MEMORANDUM

TO: Senate Judiciary Committee

FROM: Margaret Dore, Esq.

RE: Vote No on SB 167; February 9, 2011 at 8am

DATE: February 4, 2011

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I. INTRODUCTION

I am attorney in Washington State where assisted suicide is legal.[1] Our law is modeled on Oregon's law. Both laws are similar to SB 167.[2]

This memo discusses why the claim that SB 167 will assure patient control is untrue. SB 167 is instead a recipe for elder abuse. The bill puts the elderly in the crosshairs of their heirs and abusive family members.

SB 167 also eliminates safeguards such as waiting periods that supposedly render the Oregon and Washington suicide laws safe.[3] Doctor reporting is also eliminated.[4] The former Hemlock Society, Compassion & Choices, claims that this is because Oregon's reporting system has "demonstrated the safety of the

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[1] I am an elder law/appellate attorney in Washington state who has been licensed to practice law since 1986. I am a former Law Clerk to the Washington State Supreme Court for then Chief Justice Vernon Pearson. I am a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. For more information, see www.margaretdore.com.

[2] A copy of SB 167 is attached hereto at A-1 through A-12.

[3] The Oregon and Washington laws have a 15 day waiting period and a 48 hour waiting period. *See* ORS 127.850 § 3.08 & RCW 70.245.110. SB 167 does not. Oregon's and Washington's laws require a second "consulting" doctor. *See* ORS 127.820 § 302 & RCW 70.245.050. SB 167 makes the second doctor "waivable." *See* SB 167 § 7, *i.e.*, not required. Oregon and Washington require two oral requests. *See* ORS 127.840 § 306 & RCW 70.425.090. SB 167 requires one oral request and a written request. *See* SB 167, § 4.

[4] Oregon's and Washington's laws require doctor reporting to a Department of Health type entity. See ORS 127.865 Sec 3.11 & RCW 70.245.150. SB 167 does not.

practice."[5] To the contrary, Oregon's reports support that the claimed safety is speculative. The reported statistics are also consistent with elder abuse. No wonder Compassion & Choices wants the reporting system gone.

II. FACTS

A. The People at Issue are Not Necessarily Dying

SB 167 applies to patients with a "terminal illness," which is defined as having less than six months to live.[6] Such persons are not necessarily dying. Doctor predictions of life expectancy can be wrong, which is the point of the attached article from the *Seattle Weekly*.[7]

Consider also Oregon resident Jeanette Hall. She was diagnosed with cancer and told that she had six months to a year to live. She states:

> I wanted to do our [assisted suicide] law and I wanted my doctor to help me. Instead, he encouraged me to not give up . . . I had both chemotherapy and radiation. . . .

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[5] *See* Compassion & Choices' Handout, "Montana Physicians Can Now Respect Dying Patients' Decisions, [etc]," passed out as part of a media packet, January 27, 2011. *See also* Ian Dowbiggin, A Concise History of Euthanasia 146 (2007)(In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices).

[6] SB 167, § 2(15). (Attached at A-2).

[7] Nina Shapiro, *Terminal Uncertainty – Washington's new 'Death with Dignity' law allows doctors to help people commit suicide – once they've determined that the patient has only six months to live. But what if they're wrong?*, Seattle Weekly, January 14, 2009, available at www.seattleweekly.com/2009-01-14/news/terminal-uncertainty. (Attached at A-13 to A-18).

> It is now nearly 10 years later. If my doctor had believed in assisted suicide, I would be dead."[8]

B. How SB 167 Works

SB 167 first has an application process to obtain the lethal dose. This process includes a written request form.[9]

Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons.[10] Indeed, no one is required to be present.[11]

III. ARGUMENT

A. Patient "Control" is an Illusion

Proponents claim that SB 167 will assure patient control.[12] This is untrue.

1. No witnesses at the death

As set forth above, SB 167 does not require witnesses to be present at the patient's death. Without disinterested witnesses, the opportunity is created for someone else to administer the

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[8] Jeanette Hall, Letter to the Editor, *Second life*, Missoula Independent, June 17, 2010. (Attached at A-19). Author confirmed accuracy with both Ms. Hall and her doctor, Kenneth Stevens, MD. *See also* Kenneth Stevens, Letter to the editor, "Oregon mistake costs lives," *The Advocate*, the official publication of the Idaho Bar Association, September 2010, pp. 17-18 (Attached at A-20 to A-21).

[9] The request form can be viewed at SB 167, § 11.

[10] See SB 167 in its entirety. (Attached at A-1 through A-12).

[11] *Id.*

[12] Compassion & Choices' Handout, *supra* at note 5.

lethal dose to the patient without his consent. Even if he struggled, who would know?

Without witnesses, the patient's control over his death is not guaranteed.

2. Someone else is allowed to speak for the patient

Under SB 167, patients signing the lethal dose request form are required to be "competent."[13] This is, however, a relaxed standard in which someone else is allowed to speak for the patient. SB 167 states:

> "Competent" means that . . . the patient has the ability to make and communicate an informed decision . . ., *including communication through persons familiar with the patient's manner of communicating . . ." Emphasis added).* (Emphasis added).[14]

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

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[13] SB 167 § 4(2)(c)(i). (Attached at A-3).

[14] SB 167 § 2(3) states:

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

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

Under SB 167's definition of "competent," there is no requirement that a patient signing the lethal dose request form have the ability to make "responsible" or "rational" decisions, which is the definition of legal capacity for treatment decisions in Montana.[15] Yet again, the patient would not necessarily be in control.

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

SB 167 does not require competency or even awareness when the lethal dose is administered.[16] SB 167 does not require the patient's consent when the lethal dose is administered.[17]

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[15] Compare SB 167's definition of "competent" in § 2(3) and 72-5-101(1), MCA, which states:

> "Incapacitated person" means any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, except minority, *to the extent that the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the person or which cause has so impaired the person's judgment that the person is incapable of realizing and making a rational decision with respect to the person's need for treatment.* (Emphasis added).

[16] SB 167 requires that a determination of "competent" be made in conjunction with the lethal dose request, not later. *See* SB 167, §§ 2(3), (5) & (12); § 3(1)(a); § 4(2)(c)(i); § 6(1)(a)(iii) & (c). Optional determinations of competency are also in conjunction with the lethal dose request, not later. *See e.g.* SB 167, §§ 7(1)(c)(i).

[17] SB 167 requires that a determination of "voluntariness" be made in conjunction with the lethal dose request, not later. *See e.g.* SB 167 §§ 3(1)(d); 4(2)(c)(ii) & (iii); and 6(1)(a)(iv). There is no requirement that the patient be acting on a voluntary basis at the time of administration. *See* SB 167 in its entirety. (Attached at A-1 through A-12).

Without the right of consent at the time of death, the patient's control over his death is an illusion.

5. Individual "opt outs" are not allowed

SB 167 says that a provision in a will or contract that affects whether a patient may make or rescind a lethal dose request "is not valid."[18]

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

So much for your personal "control."

B. Word Play

Proponents may claim that patients are nonetheless in control due to: a requirement that the lethal dose be "self-administered"; and a prohibition against euthanasia. On close examination, these arguments are wordplay.

1. "Self-administer" does not necessarily mean that a patient administers the lethal dose to himself

SB 167 provides that patients "self-administer" the lethal

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[18] SB 167 § 13(1) states:

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

dose.[19] In an Orwellian twist, this term does not mean that administration will necessarily be by the patient. "Self-administer" is instead defined as the patient's "act of ingesting." SB 167 states:

> "*Self-administer" means a qualified patient's act of ingesting* medication to end the qualified patient's life . . . (Emphasis added).[20]

In other words, someone else putting the lethal dose in the patient's mouth qualifies as proper administration because the patient will thereby "ingest" the dose.[21] Someone else putting the lethal dose in a feeding tube or IV nutrition bag will also qualify because the patient will thereby "absorb" the dose, *i.e.*, "ingest" it.[22]

Washington's law also uses the term "self-administer," which is defined as the patient's "act of ingesting."[23] Oregon's law does not use the term "self-administer."[24] That law does,

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[19] *See* SB 167 §2(8), (12) & (14); §3.

[20] SB 167 §2(14).

[21] SB 167 does not define "ingest." Dictionary definitions include: "[T]o *take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing*" (Emphasis added). Webster's New World College Dictionary, www.yourdictionary.com/ingest. (Attached at A-42).

[22] *Id.*

[23] RCW 70.245.010(12).

[24] Or. Rev. Stat. §§ 127.800-995.

however, refer to administration as the "act of ingesting."[25] Official forms for both laws also refer to administration as "ingestion," "ingesting," and other forms of the word "ingest."[26] With administration defined as mere ingestion, someone else is allowed to administer the lethal dose to the patient.

2. Euthanasia is not prohibited

SB 167 appears to prohibit "euthanasia," which is another name for mercy killing.[27] SB 167 states:

> Nothing in [this act] may be construed to authorize a physician or any other person to end a patient's life by . . . mercy killing, or active euthanasia.[28]

This prohibition is, however, defined away in the next sentence. SB 167 states:

> Actions taken in accordance with [this act] may not, for any purposes, constitute . . . mercy killing [also known as "euthanasia"] . . . ."[29]

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[25] *See* Or. Rev. Stat. § 127.875 § 3.13 (stating "[n]either shall a qualified patient's *act of ingesting* medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy."). (Emphasis added).

[26] *See* "Oregon Dignity Act Attending Physician Follow-up Form," http://www.Oregon.gov/DHS/ph/pas/docs/mdintdat.pdf (referring to administration of the lethal dose as "ingestion," "ingesting," and other forms of the word "ingest."). (Attached at A-29 to A-34). *See also* Washington's "Attending Physician's After Death Reporting" form, http://www.doh.wa.gov/dwda/forms/AfterDeathReportingForm.pdf (referring to administration of the lethal dose as "ingestion," "ingesting," and other forms of the word "ingest").

[27] *See* http://medical-dictionary.thefreedictionary.com/mercy+killing (defining "mercy killing" as euthanasia). (Attached at A-52).

[28] SB 167, § 20.

[29] *Id.*

C. Legalization will Create New Paths of Abuse

In Montana, there has been a rapid growth of elder abuse.[30] "Elders' vulnerabilities and larger net worth make them a prime target for financial abuse."[31] "Victims may even be murdered by perpetrators who want their funds and see them as an easy mark."[32]

Abuse of the elderly is often difficult to detect. This is largely due to the unwillingness of victims to report. A recent article on KULR8.com, states: "often time the victimizer is a family member and the elderly victim doesn't want to get them into trouble."[33]

In Montana, preventing elder abuse is official state policy.[34] If assisted suicide would be legalized, new paths of

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[30] *See* Great Falls Tribune, *Forum will focus on the rapid growth in abuse of elders*, June 10 2009 ("The statistics are frightening, and unless human nature takes a turn for the better, they're almost certain to get worse"). (Attached at A-35). *See also* Nicole Grigg, *Elder Abuse Prevention*, Kulr8.com, June 15, 2010, http://www.kulr8.com/internal?st=print&id=96428934&path=/news/local (attached at A-36); and Big Sky Prevention of Elder Abuse Program, What is Elder Abuse, http://www.mtelderabuseprevention.org/whatis.html. (Attached at A-37).

[31] MetLife Mature Market Institute, "Broken Trust: Elders, Family and Finances, A Study on Elder Abuse Prevention," March 2009, p.4, available at http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

[32] *Id.* at page 24.

[33] Nicole Grigg, attached at A-36.

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

abuse would be created against the elderly, which is contrary to that policy. Alex Schadenberg, chair for the Euthanasia Prevention Coalition, International, states:

> With assisted suicide laws in Washington and Oregon, perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over the administration. . . . [E]ven if a patient struggled, "who would know?"[35]

D. The Oregon Reports Are Consistent with Elder Abuse

Oregon issues annual statistical reports based on information supplied by reporting doctors and pharmacists.[36] These reports show that the majority of people who died under Oregon's law were well-educated with private insurance.[37] Typically, people with these attributes would be those with money, *i.e.*, the middle class and above. The statistics also show that the majority of people dying have been age 65 or older.[38]

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[35] Alex Schadenberg, Letter to the Editor, *Elder abuse a growing problem*, *The Advocate*, October 2010, page 14, available at http://www.isb.idaho.gov/pdf/advocate/issues/adv10oct.pdf. (Attached at A-41).

[36] Oregon's statistical reports can be viewed here: http://www.oregon.gov/DHS/ph/pas/index.shtml/shtml The most recent report for 2010 is attached hereto at A-23 to A-28.

[37] *See e.g.*, Oregon's most recent report for 2010, which states that most people who died under the Oregon law were "well educated." (Attached at A-24). The report also states that 60% had private health insurance as opposed to 69.1% in previous years. (*Id.*).

[38] Oregon's most recent report states: "Of the 65 patients who died under DWDA in 2010, most (70.8%) were over age 65 years, the median age was 72 years." (Attached at A-24).

These statistics can be explained by older persons with money feeling a "duty to die" so as to pass on funds to their heirs.[39] The statistics are also consistent with elder abuse. Former New Hampshire Representative Nancy Elliott states:

> Assisted suicide laws empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money. There is NO assisted suicide bill that you can write to correct this huge problem.[40]

E. The Oregon Reports Do Not Demonstrate the Safety of Assisted Suicide

Oregon's annual reports contain no information as to whether the patients who died consented when the lethal dose was administered.[41] Moreover, as noted above, Oregon's law does not require such consent. The claim, that Oregon's reports demonstrate the safety of assisted suicide, is without factual basis.

F. No Liability for Administration Without Consent

Proponents may counter that SB 167 protects patients from wrongdoing due to provisions imposing civil and criminal

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[39] *See, e.g.*, Licia Corbella, *If doctors who won't kill are 'wicked,' the world is sick*, THE CALGARY HERALD, January 10, 2009, at http://www.canada.com/calgaryherald/news/story.html?id=83835868-7f89-40bd-b16e-8bc961d41b39 (last visited Jan. 10, 2010).

[40] Nancy Elliott, Letter to the Editor, *Heirs will abuse older people*, *The Advocate*, September 2010 at page 15, at http://www.isb.idaho.gov/pdf/advocate/issues/adv10sep.pdf (Attached at A-36).

[41] *See* Oregon's annual reports at http://www.oregon.gov/DHS/ph/pas/index.shtml/shtml The most recent report is attached at A-23 through A-28. None of these reports address whether patients consented when the lethal dose was administered.

liability.[42] None of these provisions purports to prohibit administration of the lethal dose without the patient's consent.[43] These provisions are instead concerned with the lethal dose request and general issues.[44]

G. No Factual Support for Murder-Suicide Claim; In Oregon, Firearms are the Dominant Mechanism Among Male Suicides; In Oregon, Other Suicide has Increased with the Legalization of Assisted Suicide

Compassion & Choices has claimed that legalizing assisted suicide will prevent murder-suicide and other violent suicides in Montana.[45] In Oregon where assisted-suicide has been legal since 1997, murder-suicide has not been eliminated.[46] Indeed, murder-

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[42] SB 167, §§ 17 & 18 (Attached at A-11 & A-12).

[43] *Id.*

[44] *Id.*

[45] *See* Michael Jamison, "Libby shooting, arson tragedy puts focus on 'aid in dying,'" *The Missoulian*, September 4, 2010, available at http://missoulian.com/news/local/article_14e5e9b6-b7db-11df-aa1c-001cc4c03286.html. *See also* Compassion & Choices' handout at note 5.

[46] *See* Don Colburn, "Recent murder-suicides follow the national pattern," *The Oregonian*, November 17, 2009 ("In the span of one week this month in the Portland area, three murder-suicides resulted in the deaths of six adults and two children") (Attached at A-43 to A-45 and available at http://www.oregonlive.com/health/index.ssf/2009/11/recent_murder-suicides_follow.html); "Murder-suicide suspected in deaths of Grants Pass [Oregon] couple," *Mail Tribune News*, July 2, 2000 (regarding husband, age 77, and wife, age 76) at http://archive.mailtribune.com/archive/2000/july/070200n6.htm; and Colleen Stewart, "Hillsboro [Oregon] police investigating couple's homicide and suicide," *The Oregonian*, July 23, 2010 ("Wayne Eugene Coghill, 67, shot and killed his wife, Nyla Jean Coghill, 65, before taking his own life in their apartment"), at http://www.oregonlive.com/hillsboro/index.ssf/2010/07/hillsboro_police_investigating_homicide_and_suicide.html. *See also* 2010 Annual Report, Oregon's Death with Dignity Act, http://www.oregon.gov/DHS/ph/pas/docs/year13.pdf (stating that Oregon's assisted suicide law was "enacted in late 1997"). (Attached at A-23).

suicide follows "the national pattern."[47] The claim that legal assisted suicide prevents murder-suicide is without factual support.

Moreover, Oregon's overall suicide rate, which excludes suicide under Oregon's assisted suicide act, is 35% above the national average.[48] This rate has been "increasing significantly since 2000."[49] Just three years prior, in 1997, Oregon legalized assisted suicide.[50] Suicide has thus increased, not decreased with legalization of assisted suicide. Many of these deaths are violent. For 2007, which is the most recent year reported, "[f]irearms were the dominant mechanism of suicide among men."[51] The claim that legalization prevents violent deaths is without factual support.

III. CONCLUSION

SB 167's promise of patient control is an illusion. SB 167

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[47] Don Colburn, "Recent murder-suicides follow the national pattern," at note 46.

[48] *See* "Suicides in Oregon, Trends and Risk Factors," Oregon Department of Human Services, Public Health Division, September 2010 ("In 2007, the age-adjusted suicide rate . . . was 35% higher than the national average." "Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified by Oregon law and therefore excluded from this report") (Attached at A-49 to A-51).

[49] Oregon Health Authority, News Release, *Rising suicide rate in Oregon reaches higher than national average*, September 9, 2010, available at http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf. (Attached at A-48).

[50] *See* 2010 Annual Report, Oregon's Death with Dignity Act, http://www.oregon.gov/DHS/ph/pas/docs/year13.pdf (stating that Oregon's assisted suicide law was "enacted in late 1997"). (Attached at A-23).

[51] Excerpt, "Suicides in Oregon, Trends and Risk Factors," (Attached at A-50).

is instead a recipe for elder abuse, especially for those with money. The most obvious gap is the lack of witnesses at the death. Even if a patient struggled, who would know?

Don't make Oregon and Washington's mistake. Reject SB 167.

Respectfully Submitted.

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SENATE BILL NO. 167

INTRODUCED BY A. BLEWETT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) proof of registration to vote in Montana;

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

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

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

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

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

request for medication to be self-administered to end the patient's life if the patient:

(a) is a competent adult;

(b) is a resident of this state;

(c) has been determined by the patient's attending physician and, except as provided in [section 7], by a consulting physician to be suffering from a terminal illness; and

(d) has voluntarily expressed the wish to receive medication to end the patient's life in a humane and dignified manner.

(2) A person may not qualify under the provisions of [sections 1 through 20] solely because of age or disability.

NEW SECTION. **Section 4. Request process -- witness requirements.** (1) A patient wishing to receive a prescription for medication to end the patient's life shall submit an oral request and a written request to the patient's attending physician.

(2) A valid written request for medication under [sections 1 through 20] must be:

(a) in substantially the form described in [section 11];

(b) signed and dated by the patient; and

(c) witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is:

(i) competent;

(ii) acting voluntarily; and

(iii) not being coerced to sign the request.

(3) One of the witnesses must be an individual who is not:

(a) related to the patient by blood, marriage, or adoption;

(b) at the time the request is signed, entitled to any portion of the patient's estate upon death of the qualified patient under a will or any operation of law; or

(c) an owner, operator, or employee of a health care facility where the patient is receiving medical treatment or where the patient resides.

(4) The patient's attending physician may not be a witness to the signing of the written request.

(5) If the patient is a patient in a long-term care facility, as defined in 50-5-1103, at the time the written request is made, one of the witnesses must be an individual designated by the facility and meeting qualifications

established by the department by rule.

NEW SECTION. **Section 5. Right to rescind request -- requirement to offer opportunity to rescind.** (1) A qualified patient may at any time rescind the qualified patient's request for medication to end the qualified patient's life without regard to the qualified patient's mental state.

(2) A prescription for medication under [sections 1 through 20] may not be written without the attending physician offering the patient an opportunity to rescind the request for medication.

NEW SECTION. **Section 6. Attending physician responsibilities.** (1) The attending physician shall:

(a) make the initial determination of whether an adult patient:

(i) is a resident of this state;

(ii) has a terminal illness;

(iii) is competent; and

(iv) has voluntarily made the request for medication pursuant to [sections 3 and 4];

(b) ensure that the patient is making an informed decision by discussing with the patient:

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

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

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

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

(c) except as provided in [section 7], refer the patient to a consulting physician to medically confirm the diagnosis and prognosis and for a determination that the patient is competent and is acting voluntarily;

(d) if appropriate, refer the patient for counseling pursuant to [section 8];

(e) ensure that the patient's request does not arise from coercion or undue influence by another person;

(f) recommend that the patient notify the patient's next of kin;

(g) counsel the patient about the importance of:

(i) having another person present when the patient takes the medication prescribed pursuant to [sections 1 through 20]; and

(ii) not taking the medication in a public place;

(h) inform the patient that the patient may rescind the request for medication at any time and in any

manner;

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

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

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

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

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

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

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

(C) complies with any applicable administrative rule; or

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

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

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

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

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

(c) verify that the patient:

(i) is competent;

(ii) is acting voluntarily; and

(iii) has made an informed decision.

(2) (a) The requirements of this section do not apply if in the attending physician's opinion the requirements would result in an undue hardship for the patient because:

(i) the patient's terminal illness is sufficiently advanced that confirmation of the illness is not necessary; or

(ii) an appointment with a consulting physician cannot be made within a reasonable amount of time or with a physician who is within a reasonable distance of the patient's residence.

(b) An attending physician who waives the requirement for a confirmation by a consulting physician shall document the reasons for the waiver in the medical documentation required pursuant to [section 12].

NEW SECTION. **Section 8. Counseling referral.** (1) An attending physician or a consulting physician shall refer a patient who has requested medication under [sections 1 through 20] for counseling if in the opinion of the attending physician or the consulting physician the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(2) Medication to end a patient's life in a humane and dignified manner may not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

NEW SECTION. **Section 9. Informed decision required.** A patient may not receive a prescription for medication to end the patient's life unless the patient has made an informed decision as defined in [section 2]. Immediately before writing a prescription for medication under [sections 1 through 20], the attending physician shall verify that the patient is making an informed decision.

NEW SECTION. **Section 10. Family notification recommended -- not required.** The attending physician shall recommend that a patient notify the patient's next of kin of the patient's request for medication pursuant to [sections 1 through 20]. A request for medication under [sections 1 through 20] may not be denied because a patient declines or is unable to notify the next of kin.

NEW SECTION. **Section 11. Form of request.** A request for medication as authorized by [sections 1 through 20] must be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE

IN A HUMANE AND DIGNIFIED MANNER

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

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

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

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

INITIAL ONE:

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

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

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

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

I understand the full import of this request and I expect to die when I take the medication to be prescribed.

I further understand that although most deaths occur within 3 hours, my death may take longer, and my attending physician has counseled me about this possibility.

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

Signed:.....

Dated:.....

DECLARATION OF WITNESSES

We declare that the person signing this request:

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

(b) signed this request in our presence;

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

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

.....Witness 1/Date

.....Witness 2/Date

NOTE: One witness may not be a relative (by blood, marriage, or adoption) of the person signing this request, may not be entitled to any portion of the person's estate upon death, and may not own, operate, or be employed at a health care facility where the person is a patient or where the person resides. If the patient is an inpatient at a health care facility, one of the witnesses must be an individual designated by the facility.

NEW SECTION. **Section 12. Medical record documentation requirements.** The following items must be documented or filed in the patient's medical record:

(1) the determination and the basis for determining that a patient requesting medication to end the patient's life in a humane and dignified manner is a qualified patient;

(2) all oral requests by a patient for medication made pursuant to [section 4] to end the patient's life in a humane and dignified manner;

(3) all written requests by a patient for medication made pursuant to [sections 3 and 4] to end the patient's life in a humane and dignified manner;

(4) the attending physician's diagnosis, prognosis, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;

(5) unless waived as provided in [section 7], the consulting physician's diagnosis, prognosis, and verification that the patient is competent, is acting voluntarily, and has made an informed decision;

(6) the reasons for waiver of confirmation by a consulting physician, if a waiver was made;

(7) a report of the outcome and determinations made during counseling, if performed;

(8) the attending physician's offer before prescribing the medication to allow the patient to rescind the patient's request for the medication; and

(9) a note by the attending physician indicating:

(a) that all requirements under [sections 1 through 20] have been met; and

(b) the steps taken to carry out the request, including a notation of the medication prescribed.

NEW SECTION. **Section 13. Effect on construction of wills, contracts, and statutes.** (1) A provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end the person's life in a humane and dignified manner, is not valid.

(2) An obligation owing under any currently existing contract may not be conditioned or affected by a

person making or rescinding a request for medication to end the person's life in a humane and dignified manner.

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

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

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

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

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

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

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

(5) (a) Unless otherwise required by law, a health care provider may prohibit another health care provider from participating in [sections 1 through 20] on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider in writing of the prohibiting provider's policy against participating in [sections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Section 21. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 22. Codification instruction.** [Sections 1 through 20] are intended to be codified as an integral part of Title 50, and the provisions of Title 50 apply to [sections 1 through 20].

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

- END -

Terminal Uncertainty

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

By Nina Shapiro
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Nina Shapiro

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

Details:

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

— Dilemmas by caretakers and other Oregon studies

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

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

— JAMA study examining the accuracy of prognosis.

She noticed the back pain first.

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

That was almost four years ago.

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

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

"I just kept going and going," says Clayton. "You kind of don't notice how long it's been." She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. "I had to have

UPDATE: "It Felt Like the Big One"

cancer to have nice hair," she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip to Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Randy Niedzielski reached that point in the summer of 2006, according to his wife Nancy. Diagnosed with brain cancer in 2000, the onetime Lynnwood property manager had been through several rounds of chemotherapy and had lived years longer than the norm. But the cancer cells had

come back in an even more virulent form and had spread to his muscle system. "He would have these bizarre muscle contractions," Nancy recalls. "His feet would go into a cone shape. His arms would twist in weird angles." Or his chest would of its own volition go into what Nancy calls a "tent position," rising up from his arms. "He'd just be screaming in pain."

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

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

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

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

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

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

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

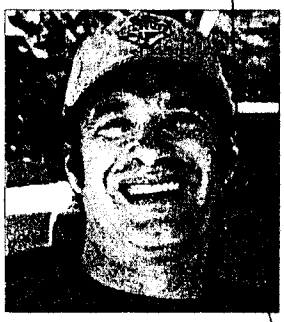
Maryanne Clayton says she has never reached that point. Still, she voted for the Death With Dignity Act. "Why force me to suffer?" she asks, adding that if she were today in as much pain as she was when first diagnosed with lung cancer, she might consider taking advantage of the new law. But for now,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

Street Talk

by Cathrine L. Walters

Asked Tuesday morning in downtown Missoula.

Q: This week arts editor Erika Fredrickson profiles Missoula singer-songwriter Ethan Thompson, whose band wrote the winning jingle for a competition hosted by Folgers. In your opinion, what's the best part of waking up?
Follow-up: What advertising slogan or jingle do you find catchiest?



David Winterburn: I'm a medical marijuana patient so I like to have a little medicine to start my day. It's more of a spiritual awakening. **Cold one:** For all you do, this Bud's for you.

Teri Gonzalez: Having a whole new day, heart beating, still have my soul and the opportunity to make a smile and not a frown. **Git 'er done:** Just do it.

Becky Douglas: There are no rules for what I have to do. We live in a liberated country. Being a woman and a momma, I have every option open to me and I really appreciate that. **Deconstructing America:** Saving wood for good. I'm the co-owner of Heritage Timber, and we take down old buildings and sell the reclaimed wood.

John Teten: Besides Folgers in my cup? I can't think of anything good about waking up. Maybe fresh sunshine on a hot day with an unannounced bucket of water in my face. **Pickled:** That's the tastiest crunch I've ever heard!

Second life

I am a retired office worker, who lives in Oregon where assisted suicide is legal. Our law was enacted via a ballot initiative, which I voted for. I write in response to your article about Sen. Hinkle's bill to prohibit assisted suicide in Montana (see "etc.," June 10, 2010).

In 2000, I was diagnosed with colon cancer and told that I had six months to a year to live. I knew that our law had passed, but I didn't know exactly how to go about doing it. I tried to ask my doctor, but he didn't really answer me.

I did not want to suffer. I wanted to do our law and I wanted my doctor to help me. Instead, he encouraged me to not give up and ultimately I decided to fight. I had both chemotherapy and radiation. I am so happy to be alive!

It is now nearly 10 years later. If my doctor had believed in assisted suicide, I would be dead. I thank him and all my doctors for helping me choose "life with dignity." I also agree with Sen. Hinkle that assisted suicide should not be legal. Don't make Oregon's mistake.

Jeanette Hall
King City, Ore.

Die free or live?

I am a state representative in New Hampshire where we recently voted down an Oregon-style assisted suicide bill. The vote was 242–133 (nearly 70 percent). I write in response to your editorial. I disagree that assisted suicide necessarily brings "choice."

In New Hampshire, many legislators who initially thought that they were for the bill, became uncomfortable when they studied it further. Contrary to promoting "choice," it was a prescription for abuse. These laws empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money. There is *no* assisted suicide law that you can write to correct this huge problem. Do not be deceived.

Nancy Elliott
Merrimack, N.H.

Another side of Israel

The only thing new in Ochenski's anti-Israel rant (see "Israel's enablers," June 3, 2010) is that he saved the "some of my best friends are Jewish" line for the end of his column. Most racists, homophobes and anti-Semites who want to express their negativity about an issue or a group usually begin their case with "Some of my best friends are black," "I have a friend who is gay," or "My Jewish coworker." The list goes on ad nauseam.

He rants about U.S. aid for Israel. Who would you rather the U.S. give aid: Iran? Syria? Yemen? North Korea?

Why did this so-called humanitarian aid flotilla decide to take this venture the day before Netanyahu was supposed to meet with President Obama? Did you ever stop to consider that this was a setup?

I suggest Mr. Ochenski take a trip to Israel. He might find a very progressive country where gays do not have to deal with a "Don't ask, don't tell" policy. He would find a country that allows its Arab minorities to serve in the Knesset. He might also find that there is a country that elected a woman prime minister before we elected a woman president. Oops! I forgot. We have never elected a woman president. But then gays, lesbians and women do not enjoy the same rights in other Middle Eastern countries as they do in Israel. Israel, with all of its internal differences, secular and religious, is a very progressive, open society.

> **"If my doctor had believed in assisted suicide, I would be dead."**

Here's one more idea: Read *The Jerusalem Post*. With little effort you will find Israel, a country of six million surrounded by 550 million Arabs, engaging in serious humanitarian discussions. There is a loud group in Israel voicing that the people of Gaza need to be treated better. This is in spite of thousands of missiles that neighboring Gaza launched into Israel. Meanwhile, the IDF does what soldiers do in a democracy, i.e. defend their tiny country so its people can engage in dissent.

In fact, when it comes to dissent the people of Israel may reflect the famous statement better than we Americans: "I may disagree with what you have to say, but I shall defend to the death your right to say it."

Edward Brown
Missoula

Hydatid hysteria

One way to save the humans? Educate yourself.

It is hard to believe that years after the irresponsible introduction of wolves infected with the parasite *Echinococcus granulosus* tapeworm into Montana, most people still don't know about this potentially fatal disease. Known as Hydatid disease, infected people develop cysts of tiny tape worm heads in their liver, lungs or brain. They have to be removed surgically, and if they are in the brain, they are inoperable and fatal. This disease has caused the confirmed deaths of over 300 Alaskans since 1950.

I recently found this information published in *The Outdoorsman*, the December 2009 edition. It is titled, "Two-Thirds of Idaho Wolf Carcasses Examined Have Thousands of Hydatid Disease Tapeworms." Now *E. granulosus* has been confirmed in two-thirds of the wolves examined by Fish and Game experts participating in a study evaluating the lower intestines of those wolves found in both Idaho and Montana. What has not been confirmed is how many coyotes, dogs, cattle and even humans it has infected. With a higher population density in Idaho and Montana than Alaska, the previously foreign disease has a new host; unsuspecting lower-48ers who have been deceived by their Fish and Game, and are now at risk of contracting and dying from the disease. Where are the warnings? They never came from the people responsible for "introducing" the infected wolves from Canada and Alaska.

Why the deception? And why wasn't anything mentioned about the disease in the latest cover article in the *Independent*? (See "One way to save the wolf? Hunt it," May 20, 2010.) It's because the people pushing for the wolves know that if the public found out about the dangers of high wolf populations infecting deer, elk, moose, coyotes, dogs and even people with this disease, there would be a public outcry over the recent population explosion of wolves in the state. All I can say now is, do the research yourself. Find out about *Echinococcus granulosus* and decide if you want wolves running around in your backyard.

Jacob Chessin Wustner
Missoula

Letters Policy: The Missoula *Independent* welcomes hate mail, love letters and general correspondence. Letters to the editor must include the writer's full name, address and daytime phone number for confirmation, though we'll publish only your name and city. Anonymous letters will not be considered for publication. Preference is given to letters addressing the contents of the *Independent*. We reserve the right to edit letters for space and clarity. Send correspondence to: Letters to the Editor, Missoula *Independent*, 317 S. Orange St., Missoula, MT 59801, or via e-mail: editor@missoulanews.com.

quest to legalize assisted suicide in Idaho, the particular doctor used by those authors to make their point may feel betrayed if an Idaho court fails to find the legal analysis contained in their article applicable to the Idaho doctor's conduct. And, whatever the court ultimately decides about the legality of the doctor's conduct will come too late for the doctor's former "patient" by now likely buried in Idaho.

Richard A. Hearn, M.D.
Racine Olson Nye Budge & Bailey, Chtd.

Wrong article for *The Advocate*

Dear Editor:

I was appalled to read the article "Aid in Dying: Law, Geography and Standard of Care in Idaho" in the last issue of *The Advocate*. What was your rationale for publishing such malarkey? Was this a vain attempt on your part to increase readership, or do you have a more sinister political motive?

According to your website:

"*The Advocate* features articles written by attorneys on topics of interest to members of the legal community."

Kathryn L. Tucker is not an Idaho attorney. She is an extremely well-paid political activist stirring up controversy through her erroneous rhetoric. I find it extremely difficult to believe that this subject matter would be of interest to the majority of your readers. Which leads me to ask why publish such an article? Are you using your position as editor to help promote your own political agenda?

Robin Sipe
Eagle, ID

Oregon's law doesn't work

Dear Editor:

I am a doctor in Portland Oregon where assisted suicide is legal. I disagree with Kathryn Tucker's rosy description of our assisted suicide law, which she terms "aid in dying."

In Oregon, the so-called safeguards in our law have proved to be a sieve. Although we are reassured that "only the patient" is supposed to take the lethal dose, there are documented cases of family members administering it.

Family members often have their own agendas and also financial interests that dovetail with a patient's death. Yet the true extent of such cases is not known as the only data published comes from second-and even third-hand reports (often from doctors who themselves who were not present at the death and who are active suicide promoters). What we do know about assisted suicide in Oregon is essentially shrouded in secrecy.

The scant information provided by the "official" Oregon statistics report that the majority of patients who have died via Oregon's law have been "well educated" with private health insurance. See official statistics at http://www.oregon.gov/DHS/ph/pas/docs/year12.pdf.

In other words, they were likely people with money. Was it really their "choice?"

Preserve choice in Idaho. Reject assisted suicide.

William L. Toffler MD
Professor of Family Medicine
OHSU--FM
Portland, OR

Doctors not always right

Dear Editor:

I live in Idaho, but formerly lived in Washington state where assisted suicide is legal. I was appalled to see Kathryn Tucker's article promoting "aid in dying," which is not only a euphemism for assisted suicide, but euthanasia. Indeed, in 1991, an "aid in dying" law was proposed in Washington State, which would have legalized direct euthanasia "performed in person by a physician." Legalizing these practices is bad public policy for many reasons. One personal to me is that doctors are not always right.

In 2005, I was diagnosed with a rare form of terminal endocrine cancer. This, along with having contracted Parkinson's disease, has made for a challenging life. Like most people, I sought a second opinion from the premier hospital in the nation that treats this form of cancer, M.D. Anderson, in Houston. But they refused to even see me, indicating they thought it was hopeless. Now five years later, it's obvious they were wrong.

Tucker's article refers to "aid in dying" is an "option." A patient hearing this "option" from a doctor, who he views as an authority figure, may just hear he has an obligation to end his life. A patient, hearing of this "option" from his children, may feel that he has an obligation to kill himself, or in the case of euthanasia, be killed. As for me, I would have missed some of the best years of my life. These are but some of the tragedies of legalized "aid in dying."

I can only hope that the people of Idaho will rise up to chase this ugly issue out of town.

Chris Carlson
Medimont, ID

Article's lousy legal analysis

Dear Editor:

I read with some dismay the article on aid in dying in the August *Advocate*. While I realize that Ms. Tucker and Ms. Salmi have strong opinions on the subject, that is no excuse for *The Advocate* to publish a diatribe so lacking in rational analysis.

The authors first address an Idaho statute dealing with "euthanasia, mercy killing, ... or... an affirmative or deliberate act or omission to end life" and, in conclusory fashion, state that this passage does not include "aid in dying." Worse, they go on to cite the Montana Supreme Court case on the application of homicide statutes in support of the conclusion that Idaho physicians "should feel safe" in helping their patients to kill themselves. I wonder what percentage of the Idaho Bar would be willing to give this advice to a physician client when that client faces loss of liberty and/or their license to practice medicine should the attorney prove to be wrong? This article is editorial comment masquerading as legal analysis and, at the very least, should have been accompanied by someone making a counter-argument.

Robert Moody
Boise, ID

Oregon mistake cost lives

Dear Editor:

I was disturbed to see that the suicide lobby group, Compassion & Choices, is beginning an attempted indoctrination of your state, to accept assisted suicide as somehow promoting individual rights and "choice." I have been a cancer doctor in Oregon for more than 40 years. The combination of assisted-suicide legalization and prioritized medical care based on prognosis has created a danger for my

patients on the Oregon Health Plan (Medicaid).

The Plan limits medical care and treatment for patients with a likelihood of 5% or less 5-year survival. My patients in that category who have a good chance of living another three years and who want to live, cannot receive surgery, chemotherapy or radiation therapy to obtain that goal. The Plan guidelines state that the Plan will not cover "chemotherapy or surgical interventions with the primary intent to prolong life or alter disease progression." The Plan WILL cover the cost of the patient's suicide.

Under our law, a patient is not supposed to be eligible for voluntary suicide until they are deemed to have six months or less to live. In the cases of Barbara Wagner and Randy Stroup, neither of them had such diagnoses, nor had they asked for suicide. The Plan, nonetheless, offered them suicide. Neither Wagner nor Stroup saw this event as a celebration of their "choice." Wagner said: "I'm not ready, I'm not ready to die," They were, regardless, steered to suicide.

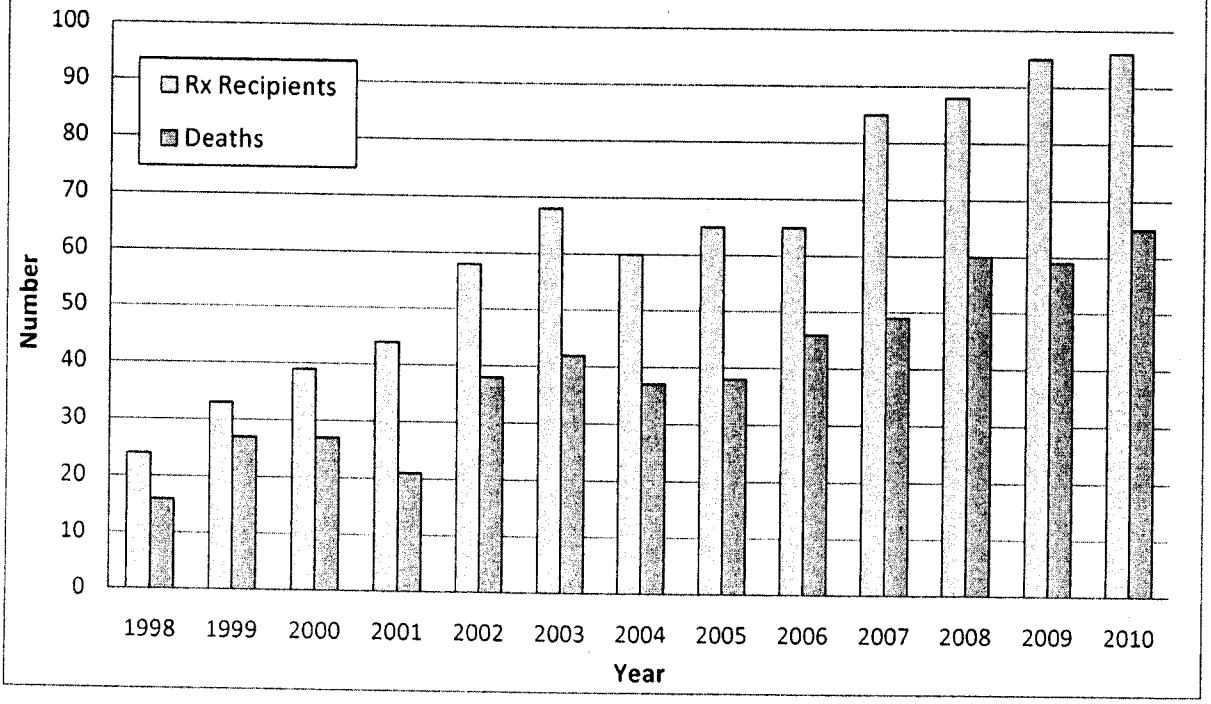
In Oregon, the mere presence of legal assisted-suicide steers patients to suicide even when there is not an issue of coverage. One of my patients was adamant she would use the law. I convinced her to be treated. Ten years later she is thrilled to be alive. Don't make Oregon's mistake.

Kenneth Stevens, MD
Sherwood, OR

Oregon's Death with Dignity Act--2010

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 2010 are listed below. The numbers of prescriptions written and deaths contained in this report are based on paperwork and death certificates received by the Public Health Division as of January 7, 2011. Because there is sometimes a delay between a death and receipt of the follow-up questionnaire and death certificate, it is possible that additional participants that received the medications in 2010 have died, but the Public Health Division has not yet received the paperwork or the death certificate. For more detail, please view the figures and tables on our web site at http://oregon.gov/DHS/ph/pas/index.shtml.

Figure 1: Number of DWDA Prescription Recipients and Deaths as of January 7, 2011, by Year, Oregon, 1998-2010



- As of January 7, 2011, 96 prescriptions for lethal medications had been written under the provisions of the DWDA during 2010, compared to 95 during 2009 (Figure 1). Of the 96 patients for whom prescriptions were written during 2010, 59 died from ingesting the medications. In addition, six patients with prescriptions written during previous years ingested the medications and died during 2010 for a total of 65 known 2010 DWDA deaths at the time of this report. This corresponds to 20.9 DWDA deaths per 10,000 total deaths.

Most recent Annual report for Oregon — No information provided regarding whether patients consented or were competent when the lethal dose was administered.

- Two of the patients who took the medications during 2010 did not die after ingestion, but died later from their underlying illness. Twenty of the patients who received prescriptions in 2010 did not take the medications and died of their underlying illness. Status is pending for 15 patients: two have died but we have not received the follow up questionnaire, and for 13 we have neither the death certificate nor follow up questionnaire (Figure 2).

- One of the two patients who awoke after ingesting the medication regained consciousness within 24 hours after ingestion and died of their underlying illness five days later; the other gained consciousness 3 ½ days after ingestion and died of their underlying illness three months later. Regurgitation was reported in both instances.

- Fifty-nine (59) physicians wrote the 96 prescriptions written in 2010 (range 1-11).

- Since the law was passed in 1997, 525 patients have died from ingesting medications prescribed under the Death with Dignity Act.

- Of the 65 patients who died under DWDA in 2010, most (70.8%) were over age 65 years; the median age was 72 years. As in previous years, most were white (100%), well-educated (42.2% had a least a baccalaureate degree), and had cancer (78.5%).

- Most (96.9%) patients died at home; and most (92.6%) were enrolled in hospice care at time of death. Most (96.7%) had some form of health care insurance, although the number of patients who had private insurance (60.0%) was lower in 2010 than in previous years (69.1%), and the number of patients who had only Medicare or Medicaid insurance was higher than in pervious years (36.7% compared to 29.6%).

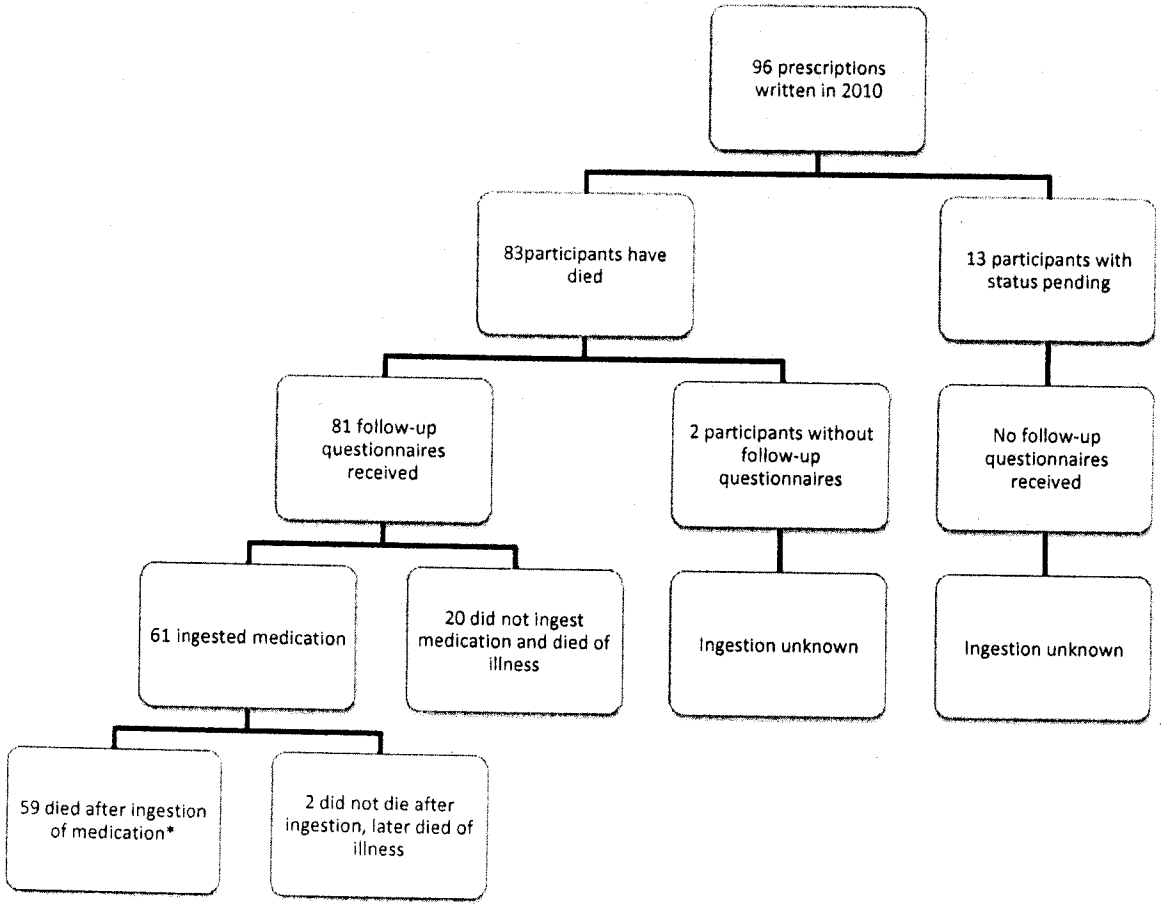
- As in previous years, the most frequently mentioned end-of-life concerns were: loss of autonomy (93.8%), decreasing ability to participate in activities that made life enjoyable (93.8%), and loss of dignity (78.5%).

- In 2010, one of the 65 patients was referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for six (9.4%) patients compared to 20.3% in previous years.

- Procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of 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 only 32 of the 65 deaths in 2010. Of those 32 patients, time from ingestion until death ranged from 5 minutes to 2.2 days (53 hours).

- During 2010, one referral was made to the Oregon Medical Board for failing to wait 48 hours between the patients written request and writing the prescription.

Figure 2: Outcome of the 96 participants for whom prescriptions were written under the provisions of DWDA in 2010, as of January 7, 2011



* An additional six patients with prescriptions written in previous years died from ingestion of medication in 2010, for a total of 65 known 2010 DWDA deaths at the time of this report.

Table 1. Characteristics and end-of-life care of 525 DWDA patients who died after ingesting a lethal dose of medication as of January 7, 2011, by year, Oregon, 1998-2010

Characteristics	2010 (N = 65)	1998-2009 (N = 460)	Total (N = 525)
Sex	N (%)*	N (%)*	N (%)*
Male (%)	38 (58.5)	244 (53.0)	282 (53.7)
Female (%)	27 (41.5)	216 (47.0)	243 (46.3)
Age			
18-34 (%)	0 (0.0)	6 (1.3)	6 (1.1)
35-44 (%)	1 (1.5)	12 (2.6)	13 (2.5)
45-54 (%)	5 (7.7)	34 (7.4)	39 (7.4)
55-64 (%)	13 (20.0)	94 (20.4)	107 (20.4)
65-74 (%)	19 (29.2)	127 (27.6)	146 (27.8)
75-84 (%)	15 (23.1)	136 (29.6)	151 (28.8)
85+ (%)	12 (18.5)	51 (11.1)	63 (12.0)
Median years (range)	72 (44-95)	71 (25-96)	71 (25-96)
Race			
White (%)	65 (100.0)	449 (97.6)	514 (97.9)
Asian (%)	0 (0.0)	7 (1.5)	7 (1.3)
American Indian (%)	0 (0.0)	1 (0.2)	1 (0.2)
African American (%)	0 (0.0)	1 (0.2)	1 (0.2)
Hispanic (%)	0 (0.0)	2 (0.4)	2 (0.4)
Other (%)	0 (0.0)	0 (0.0)	0 (0.0)
Marital Status			
Married (%)	33 (50.8)	212 (46.1)	245 (46.7)
Widowed (%)	14 (21.5)	101 (22.0)	115 (21.9)
Never married (%)	4 (6.2)	38 (8.3)	42 (8.0)
Divorced (%)	14 (21.5)	109 (23.7)	123 (23.4)
Education			
Less than high school (%)	4 (6.3)	33 (7.2)	37 (7.1)
High school graduate (%)	13 (20.3)	117 (25.5)	130 (24.9)
Some college (%)	20 (31.3)	105 (22.9)	125 (23.9)
Baccalaureate or higher (%)	27 (42.2)	204 (44.4)	231 (44.2)
Unknown	*1*	*1*	*2*
Residence			
Metro counties (%)$^{\Delta}$	29 (44.6)	197 (42.8)	226 (43.0)
Coastal counties (%)	7 (10.8)	34 (7.4)	41 (7.8)
Other western counties (%)	29 (44.6)	190 (41.3)	219 (41.7)
East of the Cascades (%)	0 (0.0)	39 (8.5)	39 (7.4)
Underlying Illness			
Malignant neoplasms (%)	51 (78.5)	373 (81.1)	424 (80.8)
Lung and bronchus (%)	8 (12.3)	88 (19.1)	96 (18.3)
Pancreas (%)	3 (4.6)	35 (7.6)	38 (7.2)
Breast (%)	3 (4.6)	38 (8.3)	41 (7.8)
Colon (%)	3 (4.6)	31 (6.7)	34 (6.5)
Prostate (%)	1 (1.5)	24 (5.2)	25 (4.8)
Other (%)	33 (50.8)	157 (34.1)	190 (36.2)
Amyotrophic lateral sclerosis (%)	7 (10.8)	35 (7.6)	42 (8.0)
Chronic lower respiratory disease (%)	2 (3.1)	18 (3.9)	20 (3.8)
HIV/AIDS (%)	0 (0.0)	8 (1.7)	8 (1.5)
Other illnesses (%)$^{\Psi}$	5 (7.7)	26 (5.7)	31 (5.9)

End of life care			
Hospice			
Enrolled (%)	50 (92.6)	404 (88.2)	454 (88.7)
Not enrolled (%)	4 (7.4)	54 (11.8)	58 (11.3)
Unknown	*11*	*2*	*13*
Insurance			
Private (%)[Ω]	36 (60.0)	315 (69.1)	351 (68.0)
Medicare, Medicaid or Other Governmental (%)	22 (36.7)	135 (29.6)	157 (30.4)
None (%)	2 (3.3)	6 (1.3)	8 (1.6)
Unknown	*5*	*4*	*9*
End of life concerns[#]			
Losing autonomy (%)	61 (93.8)	414 (90.8)	475 (91.2)
Less able to engage in activities making life enjoyable (%)	61 (93.8)	398 (87.3)	459 (88.1)
Loss of dignity (%)[§]	51 (78.5)	282 (85.2)	333 (84.1)
Losing control of bodily functions (%)	30 (46.2)	264 (57.9)	294 (56.4)
Burden on family, friends/caregivers (%)	17 (26.2)	167 (36.6)	184 (35.3)
Inadequate pain control or concern about it (%)	10 (15.4)	101 (22.1)	111 (21.3)
Financial implications of treatment (%)	1 (1.5)	12 (2.6)	13 (2.5)
DWDA process			
Referred for psychiatric evaluation (%)	1 (1.5)	38 (8.4)	39 (7.5)
Patient informed family of decision (%)**	62 (95.4)	361 (93.5)	423 (93.8)
Patient died at			
Home (patient, family or friend) (%)	63 (96.9)	435 (94.6)	498 (94.9)
Long term care, assisted living or foster care facility (%)	2 (3.1)	19 (4.1)	21 (4.0)
Hospital (%)	0 (0.0)	1 (0.2)	1 (0.2)
Other (%)	0 (0.0)	5 (1.1)	5 (1.0)
Lethal medication			
Secobarbital (%)	60 (92.3)	261 (56.7)	321 (61.1)
Pentobarbital (%)	5 (7.7)	195 (42.4)	200 (38.1)
Other (%)[ΔΔ]	0 (0.0)	4 (0.9)	4 (0.8)
Health-care provider present**			
When medication was ingested			
Prescribing physician (%)	6 (30.0)	88 (23.8)	94 (24.2)
Other provider, prescribing physician not present (%)	10 (50.0)	218 (59.1)	228 (58.6)
No provider (%)	4 (20.0)	63 (17.1)	67 (17.2)
Unknown	*45*	*21*	*66*
At time of death			
Prescribing physician (%)	6 (9.4)	77 (20.3)	83 (18.7)
Other provider, prescribing physician not present (%)	19 (29.7)	233 (61.5)	252 (56.9)
No provider (%)	39 (60.9)	69 (18.2)	108 (24.4)
Unknown	*1*	*11*	*12*
Complications[‡‡]			
Regurgitated (%)	1 (3.6)	20 (4.5)	21 (4.4)
Seizures (%)	0 (0.0)	0 (0.0)	0 (0.0)
Awakened after taking prescribed medications (%)	2 [§§]	1 [§§]	3 [§§]
None (%)	27 (96.4)	429 (95.5)	456 (95.6)
Unknown	*37*	*11*	*48*
Emergency Medical Services			
Called for intervention after lethal medication ingested (%)	0 (0.0)	0 (0.0)	0 (0.0)
Calls for other reasons (%)[##]	0 (0.0)	4 (0.9)	4 (0.8)
Not called after lethal medication ingested (%)	28 (100.0)	451 (99.1)	479 (99.2)
Unknown	*37*	*5*	*42*

Timing of DWDA event			
Duration (weeks) of patient-physician relationship			
Median	18	10	10
Range	0-1905	0-1440	0-1905
Unknown	*0*	*20*	*20*
Duration (days) between 1st request and death			
Median	64	43	46
Range	16-338	15-1009	15-1009
Minutes between ingestion and unconsciousness[‡‡]			
Median	5	5	5
Range	1-20	1-38	1-38
Unknown	*33*	*38*	*71*
Minutes between ingestion and death[‡‡]			
Median	35	25	25
Range (minutes - hours)	5min-53hrs	1min-104hrs	1min-104hrs
Unknown	*33*	*33*	*66*

* Unknowns are excluded when calculating percentages.

Δ Clackamas, Multnomah, and Washington counties.

Ψ Includes alcoholic hepatic failure, corticobasal degeneration, diabetes with renal complications, hepatitis C, organ-limited amyloidosis, scleroderma, Shy-Drager syndrome, multiple sclerosis, meningioma, pulmonary disease, chronic heart failure, diseases of the heart, cerebrovascular disease, Parkinson's disease and Huntington's disease.

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

\# Affirmative answers only ("Don't know" included in negative answers). Available for 17 patients in 2001.

§ First asked in 2003.

** First recorded beginning in 2001. Since then, 20 patients (4.4%) have chosen not to inform their families, and 8 patients (1.8%) have had no family to inform. There was one (1) unknown case in 2009.

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

++ The data shown are for 2001-2010 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001. Procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure only collects information on health care providers present at ingestion when the physician or another health care provider is present at time of death. This resulted in a larger number of unknowns in 2010.

‡‡ Procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of 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 in 2010.

§§ In 2005, one patient regained consciousness 65 hours after ingesting the medication, subsequently dying from their illness 14 days after awakening. In 2010, two patients regained consciousness after ingesting medications. One patient regained consciousness 88 hours after ingesting the medication, subsequently dying from their illness three months later. The other patient regained consciousness within 24 hours, subsequently dying from their illness five days following ingestion.

\## Calls included three to pronounce death and one to help a patient who had fallen off a sofa.

Case ID: _____ - _____ Attending ID: _____ _____ _____ _____ _____ ☐ DWD ☐ Illness
For ODPE use only.

Oregon Death with Dignity Act
Attending Physician Follow-up Form

Dear Physician:

The Death with Dignity Act requires physicians who write a prescription for a lethal dose of medication to complete this follow-up form within **10 calendar days** of a patient's death, whether from ingestion of the lethal dose of medications obtained under the Act or from any other cause.

For DHS to accept this form, it must be signed by the Attending (Prescribing) Physician, whether or not he or she was present at the patient's time of death.

This form should be mailed to the address on the last page. *All information is kept strictly confidential.* If you have any questions, call: 971-673-1150.

Date: ____/____/____ **Patient's Name:** _____

Name of Attending (Prescribing) Physician: _____

_____

Did the patient die from ingesting the lethal dose of medication, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink? **If unknown, please contact the family or patient's representative.**

☐ 1 **Death with Dignity** (lethal medication) → ***Please sign below and go to page 2.***

Attending (Prescribing) Physician Signature _____

☐ 2 **Underlying illness** → ***There is no need to complete the rest of the form. Please sign below.***

Attending (Prescribing) Physician Signature _____

☐ 3 **Other** → ***There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death andsign.***

Please specify: _____
_____
_____

Attending (Prescribing) Physician Signature _____

Oregon after-death reporting form
- questions concern "ingestion" of the lethal dose
- NO question regarding whether the patient consented to administration/ingestion.

PART A and PART B should only be completed if the patient died from ingesting the lethal dose of medication.

Please read carefully the following to determine which situation applies to you. Check the box that indicates your scenario, and complete the remainder of the form accordingly.

☐ The Attending (Prescribing) Physician was present at the time of death.

→ The Attending (Prescribing) Physician must complete this form in its entirety and sign Part A and Part B.

☐ The Attending (Prescribing) Physician was not present at the time of death, but another licensed health care provider was present.

→ The licensed health care provider must complete and sign Part A of this form. The Attending (Prescribing) Physician must complete and sign Part B of the form.

☐ Neither the Attending (Prescribing) Physician nor another licensed health care provider was present at the time of death.

→ Part A may be left blank. The Attending (Prescribing) Physician must complete and sign Part B of the form.

PART A: To be completed and signed by the Attending (Prescribing) Physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the lethal dose of medication?
   - ☐ 1 Yes
   - ☐ 2 No

   "Took" like the word "ingest," does not indicate whether such action was voluntary. No questions whether the patient consented to taking or ingesting the lethal dose, or whether the patient was competent when this occurred.

   If no: Was another physician or trained health care provider or volunteer present when the patient ingested the lethal dose of medication?
   - ☐ 1 Yes, another physician
   - ☐ 2 Yes, a trained health-care provider/volunteer
   - ☐ 3 No
   - ☐ 9 Unknown

2. Was the attending physician at the patient's bedside at the time of death?
   - ☐ 1 Yes
   - ☐ 2 No

   If no: Was another physician or a licensed health care provider or volunteer present at the patient's time of death?
   - ☐ 1 Yes, another physician or licensed health care provider
   - ☐ 3 No
   - ☐ 9 Unknown

3. On what day did the patient consume the lethal dose of medication?
   ____/____/____ (month/day/year) ☐ 9 Unknown

4. On what day did the patient die after consuming the lethal dose of medication?
   ____/____/____ (month/day/year) ☐ 9 Unknown

"Consume" — another word that gives no information about patient consent or competency.

5. Where did the patient ingest the lethal dose of medication?
   - ☐ 1 Private home
   - ☐ 2 Assisted-living residence (including foster care)
   - ☐ 3 Nursing home
   - ☐ 4 Acute care hospital in-patient
   - ☐ 5 In-patient hospice resident
   - ☐ 6 Other (specify) _____
   - ☐ 9 Unknown

6. What was the time between lethal medication ingestion and unconsciousness?
   Minutes: _____ or Hours: _____ ☐ Unknown

7. What was the time between lethal medication ingestion and death?
   Minutes: _____ or Hours: _____. ☐ Unknown

If the patient lived longer than six hours, are there any observations on why the patient lived for more than six hours after ingesting the lethal dose of mediation? _____

_____

_____

8. Were there any complications that occurred after the patient took the lethal dose of medication? For example: vomiting, seizures, or regaining consciousness?

- ☐ 1 Yes – vomiting, emesis
- ☐ 2 Yes – seizures
- ☐ 3 Yes – regained consciousness
- ☐ 4 No complications
- ☐ 5 Other – please describe: _____
- ☐ 9 Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of medication?

- ☐ 1 Yes - please describe: _____
- ☐ 2 No
- ☐ 9 Unknown

10. At the time of ingesting the lethal dose of medication, was the patient receiving hospice care?

- ☐ 1 Yes
- ☐ 2 No, refused care
- ☐ 3 No, never offered care
- ☐ 4 No, other (specify) _____
- ☐ 9 Unknown

11. And lastly, are there any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

_____

_____

_____

_____

_____

Signature of Attending (Prescribing) Physician present at time of death:

_____

Name of Licensed Health Care Provider present at time of death if not Attending (Prescribing) Physician:

_____

Signature of Licensed Health Care Provider

_____

PART B : To be completed and signed by the Attending (Prescribing) Physician

12. On what date did the attending physician begin caring for this patient?
____/____/____ (month/day/year)

13. On what date was the prescription written for the lethal dose of medication?
____/____/____ (month/day/year)

14. When the patient initially requested a prescription for a lethal dose of medication, was the patient receiving hospice care?

☐ 1 Yes
☐ 2 No, refused care
☐ 3 No, never offered care
☐ 4 No, other (specify) _____
☐ 9 Unknown

15. Seven possible concerns that may have contributed to the patient's decision to request a prescription for lethal medication are shown below. Please check "yes," "no," or "Don't know," depending on whether or not you believe that concern contributed to the request.

A concern about...

...the financial cost of treating or prolonging his or her terminal condition.
☐ Yes ☐ No ☐ Don't Know

...the physical or emotional burden on family, friends, or caregivers.
☐ Yes ☐ No ☐ Don't Know

...his or her terminal condition representing a steady loss of autonomy.
☐ Yes ☐ No ☐ Don't Know

...the decreasing ability to participate in activities that made life enjoyable.
☐ Yes ☐ No ☐ Don't Know

...the loss of control of bodily functions, such as incontinence and vomiting.
☐ Yes ☐ No ☐ Don't Know

...inadequate pain control at the end of life.
☐ Yes ☐ No ☐ Don't Know

...a loss of dignity.
☐ Yes ☐ No ☐ Don't Know

16. What type of health-care coverage did the patient have for their underlying illness?
(*Check all that apply.*)

☐ 1 Medicare
☐ 2 Oregon Health Plan/Medicaid
☐ 3 Military/CHAMPUS
☐ 4 V.A.
☐ 5 Indian Health Service
☐ 6 Private insurance (e.g., Kaiser, Blue Cross, Medigap)
☐ 7 No insurance
☐ 8 Had insurance, don't know type
☐ 9 Unknown

17. Are there any comments on this follow-up questionnaire, or any other comments or insights that you would like to share with us?

Signature of Attending (Prescribing) Physician:

Please mail this document to:
Center for Health Statistics
Oregon Department of Human Services
P. O. Box 14050
Portland, OR 97293-0050
Copies of this form are available at: http://oregon.gov/DHS/ph/pas/pasforms.shtml

greatfallstribune.com
GREAT FALLS, MONTANA

June 10, 2009

Forum will focus on the rapid growth in abuse of elders

The statistics are frightening, and unless human nature takes a turn for the better, they're almost certain to get worse.

We're talking about the numbers of seniors who fall victim to abuse, exploitation or neglect — *in Montana.*

The graphic at right shows a substantial year-over-year increase in cases — 22 percent for abuse, for example — but the numbers over the past decade in our nine-county region are even more dramatic.

Abuse cases nearly doubled, and exploitation and neglect cases both tripled from 1998 to 2008.

The state division of Adult Protective Services expects the trend to worsen.

"I anticipate that the economic stresses ... the increase in gambling addiction, the increase in child support payment enforcement and the unrealistic lifestyle expectation of the younger generation will contribute to the increased referrals," said division Director Rick Bartos.

Sheer numbers of seniors will contribute further as baby boomers age — the so-called "golden years" also are the years of increased vulnerability.

To help area residents and officials prepare and cope with these seemingly inevitable trends, an organization called the Elder Abuse Prevention Forum will sponsor a public meeting at the Rainbow Assisted Living Community from 1-7 p.m. Friday, which happens to be National Elder Abuse Prevention Day.

The public is invited, and there's no charge.

Speakers will include Sgt. Jeff Newton, Great Falls Police Department; Jim Francetich, Adult Protective Services; Sheriff Dave Castle; County Attorney John Parker; and District Judge Dirk Sandefur.

There also will be 30 booths from vendors who serve seniors. The forum is a grass-roots coalition of groups and individuals.

ELDER ABUSE PREVENTION

TOOLS

3 COMMENTS
EMAIL THIS ARTICLE
PRINT THIS ARTICLE
YOUNEWS™
DIGG THIS!
SAVE TO DELICIOUS
POST TO FACEBOOK
SHARE ON TWITTER

By Nicole Grigg
Story Published: Jun 15, 2010 at 5:15 PM MDT
(Story Updated: Jun 15, 2010 at 10:26 AM MDT)

MULTIMEDIA

WATCH THE VIDEO

BILLINGS - Elderly people across the country are victims of abuse on a daily basis. A Billings organization was one of the first in the nation to spread awareness of this often unseen abuse.
There are many warning signs to look for if your loved one is being victimized and different types of abuse. There's physical, emotional, psychological, and sexual.

Social worker Nikki Nielsen is talking about the different forms of elder abuse. She's handling 40 cases right now in Billings. Big Sky Senior Services works to prevent abuse, neglect and financial exploitation of seniors age 60 and older.

"Someone's relative coming and saying they are going to help out and in fact they end up getting hold of the person's bank account and unfortunately wiping out their savings they saved up all their lives," is the most common cases Nielsen said she sees.

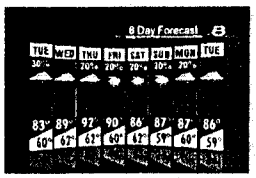
Only one in ten cases of elder abuse is actually reported. More than 900 cases of abuse were reported in Montana last year. Director of Big Sky services Denise Armstrong said financial exploitation is the fastest growing form of abuse because elders are so trustworthy.

"I encourage all seniors to review their bank statements every single month. Protect your identification and if someone calls asking for your account number or social security number never give out your information over the phone. The other thing we always say if it sounds to good to be true, then it is too good to be true," said Armstrong.

Armstrong said one reason elder abuse is so underreported is that often time the victimizer is a family member and the elderly victim doesn't want to get them in trouble.

Next article
Helping Disabled Adults

YOUR WEATHER AUTHORITY



84.0 °F
Current Temp

Partly Cloudy

Wind : North at 10.4 mph
Humidity : 25 %
Pressure : 29.89 in

More Weather

SKY CAM

AP VIDEO


BP's Hayward to Leave As CEO, Russia Job on Tap
Play


Gibbs: Leaked Documents a Potential Threat
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Swaths of Washington in Dark After Huge Storm
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ON DEMAND

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CAST YOUR VOTE

Do you believe the Wall Street Reform Law will keep another economic meltdown from happening?

- Yes
- No

Submit

MOST POPULAR

- Heights Fire
- Greenhouse Concert
- Emergency Landing
- Bison Attack Investigation
- Garage Sales Bring in Money
- Local Couple Sues State
- Body Identified
- Big Night for City Council
- Pedestrian Fatal

What is Elder Abuse

Physical Abuse • Neglect and Abuse by Caregiver
Psychological/Emotional Abuse • Abandonment
Self-Neglect • Sexual Abuse • Financial Abuse
• Signs of Distress • Two Case Studies

Physical Abuse

Any physical pain or injury that is willfully inflicted upon an elder by a person who has care of or custody of, or who stands in a position of trust with that elder, constitutes physical abuse. This includes, but is not limited to, direct beatings, sexual assault, unreasonable physical restraint, and prolonged deprivation of food or water.

Possible Indicators of Physical Abuse

- Cuts, lacerations, puncture wounds
- Bruises, welts, discoloration
- Any injury incompatible with history
- Any injury which has not been properly addressed
- Poor skin condition or poor skin hygiene
- Absence of hair and /or hemorrhaging below the scalp
- Dehydration and/or malnourished without illness-related cause
- Weight loss
- Burns: may be caused by cigarettes, caustics, acids, friction from ropes or chains, or other objects
- Soiled clothing or bed

Neglect and Abuse by Caregiver [Back to Top]

The failure of any person having the care or custody of an elder to provide that degree of care which a reasonable person in a like position would provide constitutes neglect. This includes, but is not limited to:

1. Failure to assist in personal hygiene or the provision of clothing for an elder
2. Failure to provide medical care for the physical and mental health needs of an elder
3. Failure to protect an elder from health and safety standards

Possible Indicators of Neglect by Caregiver:

- Dirt, fecal/urine smell, or other health and safety hazards in elder's living environment
- Rashes, sores, lice on elder

- Inadequate clothing
- Elder is malnourished or dehydrated
- Elder has an untreated medical condition

Possible Indicators of Abuse by Caregiver:

- The elder may not have been given an opportunity to speak for him or herself, or see others without the presence of the caregiver.
- Attitude of indifference or anger toward the dependent person, or the obvious absence of assistance
- Family members or caregiver blames the elder
- Aggressive behavior by caregiver toward the elder (threats, insults, harassment)
- Previous history of abuse of others
- Problem with alcohol or drugs
- Inappropriate display of affection by the caregiver
- Flirtations, coyness, etc. as possible indicators of inappropriate sexual relationship
- Social isolation of family, or isolation or restriction of activity of the older adult within the family unit by the caregiver
- Conflicting accounts of incidents by family, supporters, or victim
- Unwillingness or reluctance by the caregiver to comply with service providers in planning and implementing care-plan
- Inappropriate or unwarranted defensiveness by caregiver

Psychological/Emotional Abuse [Back to Top]

The willful infliction of mental suffering, by a person in a position of trust with an elder, constitutes psychological/emotional abuses. Example of such abuse are: verbal assaults, threats, instilling fear, humiliation, intimidation, or isolation of an elder.

Abandonment [Back to Top]

Abandonment constitutes the desertion or willful forsaking of an elder by a person having the care and custody of that elder, under circumstances in which a reasonable person will continue to provide care or custody.

Self-Neglect [Back to Top]

Failure to provide for self through inattention or dissipation. The identification of this type of cause depends on assessing the elder's ability to choose a lifestyle versus a recent change in the elder's ability to manage.

Sexual Abuse [Back to Top]

The non-consensual sexual contact of any kind with an elderly person.

Financial Abuse [Back to Top]

Financial Exploitation means the initial depletion of bank account, credit accounts or other resources for the benefit or advantage of the offender.

Possible indicators of Financial Abuse:

- Unusual or inappropriate activity in bank accounts
- Signatures on checks, etc. that do not resemble the older person's signature, or signed when the elder person cannot write
- Power of attorney given, or recent changes or creation of will, when the person is incapable of making such decisions
- Unusual concern by caregiver that an excessive amount of money is being expended on the care of the person
- Numerous unpaid bills, overdue rent, when someone is supposed to be paying the bills for a dependent elder
- Placement in nursing home or residential care facility which is not commensurate with alleged size of estate

- Lack of amenities, such as TV, personal grooming items, appropriate clothing, that the estate can well afford

An elderly person may be at risk for abuse, neglect and/or exploitation if:

- The level of care they are receiving is inconsistent with their resources or needs
- They seem nervous or afraid of the person accompanying or 'helping' them
- Someone displays sudden attention or affection for the elder
- Someone promises life-long care in exchange for property
- They are unable to remember signing documents or making financial transactions
- Someone is attempting to isolate them from family or other support
- Property is transferred to someone else or is reported missing
- They seem confused about transactions or withdrawals from their account
- They seem coerced into making transactions
- The elder or the acquaintance gives implausible explanations of finances or expenses
- Sudden changes in the elder's appearance or self-care
- The elder becomes emotionally or physically withdrawn
- A professional 'assisting' them behaves or responds questionably

Financial exploitation of our elderly is a growing problem and is under reported by the victim's family or caregivers. Financial exploitation means the intentional depletion of bank account, credit accounts or other resources for the benefit or advantage of the offender. Victims of financial exploitation may live in the community or in a health care facility; may be in poor health or have a diminished mental capacity and can be easily swayed. The motivation of the offender to steal will probably fall into one of two categories; greed or desperation.

Financial abuse robs many elderly victims of their homes, life savings and possessions, as well as their dignity and independence. The damage is devastating because it comes at a time when the elderly victim is least likely to recover what they have lost.

To help prevent the depletion of an elder's financial assets, Big Sky Prevention of Elder Abuse Program formed a Task Force that developed an effective training model for reporting suspect situations. This Financial Exploitation Training Manual, Video and PowerPoint includes forms, procedures and remedies for reporting to the appropriate authorities when abuse is detected and is available to the public.

Signs of Distress [Back to Top]

- Unkempt lawns/walks
- Disheveled personal appearance
- Loss of hearing, vision, weight, difficulty moving about
- Increased withdrawal, isolation
- Disorientation, forgetfulness, confusion
- Any marked change in overall ability to function>

Two Case Studies [Back to Top]

Medical Neglect

A call was received concerning an elderly man residing in an unlicensed care home. Harold was placed in the home by a relative when his care needs became too great for her to manage. Harold exhibits dementia, hearing impairment, and incontinence of urine. He ambulates with a walker and is prone to falls.

After slipping in the bathroom one evening, Harold sustained a five-inch laceration to his right calf. The care provider transported Harold to the emergency room where the cut was sutured. Care instructions and recommendations for follow-up treatment were given. Several weeks passed and Harold was seen again in the emergency room. The

LETTERS TO THE EDITOR

Legislature rejected euthanasia

Dear Editor:

I have several concerns with the article in the recent August, 2010 Advocate by Kathryn Tucker entitled "Aid in Dying: Law, Geography and Standard of Care in Idaho." Whatever one may think of Euthanasia, whether denominated "Aid in Dying" as the author calls it, or "physician assisted suicide" or "mercy killing", as it is also known, the article's suggestion that Idaho, like Montana, could legally adopt that practice by judicial decision, simply by changing the standard of care for doctors, is a gross misunderstanding of Idaho law. The article's statement that "Most medical care is not governed by statute or court decision, but is instead governed by the standard of care," relies solely on 61 Am. Jur. 2d, for that statement, without recognizing that the standard of care for doctors in Idaho is established by statute, I.C. 6-1012. The article's implication that Idaho courts can change that standard simply by judicially adopting the statutory euthanasia policies of Washington, Oregon or Montana is simply an attempt to conduct an end run around the legislature with the kind of judicial activism that prevailed in many U.S. courts during the 1970s and 80s, and which not only diminished the public's respect for the courts, but has turned judicial elections into expensive partisan contests. The author's suggestion that Idaho can judicially adopt euthanasia is false and dangerous, and fails to recognize that in both the Idaho criminal statutes as well as I.C.6-1012, the Idaho legislature has rejected physician assisted suicide.

Hon. Robert E. Bakes
Retired Chief Justice
Idaho Supreme Court

Montana doesn't permit it

Dear Editor:

I am a Montana State Senator. I disagree with Kathryn Tucker's discussion of our law in her article, "Aid in Dying: Law, Geography and Standard of Care in Idaho." (August, 2010). Contrary, to her implication, a physician can still find himself criminally or civilly liable for assisting a suicide in Montana. The recent Supreme Court decision merely gives physicians a potential defense to criminal liability. I have also proposed a bill, "The Montana Patient Protection Act," which would overrule the Supreme Court decision to eliminate the defense and render it clear that assisted suicide is prohibited in Montana.

The vast majority of states to consider legalizing assisted suicide, have rejected it. The most recent states to reject it are Connecticut and New Hampshire. Only two states allow it.

Assisted suicide, regardless, provides a path to elder abuse and steers citizens to take their own lives. These results are contrary to our state's public policies designed to value all of our citizens regardless of age.

Senator Greg Hinkle
Thompson Falls, MT

Heirs will abuse older people

Dear Editor:

I am a State Representative in New Hampshire where, in January, we voted down an Oregon-style "aid in dying" law. I write in response to Kathryn Tucker's article promoting such laws, which she claims promote "choice" for patients at the end of life. [Tucker & Salmi, "Aid in Dying: Law, Geography and Standard of Care in Idaho," August 2010]

Aid in dying is more commonly known as assisted suicide. In New Hampshire, many legislators who initially thought they were for the law, became uncomfortable when they studied it further. Contrary to promoting "choice," it was a prescription for abuse. The vote to defeat it was 242 to 113 (nearly 70%).

Assisted suicide laws empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money. There is NO assisted suicide law that you can write to correct this huge problem.

Do not be deceived.

Representative Nancy Elliott
Merrimack, New Hampshire

No assisted suicide in Idaho

To the Editor:

This letter questions your decision to publish "Aid in Dying: Law, Geography and Standard of Care in Idaho" in the August 2010 edition of *The Advocate*. Either the legal reasoning contained in the "Aid in Dying" article was reviewed prior to its publication in *The Advocate* or it was not. Hopefully, no attorney associated with the Bar read and endorsed the legal arguments contained in this article. I will only cite two of the most obvious fallacies in the authors' reasoning:

(1) the claim that a recent Montana Supreme Court case recognizing the possibility of using a "consent defense" to a charge of homicide as is allowed under Montana statutory law in cases of physician assisted suicide would provide any defense to a charge of homicide for the same conduct in Idaho, and

(2) the claim that, because Oregon, Washington and Montana allegedly permits physician assisted suicide, Idaho courts would likely find that physician assisted suicide meets the local community standard of care for doctors practicing in Idaho.

At its core, the authors' argument in "Aid in Dying: Law, Geography and the Standard of Care" amounts to no more than a plea to Idaho doctors that they ignore Idaho law and instead act based upon the law of the surrounding states. What Idaho lawyer would provide this advice to any doctor client?

Perhaps "Aid in Dying" was published in *The Advocate* out of some misguided notion of free speech rights as providing Idaho attorneys a platform to express their personal views. Although the authors certainly have a right to advocate for their personal views, they have no right to do so in *The Advocate*. And, even if one were to contend that allowing such advocacy in *The Advocate* is a good idea, that would not justify *The Advocate* allowing publication of an article falsely claiming that assisted suicide was already legal under Idaho law.

False claims about what the law of Idaho actually is, published in *The Advocate*, cannot possibly benefit public debate on this issue. If presented to Idaho doctors as a peer reviewed legal analysis of the law related to assisted suicide in Idaho, "Aid in Dying" could actually lead some Idaho doctor to assist a patient take his or her life in reliance upon the legal analysis presented in this article. While achieving this result may be understood as an important milestone in the authors'

LETTERS TO THE EDITOR

Dutch law allows euthanasia

Dear Editor:

I am a physician who has studied assisted-suicide and euthanasia since 1988, especially in the Netherlands. I respond to Margaret Dore's article, which quotes me for the proposition that those who believe that legal euthanasia and/or assisted suicide will assure their "choice," are naive. ("Aid in Dying: Not Legal in Idaho; Not About Choice"). The quote is accurate. I am also very concerned to see that Compassion & Choices, formerly known as the Hemlock Society, is beginning operations in Idaho to promote "aid in dying," which is a euphemism for euthanasia and assisted-suicide.

In the Netherlands, Dutch law calls for performing euthanasia and assisted suicide with the patient's consent. This is not, however, always done. Indeed, over time, assisted-suicide on a strictly voluntary basis evolved into allowing euthanasia on an involuntary basis. Euthanasia is also performed on infants and children, who are not capable of giving consent.

2005 is the most recent year for which we have an official report from the Dutch government. The report is "spun" to defend its law, but nonetheless concedes that 550 patients (an average of 1.5 per day) were actively killed by Dutch doctors "without an explicit request." The report also concedes that an additional 20% of deaths were not reported to the authorities as required by Dutch law.

Compassion & Choices holds out the carrot of "choice" to induce the public into believing that euthanasia and assisted suicide are somehow benign. Do not be misled.

William Reichel, M.D.
Georgetown University
Washington DC

Article deserves clarification

Dear Editor:

I would like to respond to the criticism received on the article recently published in the August 2010 edition of The Advocate entitled "Aid in Dying: Law, Geography and Standard of Care in Idaho." The article was not intended to serve as legal advice or to suggest that, under the current state of the law in Idaho, physicians need not fear criminal prosecution or civil liability in this context. Rather, the message intended was that terminally-ill Idahoans should be able to request aid in dying from their physician, as is allowed in Oregon, Washington, and Montana and that arguably this option is no different than what is permitted under current Idaho legislation, which empowers Idaho citizens to refuse or direct withdrawal of life-prolonging medical treatment. The intent was simply to advocate for a clarification of the law in this manner.

I would like to further clarify that, although I provided research and editing support for the article, any views expressed in the article are those of the author and are not necessarily those of my law firm.

Christine M. Salmi,
Perkins Coie, LLP
Boise, ID

Doctors should embrace aid in dying

Dear Editor:

In medical school, I occasionally met physicians who told me that they enjoyed working with their dying patients. While I accepted this as true for them, I knew it would take time and experience for me to understand.

Today, after a decade of private practice in family medicine, the grace and strength of the dying and of their families inspire me every time. I am honored to help them through this most intimate and sacred transition.

Palliative care involves relieving pain, anxiety and fear, and enabling conscious and loving communication within families. If unable to find refuge from unbearable suffering, patients with terminal illness deserve my greatest expression of empathy: empowering them to choose a comfortable and timely death.

I read Kathryn Tucker's article and heard about her presentation on end-of-life issues at the Idaho Medical Association conference in Boise in July, 2010. Ms. Tucker is a resident of Ketchum, Idaho, and Director of Legal Affairs for Compassion & Choices, a nonprofit organization dedicated to protecting and expanding the rights of terminally ill patients. Her presentation to the IMA focused on the fact that Idaho law does not address the intervention known as aid in dying. Physician aid in dying (PAD) refers to providing a mentally competent, terminally ill patient with a prescription for medication which the patient can self-administer to bring about a peaceful death if the patient finds their dying process unbearable.

Because Idaho has no statute or court decision pertaining to the practice, it is subject to regulation as a matter of standard of care. Idaho law positions individuals as the final arbiters in decisions about their medical care. Unlike surrounding states, we have no explicit public policy on aid in dying. It is time for Idaho's medical community to unequivocally embrace aid in dying within our standard of care so that we can make PAD available to our mentally competent, terminally ill patients who choose it.

Tom Archie, MD
Hailey, ID

Elder abuse a growing problem

Dear Editor:

I am the executive director of the Euthanasia Prevention Coalition, and chair of the Euthanasia Prevention Coalition, International. Thank you for running Margaret Dore's article, "Aid in Dying: Not Legal in Idaho; Not About Choice." She correctly describes some of the many problems with physician-assisted suicide. I write to comment on elder abuse.

A 2009 report by MetLife Mature Market Institute describes elder financial abuse as a crime "growing in intensity." (See p.16.) The perpetrators are often family members, some of whom feel themselves "entitled" to the elder's assets. (pp. 13-14.) The report states that they start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or coercing elders to sign over the deeds to their homes, change their wills, or liquidate their assets. (p. 14.) The report also states that victims "may even be murdered" by perpetrators. (p. 24.)

With assisted suicide laws in Washington and Oregon, perpetrators can instead take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over the administration. As Ms. Dore describes, even if a patient struggled, "who would know?"

In Canada, a bill that would have legalized euthanasia and assisted-suicide was recently defeated in our Parliament, 228 to 59. When I spoke with lawmakers who voted against the bill, many voiced the opinion that our government's efforts should be focused on helping our citizens live with dignity, rather than developing strategies to get them out of the way.

Alex Schadenberg
Euthanasia Prevention Coalition
London ON, Canada

ingest definition

in·gest (in jest′)

transitive verb

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

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

Related Forms:

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

in·gest (ĭn-jĕst')

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

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

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

Related Forms:

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

OregonLive.com
Everything Oregon

Recent murder-suicides follow the national pattern

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By **Don Colburn, The Oregonian**

In a span of one week this month in the Portland area, three murder-suicides resulted in the deaths of six adults and two children.

While the three cases appear to have nothing to do with one another, they do match the national pattern for such lethal outbursts. In each case, the killer or suspect was a man -- either a husband, former husband or boyfriend -- and used a gun.

Experts caution against calling three separate incidents a "cluster" or trend.

"These are very difficult cases to understand, and each one is unique," said Mark S. Kaplan, professor of community health at Portland State University and an expert on suicide. "One needs to be very careful about generalizing."

But patterns do show up in large studies, he said. Murder-suicide is carried out predominantly by white males and almost always with a firearm.

"Distressingly simple"

"The pattern to murder-suicide is distressingly simple: a male offender, a female victim and a gun -- but literally anyone can be caught in its wake," concludes a 2002 report called "American Roulette: The Untold Story of Murder-Suicide in the United States," by the Violence Policy Center, an advocacy group in Washington, D.C.

"Unlike homicides, murder-suicides are far more likely to involve family or intimate acquaintances, and have different demographics than the typical homicide or suicide," the report states.

Nationwide, between 1,000 and 1,500 people a year die in murder-suicides, the Violence Policy Center estimates.

There were eight murder-suicides in Oregon in 2007, resulting in 16 deaths, said Lisa Millet, manager of the state Public Health Division's injury and violence prevention program.

Over the past five years, Oregon recorded 42 murder-suicides, totaling 88 deaths. Most of the murder victims were women; nearly all killers were men. A firearm was involved in 86 percent of the cases.

A study by the Centers for Disease Control and Prevention found that 88 percent of murder-suicides involve firearms and more than half the murders involved the killing of a former intimate partner.

Four common threads

The National Institute of Justice studied 591 murder-suicides and found four common threads: a prior history of domestic violence; access to a gun; repeated and increasingly specific threats; and a prior history of mental health problems and drug or alcohol abuse.

Of those murder-suicides, 92 percent involved use of a firearm.

The role of the economy is less clear.

"The very low number of murder-suicide incidents makes it hard for researchers to understand exactly what role the economy plays in these cases," the National Institute of Justice concluded. "What is known is that economic distress is a factor, but it is only one of several factors that trigger a man to murder his family. In most cases, the couple have a history of disagreement over many issues, most commonly money, sex and child-rearing."

Depression plays role

And depression can be a precipitating factor, as it is in most suicides.

"One of the untold stories about depression," Millet said, "is that it doesn't look the same in men as in women."

Depressed men are less likely than depressed women to get help for their emotional health, and they are more likely to try to control external factors. In extreme cases and under the effect of other stressors, that can lead to violent outbursts, she said.

She urged any woman threatened with domestic violence to seek help right away. The most dangerous time, when relationships are most likely to turn violent, is immediately after a breakup.

The Portland Women's Crisis Line is a private nonprofit that helps women who are in a violent or potentially violent relationship, referring them to a shelter if necessary. The Crisis Line takes calls 24 hours a day, seven days a week. Most of the roughly 26,000 calls to the Crisis Line last year were prompted by fear, threats or attacks of domestic violence.

To reach the Crisis Line: call 503-235-5333. Or check **online**.

By the numbers

Murder-suicides in Oregon, 2003 through 2007

42 murder-suicides (average: eight per year)

88 deaths

78 killed by a firearm

46 homicides (31 females, 15 males; 41 adults, five children)

42 homicide suspects (38 men, four women)

Source: Oregon Violent Death Reporting System, Public Health Division

Risk factors

The top five risk factors that tend to make domestic violence escalate into homicide. Experts say they are especially insidious because they don't leave any visible mark that could be noticed by another.

1. Has the abuser ever used, or threatened to use, a gun, knife or other weapon against the victim? (If yes, the victim is 20 times more likely to be killed than others who experience domestic violence.)
2. Has the abuser ever threatened to kill or injure the victim? (15 times more likely)
3. Has the abuser ever tried to strangle or choke the victim? (10 times more likely)
4. Is the abuser violently or constantly jealous? (Nine times more likely)
5. Has the abuser ever forced the victim to have sex? (Eight times more likely)

Source: U.S. Department of Justice

Don Colburn

NEWS RELEASE

Date: Sept. 9, 2010

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

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

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

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

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

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

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

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

The report also included the following findings:

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

Suicides in Oregon
Trends and Risk Factors

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

DHS | Independent. Healthy. Safe.

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

Executive Summary

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

Key Findings

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

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

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

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

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

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

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

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

Introduction

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

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

Methods, data sources and limitations

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

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

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

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

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

mercy killing

Also found in: Dictionary/thesaurus, Legal, Acronyms, Encyclopedia, Wikipedia, Hutchinson

mer·cy killing (mûr'sē)
n.
Euthanasia.

mercy killing.
See **euthanasia**, def 1.

mercy killing
the euthanasia of animals for humane reasons is regarded by the veterinary profession as one of its responsibilities to the animal population. When the animal is in a great deal of pain and there is no chance of a favorable outcome, it is thought that the veterinarian is required to carry out euthanasia. In most Western countries this is enshrined in legislation relating to the protection of animals against cruelty. In awkward situations, e.g. when the owner resists or is not available to give consent to euthanasia, it is prudent to get another veterinary opinion if that is possible.

mercy killing
Medical ethics The termination of a person's life as a humane act. See Euthanasia.