.

The disability community bases its opposition on the dangers to people with disabilities and the devaluation of disabled peoples' lives that result from assisted suicide. Further, this opposition stems from the secrecy in which assisted suicide operates today, in states where it is legal; the lack of robust oversight and the absence of investigation of abuse; the reality of who uses it; the dangers of legalization to further erode the quality of the U.S. health care system; and its potential for other significant harms.

After addressing common misunderstandings, we examine fear and bias toward disability, and the deadly interaction of assisted suicide and our profit-driven health care system. Second, we review the practice of assisted suicide in Oregon, the first U.S. state to legalize it, and debunk the merits of the so-called Oregon model. In detailing significant problems with Oregon's supposed safeguards, we raise some of its real dangers, particularly for people with depression and other psychiatric disabilities. Third and finally, we explore the ways that so-called "narrow" assisted suicide proposals can easily expand. This article focuses primarily on conditions in the United States, though much of our discussion also applies to other countries.

It is imperative to distinguish personal wishes from the significant dangers to society of legalizing assisted suicide as public policy. The legalization of assisted suicide has many

harmful consequences.

A note about terminology: The words used in this policy debate are controversial. We use the term "assisted suicide" because it is understood by the public and is used in the legal and medical literature. A clear, specific term is needed. "Aid in dying" could mean anything done to help a dying person, while "death with dignity" has many meanings. As Carol J. Gill, Ph.D., leading researcher and disability advocate against legalization wrote, such terms euphemize assisted suicide and obscure its nature[2a]. The politicization of this terminology is discussed below.

I. FEW HELPED, MANY HARMED: DISABILITY PREJUDICE AND THE DAMAGE TO SOCIETY

Legal Alternatives Available Today

The movement for the legalization of assisted suicide is driven by anecdotes of people who suffer greatly in the period before they die. But the overwhelming majority of these anecdotes describe either situations for which legal alternatives exist today, or situations in which the individual would not be legally eligible for assisted suicide.

It is legal in every U.S. state for an individual to create an advance directive that requires the withdrawal of treatment under any conditions the person wishes and for a patient to refuse any treatment or to require any treatment to be withdrawn. It is legal to receive sufficient painkillers to be comfortable, and we now know this will not hasten death.[3] And perhaps least understood, for anyone who is dying in discomfort, it is currently legal in any U.S. state to receive palliative sedation, wherein the dying person is sedated so discomfort is relieved during the dying process. Thus, there is already a legal recourse for painful deaths. These alternatives do not raise the serious difficulties of legalizing assisted suicide.

Moreover, anyone with a chronic but non-terminal illness is not eligible for assisted suicide in either Oregon or Washington State. Anyone with depression that affects his or her judgment is also ineligible. Consequently, the number of people whose situations would actually be eligible for assisted suicide is extremely low, yet its harmful consequences would be significant.

Even assisted suicide's proponents acknowledge that a very small number of people would utilize it. They will tend to be affluent, white, and in possession of good health insurance coverage. At the same time, large numbers of people, particularly among those less privileged in society, would be at significant risk of harm.

Perhaps for these reasons, the World Health Organization (WHO) has recommended that governments not consider assisted suicide and euthanasia until they have demonstrated the availability and practice of palliative care for all their citizens. As Herbert Hendin, noted international expert on suicide prevention, explained, "All U.S. states and all countries have a long way to go to achieve this goal."[4]

Fear, Bias, and Prejudice against Disability

Fear, bias, and prejudice against disability play a significant role in assisted suicide. Who ends up using assisted suicide? Supporters advocate its legalization by suggesting that it is needed for unrelievable pain and discomfort at the end of life. But the overwhelming

majority of the people in Oregon who have reportedly used that state's assisted suicide law wanted to die not because of pain, but for reasons associated with disability, including the loss of autonomy (89.9 percent), the loss of the ability to engage in activities that make life enjoyable (87.4 percent), the loss of dignity (83.8 percent), and the loss of control of bodily functions (58.7 percent).[5] Furthermore, in the Netherlands, more than half the physicians surveyed say the main reason given by patients for seeking death is "loss of dignity."[6]

This fear of disability typically underlies assisted suicide. Janet Good, an assisted suicide advocate who worked with Jack Kevorkian in bringing about the deaths of several people with disabilities, said:

> Pain is not the main reason we want to die. It's the indignity. It's the inability to get out of bed or get onto the toilet ... [People] ... say, 'I can't stand my mother – my husband – wiping my butt.' [It's] about ... dignity.[7]

But as many thousands of people with disabilities who rely on personal assistance have learned, needing help is not undignified, and death is not better than reliance on assistance. Have we gotten to the point that we will abet suicides because people need help using the toilet?[8]

Diane Coleman, president and founder of Not Dead Yet, a grassroots disability organization opposed to legalizing assisted suicide, has written that the "public image of severe disability as a fate worse than death ... become[s] grounds for carving out a deadly exception to longstanding laws and public policies about suicide intervention services ... Legalizing assisted suicide means that some people who say they want to die will receive suicide intervention, while others will receive suicide assistance. The difference between these two groups of people will be their health or disability status, leading to a two-tiered system that results in death to the socially devalued group."[9]

And as Paul Longmore, Professor of History at San Francisco State University and a foremost disability advocate on this subject, explained that the legalization of assisted suicide would "take place within the context of a health care system and a society pervaded with prejudice and discrimination against people with disabilities."[10] This prejudice and discrimination often plays out in deadly ways, including pressure by hospital staff members on people with disabilities to sign "Do Not Resuscitate" forms:

> "Yvonne Duffy had hospital personnel constantly urging and demanding that she sign the order," while Robert Powell, a wheelchair rider, was denied admittance to a hospital when he refused to sign a DNR. The disability rights magazine *Mouth* related that a New Mexico subscriber went to a hospital emergency room during a severe asthma attack. While she struggled to breathe, a social worker carefully took the time to explain that she had a right to reject medical treatment. At last, the disabled woman demanded that the staffer summon a doctor. As she departed, the social worker insistently informed her: "It's not too late. The Right to Die is on the hospital channel 6 twenty-four hours a day. You can watch it in your room!" *Mouth* writer Joe Ehman entered a Rochester, New York, hospital for back surgery. Both before and after the operation, a squad of hospital, county, and home-health social workers pressured him to sign a Do Not Resuscitate order. Ehman shot back at them, "I'm only 30 years old! I don't want

to die!"[11]

Additional linkages between assisted suicide and the danger it poses to people with disabilities are made below, particularly in The Danger to People With Depression and Psychiatric Disabilities, and The Questionable Circumstances of Oregon Deaths.

A Deadly Mix: Managed Health Care and Assisted Suicide

An Ailing System Made Worse

A significant problem with legalization is the deadly interaction between assisted suicide and profit-driven managed health care. Again and again, health maintenance organizations (HMOs) and managed care bureaucracies have overruled physicians' treatment decisions because of the cost of care. These actions have sometimes hastened patients' deaths.[12] Financial considerations can have similar results in non-profit health plans and government-sponsored health programs such as Medicare and Medicaid, which are often under-funded.

The cost of the lethal medication generally used for assisted suicide is about $300, far cheaper than the cost of treatment for most long-term medical conditions. The incentive to save money by denying treatment already poses a significant danger. This danger is far greater where assisted suicide is legal. Direct coercion is not necessary. If patients are denied necessary life-sustaining health care treatment, or even if the treatment they need is delayed, many will, in effect, be steered toward assisted suicide.

A 1998 study from Georgetown University's Center for Clinical Bioethics underscores the link between profit-driven managed health care and assisted suicide. The research found a strong link between cost-cutting pressure on physicians and their willingness to prescribe lethal drugs to patients, were it legal to do so.[13]

The deadly impact of legalizing assisted suicide would fall hardest, whether directly or indirectly, on socially and economically disadvantaged people who have less access to medical resources and who already find themselves discriminated against by the health care system. As the New York State Task Force on Life and the Law notes, assisted suicide:

> ... will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered ... [T]here [is no] reason to believe that the practices, whatever safeguards are erected, will be unaffected by the broader social and medical context in which they will be operating. This assumption is naïve and unsupportable.[14]

Longmore underscored this point, stating, "Poor people, people of color, elderly people, people with chronic or progressive conditions or disabilities, and anyone who is, in fact, terminally ill will find themselves at serious risk."[15]

Deteriorating Health Care in Oregon

Longmore and other disability rights activists have long made the point that Oregon's

It is also often alleged that legalized assisted suicide has improved end-of-life care in Oregon. While it is true that Oregon has shown some improvements, similar improvements have occurred in other states that have not legalized assisted suicide.[21] And research strongly suggests that Oregon has seen a reduction in the quality of end-of-life palliative care during the years since the Oregon law went into effect. A 2004 Journal of Palliative Care Medicine study showed that dying patients in Oregon are nearly twice as likely to experience moderate or severe pain during the last week of life, as reported by surviving relatives, compared with patients before the Oregon law took effect.[22] An article in *The Oregonian* about the study stated, "The findings call into question the widespread view that pain control at the end of life has improved markedly in Oregon."[23] And in 2008, authorities on end-of-life care and suicide prevention Herbert Hendin, M.D., and Kathleen Foley, M.D., discussed a number of studies that show inadequate palliative and end-of-life care in that state.[24]

The Broad Indirect Impacts on Health Care

Addressing the negative impact of the legalization of assisted suicide on the practice of medicine, the two professional associations representing oncologists in California wrote in 2007 that legalization "strikes at the heart of what we do as physicians and adds ambiguity to the physician-patient relationship." Legalization, they concluded, undermines the "physician's primary directive ... to *first, do no harm*"; "destroys the trust between the patient and doctor"; and, "[u]nder the pretense of providing compassion," relieves a physician "of his or her primary responsibility ... to safeguard [patients' lives] and to provide comfort to the suffering. It is the ultimate patient abandonment."[25]

It has been argued that concerns about health care inequalities and assisted suicide are belied by the fact that the reported assisted suicide deaths in Oregon have largely occurred to white educated individuals who are not poor. However, these concerns are not strictly about the handful of official reported assisted suicides, but the wider indirect impact of legalization on medical and legal practice.

The death of Wendy Melcher in August 2005 illustrates this impact. Two nurses, Rebecca Cain and Diana Corson, gave Melcher large overdoses of morphine and phenobarbital. They claimed that she had requested assisted suicide, but they administered the drugs without her doctor's knowledge, in clear violation of the law. Yet no criminal charges have been filed against the two nurses. Proponents of assisted suicide argue that this case has no connection to it. But it is a strong indication of the legal erosion of public protections associated with assisted suicide. The case prompted one newspaper to write, "If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon's] Death with Dignity Act are for naught."[26]

Supporters of assisted suicide frequently make the claim that where it is legal, there is no longer any underground practice of assisted suicide. No documentation is ever offered to support this claim. But Melcher's death suggests the exact opposite. It appears that underground assisted suicide is thriving in Oregon, due to the breakdown in legal rules and codes of conduct that elsewhere protect health care patients, a breakdown that may be an inevitable by-product of assisted suicide's legalization.

Other indirect harms of assisted suicide are discussed below, especially in the section, One Visit, Rarely: The Impact on the Individual.

II. THE FAILURE OF SAFEGUARDS AND THE CASE OF OREGON

Oregon's Death with Dignity Act initiative, known as Measure 16, narrowly passed in November 1994, but court proceedings delayed its implementation. After the court dismissed the challenge, the Oregon legislature, concerned that Measure 16 might soon be enacted, and knowing it to be dangerously flawed, referred it back to the voters for reconsideration in a November 1997 special election. After a campaign in which assisted suicide's proponents succeeded in keeping the public's attention away from the proposal's actual problems, Oregon voters legalized assisted suicide.[27]

Washington State's Initiative 1000, nearly identical to the Oregon law, passed in November 2008, and went into effect as the Death with Dignity Act in March 2009. And the Montana Supreme Court ruled assisted suicide to be legal in December 2009.

One of the myths about assisted suicide in Oregon is that it is highly regulated and has strong safeguards. Those alleged safeguards include limiting assisted suicide to people who are terminally ill, requiring doctors to present patients with the option for palliative care, ensuring that each request is voluntary, requiring that a second opinion be obtained, ensuring that patients are competent to make the decision to end their lives, requiring a fifteen-day waiting period, and requiring doctors to inform the state of any lethal prescriptions they write.[28] However, each and every one of these reportedly strong rules is either fundamentally flawed or has been rendered an empty ritual.

The discussion that follows focuses largely on Oregon because assisted suicide has been legal in that state for over a decade. Exploring Oregon and Washington is a means to examine many significant problems with the legalization of assisted suicide. These problems include the myth of free choice and self-determination; the fundamental loophole of terminal illness prognosis; the safeguards in name only; the danger to people with depression and psychiatric disabilities; Oregon's minimal data and fatally flawed oversight; and the questionable circumstances of Oregon deaths.

The Myth of Free Choice and Self-Determination

Assisted suicide proponents frequently appeal to free choice and self-determination. But in reality, legalized assisted suicide actually diminishes individual choice, control, and self-determination.

Margaret Dore, a specialist in elder law, has extensively documented how the Oregon and Washington State assisted suicide laws, contrary to the rhetoric, dramatically undermine patient control. In a May 2009 article on the website of the King County (Seattle) Bar Association, she pointed out:

> During the election, proponents touted [assisted suicide] as providing "choice" for end-of-life decisions. A glossy brochure declared, "Only the patient—and no one else—may administer the [lethal dose]." The Act, however, does not say this —anywhere. The Act also contains coercive provisions. For example, it allows an heir who will benefit from the patient's death to help the patient sign up for the lethal dose. ... The Act also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient's heir. This does not promote patient choice; it invites coercion.

> By comparison, when a will is signed, having an heir as one of the witnesses creates a presumption of undue influence. The probate statute provides that when one of the two required witnesses is a taker under the will, there is a rebuttable presumption that the taker/witness "procured the gift by duress, menace, fraud, or undue influence."
>
> Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons. Indeed, no one is required to be present. The Act does not state that "only" the patient may administer the lethal dose; it provides that the patient "self-administer" the dose. ... Someone else putting the lethal dose in the patient's mouth qualifies as "self-administration." Someone else putting the lethal dose in a feeding tube or IV nutrition bag also would qualify. "Self-administer" means that someone else can administer the lethal dose to the patient. ... Indeed, someone could use an alternate method, such as suffocation. Even if the patient struggled, who would know? The lethal dose request would provide an alibi.
>
> This situation is especially significant for patients with money. A California case states, "Financial reasons [are] an all too common motivation for killing someone." Without disinterested witnesses, the patient's control over the "time, place and manner" of his death, is not guaranteed.
>
> If one of your clients is considering a "Death with Dignity" decision, it is prudent to be sure that they are aware of the Act's gaps. By signing the form, the client is taking an official position that if he dies suddenly, no questions should be asked. The client will be unprotected against others in the event he changes his mind after the lethal prescription is filled and decides that he wants to live. [29]

As Dore also stated, "Involuntary killing is not an 'abuse.' It is allowed by the statute."[30] And Dore pointed out that assisted would actually restrict choice and self-determination by giving insurers a supposedly humane and dignified alternative to covering a patient's health care and by making people with disabilities and chronic illness vulnerable to predators by removing the protection of illegality for assisted suicide.[31]

These concerns are developed further below in The Questionable Circumstances of Oregon Deaths.

Moreover, there is a significant danger that many people would choose assisted suicide due to external pressure. Elderly individuals who don't want to be a financial or caretaking burden on their families might take this escape. In fact, the percentage of reported Oregon cases attributed to patients' reluctance to burden their families has risen alarmingly. It totaled 12 percent in 1998, but increased to 26 percent in 1999, then 42 percent in 2005, and 45 percent in 2007.[32] Nothing in the Oregon law will protect patients when there are family pressures, whether financial or emotional, which distort patient choice.

The impact of pressures to choose assisted suicide was illustrated when Rob Miller, Director of the pro-assisted suicide group Compassion & Choices of Washington, commented on the death of Linda Fleming, the first reported death under Washington State's assisted suicide law. When asked if he knew that Fleming, who was divorced, had had

financial problems, had been unable to work due to a disability, and was forced to declare bankruptcy in 2007, Miller said he was unaware of all that, but that her case presented "none of the red flags" that would cause his organization to reconsider supporting her suicide request.[33]

Also troubling is that research has documented widespread elder abuse in the United States. The perpetrators are often family members.[34] Such abuse could easily lead to pressures on elders to "choose" assisted suicide.

Still others may undergo assisted suicide because they lack good health care, or in-home support, and are terrified about going to a nursing home. A case in point, Oregon resident Kate Cheney (discussed below) appears to have been strongly motivated to take her life by fear of the nursing home where she had just spent an unhappy week. As Diane Coleman noted regarding Oregon's law, "Nor is there any requirement that sufficient home and community-based long-term care services be provided to relieve the demands on family members and ease the individual's feelings of being a 'burden' ... The inadequacy of the in-home long-term care system is central to the assisted suicide and euthanasia debate."[35]

While the proponents of legalization argue that it would guarantee choice, assisted suicide would actually result in deaths due to a *lack* of choice. Real choice would require adequate home and community-based long-term care; universal health insurance; housing that is available, accessible, and affordable—a full range of social supports currently unavailable to many, if not most people. In a perverse twist, widespread acceptance of assisted suicide is likely to *reduce* pressure on society to provide these very kinds of support services, thus reducing genuine options even further.[36]

The Fundamental Loophole of Terminal Illness Prognosis

The Oregon and Washington laws are based on the faulty assumption that it is possible to make a clear distinction between those who are terminally ill with six months to live, and everyone else. Everyone else is supposedly protected and not eligible for assisted suicide.

But it is extremely common for medical prognoses of a short life expectancy to be wrong. Studies indicate that only cancer patients show a predictable decline, and even then, it's only in the last few weeks of life. With every disease other than cancer, prediction is unreliable.[37] Prognoses are based on statistical averages, which are nearly useless in determining what will happen to an individual patient. Thus, the potential reach of assisted suicide is extremely broad, far beyond the supposedly narrow group its proponents claim. The affected group could include many people who may be mistakenly diagnosed as terminal but who have many meaningful years of life ahead of them.

This poses considerable danger to people with new or progressive disabilities or diseases, who may often be misdiagnosed as terminally ill but who in many cases outlive these prognoses by years or even decades. Research overwhelmingly shows that people with new disabilities frequently go through initial despondency and suicidal feelings, but later adapt well and find great satisfaction in our lives.[38] However, the adaptation usually takes considerably longer than the mere fifteen-day waiting period required by assisted suicide proposals and the Oregon and Washington laws. People with new diagnoses of terminal

illness appear to go through similar stages.[39] In that early period before one learns the truth about how good one's quality of life can be, it would be all too easy, if assisted suicide is legal, to make the final choice, one that is irrevocable.

Dr. Richard Radtke, a well-known retired academic oceanographer in Hawaii, provides one such example. Dr. Radtke has had a very disabling form of muscular sclerosis for over 25 years. In the period after his diagnosis, doctors often classified him as terminally ill. He experienced severe depression for two years. Had assisted suicide been legal, he acknowledges that he would have chosen it and died long ago. Today, still with an extremely limiting disability, he has retired from a successful academic career, is a happily married father, remains the president of a charitable foundation, and is grateful for the length and varied experiences of his life.[40] How many such individuals is our society prepared to sacrifice as the collateral damage from the legalization of assisted suicide?

Safeguards in Name Only

Doctor Shopping: All Roads Lead to Rome

There are many other significant weaknesses in Oregon's safeguards. For example, physicians are not permitted to write a lethal prescription under a set of inappropriate conditions defined in the law, such as when a patient is incompetent or when a request is involuntary. But in many instances, patients have engaged in "doctor shopping," which can circumvent any of these supposed protections. When the first physician a patient approached refused to comply with the request for lethal drugs, possibly because the patient didn't meet the conditions of the law, the patient sought out a second physician, and in some cases, a third and a fourth, until someone eventually agreed to write the prescription.

As the International Task Force on Euthanasia and Assisted Suicide stated to the Montana Supreme Court in April 2009,

> Many other patients seeking assisted suicide have ... had to ask more than one physician for the lethal prescription. There is no way to know if physicians declined due to personal convictions, because they believed the patients were not terminally ill or because they determined that the patients had impaired judgment. During the first three years of legal assisted suicide in Oregon, reports indicated that, in 59 percent of cases, patients had to ask two or more physicians before receiving the lethal drugs. After the third year, official reports stopped including this category. Patients or their families can doctor shop until a willing physician is found. And, since non-prescribing physicians are not interviewed for official state reports, there is no way to know why they refused to lethally prescribe.[41]

To understand how easily the approval-by-two-doctors "safeguard" can be circumvented as well, it is important to know that the lead organization advocating for assisted suicide, Compassion & Choices, also facilitates most of Oregon's reported assisted suicides, often by referring individuals to assisted-suicide-friendly doctors. (In addition, the organization's officers "are the authors [of the law] ... and [are its] self-proclaim[ed] ... stewards ... ."[42]) Dr. Peter Goodwin, the group's former Medical Director, said that about 75 percent of those who died using Oregon's assisted suicide law through the end of 2002 did so with the organization's assistance.[43] In one example year, during 2003, the organization was involved in 79 percent of reported assisted suicide deaths.[44] According to Dr.

Elizabeth Goy of Oregon Health and Science University, Compassion in Dying (since renamed Compassion & Choices) sees "almost 90 percent of requesting Oregonians..."[45] And "in 2008 the proportion of C&C PAS deaths significantly increased to 88 percent (53/60) of all [OPHD] reported deaths."[46] (More information about the role of Compassion & Choices in the Oregon law is discussed in the section below on Minimal Data and Fatally Flawed Oversight.)

H. Rex Greene, M.D., also noted that:

> This law [referring to a California bill patterned on the Oregon law] would allow marginal physicians, say two Botox dermatologists, to diversify into end-of-life prescribing. This is a real concern as a study done a few years ago indicated that the more experience physicians have in end-of-life care the more they disapprove of PAS. Conversely, it is those that rarely care for the dying that tend to support it. Thus, this law will necessarily put vulnerable patients in the hands of physicians who either lack experience or hold philosophical beliefs that an approach to end-of-life care includes lethal overdoses to relieve "suffering."[47]

The first person reported to die under Oregon law, whose name was not revealed, represents an example of doctor shopping. Her doctor and a second physician refused her a lethal prescription. The latter diagnosed her as "depressed." Nonetheless, a doctor affiliated with Compassion in Dying wrote the prescription after knowing her for only a short time.[48]

Another example is Kate Cheney, an 85-year-old woman.[49] Cheney saw two physicians. Her daughter thought the first doctor was "dismissive" and requested another opinion. The second physician ordered a psychiatric evaluation, which found that Cheney lacked "the very high level of capacity required to weigh options about assisted suicide." Cheney's request was then denied, and her daughter "became angry." Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive." Cheney soon took the drugs and died, but only after spending a week in a nursing home.

Alternatives: Presented But Not Provided

In the Oregon law, physicians are required to discuss alternatives to assisted suicide as another safeguard. However, there is no requirement that these alternatives actually be made available to patients, or even that the professional who discusses them fully understands them. Kate Cheney's case exemplifies this. Further, her case demonstrates the shocking laxness with which safeguards in Oregon are being followed. Cheney decided to take the lethal medication immediately after spending a week in a nursing home in order to give her family a break from caregiving. The chronology shows that Cheney felt she had only three choices: burdening her family, the hell of a nursing home, or death.

As Herbert Hendin, M.D., and Kathleen Foley, M.D., suicide prevention and end-of-life care experts, wrote about Kate Cheney, "one can readily see how in the best of circumstances frail, elderly patients can feel coerced to die. ... How can any physician be sure there is no coercion unless the physician has met the family and seen the interaction among them and with the patient? ... This particular case raises the question of what real meaning or

value Oregon's prohibition of coercion has if it can be circumvented so easily."[50]

After reading about Kate Cheney, Diane Coleman of Not Dead Yet sent a letter via the Internet to Dr. Robert Richardson, who authorized Cheney's request for lethal drugs. It stated, in part:

> In my role as a long-term care advocate, I have heard for years of Oregon's claim to operate the most progressive long-term care programs in the country, model programs that emphasize in-home and community-based services, even for the most frail elderly. What in-home services was Ms. Cheney receiving? How is it that Ms. Cheney had to spend a week in a nursing home to give her family respite from caregiving? Did Ms. Cheney and her family know of other respite options? If not, who failed to tell them? How can their actions have been based on the informed consent promised in Oregon's law? Or did the family choose the nursing home respite option with the knowledge of other alternatives (an even more disturbing possibility)? ...
>
> There are many ways to resolve the feeling of being a burden on family, and the family's feelings of being burdened. In what depth were these issues explored? In this context, family relationships are complex, and the emotional dynamics could not realistically be uncovered in a brief consultation.
>
> It appears from the newspaper account, as well as your response to Dr. Hamilton, that these issues were not meaningfully addressed. Ms. Cheney appears to have been given the message that she had three choices—to be a burden on family, to go to a nursing home, or to die. After a week in a nursing home, an experience I wouldn't wish on my opponents except perhaps to educate them, it appears that Ms. Cheney felt she had only one option. How is this a voluntary and uncoerced decision based on informed consent?[51]

Dr. Richardson did not reply.

Good Faith: A Safeguard for Doctors, Not Patients

There is one foolproof safeguard in the Oregon and Washington laws. Unfortunately, it is for physicians and other health care providers rather than for patients—the good faith standard. This provision holds that no person will be subject to any form of legal liability, whether civil or criminal, if they act in good faith.[52] However, a claim of a good faith effort to meet the requirements of the law is virtually impossible to disprove. Moreover, this particular provision renders all other alleged safeguards effectively unenforceable.

Even more alarming, for all other medical procedures, doctors are liable under a much stronger legal standard, that of negligence. Yet even if negligent, practitioners of assisted suicide will not be found to have violated the law as long as they practice in good faith. In an ironic twist, assisted suicide doctors and other practitioners are safer from liability if they cause a patient's death than if they provide his or her medical treatment.

As Diane Coleman asked, "...is society really ready to ignore the risks, tolerate the abuse, marginalize or cover up the mistakes, and implicitly agree that some lives—many lives—are expendable, in order to enact a law that immunizes health care providers and other

participants in assisted suicide?"[53]

Hendin and Foley offered this analysis:

> A concern with physician protection, rather than patient protection, pervades the Oregon experience. ... Oregon physicians assisting in a suicide are exempt from the ordinary standards of care, skill, and diligence required of Oregon physicians in other circumstances (e.g., a physician's conduct when withdrawing life support).
>
> Instead, the physician is immunized from civil and criminal liability for actions taken in "good faith" in assisting a suicide irrespective of community standards in other matters and even when the physician acts negligently.
>
> Good faith is a troublesome, subjective standard. ... In professional practices a negligence standard based on objective, established medical guidelines is customary. If the intent of the assisted suicide law is to protect physicians from accountability for violating the statute's provision, the good faith standard is ideal. But if the intent of the law is to provide protection for patients, a negligence standard would be more appropriate.[54]

The Danger to People with Depression and Psychiatric Disabilities

Depression and the Wish to Die

The drive to legalize assisted suicide comes from anecdotes of painful, uncomfortable deaths. Yet available data shows that when assisted suicide is legal, those who use it are not typically acting based on current pain or other discomfort. As H. Rex Greene, M.D., stated in 2006:

> ... the psychosomatic literature [describes] ... Demoralization Syndrome, which is very common in chronic, ... life threatening illness, the features of which (hopelessness, helplessness, and despair) fit the profile of the victims of Oregon's law, who are consistently reported NOT to be in pain or disabled by their allegedly terminal illness but request [assisted suicide] because of fears of what might come in the future: helplessness, dependency, becoming a burden. Oregon in fact has proven that the only symptom driving requests for [assisted suicide] is psychological distress. Clearly the standard of care for depression and demoralization is not a lethal overdose of barbiturates.

Greene also stated:

> The wish for death is a "cry for help," a reliable sign of depression. How absurd that it would be met with a lethal prescription. Such an act violates professional standards of palliative care as much as if I were presented with a suicidal patient and handed her a gun or drove her to the Golden Gate Bridge. ...
>
> What this legislation neglects is the fact that advances in palliative medicine have made it possible to relieve ... symptoms in virtually all dying patients. The argument that five to ten percent of dying patients experience intractable symptoms relies on outdated data. (Of course, the victims of the Oregon law

that go into the request for assisted suicide."[63]

One Visit, Rarely: The Impact on the Individual

Over time, serious abuses of the Oregon law exemplified by the cases of Michael Freeland and Kate Cheney, discussed above, have come to light. But this has occurred only sporadically, in the media and by word of mouth, because neither the Oregon nor the Washington law requires any investigation of abuse (the laws' weak enforcement is examined below in Minimal Data and Fatally Flawed Oversight). The example of Michael Freeland, as well as those that follow, offer an indication of the serious problems that have beset people with depression and psychiatric disabilities since the Oregon law went into effect.

In discussing Joan Lucas, an Oregon woman whose evaluating psychologist did not "take the trouble to see," and "on the basis of a single questionnaire administered by her family, ... was willing to give an opinion that would facilitate ending [her] life," Hendin and Foley pointed out that when a psychiatric evaluation is employed in Oregon, it has a tendency to be used to protect clinicians rather than patients:

> [The Oregon Public Health Division's] monitoring procedures do not make it possible for OPHD to evaluate the care Joan Lucas received. To do so OPHD would have to interview Joan's primary care physician who had refused to assist in her suicide and to assess the quality of her psychological evaluation. Using psychologists or psychiatrists as gatekeepers only to establish a patient's capacity to make a decision for assisted suicide contributes to *pro forma*, meaningless consultations.
>
> In the Lucas case, we have no way of knowing if Joan Lucas was seriously depressed or if the doctor or psychologist was disposed to proceed even if she were. Even more troubling is that OPHD does not seem to want to know about the psychiatric status of patients requesting assisted suicide. Under the current monitoring system, OPHD collects no information from psychiatrists who did not find patients to be competent and has no direct communication with psychiatrists or psychologists who did. Its monitoring reflects a lack of concern with the welfare of depressed patients.[64]

And as N. Gregory Hamilton, M.D., pointed out,

> The Oregon law does not require ... a psychiatric evaluation. Only if the doctor intending to write the prescription, or the consultant, believes that the patient has seriously impaired judgment due to a mental disorder is there any requirement for referral to a psychiatrist. In actual practice, few patients requesting assisted suicide are ever referred for such an evaluation—it has dropped to only 5%. When made, it's to a psychiatrist or psychologist chosen by the assisted suicide doctor and the evaluations tend to be pro forma, so they provide no protective function ... even if an opinion disallows assisted suicide ... seeking alternative opinions until one that favors assisted suicide can be found, is permitted. Thus, the law provides no effective protection for the mentally ill.[65]

Only six percent of Oregon psychiatrists are confident they can diagnose depression after one visit,[66] yet the Oregon and Washington State definitions of a psychiatric

consultation permit one visit only.[67]

Psychiatric evaluation of individuals who die from assisted suicide dropped from 31 percent in 1998 to a mere five percent in 2003 – 2004.[68] In the 2007 Oregon report, *no* Oregon patients underwent a psychiatric evaluation.[69] And "over the [following] two years in Oregon, less than 2% of patients committing assisted suicide were referred for psychiatric evaluation."[70]

Yet Hendin and Foley described an Oregon example of what can happen when psychiatric consultation is not provided:

> [A] woman in her mid-fifties with severe heart disease ... requested assisted suicide from her cardiologist, despite having little discomfort and good mobility. She was referred to another doctor, who in turn referred her to a physician willing to provide assisted suicide. That doctor determined that the woman had more than six months to live, according to his best estimate. Therefore, she was eventually dismissed as ineligible. Rather than inquire further into possible causes of [her] suicidal despair [or refer her for psychiatric treatment], the physician apparently considered ... his responsibility ended ... [H]e told her to go back and make yet another appointment with her original physician and dismissed her. She killed herself the next day.[71]

Proponents of assisted suicide may argue that this event does not constitute an assisted suicide abuse, because the woman did not die from lethal drugs provided under the Oregon law. But her depression may well have been treatable by a medical provider seeking to help her. That her practitioners narrowed their consideration to her eligibility for assisted suicide surely demonstrates another of assisted suicide's significant indirect harms.

As the two associations of California oncologists stated, considering all the Oregon assisted suicides to date, "What percentage of these cases might have been helped by aggressive psychiatric intervention or spiritual counseling?"[72]

Minimal Data and Fatally Flawed Oversight

The State of Oregon's minimal data collection and gross lack of strong oversight of assisted suicide undermines any pretense of rigorous monitoring or strict regulation. A series of problems renders any conclusions based on the data to be critically flawed. Washington State's law, which is much newer, contains similarly limited, deeply flawed oversight provisions.

Oregon's annual reports tell us very little. In reality, we don't know what is happening under the Oregon law due to the following oversight problems:

1. <u>The reporting requirement lacks teeth.</u> On paper, the law requires doctors to report all lethal drug prescriptions, but sets no penalties for physicians who fail to report. As a result, there is no enforcement of this requirement.[73]

2. <u>Non-compliance is not monitored.</u> The law requires annual statistical reports from the Oregon Public Health Division (OPHD), but OPHD does not monitor underreporting,

noncompliance, or violations. Many of Oregon's reports acknowledge that the State cannot confirm compliance with the Oregon law. OPHD announced in its first year that the state cannot determine if assisted suicide is practiced outside the law's framework, stating "[W]e cannot detect or collect data on issues of noncompliance with any accuracy."[74] And every annual report through Oregon's seventh year came with disclaimer similar to this one from the fifth year: "[O]ur numbers are based on a reporting system for terminally-ill patients who legally receive prescriptions for lethal medications, and do not include patients and physicians who may act outside the law." [75]

3. Important questions go unasked. Most information in OPHD reports comes from doctors who wrote lethal prescriptions. For its first annual report, OPHD gathered most information in 20-minute telephone interviews.[76] OPHD continues to gather data through questionnaires and telephone interviews.[77] However, OPHD does not gather information from important parties other than the prescribing physicians—for example, asking why doctors refused to assist patients in suicide. Doctors who said "no" may have concluded that a patient did not meet legal requirements—essential information if one truly intends to evaluate the law's outcomes. Nor does OPHD regularly interview family members or friends to learn about the physical and emotional status of those who died, nor does it interview or collect any information from patients prior to their deaths.[78] Such information is necessary for many reasons, including because the law does not require autopsies to determine if deceased patients were actually terminally ill.

   As Hendin and Foley observe, OPHD could correct this glaring limitation by gathering information from doctors who, for whatever reason, said no; from any psychiatrists who may have evaluated these patients, regardless of the results; and from nurses, social workers, or family members who cared for the deceased. Without this data, no one can know how many annual requests for assisted suicide are made, why some doctors declined while others agreed, and what transpired in individual cases.[79]

4. There is no investigation of abuse. OPHD reports fail to investigate cases of expansion and complications reported in the media or documented by others. There is no method through which the public can report abuse. The State has no resources or even authority to investigate violations.[80] In fact, in 2005, the Oregon Department of Human Services (DHS, of which OPHD is a part) issued a news release stating:

   > The Oregon Department of Human Services has no authority to investigate individual Death with Dignity cases ... . The state law authorizing physician-assisted suicide neither requires nor authorizes investigations by DHS, said Barry S. Kast, DHS Assistant Director for Health Services.[81]

   According to Dr. Kenneth Stevens, Oregon DHS has limited funding and they do not have the time, financial resources, authorization, or desire to investigate what is happening with assisted suicide in Oregon. He pointed out that, as the years have progressed, there is less and less information in the OPHD annual reports, adding:

   > But in contrast, Compassion & Choices of Oregon has much more

information. ... C&C wrote the law; they control the data; and when they say that everything is under control with "death with dignity" (assisted suicide) in Oregon, they are correct in that they control it.[82]

5. Secrecy pervades the operation of assisted suicide. There is an unnecessarily high level of secrecy about assisted suicide that undermines the public's right to know, as well as any independent, in-depth research. As Hendin and Foley wrote regarding Oregon:

> OPHD has focused more on patient-doctor confidentiality than on monitoring compliance or abuse. The agency has developed confidentiality measures unique to physician-assisted suicide which appear to be unnecessarily secretive and limit the potential for thorough research ... .
>
> The Oregon law specifically states that although OPHD will issue a report each year based on a selected sample of cases, "the information collected shall not be a public record and may not be made available for inspection by the public."There is no provision for an independent researcher or evaluator to study whatever data are available.
>
> Medical standards require openness about facts, research data, and records to assess the appropriateness of treatment. The anonymity and secrecy about physician practice of assisted suicide makes such an assessment impossible. If physician-assisted suicide is to be part of the medical treatment for terminal illness, why are existing patient-doctor confidentiality rules not sufficient to protect physicians in this setting? Restricting access to information about the indications for assisted suicide, patient data, radiologic documentation, and specific drug therapy limits the opportunity to establish an objective standard of care, provides excessive protection to the physician and, in the name of confidentiality, leaves the patient vulnerable.[83]

And regarding Washington, an article by John Ruhl and William Watts, M.D., on the King County (Seattle) Bar Association website discussed the Washington law's extraordinary requirement that on the death certificate, a patient's underlying disease must be listed as the cause of death—even if he or she died from lethal drugs at a time when that disease manifested no symptoms:[84]

> Ferreting out victims of abuse would be even more difficult because the patient's death certificate would be required to "list the underlying terminal disease as the cause of death" rather than suicide. Nor would the press or public be able to verify the accuracy of the State's summary statistical reports, because I-1000 provides specifically that "[e]xcept as otherwise required by law, the information collected [regarding compliance with I-1000] is not a public record ... ."[85]

6. The underlying data is destroyed annually. Alarmingly, officials have acknowledged that OPHD destroys each year's underlying data records after it issues each annual report.[86]

Assisted suicide is practiced in Oregon in secret and without oversight. In this lax context, without any systematic investigation of abuse, or even a way to report it, the examples that come to light in the media and through other means are likely to be only the tip of the iceberg. An editorial in *The Oregonian* pointed out that the law established "a system that seems rigged to avoid finding" the answers.[87] These problems, in aggregate, belie the allegation by assisted suicide's proponents and backers that it is safely regulated.

In discussion of Kate Cheney, Hendin and Foley wrote, "This case makes a compelling argument for the need for openness and transparency—and perhaps even judicial review of competency determinations ... ."[88] Certainly, judicial review is required on other matters no less significant than what is at stake here.

As Daniel Callahan, Senior Research Scholar and President Emeritus of the Hastings Center, wrote:

> [The Oregon law] is a laboratory lacking all transparency and accountability, with no information other than of a statistical kind made available to the public. The proposed Washington law is no less blunt in its denial of public information: "the department of health shall adopt rules to facilitate the collection of information. ... Except as otherwise required by law, the information ... may not be made available for inspection by the public."
>
> In the case of Oregon, we have been assured that all is well, that no abuses are occurring. In their confidence and firmness, those assurances are the equal of those expressed in the Netherlands prior to its confidential surveys. But Oregon has never sponsored a confidential survey, and probably never will. If you know, just *know*, there are no abuses, why bother? The flavor of the proposed law in Washington does not suggest a survey will ever be carried out there either. Regulations of that kind, protected from public scrutiny, but with the ring of authority and oversight, are a Potemkin village form of regulatory obfuscation. They look good, sound good, feel good, but have nothing behind them."[89]

In a final blow to transparency and regulation, rather than correcting any of these fundamental limitations, OPHD responded to pressure from pro-assisted suicide advocates not to use the term "assisted suicide." OPHD had used this term each year on its website and in its annual reports. But Compassion & Choices, responding to polling data that public support for assisted suicide decreases if the word "suicide" appears, successfully pressured OPHD in 2006 to switch to more nebulous terms such as "persons who use the Oregon Death with Dignity Act."

The Questionable Circumstances of Oregon Deaths

There are additional troubling aspects of how assisted suicide is practiced in Oregon. One is that there are no monitoring mechanisms or, indeed, controls of any kind once the prescription for lethal drugs has been written. No one knows what may happen to the lethal agents that are not taken by the patients who originally request them, and the Oregon reports have made it clear that some patients have died of other causes.[90] The drugs could be stored over time in private homes or workplaces, with no oversight to protect public safety.

As if to underscore this point, Dr. Katrina Hedberg, a lead author of most of Oregon's

official reports, testified in 2004:

> Our job is to make sure that all the steps happened up to the point the prescription was written. ... In fact, after they write the prescription the physician may not keep track of that patient. ... The law itself only provides for writing the prescription, not what happens afterwards. ... We do not have a way to track if there was a big bottle [of lethal drugs] sitting in somebody's medicine cabinet and they died whether or not somebody else chose to use it.[91]

Concern about the fate of unused lethal barbiturates is compounded by the fact that the Oregon law does not necessarily require that the drugs be ingested by mouth. Barbara Glidewell, Patient Advocate at Oregon Health & Science University, said that patients who cannot swallow would "need to have an NG tube or G tube placement ... [Then, they could] express the medication through a large bore syringe that would go into their G tube."[92] Dr. David Jeffrey wrote, "The question of administration is a delicate one, a patient even had a PEG feeding tube inserted solely to allow him to have PAS."[93] Moreover, Oregon's 2008 *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* states, "The Oregon [law] does not provide guidance on the degree of assistance with self-administration that may be given by another person." The *Guidebook* also notes, "Under the Oregon Act, physicians are *not* legally permitted to provide a lethal injection if the patient's self-administered medication does not result in death."[94] But it does *not* state that a patient cannot end his or her own life by lethal injection. And according to Sue Davidson of the Oregon Nurses Association, a 2002 survey found that nurses are very actively involved in the process and that "some indicated that they had assisted [patients] in the taking of [the lethal dose]."[95]

There is at least one documented example in Oregon in which assistance by others in the dying process has been acknowledged. Discussing a case in which a man said he helped his brother-in-law take the prescribed drugs, Dr. Katrina Hedberg said, "[W]e do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted. ..."[96] Supporters of the Oregon law allege that assisted suicide is totally voluntary by virtue of the fact that the individual alone must actually ingest the lethal agents, and do so very quickly, before the drugs' effects stall the process. But if a patient or someone assisting uses a feeding tube or an injection, intravenous or intramuscular, abuse is far more difficult to detect and prove.

The ambiguity about what happens after the prescription is written is highly problematic. Again contrary to the impressions created by assisted suicide supporters, the lethal drugs are not at all simple to take quickly. According to Kenneth R. Stevens, Jr., M.D., former Chairman of Radiation Oncology at Oregon Health & Science University and Vice-president of the Physicians for Compassionate Care Education Foundation, assisted suicides in Oregon have generally used one of two agents, secobarbital or pentobarbital (Nembutal). Use of secobarbital, a powder, requires a person to take the contents of 90 to 100 large capsules. These capsules cannot feasibly be swallowed, because the individual would fall asleep before ingesting enough to achieve the intended purpose. So the capsules must be emptied into applesauce or pudding, which cannot disguise the very strong and exceptionally bitter, distasteful flavor. Taking a substance to numb the mouth is not necessarily a good way to make the drug more palatable, because it could interfere with swallowing. The other agent, pentobarbital, is only available as an injectable liquid. Four bottles, or approximately seven ounces of liquid, must be taken to reach the needed dose of ten grams, and this potion is also

exceptionally distasteful.

Dr. Stevens commented on how bitter a death oral ingestion provides, and he pointed out that in at least one known Oregon case, a feeding tube was used.[97] He observed that since the lethal agent can be administered to a willing person through a feeding tube, it is equally possible to administer it to an unwilling person by the same means. Moreover, once the injectable pentobarbital leaves the pharmacy, there is nothing to prevent it from being used through an intravenous (IV) line, or as a lethal injection. If a patient or someone assisting appears to have used a feeding tube or an injection, abuse is far more difficult to detect and prove.[98]

This slide away from self-administration is a cause of considerable concern to the disability community, which has known a long history of involuntary euthanasia at the hands of others, whether governments, medical establishments, or families that did not necessarily value their presence.[99] With no controls on the drug after the prescription is filled, and with the possibility of administration through a nasogastric tube or gastrostomy feeding tube, or even through injection by third parties—how does this scheme protect vulnerable people from abuse, particularly at home?

The two professional associations of California oncologists wrote:

> Despite the reporting requirements, death by physician-assisted suicide in Oregon largely occurs in the dark. There is little accurate information about what actually happens at the time of death, as physicians are not required to be present at the time .... In 2005, physicians were in attendance in only 23% of cases...
>
> Between 1998 and 2005, the time between ingestion and death ranged from four minutes to 48 hours. It is hard not to imagine that those patients who required 48 hours to die might have experienced suffering over and above that brought on by the terminal illness. Indeed, this has been the experience in the Netherlands, with a report from 2000 showing that so-called "problems with completion" (a longer-than-expected time to death, failure to induce coma, or induction of coma followed by awakening of the patient) occurred in 16% of cases, prompting physician intervention 18% of the time, which of course blurs the line considerably between suicide and euthanasia.[100]

Other physicians specializing in end-of-life care have also questioned the circumstances of Oregon deaths. Doctors at Physicians for Compassionate Care wrote, "The range of time between ingestion and death ranged from 2 minutes to 25 hours. Both of those times are problematic. It is very unlikely that someone would die within 2 minutes of taking an overdose of sleeping medication. Likewise, the major effect of the short-acting sleeping medication would have worn off by 25 hours. So what was the cause of death in these circumstances?"[101]

H. Rex Greene, M.D. responded to these observations by pointing out that prior reports from Oregon consistently reported five-minute deaths—and only one victim has survived. He agreed that nobody dies five minutes—or even twenty minutes—following oral ingestion of a lethal dose of barbiturates. "About 15 percent of the Dutch overdoses survive and need to be euthanized," Greene concluded. "If true, the Oregon numbers suggest they are asphyxiating the patients ... in violation of the Oregon law."[102]

III. SO-CALLED "NARROW" PROPOSALS CAN EASILY EXPAND

Most assisted suicide supporters claim that assisted suicide will be narrowly limited to people who are terminally ill, but these so-called "narrow" proposals, if enacted, can easily expand. As the New York State Task Force on Life and the Law wrote,

> Once society authorizes assisted suicide for ... terminally ill patients experiencing unrelievable suffering, it will be difficult if not impossible to contain the option to such a limited group. Individuals who are not [able to make the choice for themselves], who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of assisted suicide, and no principled basis will exist to deny [it].[103]

The Netherlands: Pandora's Box

The example of the Netherlands demonstrates clearly that assisted suicide cannot be limited to a small, targeted group once Pandora's box is opened. The Dutch example provides the longest experience with assisted suicide in any country. Although it remained technically illegal until 2002, the Netherlands first began to legally tolerate assisted suicide in the early 70s.[104] Today, active euthanasia—doctors giving lethal injections—has almost completely replaced assisted suicide.[105]

The Netherlands has become a frightening laboratory experiment because of how far assisted suicide and lethal injections have spread. Herbert Hendin documented how assisted suicide and lethal injections have become not the rare exception, but the rule for people with terminal illness in the Netherlands. Hendin was one of only three foreign observers given the opportunity to study these medical practices in the Netherlands in depth, to discuss specific cases with leading practitioners, and to interview Dutch government-sponsored euthanasia researchers.

Hendin stated in Congressional testimony, "Over the past two decades, the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical [assistance to die], i.e. euthanasia, to those who could not effect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination. Involuntary euthanasia has been justified as necessitated by the need to make decisions for patients not [medically] competent to choose for themselves."[106]

Hendin has also described how the government-sanctioned studies suggest an erosion of medical standards in the care of terminally ill patients in the Netherlands: 50 percent of Dutch cases of assisted suicide and euthanasia are not reported, more than 50 percent of Dutch doctors feel free to suggest euthanasia to their patients, and 25 percent of these doctors admit to ending patients' lives without their consent.[107] Further, he reported that, for a thousand people each year in the Netherlands, physicians have ended their patients' lives

without consulting the patients.[108]

U.S. assisted suicide advocates, attempting to distinguish the Oregon experience from that of the Netherlands, argue that the numbers of reported users of assisted suicide in Oregon are low. But in fact, the number of people requesting lethal drugs has steadily increased.[109] In the beginning, the numbers were low in the Netherlands as well, but usage grew along with social acceptance of the practice. There is no reason to believe that legalization in the U.S. would not be followed, in 20 years or more, with the kind of extraordinary growth that has taken place in the Netherlands.

Other Factors Driving Toward Expansion

Assisted suicide proponents and medical personnel alike have established that taking lethal drugs by mouth is often ineffective in causing a quick and simple death. The body sometimes expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly, as assisted suicide advocates wish. Such ineffective suicide attempts happen in a substantial percentage of cases—estimates range from 15 percent to 25 percent.[110] The way to prevent these "problems," in the view of euthanasia advocates, is by legalizing lethal injections by physicians—that is, legalizing active euthanasia. This is the likely next step if society first accepts assisted suicide as a legitimate legal option.

Assisted suicide proponents tell us that none of these things will happen in the United States. But once assisted suicide is legalized, no significant barriers remain to prevent them. The very existence of assisted suicide as a legal option is likely to gradually erode social resistance, as it has in the Netherlands. In fact, the leading public champion for assisted suicide in Washington State, former Governor Booth Gardner, openly articulated a vision of its expansion as his dream. According to the New York Times Magazine in December 2007:

> Gardner wants a law that would permit lethal prescriptions for people whose suffering is unbearable, a standard that can seem no standard at all; a standard that prevails in the Netherlands, the Western nation that has been boldest about legalizing aid in dying; a standard that elevates subjective experience over objective appraisal and that could engage the government and the medical profession in the administration of widespread suicide. ...
>
> Gardner's campaign is a compromise; he sees it as a first step. If he can sway Washington to embrace a restrictive law, then other states will follow. And gradually, he says, the nation's resistance will subside, the culture will shift and laws with more latitude will be passed ...[111]

Thus, the danger of expansion is another reason why it is important to maintain the legal barriers prohibiting assisted suicide.

CONCLUSION

The movement to legalize assisted suicide would do far better to advocate for high quality end-of-life care. Within the context of prevailing negative attitudes about disability and a profit-driven health care system, people with disabilities pay a high price for legalizing assisted suicide. But we are not alone in doing so, because the negative consequences of

legalization affect many dimensions of society, extending well beyond the disability community and the health care system.

Leading disability rights organizations and advocates in the U.S. and in many countries, as well as most health care providers and many others, will continue to oppose the legalization of assisted suicide and euthanasia. In place of legalization, we will call for adequate home and community-based long-term care, universal health coverage, and a range of social supports that provide true self-determination for everyone. As Paul Longmore wrote, "Given the absence of any real choice, death by assisted suicide becomes not an act of personal autonomy, but an act of desperation. It is fictional freedom; it is phony autonomy." [112]

ENDNOTES

[1] International Task Force on Euthanasia and Assisted Suicide, *Failed Attempts to Legalize Euthanasia/Assisted Suicide in the United States*, available at http://www.internationaltaskforce.org/usa.htm (accessed July 13, 2009).

[2] Currently, these twelve nationally prominent disability organizations have stated their opposition to the legalization of assisted suicide: American Disabled for Attendant Programs Today (ADAPT); American Association of People with Disabilities (AAPD); Association of Programs for Rural Independent Living (APRIL); Disability Rights Education and Defense Fund (DREDF); Justice For All (JFA); National Council on Disability (NCD); National Council on Independent Living (NCIL); National Spinal Cord Injury Association; Not Dead Yet (NDY); TASH; the World Association of Persons with Disabilities (WAPD); and the World Institute on Disability (WID). See Not Dead Yet, National Disability Groups Opposed To Legalization of Assisted Suicide, available at http://www.notdeadyet.org/docs/supporters.html (accessed July 11, 2009); updates from NDY staff in personal interview, March 26, 2003. Many state and local disability community leaders and organizations have declared their opposition in states where assisted suicide proposals have been introduced, and the Disability Section of the American Public Health Association has also declare opposition.

[2a] Carol J. Gill, Ph.D., *No, we don't think our doctors are out to get us: Responding to the straw man distortions of disability rights arguments against assisted suicide*, Disability and Health Journal, Volume 3, Issue 1, January 2010, p. 31. Carol J. Gill, Ph.D. is the Director of Graduate Studies & PhD in Disabilities and a clinical and research psychologist specializing in health and disability. She is an Associate Professor in the Department of Disability and Human Development at the University of Illinois at Chicago.

[3] According to Herbert Hendin and Kathleen Foley, "We now know that that proper use of pain medications in patients with chronic pain, as well as patients at the end of life, does not hasten death. Studies have demonstrated that dying patients who received morphine lived longer than those who did not receive morphine." See Herbert Hendin and Kathleen Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, June 2008, pp.

1634 – 1635, available at http://www.spiorg.org/publications/HendinFoley_MichiganLawReview.pdf (accessed July 10, 2009). Herbert Hendin is Chief Executive Officer and Medical Director, Suicide Prevention International, and Professor of Psychiatry, New York Medical College. Kathleen Foley is Attending Neurologist, Memorial Sloan-Kettering Cancer Center; Professor of Neurology, Neuroscience, and Clinical Pharmacology, Weill Medical College of Cornell University; and Medical Director, International Palliative Care Initiative of the Open Society Institute. For the first sentence, Hendin and Foley cite Frank J. Brescia et al., "Pain, Opioid Use, and Survival in Hospitalized Patients With Advanced Cancer," *Journal of Clinical Oncology,* Vol. 10, p. 149, 1992 ("reporting that increased use of pain medication for cancer patients does not affect the relative risk of survival significantly more than other variables do"). For the second sentence, they cite William C. Wilson et al., "Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support From Critically Ill Patients," *Journal of the American Medical Association,* Vol. 267, pp. 949, 952 – 53, 1992. Also see Andrew Thorns and Nigel Sykes, "Opioid use in the last week of life and implications for end-of-life decision-making," *The Lancet,* July 29, 2000, pp. 398 – 399; Gina Kolata, "When Morphine Fails to Kill," *New York Times*, July 23, 1997; and Joanna Lynn, Letter to the Editor, *New England Journal of Medicine,* April 23, 1998, p. 1230.

[4] Herbert Hendin, M.D., "Commentary: The Case Against Physician-Assisted Suicide: For the Right to End-of-Life Care," *Psychiatric Times*, Vol. 21, Num. 2, February 1, 2004, available at http://www.psychiatrictimes.com/display/article/10168/54071 (accessed July 8, 2009).

[5] Based on Oregon Public Health Division, Death with Dignity Act Annual Reports, Table 1, available at http://oregon.gov/DHS/ph/pas/docs/yr11-tbl-1.pdf (accessed July 13, 2009).

[6] Karen Birchard, "Dutch MD's Quietly Overstepping Euthanasia Guidelines: Studies." *Medical Post*, Vol. 35, Num. 11, March 16, 1999.

[7] Richard Leiby, "Whose Death Is It Anyway? The Kevorkian Debate. It's a Matter of Faith, In the End," *Washington Post*, August 11, 1996, sec. Style, p. F1.

[8] Paraphrased from Diane Coleman, Stephen Drake, and Paul Longmore, *The Real Hemlock Society,* available at http://www.normemma.com/arhemloc.htm (accessed July 13, 2009).

[9] Diane Coleman, J.D., "Not Dead Yet," *The Case Against Assisted Suicide – For the Right to End-of-Life Care*, Kathleen Foley and Herbert Hendin, eds. (Baltimore: The Johns Hopkins University Press, 2002), p. 221.

[10] Paul Longmore, "The Resistance: The Disability Rights Movement and Assisted Suicide," *Why I Burned My Book and Other Essays on Disability* (Philadelphia: Temple University Press, 2003), p. 178.

[11] Ibid. Longmore is quoting "Joint Statement from Evan Kemp and Justin Dart," November 15, 1996; Carl Weiser, "Protesting Assisted Suicide Disabled People Shout, 'We're Not Dead Yet!'," *Louisville Courier-Journal,* January 9, 1997, 4A; and Joe Ehman,

"The Politics of D.N.R. (Do Not Resuscitate)," *Mouth Magazine* 6:6 March – April 1996, pp. 14 – 16. These near-fatal encounters with anti-disability prejudice in the health care system are not limited to the U.S. See, e.g., Olga Craig, "Baroness Campbell: Believe me, I absolutely love my life," *Telegraph*, July 12, 2009, available at http://www.telegraph.co.uk/news/5803716/Baroness-Campbell-Believe-me-I-absolutely-love-my-life.html (accessed July 14, 2009).

[12] See, e.g., the story of Dr. Linda Peeno. In 1996, before the U.S. House of Representatives Commerce Committee, she testified, "In the spring of 1987, as a physician [and managed-care executive for the HMO Humana], I caused the death of a man [by denying coverage of a heart transplant] ... I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was 'rewarded' for this. It brought me an improved reputation in my job, and contributed to my advancement afterwards." See also *HMO Whisteblower Dr. Linda Peeno on the Subordination of Healthcare to a For-Profit System*, June 21, 2007, available at http://www.democracynow.org/2007/6/21/hmo_whisteblower_dr_linda_peeno_on (accessed July 13, 2009); and "Doctor to Confess Role in Man's Death," *SanFrancisco Chronicle,* April 15, 1997, p. A13.

[13] Daniel P. Sulmasy, M.D.; Benjamin P. Linas, B.A.; Karen F. Gold, Ph.D., and Kevin A. Schulman, M.D., "Physician Resource Use and Willingness to Participate in Assisted Suicide," *Archives of Internal Medicine,* Vol. 158, May 11, 1998, p. 978.

[14] New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York: New York State Task Force on Life and the Law, 1994) pp. xiii, xv.

[15] Longmore, "The Resistance: The Disability Rights Movement and Assisted Suicide," p. 195.

[16] Longmore, "The Resistance: The Disability Rights Movement and Assisted Suicide," pp. 193 – 194. For his analysis, Longmore draws on Peter Steinfels, "Beliefs: Oregon Medicaid's Doctor-Assisted Suicide," *New York Times*, March 7, 1998; Erin Hoover, "Coverage of Assisted Suicide Looks Certain," *The Oregonian,* November 24, 1998; Patrick O'Neill, "Kitzhaber Proposes New Programs, No New Taxes; The Oregon Health Plan Would Face Some Cuts, Tougher Screening under the Governor's Proposal," *The Oregonian*, December 2, 1998; Associated Press, "Oregon Health Plan Will Cover Assisted Suicide Costs," December 2, 1998; Physicians for Compassionate Care, "Assisted Suicide Report Plagued by Shortcomings," Press Release, February 23, 2000; Nat Hentoff, "Free Ticket to Eternity," *Washington Post*; February 6, 1999, A21; and Tom Bates, "Chief petitioner answers questions on Measure 16," *Sunday Oregonian*, November 26, 1994.

[17] Ibid.

[18] Kenneth R. Stevens, Jr., M.D., *Oregon Rationing Cancer Treatment But Offering Assisted Suicide to Cancer Patients—Paying to Die But Not to Live*, Physicians for Compassionate Care Educational Foundation, June 6, 2008, available at http://www.pccef.org/articles/art67.htm (accessed July 9, 2009). Stevens is Professor Emeritus and former Chairman of Radiation Oncology at Oregon Health & Science

University and Vice-president, Physicians for Compassionate Care Education Foundation.

[19] Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care," *Fox News*, July 28, 2009, available at http://www.foxnews.com/story/0,2933,392962,00.html (accessed July 9, 2009).

[20] H. Rex Greene, M.D., personal communication, July 5, 2009.

[21] Kenneth R. Stevens, Jr., M.D., and William L. Toffler, M.D., noted in 2008 in *The Oregonian* that many states do better than Oregon. For example, the latest data ranks Oregon ninth (not first) in Medicare-age use of hospice; four out of the top five are states that have criminalized assisted suicide. See Kenneth R. Stevens, Jr., M.D., and William L. Toffler, M.D., "Assisted suicide: Conspiracy and Control," *The Oregonian*, September 24, 2008. See Steven's qualifications above. Toffler is Professor of Family Medicine at Oregon Health and Science University (OHSU) and the National Director of Physicians for Compassionate Care Educational Foundation.

[22] Erik K. Fromme, M.D., Virginia P. Tilden, D.N.Sc., R.N., Linda L. Drach, M.P.H., and Susan W. Tolle, M.D., "Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002," *Journal of Palliative Care Medicine,* Vol. 7, Num. 3, 2004.

[23] Don Colburn, "An OHSU Study Finds That Pain Management Has Not Kept Up With Expectations of the 1997 Law," *The Oregonian*, July 23, 2004.

[24] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, pp. 1619 – 1620 and 1636 – 1637. Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, pp. 1619 – 1620 and 1636 – 1637. Hendin and Foley are drawing on Erik K. Fromme et al., "Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002," *Journal of Palliative Medicine,* Vol. 7, Num. 3, 2004; Linda Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act," *New England Journal of Medicine,* Vol. 342, Num. 8, 2000; Susan Tolle and Kathleen Haley, "Pain Management in the Dying ... Successes and Concerns," *BME Report* (Oregon Board of Medical Examiners), Fall 1998, pp. 1, 4; Susan W. Tolle and Susan E. Hickman, "Don't prescribe less chart better," *BME Report* (Oregon Board of Medical Examiners), Winter Spring 2002, pp. 1, 4; Last Acts Program, Robert Wood Johnson Foundation, *Means to a Better End*, 2002, pp. 10 – 43, available at http://www.rwjf.org/files/publications/other/meansbetterend.pdf (accessed July 15, 2009); Linda Ganzini et al., "Nurses' Experiences with Hospice Patients Who Refuse Food and Fluids to Hasten Death," *New England Journal of Medicine*, Vol. 349, Num. 4 (2003); Helene Starks et al., "Family Member Involvement in Hastened Death," *Death Studies,* Vol. 31, Num. 2, 2007; and Dr. David Jeffrey, Winston Churchill Fellow, 2006, "Physician-assisted suicide v Palliative Care: a Tale of Two Cities," available at http://www.pccef.org/articles/PCCEF_June07_posting.pdf (accessed July 13, 2009).

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[26] Editorial, "Another case for nursing reform," *Portland Tribune,* July 10, 2007.

[27] *Oregon's Death Wish: The Vote and the Aftermath*, International Task Force on Euthanasia and Assisted Suicide, available at http://www.internationaltaskforce.org/iua11.htm (accessed July 9, 2009).

[28] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, p. 1614.

[29] Dore, Margaret, "Death with Dignity": What Do We Advise Our Clients?," *King County Bar Association, May 2009 Bar Bulletin*, available at http://www.kcba.org:80/newsevents/barbulletin/archive/2009/09-05/article5.aspx (accessed July 13, 2009).

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[31] Margaret Dore, personal communication, June 16, 2009.

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[34] The National Elder Abuse Incidence Study (NEAIS) was conducted by the National Center on Elder Abuse at the American Public Human Services Association. It showed that, in 1996, 450,000 elders age 60 and over were abused, according to a study of observed cases. In almost 90 percent of the elder abuse and neglect incidents with a known perpetrator, the perpetrator was a family member, and two-thirds of the perpetrators were adult children or spouses. See National Center on Elder Abuse, *National Elder Abuse Incidence Study (NEAIS)*, American Public Human Services Association, 1998, p. 4–28.

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[40] Richard Radtke, "A Case Against Physician-Assisted Suicide," *Journal of Disability Policy Studies,* Vol. 16, Num. 1, Summer 2005, pp. 58 – 61.

[41] Brief of *Amicus Curiae* Int'l Task Force on Euthanasia & Assisted Suicide *et al.* at 13 – 14, *Baxter v. State of Montana,* No. DA 09-0051(Mont.)(*case pending, brief filed* Apr. 24, 2009).

[42] Kenneth R. Stevens, Jr., M.D., *The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization*, Physicians for Compassionate Care Educational Foundation, March 4, 2009, available at http://www.pccef.org/DOWNLOADS/AssistedSuicidesbyCC2009report.pdf (accessed July 13, 2009).

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National Hemlock Society Biennial Conference, "Charting a New Course, Building on a Solid Foundation, Imagining a Brighter Future for America's Terminally Ill," January 9 – 12, 2003, Bahia Resort Hotel, San Diego, California.

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[45] Dr. Elizabeth Goy of Oregon Health and Science University (OHSU) is an Assistant Professor in the Department of Psychiatry, School of Medicine, OHSU and has worked with Dr. Linda Ganzini in surveys dealing with Oregon's law. In 2004, members of the British House of Lords traveled to Oregon seeking information regarding Oregon's assisted-suicide law for use in their deliberations about a similar proposal that was under consideration in Parliament. They held closed-door hearings on December 9 and 10, 2004 and published the proceedings on April 4, 2005. House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II: Evidence (London: The Stationery Office Limited, 2005), p. 291, Question 768, available at: http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf (accessed July 13, 2009).

[46] Stevens, *The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization*.

[47] H. Rex Greene, M.D., *Letter to the Council on Ethical Affairs*, California Medical Association, February 22, 2006, available at http://dredf.org/assisted_suicide/greene.shtml. H. Rex Greene, M.D., is the former Medical Director of the Dorothy E. Schneider Cancer Center at Mills Health Center in San Mateo, California, currently a member of the AMA Ethics Council, and a leader in bioethics, health policy and oncology.

[48] Kathleen Foley and Herbert Hendin, "The Oregon Report: Don't Ask, Don't Tell," *Hastings Center Report* (May-June 1999): 37-42.

[49] Erin Hoover Barnett, "A Family Struggle: Is Mom Capable of Choosing to Die," *The Oregonian*, October 17, 1999, p. G–01.

[50] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, p. 1625. Authors' qualifications are listed in note 3 above.

[51] Coleman, "Not Dead Yet," *The Case Against Assisted Suicide*, p. 226.

[52] Or. Rev. Stat. § 127.885(1)–(3).

[53] Coleman, "Not Dead Yet," *The Case Against Assisted Suicide*, p. 227.

[54] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, pp. 1626-1627.

[55] Greene, *Letter to the Council on Ethical Affairs*.

[56] The two professional associations representing oncologists in California wrote:

"In this debate, it is critical to recognize that, contrary to belief, most patients requesting physician-assisted suicide or euthanasia do *not* do so because of physical symptoms such as pain or nausea. Rather, depression, psychological distress, and fear of loss of control are identified as the key end of life issues.

This has been borne out in numerous studies and reports. For example, ... a survey of 100 terminally ill cancer patients in a palliative care program in Edmonton, Canada ... showed no correlation between physical symptoms of pain, nausea, or loss of appetite and the patient's expressed desire or support for euthanasia/PAS. Moreover, in the same study, patients demonstrating suicidal ideation were much more likely to be suffering from depression or anxiety, but not somatic symptoms such as pain.

An important study from the Netherlands of a cohort of 138 cancer patients with a life expectancy of three months or less demonstrated similar findings. In this study, the authors had hypothesized that patients requesting euthanasia would be unlikely to have depressed mood or affect, since it would be expected that such a request would be a well-thought out decision, particularly since euthanasia has been legal in the Netherlands since 2002. The authors expected that these patients would be more accepting of their terminal diagnosis and therefore better adjusted. What they found surprised them—depressed patients were more than four times as likely to request euthanasia as patients who were not depressed. Over 40% of depressed patients requested euthanasia. Of those who requested euthanasia, about half were depressed."

See Association of Northern California Oncologists and Medical Oncology Association of Southern California, *Position Statement on Physician-Assisted Suicide and Opposition to AB 374*, April 16, 2007, available at http://dredf.org/assisted_suicide/Oncology%20Statement%20on%20AB%20374%20(Berg).pdf (accessed July 8, 2009). The statement cites ME Suarez-Almazor et al., "Attitudes of Terminally Ill Cancer Patients About Euthanasia and Assisted Suicide: Predominance of Psychosocial Determinants and Beliefs Over Symptom Distress and Subsequent Survival," *Journal of Clinical Oncology*, Vol. 20, 2002, pp. 2134 – 41 and E.J. Emanuel, "Depression, Euthanasia, and Improving End-of-Life Care," *Journal of Clinical Oncology*, Vol. 23, 2005, pp. 6456 – 8.

[57] Herbert Hendin, M.D., *Suicide, Assisted Suicide and Euthanasia: Lessons From the Dutch Experience*, Testimony Summary, U.S House of Representatives, Subcommittee on the Constitution, April 29, 1996.

[58] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, p. 1623. Also: "Contrary to much popular and professional opinion, depression is a treatable condition, even in patients who are terminally ill." Susan D. Block, "Psychological Issues in End-of-Life Care," *Journal of Palliative Medicine* 9(3), 2006: p. 762.

[59] N. Gregory Hamilton, M.D., Physicians for Compassionate Care Educational Foundation, *Testimony to the Select Committee on the Assisted Dying for the Terminally Ill Bill*, House of Lords, Portland, Oregon, December 10, 2004, available at http://www.pccef.org/articles/art32HouseOfLords.htm (accessed July 13, 2009). Also see House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II, pp. 329 – 343, available at http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf (accessed

July 13, 2009). Also see N. Gregory Hamilton, M.D. and Catherine Hamilton, M.A., *Competing Paradigms of Responding to Assisted-Suicide Requests in Oregon: Case Report*, presented at American Psychiatric Association Annual Meeting, Symposium on Ethics and End-of-Life Care: New Insights and Challenges, New York City, May 6, 2004.

[60] Linda Ganzini, Elizabeth R. Goy, and Steven K. Doscha, "Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey," *British Medical Journal,* Vol. 337, a1682.

[61] Revised Code of Washington 70.245.010; Oregon Legislative Statue 127.800 §1.01.

[62] Linda Ganzini, M.D., Gregory B. Leong, M.D., Darien S. Fenn, Ph.D., J. Arturo Silva, M.D., and Robert Weinstock, M.D., "Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists," *American Journal of Psychiatry*, Vol. 157, April 2000, pp. 595 and 598.

[63] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, p. 1631.

[64] Ibid., p. 1623.

[65] N. Gregory Hamilton, M.D., Physicians for Compassionate Care Educational Foundation, *Testimony to the Select Committee on the Assisted Dying for the Terminally Ill Bill*, House of Lords, Portland, Oregon, December 10, 2004, available at http://www.pccef.org/articles/art32HouseOfLords.htm.

[66] L. Ganzini, et al., "Attitudes of Oregon Psychiatrists Towards Assisted Suicide," *American Journal of Psychiatry,* Vol. 153, 1996, pp. 1469 – 75.

[67] Revised Code of Washington 70.245.010; Oregon Legislative Statue 127.800 §1.01.

[68] Oregon Public Health Division, *Fourth Annual Report on Oregon's Death with Dignity Act*, 2002, p. 16, available at http://www.oregon.gov/DHS/ph/pas/docs/year4.pdf (accessed July 13, 2009); Oregon Public Health Division, *Sixth Annual Report on Oregon's Death with Dignity Act*, 2004, p. 11, available at http://www.oregon.gov/DHS/ph/pas/docs/year6.pdf (accessed July 13, 2009); and Oregon Public Health Division, *Seventh Annual Report on Oregon's Death with Dignity Act*, 2005, p. 13, available at http://www.oregon.gov/DHS/ph/pas/docs/year7.pdf (accessed July 13, 2009).

[69] Data taken from Oregon Public Health Division, Death with Dignity Act Annual Reports, available at http://oregon.gov/DHS/ph/pas/ar-index.shtml (accessed July 13, 2009); and *Oregon Death With Dignity Act: A Guidebook for Health Care Professionals*, 2008, developed by The Task Force to Improve the Care of Terminally-Ill Oregonians, convened by The Center for Ethics in Health Care, Oregon Health & Science University, available at http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf (accessed July 17, 2009).

[70] Physicians for Compassionate Care Educational Foundation, *2008 Annual PAS Report*

Press Release, March 4, 2009, available at http://www.pccef.org/pressreleases/press34.htm (accessed July 13, 2009).

[71] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, p. 1621.

[72] Association of Northern California Oncologists and Medical Oncology Association of Southern California, *Position Statement on Physician-Assisted Suicide and Opposition to AB 374*.

[73] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, p. 1627.

[74] See Oregon Public Health Division, *Oregon's Death With Dignity Act: The First Year's Experience*; and also A. E. Chin, et al., "Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience," *The New England Journal of Medicine*, Vol. 340, Num. 7, February 18, 1999, pp. 577 – 83.

[75] Oregon Public Health Division, *Fifth Annual Report on Oregon's Death with Dignity Act*, 2003, available al http://www.oregon.gov/DHS/ph/pas/docs/year5.pdf (accessed July 7, 2009).

[76] Joseph P. Shapiro, "Casting a Cold Eye on 'Death With Dignity,'" *U.S. News & World Report*, March 1, 1999.

[77] Oregon Public Health Division, "Methods," Death with Dignity Annual Reports, available at http://www.oregon.gov/DHS/ph/pas/ar-index.shtml (accessed July 13, 2009).

[78] Ibid.

[79] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, p. 1637.

[80] Though OPHD has no investigative authority, assisted suicide's defenders have occasionally responded to this critique by pointing out that the annual reports detail 20 referrals made to the Oregon Board of Medicine and one referral to the Board of Pharmacy. But no reports suggest that any disciplinary action was ever taken. Such referrals are made when physician-completed questionnaires or interviews involve minor paperwork irregularities such as "incorrectly completed report forms" or "an incomplete written consent." Yet these referrals do not constitute a meaningful investigation or a true safeguard, as they depend entirely on self-reporting; they address very minor irregularities, and there has not been disciplinary action. Oregon's second report acknowledges this problem, noting, "Under reporting and non-compliance is thus difficult to assess because of possible repercussions for noncompliant physicians reporting to the division." Oregon Public Health Division, *Oregon's Death with Dignity Act: The Second Year's Experiences*.

[81] Oregon Department of Health Services News Release, *No Authority to Investigate Death with Dignity Case, DHS Says*, March 4, 2005, available at

http://www.oregon.gov/DHS/news/2005news/2005-0304a.shtml (accessed July 7, 2009).

[82] Kenneth R. Stevens Jr., M.D., personal communication, July 10, 2009.

[83] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review,* pp. 1627-1628.

[84] Revised Code of Washington 70.245.020 (2).

[85] John Ruhl and William Watts, MD, "I-1000: Prescription for Coercion, Not Freedom," King County (Seattle, Washington) Bar Association website, available at http://www.kcba.org/newsevents/barbulletin/archive/2008/08-10/article27.aspx. John Ruhl was the president of the King County Bar Association in 2006 – 2007. William Watts, M.D., was the president of the King County Medical Society in 2007.

[86] Testimony of Dr. Katrina Hedberg, December 9, 2004, in House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL],* Vol. II, p. 262, question 592.

[87] Editorial, "Living With the Dying Experiment," *The Oregonian*, March 8, 2005.

[88] Hendin and Foley, "Physician Assisted Suicide: A Medical Perspective," *Michigan Law Review*, June 2008, p. 1625.

[89] Daniel Callahan, "Organized Obfuscation: Advocacy for Physician-Assisted Suicide," *Hastings Center Reports*, September-October 2008, p. 32.

[90] Based on data taken from Oregon Public Health Division, Death with Dignity Act Annual Reports, Years 1 – 11, available at http://oregon.gov/DHS/ph/pas/ar-index.shtml (accessed July 13, 2009).

[91] Testimony of Hedberg in House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II, p. 256, questions 566-567, and p. 262, question 591.

[92] Letter from Barbara Glidewell, included in testimony transcript, House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II, p. 268, number 3; p. 270, question 623; p. 275, question 653.

[93] Dr. David Jeffrey, Winston Churchill Fellow, 2006, "Physician-assisted suicide v Palliative Care: a Tale of Two Cities," available at http://www.pccef.org/articles/PCCEF_June07_posting.pdf (accessed July 13, 2009).

[94] "*Oregon Death With Dignity Act: A Guidebook for Health Care Professionals.* See Chapter 8, "The Role of Other Health Care Professionals," p. 4; and Chapter 7, "Attending Physician and Consulting Physician," p. 10.

[95] Witnesses' testimony was published in House of Lords Select Committee on the

Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II, pp. 352-353, Question 1058.

[96] Testimony of Hedberg, House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II, p. 267, question 621.

[97] On March 11, 2007, a Los Angeles Times story described David Bradley, a man with esophageal cancer, who moved to Oregon from New Mexico, and reportedly underwent assisted suicide in summer 2005. The lethal substance was poured into his feeding tube. Lauren Kessler, "The End in Two Acts," *Los Angeles Times*, March 11, 2007.

[98] Kenneth R. Stevens, Jr., M.D., personal communication, July 8, 2009; information on lethal drugs based on data taken from Oregon Public Health Division, Death with Dignity Act Annual Reports.

[99] See, for example, Hugh Gallagher, *By Trust Betrayed: Patients, Physicians and the License to Kill in the Third Reich* (St. Petersburg, FL: Vandamere Press, 1995) and the work of Richard (Dick) Sobsey on maltreatment and killing of children with disabilities, including "Exceptionality, Education, and Maltreatment," Lawrence Earlbaum Associates, Inc., 2002, available at http://www.childinfo.org/files/childdisability_Sobsey2002.pdf (accessed July 7, 2009) and "Murder and Social Endorsement, Part II," International Coalition on Abuse & Disability, available at http://icad.wordpress.com/2008/12/03/murder-and-social-endorsement-part-ii/ (accessed July 8, 2009).

[100] Association of Northern California Oncologists and Medical Oncology Association of Southern California, *Position Statement on Physician-Assisted Suicide and Opposition to AB 374*. The position statement is in part discussing JH Groenewoud et al., "Clinical Problems With the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands," *New England Journal of Medicine*, Vol. 342, 2000, pp. 551 – 556.

[101] Physicians for Compassionate Care Educational Foundation, *2008 Annual PAS Report Press Release*.

[102] H. Rex Greene, M.D., personal communication, March 11, 2009.

[103] New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context,* 1997 Supplement.

[104] Both euthanasia and assisted suicide have been widely practiced in the Netherlands since 1973, although they were against the law until 2002. The Dutch situation between 1973 and 2002 was an outgrowth of a series of court decisions and medical association guidelines, beginning with a 1973 District Court case in which Geertruida Postma, a Dutch physician, was convicted of the crime of euthanasia after she ended the life of her seriously ill mother. See *Nederlandse Jurisprudentie* 1973, no. 183, District Court of Leeuwarden, 21, February 21, 1973; translation in Walter Lagerway, *Issues in Law and Medicine*, Vol. 3, pp. 429, 439 – 42, 1988. Her admission that she had given her mother a lethal injection seemed calculated to force public and legal reconsideration of the laws against assisted suicide (Penal Code of the Netherlands, §294) and euthanasia (Penal Code of the Netherlands, §293). While finding Dr.

Postma guilty of the crime of mercy killing that was punishable by imprisonment for a maximum of 12 years, the court imposed a one-week suspended sentence and a week's probation. The Dutch court relied heavily on expert testimony by the District's medical inspector who set forth certain conditions "under which the average physician thought euthanasia should be considered acceptable." Inclusion of those conditions formed the basis for subsequent acceptance of euthanasia and assisted suicide in the Netherlands. The guidelines required that the patient must be considered incurable and experiencing subjectively unbearable suffering; the request for termination of life should be in writing; and there should be adequate consultation with other physicians before death could be induced. See Carlos Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands (Old Tappan, NJ: Free Press,* 1991), p. 30. Other cases followed, each widening the boundaries and further liberalizing the conditions under which euthanasia and assisted suicide, although remaining illegal, would not be punished. Among the cases was the *Alkmaar* case (*Nederlandse Jurisprudentie* 1985, no. 106) in which a woman died after requesting death because "her advancing age and physical condition caused her to be dependent on others, thus leading to psychological suffering." The case gave rise to the 1986 decision by the Hague Court of Appeals that recognized "psychic suffering" and "potential disfigurement of personality" as grounds for induced death. The courts have also exonerated physicians who assisted in the suicides of a young woman with anorexia nervosa (Amelo, *Tijdschrift voor Gezondheidsrecht,* 1992, No. 19) and a woman who was depressed over the death of her two children and the failure of her marriage (Assen, *Nederlandse Jurisprudentie* 1994, No. 656). This discussion is drawn from the International Task Force on Euthanasia and Assisted Suicide, *Assisted Suicide & Death with Dignity: Past, Present & Future—Part III, International Perspective,* available at http://www.internationaltaskforce.org/rpt2005_3.htm (accessed July 13, 2009). For additional discussion of these and other cases, see Gomez, *Regulating Death*; I .J. Keown, "The Law and Practice of Euthanasia in the Netherlands," *Law Quarterly Review,* Vol. 108, 1992, pp. 51 – 52; Herbert Hendin, *Seduced by Death: Doctors, Patients, and Assisted Suicide* (New York: W.W. Norton & Co., 1997); and Jonathan T. Smies, "The Legalization of Euthanasia in the Netherlands," *Across Borders International Law Journal,* Vol. 7, 2004.

[105] "Doctors had reported that a total of 2,146 people were euthanised and 152 died in assisted suicides in 2008, while in 33 cases there was a combination of the two practices." See "Dutch Court Jails Euthanasia Group Chairman For Aiding Suicide," *Expatica.com*, May 30, 2009, available at http://www.expatica.com/nl/news/dutch-news/Dutch-court-jails-euthanasia-group-chairman-for-aiding-suicide_53107.html# (accessed July 13, 2009).

[106] Hendin, *Suicide, Assisted Suicide and Euthanasia: Lessons From the Dutch Experience*, Testimony Summary.

[107] Hendin, "Commentary: The Case Against Physician-Assisted Suicide: For the Right to End-of-Life Care," *Psychiatric Times*.

[108] "The most alarming concern has been the documentation of several thousand cases a year in which patients who have not given their consent have their lives ended by physicians. A quarter of physicians stated that they 'terminated the lives of patients without an explicit request' from the patient. Another third of the physicians could conceive of doing so." Ibid.

[109] The following table demonstrates the steadily increasing numbers of reported lethal prescriptions and deaths under Oregon's assisted suicide law.

Eleven-year Breakdown of Reported Oregon Requests for Lethal Prescriptions and Reported Assisted Suicide Deaths from Oregon's Annual Reports

Year	Reported Lethal Prescription Recipients	Reported Deaths After Lethal Drug Administration*	Reported Deaths from Underlying Terminal Illness	Reported Alive at Year's End
1 (1998)	24	16	6	2
2 (1999)	33	27	5	2
3 (2000)	39	27	8	5
4 (2001)	44	21	14	11
5 (2002)	58	38	16	6
6 (2003)	67	42	18	10
7 (2004)	60	37	13	12
8 (2005)	64	38	15	17
9 (2006)	65	46	19	11
10 (2007)	85	49	26	13
11 (2008)	88	60	22	12

Total Reported Lethal Prescription Recipients: 627

Total Reported Deaths After Lethal Drug Administration: 401

Total Reported Deaths from Terminal Illness Within One Year of Receiving Prescription: 162

Total Reported Alive Within Year of Receiving Prescription: 101

* Annual reports note that death total includes patients who received prescriptions in previous years.

[110] Ezekiel J. Emanuel, Elisabeth R. Daniels, Diane L. Fairclough, et. al, "The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians," *Journal of the American Medical Association,* Vol. 280, No. 6, August 12,1998, p. 512; and Derek Humphrey, Letter to the Editor, *New York Times,* December 3, 1994.

[111] Daniel Bergner, "Death in the Family," *New York Times Magazine,* December 2, 2007, available at http://www.nytimes.com/2007/12/02/magazine/02suicide-t.html?_r=2&adxnnl=1&oref=slogin&adxnnlx=1197327386-QFZ8VR5Wz/XiMRmZOcX3zA (accessed July 13, 2009).

[112] Paul Longmore, "The Resistance: The Disability Rights Movement and Assisted Suicide," p. 195.

Sawyers go to prison; victims see justice - but money?

Mexico, Bend homes to be auctioned off -- but much of millions gone

Nina Mehlhaf
Barney Lerten

POSTED: 11:18 PM PDT April 29, 2013
UPDATED: 10:25 AM PDT May 1, 2013

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Lane County Jail

Tami and Kevin Sawyer were booked into the Lane County Jail in Eugene last spring after their federal sentencing on fraud charges

EUGENE, Ore. - After four years of investigations and court proceedings, 33 fraud victims of former Bend real estate broker Tami Sawyer and her ex-police lieutenant husband, Kevin, finally saw justice Tuesday in a Eugene federal courtroom, as the pair were sentenced to years in prison -- nine for her, two-plus for him -- for fraud, money-laundering and other crimes. Whether and when they might see some or all of the lost millions repaid is still hard to say.

Three months after pleading guilty on the day their trial was to start, after U.S. District Judge Ann Aiken shot down their planned line of defense, the Bend couple, who for years maintained their innocence, also were ordered to repay more than $5.82 million to the investors they defrauded.

Tami Sawyer, 49, pleaded guilty in January to 21 counts of bank and wire fraud, conspiracy and money laundering, her 60-year-old husband to one charge, of lying to a bank on a Bend mortgage application.

As they arrived with family and friends on a blue-sky Tuesday morning at the federal courthouse, the couple declined to comment: "We'd like to, but we cannot,' Kevin said as he headed up the steps.

Once the hearing began, it took hours to get property values decided. Then, before the judge imposed sentence, the once socially prominent couple spoke to those in the courtroom.

Never once apologizing, Kevin Sawyer said he felt awful about what had happened. His wife said something very familiar, and quite similar to a much earlier vow to make good on what they owe. That also was voiced toward the start of this long saga -- before the growing cloud of a federal investigation prompted the pair to plead the Fifth (the right against self-incrimination) in contentious debtors' exams.

"As long as there's breath in my body, they (the investors) will be paid back," Tami Sawyer said in court. "It's our absolute first priority to do that."

Three of their victims read letters in court, emotional speeches in which they asked the judge to impose the maximum sentence. They talked of life savings stolen, of feeling used and betrayed, of lies told and lives ruined.

"This is horrifying, what happened to these victims," Aiken told the pair as family members wept in the

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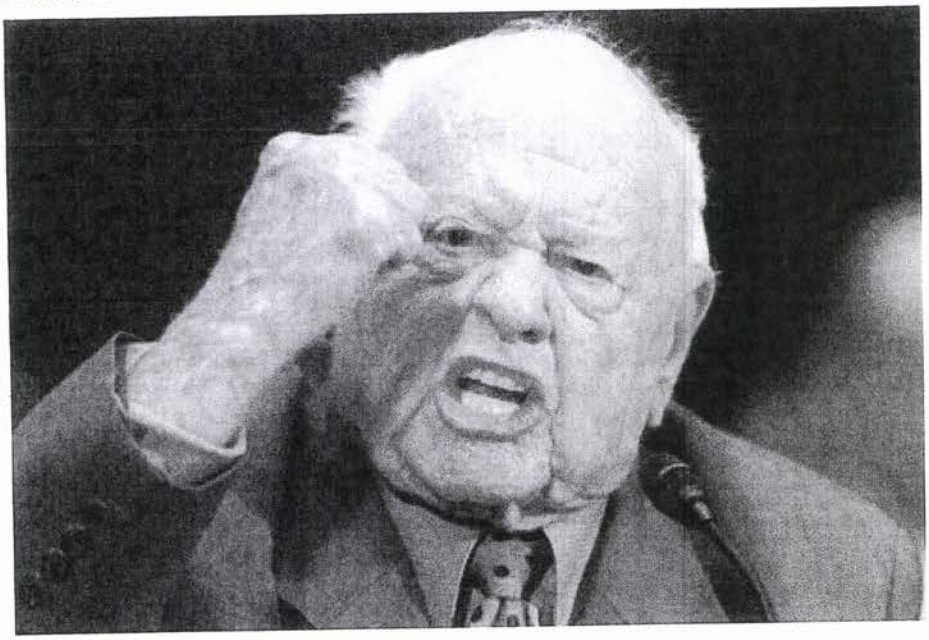
THURSDAY, MAR 3, 2011 9:04 PM UTC

Mickey Rooney's heartbreaking elder abuse story

The Hollywood icon draws attention to a problem that will soon affect a generation of baby boomers

BY MARY ELIZABETH WILLIAMS



Entertainer Mickey Rooney testifies on Capitol Hill in Washington, Wednesday, March 2, 2011, about elder abuse, before the Senate Aging Committee. (AP Photo/Alex Brandon) (Credit: AP)

Of the many evil aspects of abuse — whether it's physical, emotional or financial — the shame that too often accompanies it, the way it can make its victims feel complicit in their exploitation, is right up there. But on Wednesday, one prominent survivor spoke to Congress to deliver a message to the world: "You are not alone and you have nothing to be ashamed of."

The message came from 90-year-old screen legend Mickey Rooney. In an emotional testimony before a Senate Special Committee on Aging inquiring on elder abuse, the actor told how he was kept a "prisoner in his own home." He currently has a restraining order against his 52-year-old stepson Christopher Aber. In court papers, Rooney has accused him of intimidating him, preventing him from leaving his house, and withholding his mail, medication and food. "My money was stolen from me, by someone close," he told the committee. "My money was taken and misused. When I asked for information, I was told that I couldn't have any of my own information. I was literally left powerless."

There are myriad reasons why the elderly are easy targets for abusers, from fragile physical conditions to memory-impairing problems like Alzheimer's to easily manipulated insecurities and misunderstandings about their legal rights or financial options. And the closer an abuser is to the victim, the easier the crime can be to pull off, and the harder it can be to break the silence. It all comes down, as it so frequently does — whether the victim is a child or a woman with no support system or a Hollywood legend who's made over 300 films — to the abuser's hold over someone who may not have the ability to leave.

Astor Case Raises Awareness of Elder Abuse and Need to Fight It

by: Sean Gardiner, from: AARP Bulletin, October 15, 2009

At its heart, the case against Anthony Marshall, the son of renowned New York philanthropist Brooke Astor, is no different from thousands and thousands of other crimes against elders: a trusted caregiver takes advantage of an older person's declining state to enrich himself.

True enough. But that's a little like saying the Queen Mary II and a dinghy are both boats.

In many ways the Astor case, which ended in Manhattan last week with Marshall's conviction on charges that he defrauded his mother, was a once-in-a-lifetime legal saga. It showcased A-list celebrity witnesses like Henry Kissinger and Barbara Walters. It peered voyeuristically into the opulent lifestyle and dysfunction of the grande dame's family. And it laid bare the financial and legal machinations it took to siphon off a $185 million fortune.

All of that glamour, glitz, gossip and detail through 19 weeks of daily full-press coverage could have overwhelmed the elder abuse issue at the case's core.

But it didn't, elder abuse professionals and experts say. In fact, there are signs that the trial raised the public's awareness and understanding of elder abuse. It's likely that prosecutors will be emboldened to bring more suspected abusers to trial. And the Elder Justice Act, a bill that would authorize millions of dollars to protect older people, but which has languished in Congress since 2002, might have received a boost from the trial's publicity. It was attached as an amendment to the health care reform bill approved by the Senate Finance Committee this week.

The Astor case also brought to the fore crimes often overlooked as elder abuse: financial exploitation, for example. After deliberating for 12 sometimes contentious days, the jury convicted Anthony Marshall, who turned 85 during the trial, of committing a scheme to defraud, grand larceny and 12 other counts of financial misdeeds. Marshall's lawyer friend and codefendant, Francis X. Morrissey, was also found guilty of forging one of Astor's wills.

"This case raised awareness to a new level on what constitutes elder abuse," says Robert B. Blancato, national coordinator of the Elder Justice Coalition, which includes AARP.

That wasn't expected three years ago when a petition filed by Astor's grandson Philip Marshall to have Anthony Marshall, his father, removed as his grandmother's guardian thrust the case into public light. "The big issue we were concerned about was the psychological abuse, which was prominent," Philip Marshall told the Bulletin. "Undue influence would be a polite way of describing this. But it went far beyond undue influence. This was psychological warfare in an effort to get what they wanted out of her."

Initial stories of Astor's mistreatment at the hands of her only child detailed her abuse by neglect and mistreatment: cutting back on everything from her doctor visits to the brand of makeup she used; dressing her in rags and not allowing nurses to buy her a new outfit for her 104th birthday; locking her beloved dogs, Boysie and Girlsie, away from her because they damaged the antique furniture.

Elder Financial Abuse

00:00 / 00:00

Knowing what money normally goes in and out of a loved one's checking account is a good way to spot elder financial abuse. (Prime Time Focus)

for almost 10 years that the non-partisan New York State Task Force on Life and the Law reached the conclusion that "the so-called right to die all too easily becomes a duty to die." The 25-member task force, comprised of prominent physicians, nurses, lawyers, academics, and representatives of numerous religious communities, held differing views on physician-assisted suicide and euthanasia. However, the group unanimously concluded that the dangers of physician-assisted suicide vastly exceed any possible benefits.[50]

Moreover, the "duty to die" is demonstrated in Oregon, where the state actively promotes assisted suicide over medical care. In just one month in 2008, at least two different terminally-ill patients were denied medical treatment under the state health insurance plan, and instead were told that the state would pay for the patients' suicides. The message was clear: "We won't treat you, but we will help you die." The duty to die cannot be much clearer.

Myth: The availability of physician-assisted suicide will not inhibit the availability of palliative care.

Fact: Palliative care actually "languishes as a consequence" of the easy availability of physician-assisted suicide and euthanasia.[51] Physicians are likely to grant requests for physician-assisted suicide before all avenues of palliative care have been explored.[52] In addition, physicians are not pushed to better educate themselves on palliative care, and researchers spend less time looking for better palliative medications and techniques.[53]

Endnotes

[1] K.L. Tucker & C. Salmi, *Aid in Dying: Law, Geography and Standard of Care in Idaho*, THE ADVOCATE, August 2010, at 42.
[2] *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).
[3] *Baxter v. State*, 2008 Mont. Dist. LEXIS 482 (First Jud. Dist. Ct. Mont. Dec. 5, 2008)..
[4] *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).
[5] *Blick v. Connecticut*, 2010 Conn. Super. LEXIS 1412, at *39-40 (Conn. Super. Ct. June 1, 2010).
[6] K.B. O'Reilly, *Assisted-Suicide Statute Challenged by 2 Connecticut Doctors*, AMER. MED. NEWS (Oct. 19, 2009), available at http://www.ama-assn.org/amednews/2009/10/19/prsd1019.htm (last visited Aug. 31, 2011).
[7] Plaintiffs' Answers to State's Interrogatories, *Baxter v. State* (Mont. 1st Jud. Dist. Ct. 2008) (on file with Americans United for Life).
[8] *See, e.g.*, New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 13 (1994) [hereinafter "Task Force"].
[9] *Id.* at 32.
[10] *Id.* at 26.
[11] *See Oregon Death with Dignity Act Annual Report for Year 13*, available at http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx (last visited Aug. 31, 2011).
[12] *Washington State Department of Health 2010 Death with Dignity Act Report*, available at http://www.doh.wa.gov/dwda/forms/DWDA2010.pdf (last visited Aug. 31, 2011).
[13] *Oregon Death with Dignity Act Annual Report for Year 13, supra.*
[14] *Washington State Department of Health 2010 Death with Dignity Act Report, supra.*
[15] *See, e.g.*, T.E. Quill & C.K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality, ANNALA OF INTERNAL MED.* 138(3):208 (2003), available at http://www.annals.org/cgi/reprint/138/3/208.pdf (last visited Aug. 31, 2011). *See also* Project on Death in America/Open Society Institute, Brief of *Amicus Curiae* for Reversal of the Judgments Below at Part II.A.1, *Vacco v. Quill*, 521 U.S. 793 (1997) (stating that pain can be alleviated in 98 percent of cases); Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 DUQ. L. REV. 159, 166 (1996) (stating that knowledgeable physicians and researchers claim that pain can be alleviated in 98 percent of cases).
[16] Task Force, *supra*, AT 108 N.113.
[17] *Id.* at 178
[18] *Glucksberg*, 521 U.S. at 732 (quoting New York State Task Force on Life and the Law, *supra*, at 120).
[19] *See* Brief *Amicus Curiae* of International Task Force et al., filed in *Baxter v. Montana*, available at http://www.internationaltaskforce.org/montana.htm (last visited Aug. 31, 2011) (citing House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Testimony of Sue Davidson of the Oregon Nurses Ass'n*, response to question 1098).
[20] American Medical Association, *Code of Medical Ethics, Opinion 2.211 – Physician-Assisted Suicide*, available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml (last visited Aug. 31, 2011).

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The Average Net Worth at Retirement

By Vince Bethel, eHow Contributor

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According to a 2011 U.S. Census Bureau report, the median net worth for family heads between the ages of 65 and 74 is $239,400. Your net worth is important because it is a measure of your financial health. It is an indicator of how well you have managed your debts, savings and investments. At retirement your financial health takes on added significance, because for most people, wealth accumulation has already taken place. Retirees often depend on the financial resources they have on hand to maintain their lifestyle

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Calculation

Your net worth consists of the value of all your property, savings and investments minus your debts. If your debts exceed the value of your property, you may be on the road to financial trouble. However, if the value of your property greatly exceeds your debts, you are considered financially healthy. Your net worth will change as the value of your property and debts increases or decreases. Because changes can occur on a regular basis, net worth is calculated as of a specific date.

Importance

Your net worth is an indicator of how well you are doing. Therefore, you can make better financial decisions if you have this information. For example, you will know if you can afford to take on additional debt. Based on your current net worth, you can set realistic goals and measure your progress. Calculating your net worth annually can help you determine if you are headed in the right direction. This exercise can also help you identify potential problems early and address them.

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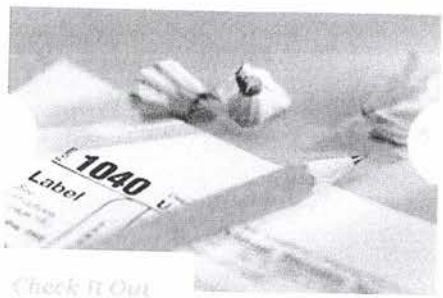

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Death Takes No Holiday

Swango, during one of many practice-suspension hearings (Argus Leader, Sioux Falls, SD)

Kristin Kinney was in her grave. By the end of June, 1993, Swango was off to New York State. He had his own ass to worry about. He had successfully acquired yet another position in a favored hospital.

Having had the ability so far to pick and choose his fields of endeavor, as a child pretends to be a cowboy one minute and a Martian the next, this time it was with a psychiatric residency program offered by the State University of New York through its Stony Brook Medical School. He had been interviewed in the spring. When the issue of his conviction in Illinois arose, Swango again used the barroom brawl alibi, and again displayed the forged Virginia pardon. Sufficiently dazzling Dr. Alan Miller, Director of the Psychiatric Department, as well as other professorial types, no one checked with the administration that convicted him or on the standing of his credentials. Had they done so, they would have realized he was a doctor in search of practice without a license. Instead, they hired him and slated his first tour of duty to commence July 1.

His first assignment was with Internal Medicine at the Veterans Administration complex on picturesque Northport, Long Island. The hospital, one of the institutions that made up Stony Brook, sat in the midst of the pleasant community, which enjoyed having a medical establishment of such good merit in its fold.

But, reverberations of oncoming trouble began the first evening of Swango's duty. His first patient, Dominic Buffalino, mysteriously died that night within hours after Swango taking charge of his case. Wife Teresa Buffalino could not understand how her husband, a man who entered the hospital with a mild case of pneumonia and who had been sitting up teasing her and the nurses that very afternoon, could suddenly succumb to paralysis of the heart and other organs.

A rare case as it was, Mrs. Buffalino's query was matched by other startled relatives of patients over the next couple of months. Aldo Serinei died suddenly. As did Thomas Sammarco. As did George Siano. All died of heart failure after paralysis struck in the night. As they lay breathing their last, Swango had placed a DNR order on every one of them. DNR, or in its entirety "Do Not Resuscitate," meant that a patient's condition was fatal and inoperable.

The case of Barron Harris is one of the more dramatic because his wife, Elsie, proved later to be one of Swango's more vocal detractors. Elderly Harris had been admitted into the hospital after contracting pneumonia in September. At first, the wife approved of the resident doctor put in his charge, the tall, congenial Swango. But her attitude of him soon soured. He grew distant and silent towards her. One night when she came to visit Barron, she found the doctor in the room, lights off, injecting something into his patient's neck. When she asked what the shot was for, Swango answered unemotionally, "Vitamins," then shuffled off with no further explanation.

Mrs. Harris must have sensed his response amiss, for later she asked the nurse on duty about the shot she saw Swango administer. The nurse stared back incredulously. "Doctors don't give shots," she reported. "That's what we're supposed to do."

Within days, Harris' condition faltered. He was forced to a respirator, then slipped into a coma. When she heard that Swango assigned a DNR to be placed across Barron Harris' chart, Elsie demanded to know why. "Because," Swango groaned as if annoyed, "his brain is virtually dead."

Front Page

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Mr. Harris lived for some time after the incident, but never awoke from the coma. When his wife later sued the hospital for negligence, the case was tossed out of court for lack of evidence that Swango had committed a crime.

Since then, things have changed.

*****

Mr. and Mrs. Cooper, Kristin Kinney's parents, could not accept her suicide. They knew she had been driven to it by a very evil man. And they wanted answers. They wanted to know why this fellow was still practicing medicine, maybe hurting more good people like their beloved KK. In communicating with one of Kristin's nursing friends in South Dakota, Sharon Cooper relayed her wariness over the elusive Swango. She knew he had left to take a residency in Stony Brook and, after what she had found about him through the 20/20 program and subsequent newspaper exposes, she felt that there had been a gross error committed somewhere.

Kristin's friend was aghast — she hadn't known Swango was working again — and pledged to elevate Mrs. Cooper's concerns. She followed through with her promise. The next day she sought audience with Dean Robert Talley.

Horrified, Dr. Talley directly phoned Dr. Jordan Cohen, Dean of Stony Brook. An emergency meeting ensued, to which Dr. Miller and Swango were summoned. When Miller insisted to hear the real reason for Swango's prison time in Illinois, the latter shrugged, then admitted it had not been for a barroom brawl, but for suspicion of poisoning fellow paramedics.

Swango was terminated, but not before the media got ahold of the incident. Local and national press rallied at the threshold of Stony Brook. People who lost loved ones under Swango's care sent out a war cry, among them Barron Harris' wife, Elsie. The University of New York, gun shy, shook the hierarchy trellis and before the year was out both Drs. Miller and Cohen resigned. Looking back, Cohen later told AP reporter Larry McShane, "(Swango was) a charming, pathological liar."

According to ABC News, Dr. Cohen resigned gracefully, taking a step no other of his profession had done before. "He sent a letter to every medical school in the country, warning them about Swango."

The Justice Department now moved in quietly to investigate. However, Swango had left New York for parts unknown. Agents checked for his whereabouts in several locations that he was known to have visited; they followed leads from friends and associates, including the Coopers, who thought he might have gone here or there. But, months passed without results. In mid-1994, they finally traced him to friend Bert Gee's home near Atlanta, Georgia. Gee, an acquaintance for years, was unaware of Swango's crimes and unaware that the FBI had put his house under surveillance.

No order had yet come down from headquarters to arrest the runaway doctor-who-wasn't, so agents bided their time shadowing Swango's movements. They panicked when they discovered he was working at a wastewater treatment facility, which connected to Atlanta's water supply! Before they could confront the local authorities, warning them of the dangers inherent, their suspect suddenly left Atlanta.

Within weeks, the long-awaited arrest warrant arrived, charging Michael Swango with falsifying documents in order to enter the service of the federally granted Veterans Administration hospital at Stony Brook.

But, this time, Swango had vanished, not to be found. Federal Bureau of Investigation agents predicted he had either killed himself or left the country. Having dealt with the likes of Swango many times in its history, the FBI laid its money on the second.

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Brown Announces Arrests of Nursing Home Employees Who Drugged Patients for Staff's Convenience

Wednesday, February 18, 2009
Contact: (415) 703-5837

FOR IMMEDIATE RELEASE
February 18, 2009
Contact: Christine Gasparac (916) 324-5500

Brown Announces Arrests of Nursing Home Employees Who Drugged Patients for Staff's Convenience

BAKERSFIELD –Attorney General Edmund G. Brown Jr. today announced the arrests of a nurse, physician, and a pharmacist of a nursing home for "forcibly administering" psychotropic medications for their own convenience, rather than for their patients' therapeutic interests, actions that are alleged to have resulted in the deaths of three residents.

"These people maliciously violated the trust of their patients, by holding them down and forcibly administering psychotropic medications if they dared to question their care," Attorney General Brown said. "This is appalling behavior, which amounts to assault with a deadly weapon."

Earlier today, California Department of Justice special agents arrested three individuals:

• Gwen Hughes, the former Director of Nursing at the skilled nursing facility of the Kern Valley Healthcare District in Lake Isabella, Kern County on charges of elder abuse and assault with a deadly weapon.

• Debbi Hayes, the former pharmacist at the Valley Healthcare District, on charges of elder abuse and assault with a deadly weapon.

• Dr. Hoshang Pormir, a staff physician at Kern Valley Healthcare District, who was serving as the medical director of the skilled nursing facility, on charges of elder abuse.

Upon taking over as Director of Nursing in September 2006, Gwen Hughes ordered that Alzheimer's and other dementia patients be given high doses of psychotropic medications to make them more tranquil and easy to control. She ordered the administration of these medications to patients who argued with her, were noisy, or who were otherwise disruptive. Two patients who resisted were held down and forcibly given injections.

Ms. Hughes is also alleged to have directed Debbi Hayes, the hospital pharmacist, to fill prescriptions for these psychotropic medications. Hayes wrote and filled these prescriptions without first obtaining a doctor's approval.

Dr. Hoshang Pormir approved these psychotropic medications only some time after they had been administered and without examining the patients first and determining whether these psychotropic medications were medically necessary.

Several of these patients are alleged to have had medical complications as a result of being given these psychotropic medications, including lethargy and the inability to eat or drink properly. It is believed that that three

patients died and one patient suffered great bodily injury as a result.

The investigation

Kern Valley Healthcare District operates a small community hospital and skilled nursing facility in Lake Isabella. The case came to the attention of authorities in January 2007, when an ombudsman reported to the Bakersfield office of the California Department of Public Health that a patient in the skilled nursing facility had been held down and given an injection of psychotropic medication by force.

The Department of Public Health immediately sent an investigative team with a doctor, a nurse, and a doctor of pharmacology. They determined that 22 patients, including some who were suffering from Alzheimer's at the skilled nursing facility, were being given high doses of psychotropic medication not for therapeutic reasons, but to simply control and quiet them for the convenience of the staff.

The Department of Public Health issued a Certificate of Immediate Jeopardy which resulted in the immediate dismissal of the Ms. Hughes. The matter was then turned over to the California Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse.

Special Agents from the Bureau of Medi-Cal Fraud and Elder Abuse began a year-long investigation, with the co-operation and assistance of the Department of Public Health and the administration of the Kern Valley Healthcare District.

A search warrant was served on the facility in August 2008, resulting in the seizure of numerous medical files and records.

Criminal charges were filed in Kern County Superior Court. The defendants are being held in Kern County Jail in Bakersfield. They will be arraigned on Friday. If convicted, the defendants could face up to 11 years in prison.

The case is being prosecuted by the Attorney General's Bureau of Medi-Cal Fraud and Elder Abuse, with the co-operation and assistance of the Kern County District Attorney's Office.

To report elder abuse or Medi-Cal fraud, call the Bureau of Medi-Cal Fraud and Elder Abuse's hotline at (800) 722-0432.

The complaints are attached.

###

Attachment	Size
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Deaths are reviewed at home where accused nurse worked
THE ASSOCIATED PRESS

06/21/2002 08:52 PM

JEFFERSON CITY - The death of five patients at an Ashland, Mo., nursing home have been reviewed after a former nurse who had worked at the
facility was charged with murder in the deaths of 10 people at a hospital where he also had worked.

The review of the deaths at the nursing home , Ashland Healthcare, found no rule violations, but a state official said Friday that the information would be given to a prosecutor handling the case against the former nurse.

The former nurse, Richard Williams, is charged with 10 counts of first-degree murder in the deaths in 1992 of patients under his care when he worked at the Truman Memorial Veterans Hospital in Columbia, Mo. He is accused of killing the patients with the drug succinylcholine, a powerful muscle relaxant that causes a person to stop breathing. The drug typically is used before inserting a breathing tube for surgeries.

Williams worked as director of nursing at Ashland Healthcare from July 1993 to July 1994. In that 12-month period, about 30 patients died at the nursing home.

In the 10 months after his dismissal, six patients died. He is not charged in any of the deaths. But after Williams was charged earlier this month in the hospital deaths, the state Division of Health Standards and Licensing began a review of some of the deaths in the nursing home that happened while Williams worked there.

"As a result of that review, we have not found that the facility violated any regulations dealing with nursing homes," said Darrell Hendrickson, deputy director of the division that licenses nursing homes and hospitals.

Hendrickson is to meet next week with Boone County prosecutor Kevin Crane to share information and discuss the next steps. Crane has said that additional charges tganey@post-dispatch.com remained a possibility.

"We're pursing the investigation, be it at the VA or elsewhere," Crane said.
The state review looked for any inconsistencies or anomalies in patient care, such as notations that a person was doing well

Efren Saldivar: Hospital Executioner

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BY *Katherine Ramsland*

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'Who Do We Have to Get Rid Of?'

Forensic Science Center emblem

To put Saldivar in jail for life, they only needed a few obvious murders. One by one, throughout the summer months of 1999, the investigators brought potential victims up out of the ground. The pathologists examined them and took tissue samples from the livers, bladders, and muscles and the toxicology lab then went to work. Brian Andreson, at the Lawrence Livermore Forensic Science Center in Oakland, California, demonstrated a new scientific protocol for the proper procedure to retrieve and preserve the biological evidence. He concentrated on Pavulon, because succinylcholine chloride breaks down into elements natural to the human body and because the test recently discovered for its detection in Sweden was expensive. Pavulon was a synthetic muscle relaxant sometimes given in low doses to patients on respirators, and it could remain detectable in the body for years. In order to prove that a homicide had taken place, Andreson and his team looked for dosage levels out of the normal range.

At first, they reported only negative results, which disappointed the task force. They hoped they had not just spent a year and a half of their time for nothing. Then Andreson got some hits. First there were three, and then after the 20 exhumations were complete, he found six that gave positive results.

Efren Saldivar, arrested (AP)

In January 2001, criminal charges were prepared. The officers followed Saldivar, now 31, to work one morning on his way to a construction job and then arrested him for the murder of six patients—all of them elderly and one of them a retarded woman. He was booked and reminded of his rights. He began to talk once more, but this time he said that he'd been understaffed on some shifts, so to ease the workload, he'd eliminated a few patients. As Lieberman describes it, when he was at his wit's end, he would look at the board and decide, "Who do we have to get rid of?"

He admitted that he'd killed patients at other hospitals, too, where he'd worked part-time. He had mentioned this before but had not admitted to actually giving injections. After 60 victims, he'd lost count. He figured it was more than 100. It had just been a gradual thing, an act that had bothered him a little at first but then he'd grown used to it and let it all slip from his mind. "You don't plan it," he said to the investigators. "After that, you don't think about it for the rest of the day, or ever."

Between this confession and the evidence, it was enough to go to court. Lead prosecutor prepared the case, finding a star witness in Jean Coyle, the complaining patient whom Saldivar had attempted and failed to kill. Thus, along with the six murder charges was an attempted murder charge, too. Ursula Anderson, the female respiratory therapist who knew what Saldivar was doing, got immunity in exchange for her agreement to testify that she had given Saldivar the Pavulon and knew what he was doing with it.

Around this time, three full years after the murders first came to light, the Glendale Adventist

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4 REASONS WHY YOU MIGHT WANT TO DATE A CRIMINAL
Seriously. Consider it. [Your Tango]

Dr. Will Johnston

Photograph by: Photo courtesy Ami Sanyal Photography

The daughters are beside themselves. One sat in my office recently, telling me about her father's trips to the bank that are draining his savings. He gets angry when his daughters challenge him.

The money — thousands of dollars, slowly saved from a meagre pension and needed for his care — seems to be going to a recently acquired girlfriend some years younger than himself. He speaks almost no English. The situation was detected by chance when a daughter gave him a ride to the bank and saw his bank book.

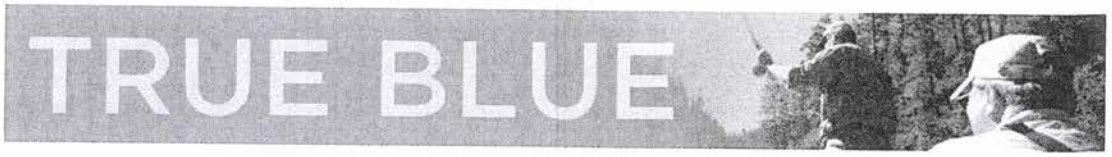
Some time ago, I performed a competency assessment on a socially isolated older person who had been placed in a nursing home. An unrelated neighbour had listed the person's home for sale and was receiving inquiries before a relative became aware.

On another occasion, an older woman had adequate resources to stay in her attractive home and employ a live-in caregiver. A family member, an heir and beneficiary, arranged to have her met at her door by an ambulance crew with a gurney. She was told that if she did not co-operate, the police would be called. She submitted and was transported to a dingy nursing home that she described as a prison. Her home was sold.

A colleague recalls being on duty in an emergency room several years ago when an older bachelor came in desperately ill and confused, accompanied by his niece and nephew.

"He's had a good life. He wouldn't want any treatment," his only relatives (and presumably heirs) attested. With ordinary care and rehydration, the older man walked out of hospital a week later.

Each of these scenarios is different, and none of them grace a research paper, but all of them are the real face of elder abuse. I could list 10 more from my own experience. Government of Canada policy recognizes the epidemic of elder abuse and the unusual difficulty of detecting it, often because the victim resists the revelation of abuse.



Ex-Nurse Claims to Have Killed 30-40 Patients

Published December 16, 2003 *Associated Press*

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A former nurse who claims to have killed as many as 40 patients over the past 16 years was fired from at least two hospitals and was even the subject of a murder investigation. But Charles Cullen kept managing to land another job.

Authorities say the case underscores serious flaws in a system in which hospitals report only limited information about nurses to other prospective employers for fear they might get sued. A severe nursing shortage may have also played a part.

"Short of an actual conviction for a criminal act, there is nothing that needs to be reported when someone is fired," said Dr. William Cors, **Somerset Medical Center's** (search) chief medical officer. "That needs to change."

Cullen, 43, is charged with murdering a Roman Catholic clergyman and attempting to kill another patient at Somerset Medical Center. More charges could follow after prosecutors complete their investigation of Cullen's claims that he killed 30 to 40 patients at nine hospitals and a nursing home in New Jersey and Pennsylvania.

Prosecutors say he gave the seriously ill patients lethal drug overdoses to end their suffering.

Despite Cullen's spotty record, officials at Somerset had found nothing wrong after checking his credentials. That is because most hospitals will only confirm the dates of employment for a former worker, and will not make a positive or negative recommendation.

"We validated that he had an active New Jersey nursing license,"

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Cors said. "We had reference checks from a previous employer. It was your standard `He worked from this date to that date' without any recommendation either way."

Similarly, Donna Leusner, a spokeswoman for the state Department of Health and Senior Services, said hospitals are only required to report to the state agency suspicions of criminal activity that endangers the lives of patients or employees.

Cors said the health-care industry needs to be able to share information about fired workers, either through voluntarily changing reference policies, or through legislation compelling hospitals to do so. Somerset officials have already spoken with several New Jersey legislators asking for new laws to improve reporting requirements on fired workers.

"It's not acceptable to be so afraid of our shadows that we can't pass along information of concern because we're afraid of getting sued," Cors said.

Cullen had bounced from hospital to hospital.

In August 1997, he was fired from **Morristown Memorial Hospital** (search) for "poor performance," said Joan Lebow, a spokeswoman for the hospital's parent corporation.

He worked at **Sacred Heart Hospital** (search) in Allentown, Pa., for only two weeks in July 2002 before being fired for "interpersonal problems with existing employees."

Sacred Heart spokesman Chris Sodl said hospital officials had checked his references before hiring him, but in most cases, all they learned were the dates of his employment.

"If somebody called here, that's what we would do, too," Sodl said. "We would give their dates of employment, and nothing else. It is basically a confidentiality issue."

In some instances, previous employers recommended Cullen. A spokesman for St. Luke's Hospital in Bethlehem, Pa., where Cullen worked from June 2000 to June 2002, said the hospital got positive references from Lehigh Valley Hospital and Liberty Nursing home in Allentown.

Cullen was later removed from patient contact at St. Luke's after two unopened heart medications were found hidden in a hypodermic needle disposal bin in June 2002. He quit rather than cooperate with the inquiry, hospital spokesman Susan Schantz

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said.

Simultaneously, a nurse at the hospital complained to prosecutors that she suspected that Cullen had been involved in "inappropriate medication of patients," according to Lehigh County, Pa., prosecutor James Martin. Authorities reviewed the records of 67 patients who died in the coronary care unit in the last six months of Cullen's employment but found no evidence of wrongdoing.

Martin sent a letter to the hospital on May 28, informing it that the investigation was closed. The hospital said it notified the Pennsylvania nurse licensing board about its concerns regarding Cullen.

A board spokesman said such allegations remain secret from prospective employers unless they result in formal disciplinary action -- and that did not occur in Cullen's case.

The Pennsylvania board is now moving to revoke Cullen's license. As of Tuesday, New Jersey had not taken any action against Cullen's license.

The nationwide nursing shortage also may have helped Cullen get so many jobs.

Hospitals and other health care institutions compete fiercely for nurses, offering cash bonuses and even recruiting overseas. More than 30 states are grappling with a shortage estimated at 136,000 nurses.

"The nursing shortage doesn't make it easier to do the right thing," Cors said. "If someone shows up at your hospital and says, 'Guess what? I'll work the overnight shift in your ICU,' most places would be hard-pressed to say no to that."

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A Sexual Game

Gilbert's idea of excitement pales in comparison to the next team of caregivers. It was in Walker, Michigan in 1987 where a pair of lesbians made death a sexual game. Gwedolyn Gail Graham, 23, and Catherine May Wood, 24, worked together at the Alpine Manor Nursing Home. Graham was a nurse's aide and Wood was her immediate superior. Wood had divorced and gained an enormous amount of weight, so she was hungry for a friend. When she met Graham, they immediately hit it off and soon became lovers.

It was Graham who first broached the subject of murder. They practiced sexual asphyxia to achieve greater orgasms, so Wood later claimed she thought Graham was kidding. Yet the linked pain and pleasure of their sexual games became threaded with the idea of cruelty. Just talking about murder got them both excited.

They started killing patients in January and continued for three months, picking patients to kill whose initials would end up spelling "murder." Graham called this "the Murder Game." Posting Wood as sentry, she started with several elderly women, but they struggled so hard, she had to back off. Yet they did not register a complaint, and in fact, most of the patients liked these two women.

Then Graham went into the room of a woman suffering from Alzheimer's who would not be able to fight her off. She smothered the woman with a washcloth. In the weeks that followed, she moved on to another, and then another. There were times when the act of killing so excited her that she and Wood went to an unoccupied room for sex. Graham even took items off the victims — jewelry or dentures — to help her to relive what she had just done, and she found enormous emotional release in murder.

When they washed the bodies down as part of the postmortem routine, they grew even more excited.

Then they got bolder. They told colleagues what they were doing, because even the confessions added to their heightened sexual drive, but their accounts were dismissed as sick jokes. Graham showed three aides her shelf of souvenirs, and still no one stopped them.

Then Graham wanted Wood to take a more active role. To prove her love, she would have to kill one of the patients herself. Wood wasn't ready for this, so she got transferred to another shift.

Graham took up with another woman and then left Michigan to go work at a hospital in Texas taking care of infants. A terrified Wood confessed everything to her former husband, but it took him over a year to take action. Finally he called the police.

Of the 40 patients who had died in that three-month period, eight seemed suspicious enough for further investigation. Then they settled on five, and arrested both women. Wood turned state's witness against her former lover for a sentence of 20 to 40 years. She told them she'd come forward because of Graham's claim to her that she wanted to "take one of the babies and smash it up against a window."

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THE WORLD'S STRONGEST HOO-HA
Watch: She can lift weights with her

To offer a mitigating circumstance, Graham said that her father had molested her, but this charge was never proven. Her lawyer also claimed that Wood came forward with lies just to get even with a lover who had left her. This was a set up.

The jury believed Wood. Graham was convicted on five counts of first-degree murder and one count of conspiracy to commit murder (although Wood had claimed that she'd tried to smother five more patients.) She got six life sentences, with no possibility of parole.

People, both male and female, who take advantage of vulnerable patients to feed their own needs are in some way depraved. They defy society's code of trust, and some of them are obviously sadistic. Whether it's because something terrible was once done to them or because they just needed to feel more powerful, they make people everywhere wary entrusting themselves to the healthcare system. Thus their damage is more profound than whatever they do to their victims. In a real way, society itself becomes their ultimate victim.

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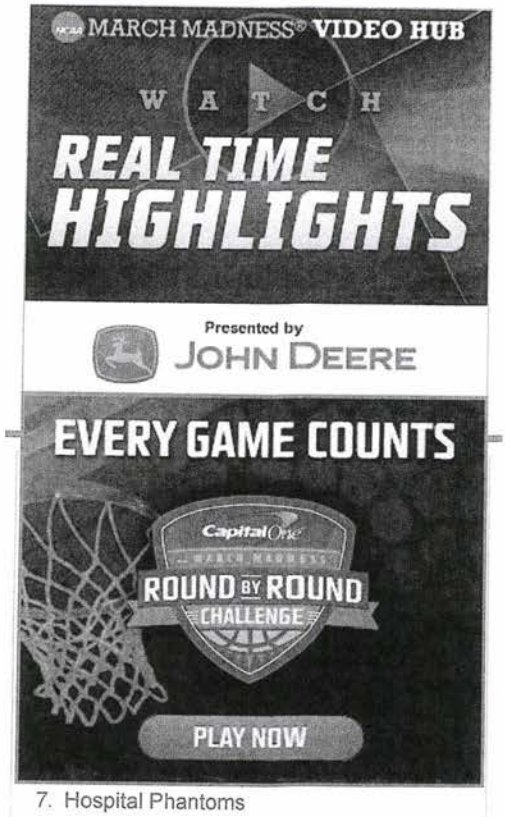

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Lowell Cauffiel · Author/Screenwriter/Producer at Page 63 Productions

As author of Forever and Five Days, my thoroughly documented true crime book of the Wood and Graham serial murder case, I feel it's important to point out that much of the version of these killings in the summary above is coming entirely from the account of Cathy Wood -- a

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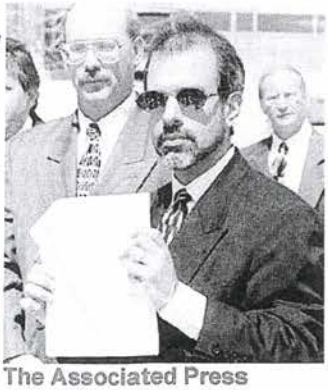
Prosecutors Say Doctor Killed To Feel a Thrill

New York Times
September 7, 2000
By CHARLIE LeDUFF

ENTRAL ISLIP, N.Y., Sept. 6 — Most people in the courtroom knew how the small, skittish man had managed to murder at least four of his patients without getting caught: he injected them with poison, he admitted today. The question observers wanted answered was "Why?"


The Associated Press

Assistant United States Attorney Gary R. Brown said a diary kept by Michael Swango explained his motive for murder.

And then prosecutors offered five scrawled pages from the killer's spiral-bound diary as the motive. It seems that Michael J. Swango, a former doctor, killed for the pure joy of watching and smelling death.

Reading from a notebook confiscated from Mr. Swango when he was arrested in a Chicago airport in 1997 on his way to Saudi Arabia, where he had a job in a hospital, prosecutors painted a portrait of a delusional serial killer. The written passages show that Mr. Swango, 45, was a voracious reader of macabre thrillers about doctors who thought they had the power of the Almighty.

In small, tight script, Mr. Swango transcribed a passage from what prosecutors said was "The Torture Doctor," which they described as an obscure true-to-life novel published in 1975 about a 19th-century doctor who goes on a quiet murder spree and tries to poison his wife with succinylcholine chloride, a powerful muscle relaxant.

"He could look at himself in a mirror and tell himself that he was one of the most powerful and dangerous men in the world — he could feel that he was a god in disguise," the notebook read.

Another of Mr. Swango's favorite books, according to prosecutors, was "The Traveler," written by John Katzenbach. One passage that prosecutors contended offered a window into Mr. Swango's mind was: "when I kill someone, it's because I want to. It's the only way I have of reminding myself that I'm still alive."

With the victim's relatives weeping in the rear of the courtroom, Assistant United States Attorney Gary R. Brown read more excerpts from the notebook. From what he identified as the text of "My Secret Life," Mr. Swango was inspired to copy: "I love it. Sweet, husky, close smell of an indoor homicide."

Mr. Brown, on the steps of United States District Court, said today: "Basically, Dr. Swango liked to kill people. By his own admission in his diary, he killed because it thrilled him."

Wearing prison blues and faded slippers, Mr. Swango stood in the courtroom and admitted that he murdered three of his patients at a Long Island hospital with lethal injections.

Each time Judge Jacob Mishler asked Mr. Swango how he pleaded, he answered impassively: "Guilty, your honor."

Accusations, incriminations and death followed Mr. Swango wherever he went, from the time he began medical school at Southern Illinois University in the early 1980's to his tenure as a physician in Zimbabwe. And although an inordinate amount of his patients died over the years — some officials estimate as many as 60 — Mr. Swango always managed to find employment.

Prosecutors in New York could charge him only with the three murders in their jurisdiction, committed when he worked for three months as a resident at the Veterans Affairs Medical Center in Northport in 1993. His victims were Thomas Sammarco, 73; George Siano, 60; and Aldo Serini, 62, all of Long Island. He faced federal, rather than state, charges because those three murders were committed at a federal institution.

And for the first time, Mr. Swango acknowledged today that he killed Cynthia McGee, 19, a student who was in his care at Ohio State University Hospitals in 1984 when he worked there as a resident.

He was not charged with her murder, because it was not a federal crime, but he pleaded guilty to lying about his role in her death, and also to falsifying records about prison time he served in the mid-1980's for poisoning co-workers' coffee and doughnuts with ant poison.

When Judge Mishler asked for an explanation of the death of Mr. Siano, Mr. Swango read from a prepared text. "I intentionally killed Mr. Siano, who was at the time a patient at the veterans' hospital in Northport," he read. "I did this by administering a toxic substance which I knew was likely to cause death. I knew it was wrong."

Not only did Mr. Swango administer the lethal injection to Mr. Siano, prosecutors said, he did it on his day off, a day when he was not even on call. Prosecutors said that a nurse saw Mr. Swango sitting on a radiator near Mr. Siano's bed watching the man die from the lethal dose.

"I'm still shaking my head that a madman got a plea bargain today," said Mr. Siano's stepdaughter, Roselinda Conroy. "He's worse than an animal. Animals don't kill for pleasure."

Judge Mishler sentenced Mr. Swango to three consecutive life sentences, without the possibility of parole, in a maximum-security prison in Colorado.

Mary A. Dowling, director of the hospital in Northport, tried to answer the wider question of how a man with Mr. Swango's background could find employment there.

She said that he was hired by the State University of New York at Stony Brook, and rotated through Northport as part of his Stony Brook residency training.

"Michael Swango failed to truthfully disclose the reason for a prior criminal conviction on his application," Ms. Dowling said, explaining that Mr. Swango had told administrators that his jail time had to do with a barroom brawl. "It was an offense he pled guilty to and for which he served three years in prison."

That explanation was not good enough for the relatives of the dead men. "He left a trail of death wherever he went," Ms. Conroy said. "Because of the gross negligence of these institutions, Swango was allowed to kill. They, too, should be held accountable."

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Serial Killers

Famous Serial Killer Profiles

Donald Harvey

The so-called "Angel of Death" killer was an inside man, a hospital employee and orderly whose access to unattended hospital patients and means to extinguish their lives proved fatal in double digits for American patients in the Midwest and Southeast. Donald Harvey started his criminal career simply by strangling patients too weak to struggle or using drugs to subdue them when nobody else was near. True to the nature of every serial killer, Harvey continued killing for little or no material gain, and even falsified job information for employment where he could kill again.

Born in Ohio in 1952, Harvey was part of a normal family. Growing up a 'nice boy", Donald Harvey won the praise and notice of teachers but not friends. Harvey was not happy to be a factory worker and when nuns noticed his adeptness around the building they suggested instead he train to be a medical orderly. At this time, many religious orders governed medical care in hospitals and medical wards. Harvey enjoyed an advantage to be trained without earning his vocation or showing moral turpitude before being considered for medical training. Soon Harvey would be charged with full care of patients on an unsupervised basis.

A homosexual man, this serial killer came by his moniker of murder because he always seemed to be around when death struck a patient. Yet to the inside atmosphere and world of the nurse or orderly, death was a

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constant enough attendant to the work life that few made connections until it was much too late for the victims. By using alternate methods in varying deaths converging with patient illnesses and symptoms, much of the initial activity of Donald Harvey passed relatively unnoticed. As medical equipment changed, Harvey disconnected ventilators and poisoned food. Despite discharges from hospitals, Harvey utilized a common trait among serial killers and obtained employment in the same field he would otherwise have been disqualified from.

Donald Harvey effected the deaths of many patients simply by reason of access and opportunity. Harvey may have claimed that his early victims were killed for "empathetic" reasons, but he would hardly have hidden his methods so carefully if such were the case. Like many serial killers, when the method of killing is carefully masked by conditions of reality and circumstance, they can continue to keep killing. Harvey cannot have planned such "empathy" in advance for all his patients without being a serial killer. Almost two decades of murders took place while Harvey quietly fulfilled his ghastly duties.

The young man traveling the corridors of the hospital, smiling at staff and greeting patients by name had another life. His stash of weapons, poisons, drugs, drug delivery equipment, and more accessories of death lay at home. The Angel of Death might come to work with a bag of "supplies" and a gun, and by the end of the day another death had been reported. Harvey fancied himself an occultist, vacillating around Death like a prizefighter. From about 1970 through 1987, Harvey delivered his patients to their greater reward on an ad-hoc basis. No program, stars or lust drove his schedule.

Harvey slept soundly and was not troubled by shame or guilt, he did not need to drink or get stoned to kill. Donald Harvey was termed the Angel of Death because the mortality rate of his patients swung higher every day he worked at the place. But Harvey did not limit his experiments with death to patients. His lover Carl Hoeweler got homemade poisons, and his parents died of mysterious poisonings. Harvey was caught one time leaving a hospital with a bag full of syringes, a gun, and other medical equipment.

Unlike some serial killers, Donald Harvey had a pleasant disposition that put people at ease. Yet Harvey was committed twice, with over 20 electroshock treatments. Donald Harvey might have kept on killing except for his gruesome insistence on an occult leaning and the untoward murder of Hoeweler's parents. The locales of Cincinnati, California, and Kentucky in the 1970's and 1980's were well known for a while as the hunting grounds of the "Angel of Death". Locals would never take their medical staff on face value again.

In all Donald Harvey claims to have murdered 87 people in all. Legal authorities believe his serial killing resulted in the deaths of between 36 and 57 people. He is currently incarcerated in the Southern Ohio Correctional Facility serving four consecutive life sentences for his

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Patients of Oklahoma doctor line up for tests

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This 1977 license picture provided by the Oklahoma Board of Dentistry shows Dr. Scott Harrington. Health officials urged thousands of patients of Harrington, an oral surgeon, to undergo hepatitis and HIV testing, saying unsanitary conditions behind his office's spiffy facade posed a threat to his clients and made him a "menace to the public health." (AP Photo/Oklahoma Board of Dentistry)

(0) Comments

About 150 to 200 patients of a Tulsa oral surgeon accused of unsanitary practices queued outside a health clinic Saturday, hoping to discover whether they had been exposed to hepatitis or the virus that causes AIDS.

Letters began going out Friday to 7,000 patients who had seen Dr. W. Scott Harrington during the past six years, warning them that poor hygiene at his clinics created a public health hazard. The one-page letter said how and where to seek treatment but couldn't explain why Harrington's allegedly unsafe practices went on for so long.

Testing for hepatitis B, hepatitis C and the virus that causes AIDS began at 10 a.m. Saturday, but many arrived early and stood through torrential downpours.

Kari Childress, 38, showed up at the Tulsa Health Department North Regional Health and Wellness Center at 8:30 a.m., mainly because she was nervous.

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How Cruise Lines Fill All Those Unsold Cruise Cabins

"I just hope I don't have anything," said Childress, who had a tooth extracted at one of Harrington's two clinics five months ago. "You trust and believe in doctors to follow the rules, and that's the scariest part."

Inspectors found a number of problems at the doctor's clinics in Tulsa and suburban Owasso, according to the state Dentistry Board, which filed a 17-count complaint against Harrington pending an April 19 license revocation hearing. According to the complaint, needles were reinserted into drug vials after being used on patients, expired drugs were found in a medicine cabinet and dental assistants administered sedatives to patients, rather than the doctor.

One patient, Orville Marshall, said he didn't meet Harrington until after he had two wisdom teeth pulled about five years ago at the Owasso clinic. A nurse inserted the IV for his anesthesia; Harrington was there when Marshall came to.

"It's just really scary. It makes you doubt the whole system, especially with how good his place looked," said Marshall, 37.

An instrument set reserved for use on patients with infectious diseases was rusty, preventing its effective sterilization, and the office autoclave _ a pressurized cleaner _ was used improperly and hadn't been certified as effective in at least six years, according to the complaint.

Dr. Matt Messina, a practicing dentist in Cleveland and a consumer adviser for the American Dental Association, said creating a safe and hygienic environment is "one of the fundamental requirements" before any dental procedure can be performed.

"It's not hard. It just takes effort," he said.

Weekly autoclave testing can be performed for less than $400 annually, according to the website of the Autoclave Testing Services of Pearl River, New York.

Autoclaves themselves typically can be purchased for $1,000 to $8,000, depending on their size and features. And an average dental practice can expect to pay more than $40,000 a year in equipment, tools and supplies alone, according to several dental organizations.

Attempts to reach Harrington have been unsuccessful. No one answered the door Thursday at his Oklahoma home, which property records show is worth more than $1 million. His practice a few miles away, in a tony section of Tulsa where plastic surgeons operate and locals congregate at bistros and stores like Saks Fifth Avenue, has a fair-market value of around $851,000.

Property and tax records show Harrington owns another residence in Carefree, Ariz., in an area of upscale homes tucked into in the boulder-strewn mountains north of Phoenix.

Nobody was at home Saturday at the low-slung, 1950s-style vacation home, across from the tony Boulders Resort. Neighbors said they had seen a lot of activity at the home in recent weeks.

Harrington's malpractice lawyer, Jim Secrest II, did not respond to phone messages left Thursday or Friday. A message at Harrington's Tulsa office said it was closed and an answering service referred callers to the Tulsa Health Department.

Nursing student Anisa Lewis, 22, said her friends recommended Harrington's practice when she had to get her wisdom teeth taken out in 2005.

"I'm a little nervous because I read the complaints filed against him, and in nursing school, we're taught how to handle and clean our instruments, she said. "It was very shocking to read some of the allegations," which she called "far beyond the pale of the precautions you're supposed to be taking."

Susan Rogers, the executive director of the state Dentistry Board, said her agency has a budget of around $1 million, much of that generated from license renewal fees and dentist certification. It has only five employees to monitor more than 2,000 dentists, and the staff does inspections only if the agency receives a complaint.

"With three incoming telephone lines and essentially one person handling the phones, emails, snail mail, renewals, new license/permit applications, walk ins ... we will miss phones calls," the board's website says.

"So follow the instructions on the message," the site says. "We will respond to your request as soon as we can in the order in which it is received, but it will take time. We appreciate your patience."

—

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Michael Swango: Doctor of Death

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Physician on Trial

Michael Swango.

In 2000, a doctor was convicted in two separate cases of murdering his patients. Three in a Veterans Hospital in New York and one young woman when he was an intern in Ohio State University Hospital.

A press release issued by Swango's alma mater, SIU, states, "If Swango (is) legally connected to all the suspicious deaths of patients under his care since he began his residency with Ohio State University's medical program in 1983, it would make him the most prolific serial killer in history." The numbers of suspected deaths differ according to various publications, but estimates range from 35-60.

Following is a story of the alleged intercontinental murder spree of Michael Swango that stretches from 1983 to 1997.

Pulitzer Prize winner James B. Stewart's book, *Blind Eye - The Terrifying Story of a Doctor Who Got Away With Murder*, tirelessly follows Swango's career through interviews with his professional peers and tomes of documentia. He points a finger at the nation's hospital administration system as being part of the cause of Swango's ability to elude charges for so long. Nurses and patients alike saw forewarnings, but, according to Stewart, the departmental doctors scoffed and did nothing. As Swango moved from institution to institution, neither personnel nor hiring directors checked his past history, and when they did, they accepted his own testimony over anything incriminating on record.

After Swango's arrest, Stewart told the *New York Times*, "(His) case shows that the medical establishment will blindly trust the word of a fellow doctor over the word of other witnesses, and that the medical profession cannot adequately police itself."

That Swango demonstrated a charm and sincerity cannot be denied. Good looking, blonde, blue eyed and affable, openly supportive of his authorities, he was often well liked and appreciated by fellow professionals. He was aware of his charisma and used it to cover his suspicious maneuvers and his chronic lies.

Loretta Lynch, U.S. District Attorney for the Eastern District of New York, exclaimed that, "Instead of using his medical license to become a healer, Swango inveigled his way into the confidence of hospital administrators (and), once in their trust and in their employ, he searched for victims and took their lives."

While reading this story, keep in mind that the naivete of the industry that hired Swango has not gone unlearned. In the wake of the Swango case, the Federation of State Medical Boards has announced proposals to tighten the governance of medical practitioners. In the highly respected *Observer*, which is published by the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), staff writer Jodi Knapp states that among these recommendations are that "residents would have to register for a special permit to practice from their local state medical

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Absolutely hilarious. [Bleacher Report]

4 REASONS WHY YOU MIGHT WANT TO DATE A CRIMINAL
Seriously. Consider it. [Your Tango]

Swango, who had been put on probation, was reinstated with full intern privileges.

Near victim Rena Cooper, who survived her ordeal, left the hospital confounded and very disturbed by the light judgement passed on Swango. As she told {20/20}, somehow — she doesn't know how — investigators concluded that her description of the individual who entered her room did *not* match Swango at all. Overnight, her account of the syringe-brandishing ghost had become a metamorphosis. It went down on paper not as a "tall, blonde" male, but as a *short female*!

"I think at that time words were trying to be put in my mouth," Cooper expressed.

*****

Gossip barely subsided in Rhodes Hall when unexplainable deaths began to occur in neighboring Doan Hall — immediately following Swango's transfer there to work surgery rotation.

February 19, 1984: Charlotte Warner, 72 years old, was found dead in her room. Only hours earlier, her doctor had told her she was doing well after a recent surgery, well enough to go home in a day. Something...someone...had caused her blood to clot in several organs.

February 19: Patient Evelyn Pereney began bleeding profusely from body orifices, even through her eyes, after being examined by Michael Swango. Resident physician Dr. Birkin had no explanation for the hemorrhaging.

February 20: Anna Mae Popko, 22, recovering from a simple intestinal operation, rolled up her sleeve to permit Swango to give her a shot to (as he claimed) increase her blood pressure. The girl's mother did not understand why the doctor wanted to shoo her from the room, but after a brief argument the woman relented. Not long afterwards, Swango confronted Mrs. Popko with an attitude that seemed almost victorious. "She's dead now," Swango droned. "You can go look at her."

*****

A residency review committee in late February pondered Michael Swango's ability to become a resident doctor at Ohio State. Even apart from the suspicious deaths, his performance was ruled as "poor" by supervising doctors. For that reason, the university decided not to accept Swango as a resident physician after his internship concluded in June. After being notified in March, he left angrily.

*****

Ohio State University would later regret not having taken the nurses' claims further. In the months ahead, as Swango had further dealings with the law, its handling of the Swango case would reap scandal. After Swango became a target of national suspicion in the late 1990s, the press lambasted it. *Columbus Dispatch* Science Reporter David Lore would write, "OSU's critics say the university still has not cleaned up the mess that was created when doctors and attorneys at OSU Medical Center gave Swango a pass after bungling their cursory and closed-door investigation...Last month, in response to ABC News, OSU conceded in a written statement (that) 'we should have called in outside police authorities to investigate.'"

*****

Hindsight, however, didn't help the patients who died. In the meantime, in 1984, the Ohio State Medical Board, routinely investigating Swango for a state medical license, learned of his behavioral problems and alleged link to patients' deaths. In response to the board's inquiries, Surgery Director Dr. Larry Carey expressed misgivings about Swango, citing run-ins with hospital personnel and, specifically, the Rena Cooper episode.

The crazy luck that followed Swango again struck, however. In the face of negative reports from those, like Carey's, who worked with him, the medical board granted Michael Swango a license to

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