

MEMORANDUM

TO: Public Health Committee
FROM: Margaret Dore, Esq., MBA
RE: Vote No on H.B. No. 5326 (No Assisted Suicide)
HEARING: March 17, 2014 at 10:30 a.m.
DATE: March 15, 2014

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I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.¹ Our law is based on a similar law in Oregon. Both laws are similar to H.B. No. 5326.²

This memo discusses why the claim that H.B. No. 5326 will assure patient choice is untrue. The bill is instead a recipe for elder abuse, or more bluntly, an efficient wealth transfer mechanism. Key provisions include that a patient's heir, who will benefit from his death, is allowed to help him sign up for the lethal dose. I urge you to reject this measure.

II. FACTUAL AND LEGAL BACKGROUND

A. Compassion & Choices

Passage of H.B. No. 5326 is spearheaded by the former Hemlock Society, now known as Compassion & Choices.³ By their own admission, they have "professional organizers, dedicated

¹ I am an elder law 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 and the Washington State Court of Appeals. I also worked for a year for the United States Department of Justice. I am a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. I am President of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. I have written multiple scholarly articles against assisted suicide legalization. For more information, see www.margaretdore.com and www.choiceillusion.org

² A copy of H.B. No. 5326 is attached hereto at A-1 to A-11.

³ See Ian Dowbiggin, A Concise History of Euthanasia 146 (2007) ("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices").

media strategists and experienced lobbyists."⁴ They are running a media blitz to convince this Committee to pass their bill. In Montana, where a similar bill failed in 2013, a Montana State Senator made this observation:

I found myself wondering, "Where does all the lobby money come from?" If it really is about a few terminally ill people who might seek help ending their suffering, why was more money spent on promoting assisted suicide than any other issue in Montana?⁵

She also states:

When considering the financial aspects of assisted suicide, it is clear that millions, maybe billions of dollars, are intertwined with the issue being marketed as "Compassion and Choices." Beware.⁶

B. Physician-assisted Suicide

The American Medical Association (AMA) defines physician-assisted suicide as occurring "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."⁷ An example would be a doctor's prescription for a lethal

⁴ Compassion & Choices website, "It's Crunch Time in Connecticut," March 11, 2014

⁵ Senator Jennifer Fielder, "Communication from Your State Senator: Beware of Vultures," Sanders County Ledger, <http://www.scledger.net>, page 2, 6-4-13. See also online version at <http://www.choiceillusion.org/2013/12/beware-of-vultures-senator-jennifer.html> (Attached at A-13)

⁶ Id.

⁷ AMA Code of Medical Ethics, Opinion 2.211, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page>

drug to facilitate a patient's suicide.⁸ The AMA rejects this practice, stating:

Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.⁹

C. Most States Have Rejected Assisted Suicide

There have been more than 100 attempts to legalize physician-assisted suicide and/or euthanasia in the United States.¹⁰ Most have failed. Just last week, the New Hampshire House of Representatives defeated a bill similar to H.B. No. 5326. The vote to defeat the bill was by a 3 to 1 margin, 219 to 66.¹¹ Moreover, in the last three years, three states have strengthened their laws against assisted suicide.¹² These states are: Idaho, Georgia and Louisiana.¹³

There are four states where assisted suicide is legal: Oregon, Washington, Vermont and New Mexico. Oregon's law was

⁸ Id.

⁹ Id.

¹⁰ See tabulation at http://epcdocuments.files.wordpress.com/2011/10/attempts_to_legalize_001.pdf

¹¹ "Live Free or Die. New Hampshire Obliterates Oregon-style Death with Dignity Act!," Choice is an Illusion, March 6, 2014, <http://www.choiceillusion.org/2014/03/live-free-or-die-new-hampshire.html>

¹² See Margaret Dore, "US Overview," updated May 20, 2013, at <http://www.choiceillusion.org/p/us-overview.html>

¹³ Id.

enacted by a ballot initiative in 1997.¹⁴ Washington's law was enacted via another initiative in 2008 and went into effect in 2009.¹⁵ Last year, Vermont's law was passed by its legislature; opponents are now calling for a repeal.¹⁶ In New Mexico, there is a district court opinion, which legalizes assisted suicide.¹⁷ That case is on appeal.¹⁸

III. THE BILL

A. How the Bill Works

H.B. No. 5326 has an application process to obtain the lethal dose, which includes a written lethal dose request form.¹⁹ Once the lethal dose is issued by the pharmacy, there is no oversight.²⁰ The death is not required to be witnessed by disinterested persons. Indeed, no one is required to be present.

B. Patients are Not Necessarily Dying

H.B. No. 5326 applies to patients with a "terminal illness," which is defined in terms of a doctor's prediction of

¹⁴ Oregon's physician-assisted suicide act was passed as Ballot Measure 16 in 1994 and went into effect after a referendum in 1997.

¹⁵ Washington's act was passed as Initiative 1000 on November 4, 2008 and went into effect on March 5, 2009. See <http://www.doh.wa.gov/dwda/default.htm>

¹⁶ See e.g., Morgan True, "Opponents Call for Repeal of Assisted Suicide," VT.Digger.org, February 27, 2014. (Excerpt attached at A-14).

¹⁷ See e.g., Associated Press, "N.M. official appeals 'right to die' ruling," KFDA News Channel 10, March 13, 2014. (Attached at A-15).

¹⁸ Id.

¹⁹ The lethal dose request form can be viewed at H.B. No. 5326, Section 4.

²⁰ See H.B. No. 5326 in its entirety. (Attached at A-1 through A-11).

less than six months to live.²¹

In Oregon, a similar definition of "terminal disease" is being interpreted to include chronic conditions such as diabetes.²² See, for example, Oregon's most recent assisted suicide report for 2013, issued on January 28, 2014.²³ The report lists "chronic lower respiratory disease" and "diabetes" as underlying terminal diseases justifying assisted suicide.²⁴ Oregon doctor William Toffler explains:

Our [assisted suicide] law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions such as "chronic lower respiratory disease" and "diabetes." Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live. They are unlikely [to] die in less than six months unless they don't receive their medications. Such persons, with treatment, could otherwise have years or even decades to live.²⁵

Consider also Oregon resident, Jeanette Hall, who was

²¹ Bill 5326, Section 1(19) states: "'Terminal illness' means the final stage of an incurable and irreversible medical condition that an attending physician anticipates, within reasonable medical judgment, will produce a patient's death within six months." (Attached at A-3).

²² Or. Rev. Stat. 127.800 s.1.01(12) states: "'Terminal disease' means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."

²³ A copy of the report is attached hereto at A-16 through A-22.

²⁴ "Chronic lower respiratory disease" and "diabetes" are listed on the report at pp. 6 & 7. (Attached hereto at A-21 & A-22).

²⁵ Letter to the Editor, from William Toffler MD to the New Haven Register, February 24, 2014 (Attached at A-23).

diagnosed with cancer in 2000 and adamant that she would "do" Oregon's law.²⁶ Her doctor, Ken Stevens, convinced her to be treated instead.²⁷ In a 2012 affidavit, she states:

This July, it was 12 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead.²⁸

IV. "CHOICE" IS AN ILLUSION

In Connecticut, Compassion & Choices' campaign is focused on six words: "My Life. My Death. My Choice." This comforting slogan is an illusion and propaganda when compared to what H.B. No. 5326 actually says and does. See below.

A. Specific Bill Provisions

1. No witnesses at the death

As set forth above, H.B. No. 5326 does not require witnesses at the patient's death.²⁹ Without disinterested witnesses, the opportunity is created for someone else to administer the lethal

²⁶ Affidavit of Kenneth Stevens, MD, ¶¶ 3-7. (Attached at A-24 & A-25); Affidavit of Jeanette Hall Opposing Assisted Suicide, August 17, 2012 (Attached at A-31).

²⁷ Id.

²⁸ Affidavit of Jeanette Hall, ¶ 4. (Attached at A-32) See also: Affidavit of John Norton, attached at A-33 to A-35 ("If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come"); and 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? The Seattle Weekly, January 14, 2009. (Attached at A-36 to A-41)

²⁹ See H.B. No. 5326 in its entirety, attached hereto at A-1 to A-11.

dose to the patient without his consent.³⁰ Even if he struggled, who would know? This situation is especially significant for patients with money. A California case, *People v. Stuart*, 67 Cal.Rptr.3d 129, 143 (2007), states:

Financial considerations [are] an all too common motivation for killing someone.³¹

Regardless, without disinterested witnesses, the patient's choice is not guaranteed.

2. Adding witnesses will not fix the problem

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

3. Witnesses can be coercive

Witnesses can also be coercive. Consider Oregon resident Lovelle Svart, age 62, who threw herself an "exit party," during which she danced the polka with George Eighmey of Compassion & Choices.³² The party was reported in a newspaper article, with a

³⁰ The drugs used for assisted suicide in Oregon and Washington, Secobarbital and Pentobarbital (Nembutal), are water soluble, such that they can be injected without consent, for example, to a sleeping person. See "Secobarbital Sodium Capsules, Drugs.Com, at <http://www.drugs.com/pro/seconal-sodium.html> and <http://www.drugs.com/pro/nembutal.html> See also Oregon's report, page 6, attached at A-21 (listing these drugs).

³¹ Excerpt attached at A-42.

³² Don Colburn, "Last day of life all planned out, down to the polka," October 26, 2007, available at http://seattletimes.com/html/localnews/2003918100_suicide02.html

spin that she was in control.³³ But, at the end of the party, when it was time for her to die, the article contains this exchange between her and Eighmey, which took place in front of ten people:

"Is this what you want?"

"Actually, I'd like to go on partying," Lovelle replied, laughing before turning serious. "But, yes."

"If you do take it, you will die."

"Yes."³⁴

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

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

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

³³ Id.

³⁴ Id.

4. The patient's heir is allowed to be a witness on the lethal dose request form

H.B. No. 5326 allows one of two witnesses on the lethal dose request form to be the patient's heir who will financially benefit from the patient's death.³⁵ In the context of making a will, such active participation by an heir is a marker of undue influence. Consider, for example, Washington's probate statute. It states that when one of two witnesses receives a gift under a will, there is a rebuttable presumption that the receiver/witness:

procured the gift by duress, menace, fraud,
or undue influence.

Rev. Code Wash. 11.12.160, attached at A-43.

5. Individual "opt outs" are not allowed

H.B. No. 5326 does not allow patients to opt out of its provisions. H.B. No. 5326 says that a provision in a contract or will that affects whether a patient may make or rescind a lethal dose request "is not valid."³⁶

³⁵ H.B. No. 5326, Section 3 requires two witnesses on the lethal dose request form. Per Section 3(b)(2), at least one of these witnesses shall be a person who is not an heir, i.e., "entitled to any portion of the estate of the patient upon the patient's death under any will or by operation of law." The other witness is allowed to be an heir. (Attached hereto at A-3).

³⁶ H.B. No. 5326, Section 13(a) states:

Any provision in a contract, will, insurance policy, annuity or other agreement, whether written or oral, that is entered into on or after October 1, 2014, that would affect whether a person may make or rescind a request for aid in dying is not valid.

Attached at A-7 & A-8.

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. Any such arrangement "is not valid."

So much for your personal "control."

6. Someone else is allowed to speak for the patient, as long as that person is not the patient's designated agent such as an attorney-in-fact

Under H.B. No. 5326, a patient is required to be "competent."³⁷ This term is, however, specially defined to allow someone else to speak for the patient during the lethal dose request process, as long as the speaking person is "familiar with the patient's manner of communicating." H.B. No. 5326, Section 1(4) states:

"Competent" means . . . that the patient has the capacity . . . to make an informed decision and to communicate such decision to a health care provider, *including communicating through a person familiar with the patient's manner of communicating.* (Emphasis added)³⁸

³⁷ H.B. No. 5326, Section 1(17) defines a "qualified patient" as a "competent" adult. (Attached at A-3).

³⁸ H.B. Section 5326, 1(4), attached at A-1, states:

"Competent" means, in the opinion of the patient's attending physician, consulting physician, psychiatrist, psychologist or a court, that the patient has the capacity to understand and acknowledge the nature and consequences of health care decisions, including the benefits and disadvantages of treatment, to make an informed decision and to communicate such decision to a health care provider, *including communicating through a person familiar with the patient's manner of communicating.* (Emphasis added).

Being "familiar with the patient's manner of communicating" is a very minimal standard. Consider, for example, a doctor's assistant who is familiar with a patient's "manner of communicating" in Spanish, but does not herself understand Spanish. That, however, would be good enough. Indeed, the doctor's janitor could speak for the patient as long as he was "familiar with the patient's manner of communicating."

The speaking person, cannot, however, be the patient's officially designated agent such as an attorney-in-fact under a durable power of attorney. H.B. No. 5326, Section 2(c) states:

No person, including, but not limited to, an agent under a living will, an attorney-in-fact under a durable power of attorney, a guardian, or a conservator, may act on behalf of a patient for purposes of sections 1 to 18, inclusive, of this act.

Attached at A-3.

To the extent that this section would seem to prevent any person from acting on the patient's behalf, there is the rule of "ejusdem generis," which requires a different result. The rule, in Latin, means "of the same kind" and is used to interpret statutes, as follows:

Where a law lists specific classes of persons or things and then refers to them in general, the general statements only apply to the same kind of persons or things specifically listed. Example: if a law refers to automobiles, trucks, tractors, motorcycles and other motor-powered vehicles, "vehicles" would not include airplanes, since the list

was of land-based transportation.³⁹

Applying the rule to Section 2(c), the general statement ("No person") only applies to the same kind of persons listed, *i.e.*, the patient's officially designated agents such as an attorney in fact under a durable power of attorney. Any other person could speak for the patient as long as he or she was "familiar with the patient's manner of communicating."

The practical upshot is that if a patient is pushed into signing up for the lethal dose, her officially designated agent would have no power to protect her, for example, by acting on her behalf to rescind the request for the lethal dose.⁴⁰

B. Word Play

Proponents may claim that patients are nonetheless in control due to a requirement of "self-administration" and a prohibition against euthanasia and assisted suicide. These arguments are word play.

1. "Self-Administer" allows someone else to administer the lethal dose

H.B. No. 5326's "Statement of Purpose" says that a patient "may" self-administer medication to bring about his or her death.⁴¹ There is, however, no provision that administration of

³⁹ <http://legal-dictionary.thefreedictionary.com/Ejusdem+generis>

⁴⁰ See H.B. No. 5326 Section 5, which allow a patient to "rescind" his or her request for the lethal dose. (Attached at A-5).

⁴¹ The Bill's Statement of Purpose is attached hereto at A-11.

the lethal dose "must" be by self-administration.⁴² The bill also defines "self-administer" as the patient's "act of ingesting medication."⁴³ The bill does not define "ingesting." Dictionary definitions include:

[T]o take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing."⁴⁴

With this definition, someone else putting the lethal dose in the patient's mouth qualifies as self-administration because the patient will thereby be "swallowing" the lethal dose, *i.e.*, "ingesting" it. Someone else placing a medication patch on the patient's arm or providing a lethal injection will also qualify because the patient will thereby be "absorbing" the dose, *i.e.*, "ingesting" it. Someone else turning on gas administration, similarly, qualifies because the patient will thereby be "inhaling" the dose, *i.e.*, "ingesting" it. With self-administer defined as mere ingesting, someone else is allowed to administer the lethal dose to the patient.

2. Euthanasia and physician-assisted suicide are generally accepted medical terms

Allowing someone else to administer the lethal dose to the patient is "euthanasia" under generally accepted medical terminology. For example, the AMA Code of Medical Ethics,

⁴² See H.B. No. 5326 in its entirety, attached hereto at A-1 to A-11.

⁴³ Bill 5326 Section 1(18) says: "'Self-administer' means a qualified patient's act of ingesting medication." (Attached at A-3).

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

Opinion 2.21, states:

Euthanasia is the administration of a lethal agent by another person to a patient . . . ⁴⁵

If instead, the patient administers the lethal dose to himself, this is "physician-assisted suicide" under generally accepted medical terminology. The AMA Code of Medical Ethics, Opinion 2.211 states:

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).⁴⁶

3. Orwellian re-definition

In an Orwellian twist, H.B. No. 5326 effectively removes the medical terms, "euthanasia" and "physician-assisted suicide" out of the law, replacing them with the euphemism, "aid in dying." This is accomplished via Sections 1(2) and 16, which are set forth in the footnote below.

C. The Change in Terminology Facilitates a Lack of Understanding as to What is at Stake.

The significance of the above change in terminology, from generally accepted medical terms to a vague euphemism using the word "dying," is that it facilitates a lack of understanding as to what is really at stake: the legalization of assisted suicide

⁴⁵ Attached hereto at A-45.

⁴⁶ Attached hereto at A-46.

and euthanasia for people who may have years, even decades, to live. In addition, there is also no guarantee that these practices will be imposed according to individual choice.

D. A Lack of Transparency

1. The cause of death is falsified

H.B. No. 5326, Section 9(b), states that the death certificate, which the official record of the cause, date, and place of a person's death, "shall list the underlying terminal illness as the cause of death." (Attached at A-7).

This is as opposed to the true cause of death, *i.e.*, a lethal dose of medication. The official cause of death is thus falsified, which creates a lack of transparency regarding specific deaths and also a lack of transparency for the purpose of later review should anyone want to know how the law is working in practice.

2. No doctor reporting

Doctor reporting to a health department type entity, which supposedly renders the Oregon and Washington laws safe, is eliminated in H.B. No. 5326.⁴⁷ In Oregon and Washington, this reporting provides the factual basis for annual reports such as the 2013 Oregon report already cited herein.

⁴⁷ Oregon's and Washington's laws require doctor reporting to a Department of Health type entity. See ORS 127.865 § 3.11 & RCW 70.245.150. H.B. No. 5326 does not.

3. Private record keeping

H.B. No. 5326 provides that a doctor's compliance with its provisions be tracked in the patient's medical record, which is a private document protected by HIPPA.⁴⁸ H.B. No. 5326 also restricts judicial access to these records, as follow:

Records or information collected or maintained pursuant to sections 1 to 18, inclusive, of this act shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding except to resolve matters concerning compliance with the provisions of sections 1 to 18, inclusive, of this act, or as otherwise specifically provided by law.

This is not an effective method of oversight. Moreover and once again, there is a lack of transparency. Without transparency, there is a lack of accountability.

E. The Proposed Penalties are Illusory

H.B. No. 5326 purports to impose criminal liability for undue influence.⁴⁹ This purported liability is, however, illusory. This is because the circumstances relevant to proving undue influence are specifically allowed by H.B. No. 5326 (taking

⁴⁸ See H.B. No. 5326 Section 10.

⁴⁹ H.B. No. 5326, Section 15(b) states:

Any person who coerces or exerts undue influence on a patient to complete a request for aid in dying, as described in sections 3 and 4 of this act, or coerces or exerts undue influence on a patient to destroy a rescission of such request with the intent or effect of causing the patient's death, is guilty of attempted murder or murder under section 53a-54a of the general statutes.

an active role in procuring the lethal dose, being a witness on the lethal dose request form, talking for the patient, etc.).⁵⁰

V. THE OREGON AND WASHINGTON EXPERIENCE

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

During Montana's 2011 legislative session, the lack of oversight in Oregon's law prompted Senator Jeff Essmann to make this observation: the Oregon studies are invalid. He stated:

[All] the protections end after the prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is self administered.

So frankly, any of the studies that come out of the state of Oregon's experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.⁵¹

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

If H.B. No. 5326 is passed, health care providers and insurers in Connecticut will be able to steer patients to suicide. Consider the case of Oregon resident, Barbara Wagner. In 2008, the Oregon Health Plan (Medicaid) refused to cover a drug to possibly cure her cancer and offered to cover her assisted suicide instead.

⁵⁰ Cf. *Pickman v. Pickman*, 6 Conn.App. at 276 (relevant factors for undue influence include "active solicitations and persuasions by the other party")

⁵¹ http://www.margaretdore.com/pdf/senator_essmann_sb_167_001.pdf

"It was horrible," Wagner told ABCNews.com. "I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won't give you the medication to live."⁵²

Wagner, who was unable to afford the drug, was steered to suicide. The drug's manufacturer then agreed to provide the drug for free.⁵³ She nonetheless died a short time later.

To learn more about steerage to suicide in Oregon, see Dr. Ken Stevens' affidavit attached hereto at A-24 to A-30.

Do you want this to happen to you or your family?

C. Compassion & Choices' True Agenda is the Promotion of Managed Care with Less Choice for Individual Patients

On November 29, 2008, Compassion & Choices President, Barbara Coombs Lee, published an op-ed in *The Oregonian*, which is Oregon's largest paper.⁵⁴ Therein, she took issue with Wagner's choice to live.⁵⁵ Coombs Lee argued that Wagner should have instead given up hope and accepted her pending death. But, this was not Wagner's choice. In a KATU TV interview, Wagner said:

I'm not ready, I'm not ready to die. . . .
I've got things I'd still like to do.⁵⁶

⁵² Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (Excerpt attached at A-47)

⁵³ "Letter noting assisted suicide raises questions," KATU TV, July 30, 2008. (Attached at A-48 & 49)

⁵⁴ Barbara Coombs Lee, "Sensationalizing a sad case cheats the public of sound debate," *The Oregonian*, November 29, 2008 (Attached hereto at A-50)

⁵⁵ Id.

⁵⁶ KATU story at note 52, supra. (Attached at A-48).

Coombs Lee also defended the Oregon Health Plan and argued for a public policy change to discourage patients from seeking cures.⁵⁷ She thus showed her organization's true agenda: managed care, not individual patient choice.

Compassion & Choices President, Barbara Coombs Lee, is a former "managed care executive."⁵⁸

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

According to Oregon's assisted suicide report for 2013, most of the people who died from a lethal dose were white, aged 65 or older, and well-educated.⁵⁹ People with these attributes are typically well off, *i.e.*, the middle class and above.

The report's introduction implies that their deaths were voluntary, stating that Oregon's act "allows" residents to obtain a lethal dose for self-administration.⁶⁰ There is, however, nothing in the report actually stating that.⁶¹ Older well-off people are, regardless, in a vulnerable demographic for abuse and

⁵⁷ Coombs Lee stated:

The burning public policy question is whether we inadvertently encourage patients to act against their own self-interest, chase an unattainable dream of cure, and foreclose the path of acceptance that curative care has been exhausted Such encouragement serves neither patients, families, nor the public. (Attached at A-51)

⁵⁸ Barbara Coombs Lee Bio, attached hereto at A-53.

⁵⁹ Report, page 2, attached hereto at A-17, last full paragraph.

⁶⁰ *Id.*, page 1, attached hereto at A-16.

⁶¹ Report, pages 1-7, starting at A-16.

exploitation. This includes murder. A 2009 MetLife Mature Market Institute Study states:

Elders' vulnerabilities and larger net worth make them a prime target for financial abuse . . . Victims may even be murdered by perpetrators who just want their funds and see them as an easy mark.⁶²

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

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

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

Oregon's assisted suicide act went into effect on October 27, 1997.

⁶² The MetLife Study can be viewed at this link: <https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf> See other MetLife elder abuse materials attached hereto at A-54 to A-59.

By 2000, Oregon's regular suicide rate was "increasing significantly."⁶³

In 2010, Oregon's regular suicide rate was 35% above the national average.⁶⁴

In 2012, Oregon's regular suicide rate was 41% above the national average.⁶⁵

Per the most recent regular suicide report, the financial cost of these other (regular) suicides is huge. The report, page 3, elaborates:

Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars. (Footnotes omitted).

Attached at A-63.

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

⁶³ See Oregon Health Authority News Release, September 9, 2010, at <http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf> ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached at A-60)

⁶⁴ Id.

⁶⁵ Oregon Public Health Division, "Suicides in Oregon: Trends and Risk Factors - 2012 Report," attached at A-61 to A-64; <http://choiceisanillusion.files.wordpress.com/2014/02/oregon-suicide-report-2012-through-2010-pdf.pdf>

vote on H.B. No. 5326, which seeks to legalize physician-assisted suicide in Connecticut.

F. Legalization of Assisted Suicide will Bring Stress, Trauma and Fear

In 2012, a study was released in Switzerland, addressing trauma suffered by persons who witnessed an assisted suicide.⁶⁶ The study found that 1 out of 5 family members or friends present at an assisted suicide were traumatized. These persons "experienced full or sub-threshold PTSD [Post Traumatic Stress Disorder] related to the loss of a close person through assisted suicide."

G. My Cases Involving the Oregon and Washington Assisted Suicide Laws

I have had two clients whose parents signed up for the lethal dose. In the first case, one side of the family wanted the father to take the lethal dose, while the other did not. He spent the last months of his life caught in the middle and traumatized over whether or not he should kill himself. My client, his adult daughter, was also traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it's not clear that administration of the lethal dose was voluntary. A man who was present told my client

⁶⁶ "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," B. Wagner, J. Muller, A. Maercker; *European Psychiatry* 27 (2012) 542-546, available at <http://choiceisanillusion.files.wordpress.com/2012/10/family-members-traumatized-eur-psych-2012.pdf> (First page attached at A-65).

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

H. Legal Assisted Suicide is not About Pain

The Oregon assisted suicide report for 2013 lists "concerns" as to why the people who ingested the lethal dose did so.⁶⁷ One listed concern is "inadequate pain control or concern about it."⁶⁸ There is, however, no claim that anyone who ingested the lethal dose was actually in pain.⁶⁹

Per the report for 2013, there were 20 patients who listed a concern about "inadequate pain control or concern about it" as a reason to do Oregon's act.⁷⁰ This is 20 people out of 32,475 total deaths in Oregon.⁷¹ Again, there is no report that any one of these persons was actually in pain. Pain is not the issue.

VII. CONCLUSION

H.B. No. 5326's promise of patient choice is an illusion. The bill is instead a recipe for elder abuse, especially for

⁶⁷ Oregon Report, page 6, attached hereto at A-21.

⁶⁸ Id.

⁶⁹ See entire report, attached hereto at A-16 to A-22.

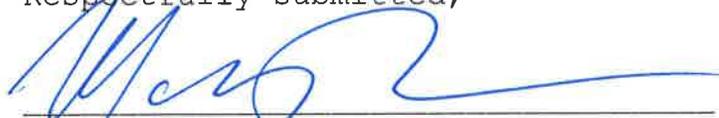
⁷⁰ Report at A-21.

⁷¹ Report at A-17, footnote 1 (total Oregon deaths in 2012 was 32,475)

people 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. I urge you to reject H.B. No. 5326.

Respectfully submitted,



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General Assembly

Raised Bill No. 5326

February Session, 2014

LCO No. 1569

*01569 _____ PH *

Referred to Committee on PUBLIC HEALTH

Introduced by:

(PH)

AN ACT CONCERNING COMPASSIONATE AID IN DYING FOR TERMINALLY ILL PATIENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (Effective October 1, 2014) As used in this section and sections 2 to 18, inclusive, of this act:

- (1) "Adult" means a person who is eighteen years of age or older;
- (2) "Aid in dying" means the medical practice of a physician prescribing medication to a qualified patient who is terminally ill, which medication a qualified patient may self-administer to bring about his or her death;
- (3) "Attending physician" means the physician who has primary responsibility for the medical care of the patient and treatment of the patient's terminal illness;
- (4) "Competent" means, in the opinion of the patient's attending physician, consulting physician, psychiatrist, psychologist or a court, that the patient has the capacity to understand and acknowledge the nature and consequences of health care decisions, including the benefits

and disadvantages of treatment, to make an informed decision and to communicate such decision to a health care provider, including communicating through a person familiar with the patient's manner of communicating;

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

(6) "Counseling" means one or more consultations as necessary between a psychiatrist or a psychologist and a patient for the purpose of determining that the patient is competent and not suffering from depression or any other psychiatric or psychological disorder that causes impaired judgment;

(7) "Health care 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, including, but not limited to, a physician, psychiatrist, psychologist or pharmacist;

(8) "Health care facility" means a hospital, residential care home, nursing home or rest home, as such terms are defined in section 19a-490 of the general statutes;

(9) "Informed decision" means a decision by a qualified patient to request and obtain a prescription for medication that the qualified patient may self-administer for aid in dying, that is based on an understanding and acknowledgment of the relevant facts and after being fully informed by the attending physician of: (A) The patient's medical diagnosis and prognosis; (B) the potential risks associated with self-administering the medication to be prescribed; (C) the probable result of taking the medication to be prescribed; and (D) the feasible alternatives and health care treatment options, including, but not limited to, palliative care;

(10) "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;

(11) "Palliative care" means health care centered on a terminally ill patient and such patient's family that (A) optimizes the patient's quality of life by anticipating, preventing and treating the patient's suffering throughout the continuum of the patient's terminal illness, (B) addresses the physical, emotional, social and spiritual needs of the patient, (C) facilitates patient autonomy, the patient's access to information and patient choice, and (D) includes, but is not limited to, discussions between the patient and a health care provider concerning the patient's goals for treatment and appropriate treatment options available to the patient, including hospice care and comprehensive pain and symptom management;

(12) "Patient" means a person who is under the care of a physician;

(13) "Pharmacist" means a person licensed pursuant to chapter 400j of the general statutes;

(14) "Physician" means a person licensed to practice medicine and surgery pursuant to chapter 370 of the general statutes;

(15) "Psychiatrist" means a psychiatrist licensed pursuant to chapter 370 of the general statutes;

(16) "Psychologist" means a psychologist licensed pursuant to chapter 383 of the general statutes;

(17) "Qualified patient" means a competent adult who is a resident of this state, has a terminal illness and has satisfied the requirements of this section and sections 2 to 9, inclusive, of this act, in order to obtain aid in dying;

(18) "Self-administer" means a qualified patient's act of ingesting medication; and

(19) "Terminal illness" means the final stage of an incurable and irreversible medical condition that an attending physician anticipates, within reasonable medical judgment, will produce a patient's death within six months.

Sec. 2. (NEW) (*Effective October 1, 2014*) (a) A person who (1) is an adult, (2) is competent, (3) is a resident of this state, (4) has been determined by such person's attending physician to have a terminal illness, and (5) has voluntarily expressed his or her wish to receive aid in dying, may request aid in dying by making two written requests pursuant to sections 3 and 4 of this act.

(b) A person is not a qualified patient under sections 1 to 18, inclusive, of this act, solely because of age, disability or any specific illness.

(c) No person, including, but not limited to, an agent under a living will, an attorney-in-fact under a durable power of attorney, a guardian, or a conservator, may act on behalf of a patient for purposes of sections 1 to 18, inclusive, of this act.

Sec. 3. (NEW) (*Effective October 1, 2014*) (a) A patient wishing to receive aid in dying shall submit two written requests to such patient's attending physician in substantially the form set forth in section 4 of this act. A valid written request for aid in dying under sections 1 to 18, inclusive, of this act, shall be signed and dated by the patient. Each request shall be witnessed by at least two persons who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is (1) of sound mind, and (2) acting voluntarily and not being coerced to sign the request. The patient's second written request for aid in dying shall be submitted not earlier than fifteen days after the patient submits the first request.

(b) At least one of the witnesses described in subsection (a) of this section shall be a person who is not: (1) A relative of the patient by blood, marriage or adoption; (2) at the time the request is signed, entitled to any portion of the estate of the patient upon the patient's death, under any will or by operation of law; or (3) an owner, operator or employee of a health care facility where the patient is receiving medical treatment or is a resident.

(c) The patient's attending physician at the time the request is signed shall not be a witness.

(d) If the patient is a resident of a residential care home, nursing home or rest home, as such terms are defined in section 19a-490 of the general statutes, at the time the written request is made, one of the witnesses shall be a person designated by such home.

Sec. 4. (NEW) (*Effective October 1, 2014*) A request for aid in dying as authorized by sections 1 to 18, inclusive, of this act, shall be in substantially the following form:

REQUEST FOR MEDICATION TO AID IN DYING

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

I am a resident of the State of Connecticut.

I am suffering from . . . , which my attending physician has determined is an incurable and irreversible medical condition that will, within reasonable medical judgment, result in death within six months. This diagnosis of a terminal illness has been confirmed by another physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed to aid me in dying, the potential associated risks, the expected result, feasible alternatives and additional health care treatment options, including palliative care.

I request that my attending physician prescribe medication that I may self-administer for aid in dying. I authorize my attending physician to contact a pharmacist to fill the prescription for such medication, upon 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 if and when I take the medication to be prescribed. I further understand that although most deaths occur within three 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 responsibility for my decision to request aid in dying.

Signed: . . .

Dated: . . .

DECLARATION OF WITNESSES

By initialing and signing below on the date the person named above signs, I declare that the person making and signing the above request:

Witness 1 Witness 2

Initials Initials

.... 1. Is personally known to me or has provided proof of identity;

.... 2. Signed this request in my presence on the date of the person's signature;

.... 3. Appears to be of sound mind and not under duress, fraud or undue influence; and

.... 4. Is not a patient for whom I am the attending physician.

Printed Name of Witness 1

Signature of Witness 1 Date

Printed Name of Witness 2

Signature of Witness 2 Date

Sec. 5. (NEW) (*Effective October 1, 2014*) (a) A qualified patient may rescind his or her request for aid in dying at any time and in any manner without regard to his or her mental state.

(b) An attending physician shall offer a qualified patient an opportunity to rescind his or her request for aid in dying at the time such patient submits a second written request for aid in dying to the attending physician.

(c) No prescription for medication for aid in dying shall be written without the qualified patient's attending physician first offering the qualified patient a second opportunity to rescind his or her request for aid in dying.

Sec. 6. (NEW) (*Effective October 1, 2014*) When an attending physician is presented with a patient's first written request for aid in dying made pursuant to sections 2 to 4, inclusive, of this act, the attending physician shall:

(1) Make a determination that the patient (A) is an adult, (B) has a terminal illness, (C) is competent, and (D) has voluntarily requested aid in dying;

(2) Require the patient to demonstrate residency in this state by presenting: (A) A Connecticut driver's license; (B) a valid voter registration record authorizing the patient to vote in this state; (C) evidence that the patient owns or leases property in this state; or (D) any other government-issued document that the attending physician reasonably believes demonstrates that the patient is a current resident of this state;

(3) Ensure that the patient is making an informed decision by informing the patient of: (A) The patient's medical diagnosis; (B) the patient's prognosis; (C) the potential risks associated with self-administering the medication to be prescribed for aid in dying; (D) the probable result of self-administering the medication to be prescribed for aid in dying; and (E) the feasible alternatives and health care treatment options including, but not limited to, palliative care, ^{A-5}

(4) Refer the patient to a consulting physician for medical confirmation of the attending physician's diagnosis of the patient's terminal illness, the patient's prognosis and for a determination that the patient is competent and acting voluntarily in requesting aid in dying.

Sec. 7. (NEW) (*Effective October 1, 2014*) In order for a patient to be found to be a qualified patient for the purposes of sections 1 to 18, inclusive, of this act, a consulting physician shall: (1) Examine the patient and the patient's relevant medical records; (2) confirm, in writing, the attending physician's diagnosis that the patient has a terminal illness; (3) verify that the patient is competent, is acting voluntarily and has made an informed decision to request aid in dying; and (4) refer the patient for counseling, if required in accordance with section 8 of this act.

Sec. 8. (NEW) (*Effective October 1, 2014*) (a) If, in the medical opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological condition or depression that is causing impaired judgment, either the attending or consulting physician shall refer the patient for counseling to determine whether the patient is competent to request aid in dying.

(b) An attending physician shall not provide the patient aid in dying until the person providing such counseling determines that the patient is not suffering a psychiatric or psychological condition or depression that is causing impaired judgment.

Sec. 9. (NEW) (*Effective October 1, 2014*) (a) After an attending physician and a consulting physician determine that a patient is a qualified patient, in accordance with sections 6 to 8, inclusive, of this act and after such qualified patient submits a second request for aid in dying in accordance with section 3 of this act, the attending physician shall:

- (1) Recommend to the qualified patient that he or she notify next of kin of the qualified patient's request for aid in dying and inform the qualified patient that a failure to do so shall not be a basis for the denial of such request;
- (2) Counsel the qualified patient concerning the importance of: (A) Having another person present when the qualified patient self-administers the medication prescribed for aid in dying; and (B) not taking the medication in a public place;
- (3) Inform the qualified patient that the qualified patient may rescind his or her request for aid in dying at any time and in any manner;
- (4) Verify, immediately before writing the prescription for medication for aid in dying, that the qualified patient is making an informed decision;
- (5) Fulfill the medical record documentation requirements set forth in section 10 of this act; and
- (6) (A) Dispense such medications, including ancillary medications intended to facilitate the desired effect to minimize the qualified patient's discomfort, if the attending physician is authorized to dispense such medication, to the qualified patient; or (B) upon the qualified patient's request and with the qualified patient's written consent (i) contact a pharmacist and inform the pharmacist of the prescription, and (ii) deliver the written prescription personally.

by mail, by facsimile or by another electronic method that is permitted by the pharmacy to the pharmacist, who shall dispense such medications directly to the qualified patient, the attending physician or an expressly-identified agent of the qualified patient.

(b) The attending physician may sign the qualified patient's death certificate that shall list the underlying terminal illness as the cause of death.

Sec. 10. (NEW) (*Effective October 1, 2014*) With respect to a request by a qualified patient for aid in dying, the attending physician shall ensure that the following items are documented or filed in the qualified patient's medical record:

- (1) The basis for determining that the qualified patient requesting aid in dying is an adult and is a resident of the state;
- (2) All oral requests by a qualified patient for medication for aid in dying;
- (3) All written requests by a qualified patient for medication for aid in dying;
- (4) The attending physician's diagnosis of the qualified patient's terminal illness and prognosis, and a determination that the qualified patient is competent, is acting voluntarily and has made an informed decision to request aid in dying;
- (5) The consulting physician's confirmation of the qualified patient's diagnosis and prognosis, confirmation that the qualified patient is competent, is acting voluntarily and has made an informed decision to request aid in dying;
- (6) A report of the outcome and determinations made during counseling, if counseling was recommended and provided in accordance with section 8 of this act;
- (7) Documentation of the attending physician's offer to the qualified patient to rescind his or her request for aid in dying at the time the attending physician writes the qualified patient a prescription for medication for aid in dying; and
- (8) A statement by the attending physician indicating that all requirements under this section and sections 1 to 9, inclusive, of this act, have been met and indicating the steps taken to carry out the qualified patient's request for aid in dying, including the medication prescribed.

Sec. 11. (NEW) (*Effective October 1, 2014*) Records or information collected or maintained pursuant to sections 1 to 18, inclusive, of this act shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding except to resolve matters concerning compliance with the provisions of sections 1 to 18, inclusive, of this act, or as otherwise specifically provided by law.

Sec. 12. (NEW) (*Effective October 1, 2014*) Any person in possession of medication prescribed for aid in dying that has not been self-administered shall dispose of such medication in accordance with section 21a-252 of the general statutes.

Sec. 13. (NEW) (*Effective October 1, 2014*) (a) Any provision in a contract, will, insurance policy

annuity or other agreement, whether written or oral, that is entered into on or after October 1, 2014, that would affect whether a person may make or rescind a request for aid in dying is not valid.

(b) Any obligation owing under any currently existing contract shall not be conditioned or affected by the making or rescinding of a request for aid in dying.

(c) On and after the effective date of this section, the sale, procurement or issuance of any life, health or accident insurance or annuity policy or the rate charged for any such policy shall not be conditioned upon or affected by the making or rescinding of a request for aid in dying.

(d) A qualified patient's act of requesting aid in dying or self-administering medication prescribed for aid in dying shall not: (1) Affect a life, health or accident insurance or annuity policy, or benefits payable under such policy; (2) be grounds for eviction from a person's place of residence or a basis for discrimination in the terms, conditions or privileges of sale or rental of a dwelling or in the provision of services or facilities in connection therewith; (3) provide the sole basis for the appointment of a conservator or guardian; or (4) constitute suicide for any purpose.

Sec. 14. (NEW) (*Effective October 1, 2014*) (a) As used in this section, "participate in the provision of medication" means to perform the duties of an attending physician or consulting physician, a psychiatrist, psychologist or pharmacist in accordance with the provisions of sections 2 to 10, inclusive, of this act, and does not include: (1) Making an initial diagnosis of a patient's terminal illness; (2) informing a patient of his or her medical diagnosis or prognosis; (3) informing a patient concerning the provisions of this section and sections 2 to 18, inclusive, of this act, upon the patient's request; or (4) referring a patient to another health care provider for aid in dying.

(b) Participation in any act described in sections 1 to 18, inclusive, of this act by a patient, health care provider or any other person shall be voluntary. Each health care provider shall individually and affirmatively determine whether to participate in the provision of medication to a qualified patient for aid in dying. A health care facility shall not require a health care provider to participate in the provision of medication to a qualified patient for aid in dying, but may prohibit such participation in accordance with subsection (d) of this section.

(c) If a health care provider or health care facility is unwilling to participate in the provision of medication to a qualified patient for aid in dying, such health care provider or health care facility shall transfer all relevant medical records to any health care provider or health care facility, as requested by a qualified patient.

(d) A health care facility may adopt written policies prohibiting a health care provider associated with such health care facility from participating in the provision of medication to a patient for aid in dying, provided such facility provides written notice of such policy and any sanctions for violation of such policy to such health care provider. Notwithstanding the provisions of this subsection or any policies adopted in accordance with this subsection, any qualified health care provider may: (1) Diagnose a patient with a terminal illness; (2) inform a patient of his or her medical prognosis; (3) provide a patient with information concerning **Ans**

provisions of sections 1 to 18, inclusive, of this act upon a patient's request; (4) refer a patient to another health care facility or health care provider; (5) transfer a patient's medical records to a health care provider or health care facility, as requested by a patient; or (6) participate in the provision of medication for aid in dying when such health care provider is acting outside the scope of his or her employment or contract with a health care facility that prohibits participation in the provision of such medication.

Sec. 15. (NEW) (Effective October 1, 2014) (a) Any person who without authorization of a patient wilfully alters or forges a request for aid in dying, as described in sections 3 and 4 of this act, or conceals or destroys a rescission of such a request for aid in dying with the intent or effect of causing the patient's death, is guilty of attempted murder or murder under section 53a-54 of the general statutes.

(b) Any person who coerces or exerts undue influence on a patient to complete a request for aid in dying, as described in sections 3 and 4 of this act, or coerces or exerts undue influence on a patient to destroy a rescission of such request with the intent or effect of causing the patient's death, is guilty of attempted murder or murder under section 53a-54a of the general statutes.

Sec. 16. (NEW) (Effective October 1, 2014) (a) Nothing in sections 1 to 17, inclusive, of this act, authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, assisting a suicide or any other active euthanasia.

(b) Any action taken in accordance with sections 1 to 18, inclusive, of this act, does not constitute causing or assisting another person to commit suicide in violation of section 53a-54a or 53a-56 of the general statutes.

(c) No report of a public agency, as defined in section 1-200 of the general statutes, may refer to the practice of obtaining and self-administering life-ending medication to end a qualified patient's life as "suicide" or "assisted suicide", and shall refer to such practice as "aid in dying".

Sec. 17. (NEW) (Effective October 1, 2014) Sections 1 to 18, inclusive, of this act, do not limit liability for civil damages resulting from negligent conduct or intentional misconduct by any person.

Sec. 18. (NEW) (Effective October 1, 2014) Nothing in this section or sections 1 to 17, inclusive, of this act, shall preclude criminal prosecution under any provision of law for conduct that is inconsistent with this section or sections 1 to 17, inclusive, of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2014	New section
Sec. 2	October 1, 2014	New section

Sec. 3	<i>October 1, 2014</i>	New section
Sec. 4	<i>October 1, 2014</i>	New section
Sec. 5	<i>October 1, 2014</i>	New section
Sec. 6	<i>October 1, 2014</i>	New section
Sec. 7	<i>October 1, 2014</i>	New section
Sec. 8	<i>October 1, 2014</i>	New section
Sec. 9	<i>October 1, 2014</i>	New section
Sec. 10	<i>October 1, 2014</i>	New section
Sec. 11	<i>October 1, 2014</i>	New section
Sec. 12	<i>October 1, 2014</i>	New section
Sec. 13	<i>October 1, 2014</i>	New section
Sec. 14	<i>October 1, 2014</i>	New section
Sec. 15	<i>October 1, 2014</i>	New section
Sec. 16	<i>October 1, 2014</i>	New section
Sec. 17	<i>October 1, 2014</i>	New section

Sec. 18

October 1, 2014

New section

Statement of Purpose:

To allow a physician to prescribe medication at the request of a mentally competent patient that has a terminal illness that such patient may self-administer to bring about his or her death.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

"CHOICE" IS AN ILLUSION

A human rights organization opposing assisted suicide and euthanasia, sometimes termed "death with dignity" or "aid in dying"



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- Quick Facts About Assisted Suicide
- Washington's Assisted Suicide Act
- Beware of Vultures**
- VSED
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- The High Financial Cost of (Regular) Suicides
- New Hampshire Obliterates Assisted Suicide Act

ASSISTED SUICIDE BATTLE MOVES BACK TO COURT



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

VOICES AGAINST ASSISTED SUICIDE AND EUTHANASIA

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

ISSUES BY STATE & CANADA

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SATURDAY, DECEMBER 21, 2013

Beware of Vultures: Senator Jennifer Fielder on Compassion & Choices

"[I]t seems odd that the top lobby spender in Montana this year was Compassion and Choices, a 'nonprofit' group that spent \$160,356 advocating for legalization of assisted suicide."

By Senator Jennifer Fielder

As we wrangled through the budget this spring, the beautiful state capitol began to feel like a big, ripe carcass with a dark cloud of vultures circling about.

The magnitude of money in government attracts far more folks who want to be on the receiving end than it does those who just want fair and functional government. Until that ratio improves, it may be impossible to rein in unnecessary regulation and spending.

Special interest groups spent over \$6 million dollars on lobbyists to pressure Montana legislators during the 2013 session. Seems like a lot of money, until you compare it to the billions of taxpayer dollars at stake. Does the average taxpayer stand a chance against organized forces like that?



Senator Jennifer Fielder

As your Senator one of my main duties is to sort out who wants your money, or a change in a law, and why. Getting to the bottom of it takes work. It would certainly help if well-intentioned citizens would do a little more research before clamoring onto any particular bandwagons as well.

We have to be careful not to be fooled by catchy slogans, shallow campaign propaganda, biased media reports, or plays on our emotions which, too often, conceal a multitude of hidden agendas.

For example, it seems odd that the top lobby spender in Montana this year was Compassion and Choices, a "nonprofit" group that spent \$160,356 advocating for legalization of assisted suicide. The second biggest spender was MEA-MFT, the teachers and public employees union who spent \$120,319 pushing for state budget increases.

I earned a reputation for asking a lot of questions. I certainly didn't take this job to rubber stamp anything. It's my duty to determine whether a proposal relates to an essential, necessary service of fair and functional government, or if it is motivated by piles of money to be gained from ill-advised government decisions.

You see, there is so much money in government that almost

WELCOME

Legal assisted suicide encourages people with years to live to throw away their lives. See here.

In Oregon where assisted suicide is legal, the Oregon Health Plan (Medicaid) uses coverage incentives to steer patients to suicide. See Id.

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

Legalization especially invites abuse of seniors, for example, in an inheritance situation. See here.

Jurisdictions without legal assisted suicide already have a significant problem with palliative care abuse by some doctors and nurses. If you can't control the abuse now, when assisted suicide is not legal, why would you give these doctors and nurses even more power to abuse patients by legalizing it? See here.

Being steered to suicide, killed and/or abused is not "choice."

"Choice" is an illusion.

DO YOU HAVE A STORY TO TELL?



Please click on the photo

Washington Assisted Suicide Laws

- Idaho Strengthens its Law Against Assisted Suicide
- New Hampshire Defeats Assisted Suicide Again
- Hawaii AG Rejects Claim That Assisted Suicide is "Already Legal"
- What People Mean When They Say They Want to Die
- Who is at Risk?
- Definitions

NO ASSISTED SUICIDE



Demonstration at University of Washington Hospital - Seattle WA

LABELS

- aid in dying (16)
- Alex Schadenberg (3)
- annual report (3)
- assisted dying (3)
- assisted suicide (96)
- assisted suicide; physician-assisted suicide (5)
- australia (1)
- Ballot Question 2 (1)
- Baloney (2)
- Barbara Coombs Lee (6)
- Barbara Wagner (2)
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- Bennett Blum MD (1)
- Blewett (3)
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- Donations (1)
- Donna Cohen (1)
- DPOA (1)
- Dying with Dignity (1)
- Elder abuse (44)
- England (1)

everything in government is about the money. The usual tactic is to disguise a ploy as "the humane thing to do". . . .

Some groups work very hard to provide factual information about their issue. Others stoop to the lowest of lows to invoke heart wrenching emotions, twisted half-truths, or outright lies. You really have to look carefully for all the angles.

Assisted suicide is another issue that can be highly emotional. There are deep and valid concerns on both sides of this life and death debate. But I found myself wondering, "Where does all the lobby money come from?" If it really is about a few terminally ill people who might seek help ending their suffering, why was more money spent on promoting assisted suicide than any other issue in Montana?

Could it be that convincing an ill person to end their life early will help health insurance companies save a bundle on what would have been ongoing medical treatment? How much would the government gain if it stopped paying social security, Medicare, or Medicaid on thousands of people a few months early? How much financial relief would pension systems see? Why was the proposed law to legalize assisted suicide [SB 220] written so loosely? Would vulnerable old people be encouraged to end their life unnecessarily early by those seeking financial gain?

When considering the financial aspects of assisted suicide, it is clear that millions, maybe billions of dollars, are intertwined with the issue being marketed as "Compassion and Choices". Beware.

Public issues are not easy, and they are not always about money. But often times they are. If we want fair and functional government, we need to look deeper than most people are willing to look. . . .

* * *

Published as Communication from Your State Senator, "Beware of Vultures," by Montana State Senator Jennifer Fielder, Sanders County Ledger, <http://www.sclledger.net>, page 2, 6-4-13. Senator Fielder lives in Thompson Falls MT, representing Montana State Senate District 7.

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- 'Death with Dignity': What Do We Advise Our Clients?
- Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice
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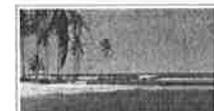
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UTAH AGAINST ASSISTED SUICIDE



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HAWAII AGAINST ASSISTED SUICIDE & FOR LIVING WITH DIGNITY



Click on the photo to read the Attorney General's Opinion that assisted suicide is not legal in Hawaii



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OPPONENTS CALL FOR REPEAL OF ASSISTED SUICIDE

MORGAN TRUE FEB. 27, 2014 12 COMMENTS

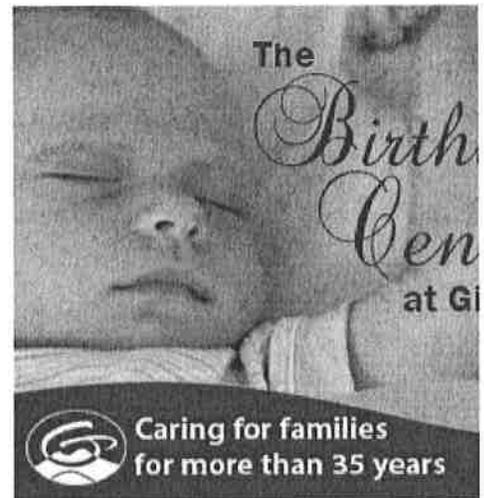
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Opponents of Vermont’s physician-assisted suicide law are calling on legislators and the governor to place a moratorium on the prescription of life-ending drugs.

Edward Mahoney, president of the Vermont Alliance for Ethical Health Care, said at a news conference Thursday that the law is poorly crafted and its supporters have not fully considered the ramifications of the law.

He raised several concerns about its implementation, including the lack of immunity for clinicians and pharmacists and the requirement that physicians notify terminally ill patients of the assisted-suicide option – whether or not the physician thinks it’s an ethical or a good care practice.

Mahoney and other opponents said the bill doesn’t have proper patient protections to ensure that people with



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N.M. official appeals 'right to die' ruling

Posted: Mar 13, 2014 11:56 AM PST
Updated: Mar 13, 2014 11:56 AM PST

ALBUQUERQUE, N.M. (AP) - New Mexico Attorney General Gary King is appealing a court ruling that terminally ill patients can seek a physician's help in dying.

King tells the Albuquerque Journal (<http://bit.ly/1cUERBb>) that one of the problems with District Judge Jan Nash's January ruling is that it doesn't apply statewide.

King also says he wants to protect the assisted suicide law. That law classifies helping with suicide as a felony.

The case centers on Aja Riggs, a Santa Fe resident who was diagnosed with an aggressive uterine cancer. Her cancer is in remission, but doctors expect it to return.

Nash ruled that terminally ill patients have the right to aid in dying, and that "such deaths are not considered 'suicide' under the assisted suicide law.

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'Warren Buffett Indicator' Signals Collapse in Stock Market



Seattle arrest records. Who do you know?



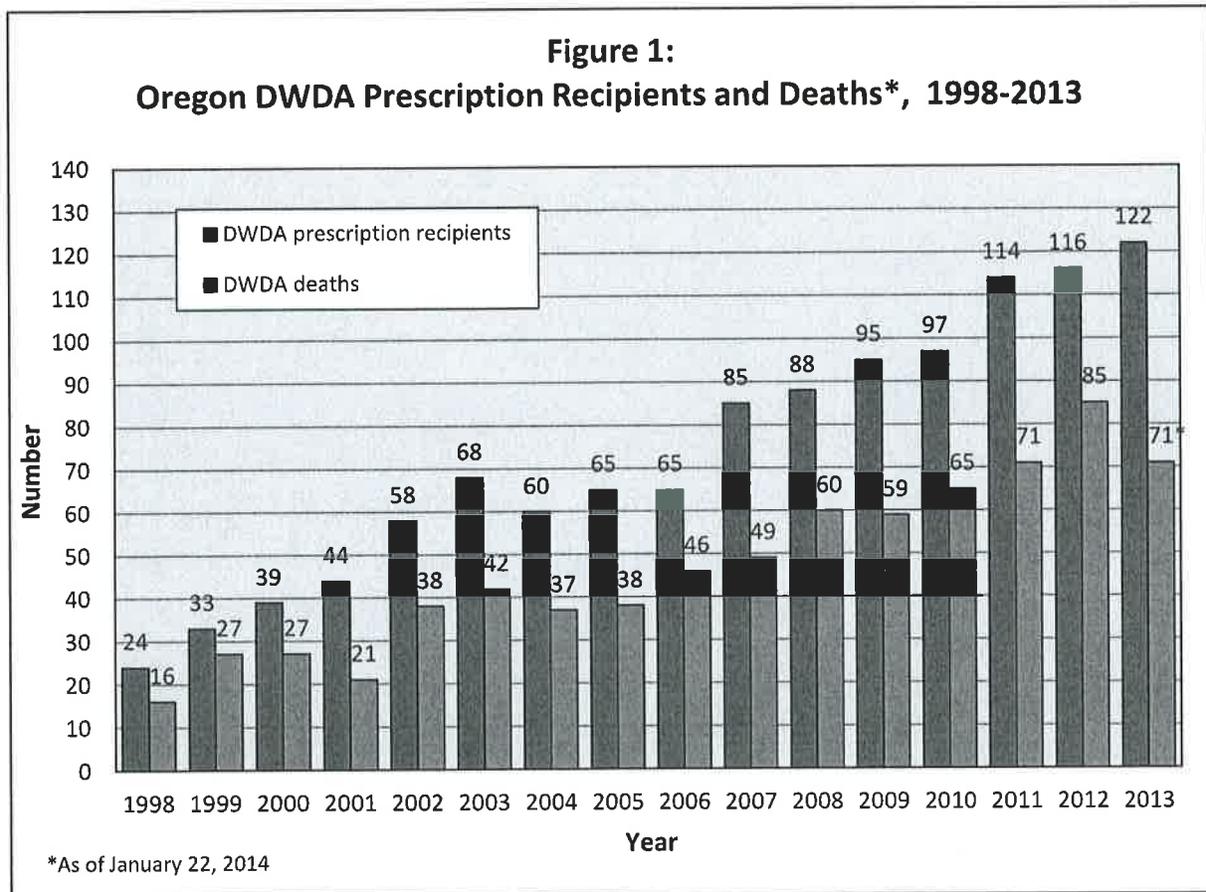
Rumor has it this stock might explode. Can you turn \$5,000 into \$500,000?



Phytoceramides is the "Botox Alternative" in a bottle.

Oregon's Death with Dignity Act--2013

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



- As of January 22, 2014, prescriptions for lethal medications were written for 122 people during 2013 under the provisions of the DWDA, compared to 116 during 2012 (Figure 1). At the time of this report, there were 71 known DWDA deaths during 2013. This corresponds to 21.9 DWDA deaths per 10,000 total deaths.¹
- Since the law was passed in 1997, a total of 1,173 people have had DWDA prescriptions written and 752 patients have died from ingesting medications prescribed under the DWDA.
- Of the 122 patients for whom DWDA prescriptions were written during 2013, 63 (51.6%) ingested and died from the medication. Eight (8) patients with prescriptions written during the previous years (2011 and 2012) died after ingesting the medication during 2013, for a total of 71 DWDA deaths.
- Twenty-eight (28) of the 122 patients who received DWDA prescriptions during 2013 did not take the medications and subsequently died of other causes.
- Ingestion status is unknown for 31 patients who were prescribed DWDA medications in 2013. Seven (7) of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received. For the remaining 24 patients, both death and ingestion status are pending (Figure 2).
- Of the 71 DWDA deaths during 2013, most (69.0%) were aged 65 years or older; the median age was 71 years (42 years – 96 years). As in previous years, most were white (94.4%), well-educated (53.5% had a least a baccalaureate degree), and had cancer (64.8%). In 2013, fewer patients had cancer (64.8%) compared to previous years (80.4%), and more patients had chronic lower respiratory disease (9.9%), and other underlying illnesses (16.9%).
- Most (97.2%) DWDA patients died at home, and most (85.7%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, most (96.7%) had some form of

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

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

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

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

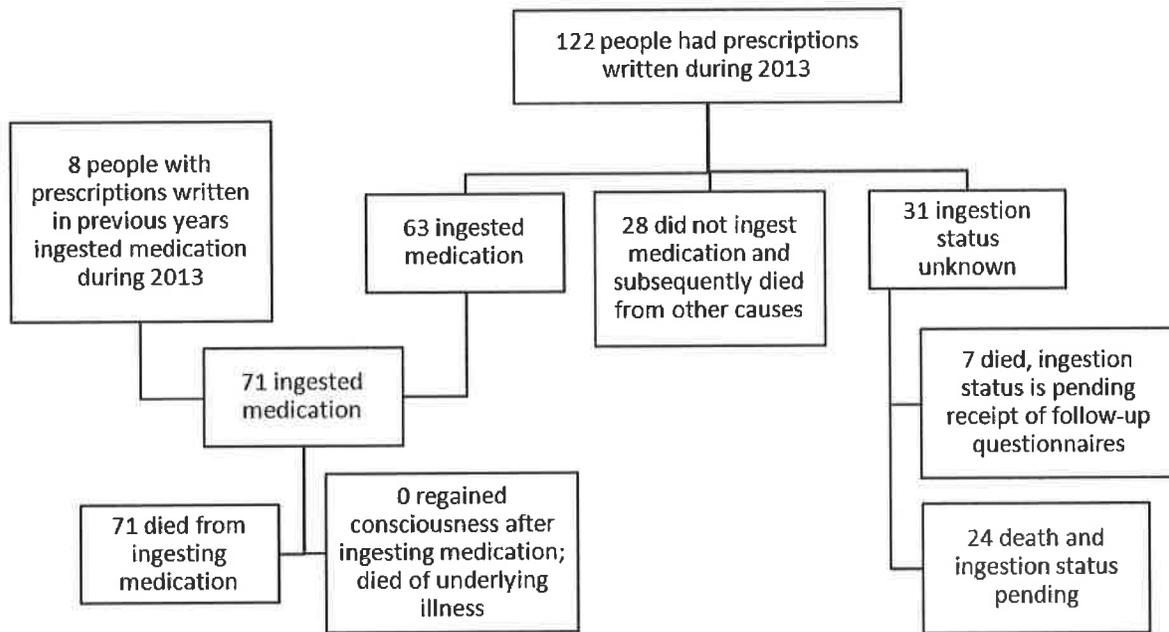


Table 1. Characteristics and End-of-life Care of 752 DWDA Patients who Died from Ingesting a Lethal Dose of Medication as of January 17, 2014, Oregon, 1998-2013

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

Characteristics	2013 (N=71)	1998-2012 (N=681)	Total (N=752)
Underlying illness			
Malignant neoplasms (%)	46 (64.8)	545 (80.4)	591 (78.9)
Lung and bronchus (%)	10 (14.1)	129 (19.0)	139 (18.6)
Breast (%)	1 (1.4)	56 (8.3)	57 (7.6)
Colon (%)	6 (8.5)	43 (6.3)	49 (6.5)
Pancreas (%)	2 (2.8)	45 (6.6)	47 (6.3)
Prostate (%)	2 (2.8)	31 (4.6)	33 (4.4)
Ovary (%)	1 (1.4)	27 (4.0)	28 (3.7)
Other (%)	24 (33.8)	214 (31.6)	238 (31.8)
Amyotrophic lateral sclerosis (%)	5 (7.0)	49 (7.2)	54 (7.2)
Chronic lower respiratory disease (%)	7 (9.9)	27 (4.0)	34 (4.5)
Heart Disease (%)	1 (1.4)	13 (1.9)	14 (1.9)
HIV/AIDS (%)	0 (0.0)	9 (1.3)	9 (1.2)
Other illnesses (%)⁶	12 (16.9)	35 (5.2)	47 (6.3)
Unknown	0	3	3
DWDA process			
Referred for psychiatric evaluation (%)	2 (2.8)	42 (6.2)	44 (5.9)
Patient informed family of decision (%) ⁷	62 (91.2)	570 (93.9)	632 (93.8)
Patient died at			
Home (patient, family or friend) (%)	69 (97.2)	645 (95.1)	714 (95.3)
Long term care, assisted living or foster care facility (%)	2 (2.8)	27 (4.0)	29 (3.9)
Hospital (%)	0 (0.0)	1 (0.1)	1 (0.1)
Other (%)	0 (0.0)	5 (0.7)	5 (0.7)
Unknown	0	3	3
Lethal medication			
Secobarbital (%)	7 (9.9)	396 (58.1)	403 (53.6)
Pentobarbital (%)	64 (90.1)	278 (40.8)	342 (45.5)
Other (%) ⁸	0 (0.0)	7 (1.0)	7 (0.9)
End of life concerns⁹			
Losing autonomy (%)	66 (93.0)	618 (91.3)	684 (91.4)
Less able to engage in activities making life enjoyable (%)	63 (88.7)	602 (88.9)	665 (88.9)
Loss of dignity (%) ¹⁰	52 (73.2)	452 (81.9)	504 (80.9)
Losing control of bodily functions (%)	26 (36.6)	350 (51.7)	376 (50.3)
Burden on family, friends/caregivers (%)	35 (49.3)	264 (39.0)	299 (40.0)
Inadequate pain control or concern about it (%)	20 (28.2)	157 (23.2)	177 (23.7)
Financial implications of treatment (%)	4 (5.6)	18 (2.7)	22 (2.9)
Health-care provider present¹¹			
When medication was ingested¹²			
Prescribing physician	8	111	119
Other provider, prescribing physician not present	3	235	238
No provider	3	73	76
Unknown	57	192	249
At time of death			
Prescribing physician (%)	8 (11.4)	99 (16.5)	107 (16.0)
Other provider, prescribing physician not present (%)	5 (7.1)	258 (43.1)	263 (39.3)
No provider (%)	57 (81.4)	242 (40.4)	299 (44.7)
Unknown	1	12	13
Complications¹²			
Regurgitated	0	22	22
Seizures	0	0	0
Other	1	0	1
None	10	477	487
Unknown	59	182	241
Other outcomes			
Regained consciousness after ingesting DWDA medications ¹³	0	6	6

* See footnote 6 on p. 7 - d. a. Jeter is listed

drugs used are water soluble to be drunk / injected

20 people

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

- 1 Unknowns are excluded when calculating percentages.
- 2 Includes Oregon Registered Domestic Partnerships.
- 3 Clackamas, Multnomah, and Washington counties.
- 4 Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.
- 5 Private insurance category includes those with private insurance alone or in combination with other insurance.
- 6 Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.
- 7 First recorded beginning in 2001. Since then, 31 patients (4.6%) have chosen not to inform their families, and 12 patients (1.8%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and three in 2013.
- 8 Other includes combinations of secobarbital, pentobarbital, and/or morphine.
- 9 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.
- 10 First asked in 2003. Data available for all 71 patients in 2013, 552 patients between 1998-2012, and 623 patients for all years.
- 11 The data shown are for 2001-2013 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.
- 12 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.
- 13 There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (<http://www.healthoregon.org/dwd>) for more detail on these deaths.
- 14 Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.

X O

A.22

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 From: William Toffler <toffler@ohsu.edu>
 To: "letters@nhregister.com" <letters@nhregister.com>
 Subject: Letter to editor, New Haven Register
 Thread-Topic: Letter to editor, New Haven Register
 Thread-Index: AQHPMQ/Xxr2Hh5w0xkOboc5jffdJ4g==
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Dear Editor,

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

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

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

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

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

To read a commentary on the most recent Oregon government assisted-suicide report, which lists chronic conditions as the "underlying illness" justifying assisted suicide, please go here:

<http://www.noassistedsuicideconnecticut.org/2014/02/oregons-new-assisted-suicide-report.html>

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

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

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A. 23

A. 23

CANADA

C O U R S U P É R I E U R E

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

GINETTE LEBLANC,
demanderesse

C.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

1. I am a doctor in Oregon USA where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have treated thousands of patients with cancer.
2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify for the court that this does not necessarily mean that patients are dying.
3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for cancer. I understand that he had referred her to me.

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

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

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

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

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

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

Attached hereto at page SI-1.

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

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

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

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

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

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

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

NAME: *Jessica Borgo*

A notary in and for the
State of Oregon

ADDRESS: *16100 Sw Tualatin - Sherwood Rd*

EXPIRY OF COMMISSION: *Aug, 30, 2015*

PLACE SEAL HERE: *Jessica Borgo*

Ken Stevens MD
Ken Stevens, MD



STATEMENTS OF INTENT FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

- A) without regard to a patient's expected length of life:
 - Inpatient palliative care consultation; and,
 - Outpatient palliative care consultation, office visits.
- B) with an expected median survival of less than one year, as supported by the best available published evidence:
 - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.
- C) with an expected median survival of six months or less, as supported by peer-reviewed literature:
 - Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

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

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

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

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

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

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

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

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

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

Ventricular assist devices are not covered for destination therapy.

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

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

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

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

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

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

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

CANADA

C O U R S U P É R I E U R E

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

GINETTE LEBLANC,
demanderesse

c.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

**AFFIDAVIT OF JEANETTE HALL
OPPOSING ASSISTED SUICIDE**

THE UNDERSIGNED, being first duly sworn under oath, states:

1. I live in Oregon where physician-assisted suicide is legal. Our law was enacted in 1997 via a ballot initiative that I voted for.
2. In 2000, I was diagnosed with cancer and told that I had 6 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, Ken Stevens MD, but he didn't really answer me. In hindsight, he was stalling me.
3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!

Affidavit of Jeanette Hall - Page 1

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4. This July, it was 12 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 17th day of August 2012

Jeanette Hall
Jeanette Hall

SWORN BEFORE ME at
OREGON, USA
on, August 17, 2012

NAME: Sheena Leslie

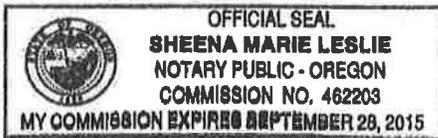
JEANETTE HALL

A notary in and for the
State of Oregon

ADDRESS: 15405 SW 116th Ave
Tigard, OR 97224

EXPIRY OF COMMISSION:
September 28, 2012

PLACE SEAL HERE:



Copy

CANADA

C O U R S U P É R I E U R E

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

GINETTE LEBLANC,
demanderesse

c.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

**AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO
ASSISTED SUICIDE AND EUTHANASIA**

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

1. I live in Florence Massachusetts USA. When I was eighteen years old and in my first year of college, I was diagnosed with Amyotrophic Lateral Sclerosis (ALS) by the University of Iowa Medical School. ALS is commonly referred to as Lou Gehrig's disease. I was told that I would get progressively worse (be paralyzed) and die in three to five years.
2. I was a very physical person. The diagnosis was devastating to me. I had played football in high school and was extremely active riding bicycles. I also performed heavy labor including road construction and farm work. I prided myself for my physical strength, especially in my hands.
3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the

AFFIDAVIT OF JOHN NORTON- Page 1

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

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

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

AFFIDAVIT OF JOHN NORTON- Page 2

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

NAME: Heidi Pruzynski
Heidi Pruzynski

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

ADDRESS: 85 Main St
Florence MA 01062

EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:



[Handwritten signature]

JOHN NORTON

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Terminal Uncertainty

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

By **Nina Shapiro**

published: January 14, 2009

Nina Shapiro



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

Details:

- Study: [Why Now?](#) Timing and Circumstances of Hastened Deaths
- [Dilemmas by caretakers](#) and other Oregon studies
- [Stats on people](#) who have used Oregon's Death with Dignity law.
- [Harvard professor Nicholas Christakis](#) looking at the accuracy of prognosis.
- [JAMA study](#) examining the accuracy of prognosis.

UPDATE: ["It Felt Like the Big One"](#)

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

That was almost four years ago.

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

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

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

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.

A-38

A-38

"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."

A. 40

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

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

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

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

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

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

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

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

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consented to defendant's acts, we are satisfied from our independent research that defendant's actions should not be treated in effect as assisting a suicide. Our Supreme Court rejected an "assisted suicide" argument in *People v. Matlock* (1959) 51 Cal.2d 682, 336 P.2d 505 (*Matlock*), stating " 'where a person actually performs, or actively assists in performing, the overt act resulting in death, such as shooting or stabbing the victim, administering the poison, or holding one under water until death takes place by drowning, his act constitutes murder, and it is wholly immaterial whether this act is committed pursuant to an agreement with the victim....' " (*Id.* at p. 694, 336 P.2d 505, followed in *People v. Cleaves* (1991) 229 Cal.App.3d 367, 376-377, 280 Cal.Rptr. 146; but see *In re Joseph G.* (1983) 34 Cal.3d 429, 194 Cal.Rptr. 163, 667 P.2d 1176 [making an exception to *Matlock's* murder rule when one of two people engaged in a simultaneous suicide effort actively employs the single instrumentality involved].)

B. Defendant's "Unusual Case" Argument

[10] Defendant argues that she plainly overcame the presumption against probation because "this was extremely unusual in the most basic, fundamental way central to the statutory bar: Ms. Stuart inflicted great bodily injury or death upon her mother out of a felt love for and duty to her. However misdirected those laudable impulses were, she acted 'from a heartfelt place,' which can rarely if ever be said about the willful infliction of death or great bodily injury." Defendant also asserts that "[t]he homicide of one's beloved parent prompted by care and concern for that aged parent and filial obedience to and honor of that parent's apparent wishes is a most peculiar manslaughter indeed, and one that is at the lowest end of the spectrum**143 of moral opprobrium when

examining the motives of those who willfully inflict great bodily injury or death." We disagree.

As we have already discussed, a reasonable person could conclude that defendant acted at least in part out of financial considerations, an all too common motivation for killing someone, and without Isabel's knowledge or consent. This undermines defendant's argument that she acted with a reduced moral culpability.

Furthermore, a killer's subjective belief about the reason for a crime, including that he or she acted out of the "compassion and empathy" that *183 defendant contends she acted upon here, does not necessarily mean the case is "unusual." It is not particularly unusual for a killer to believe his or her action was justified; it is, for example, the root of any vigilantism. Moreover, that defendant believes she acted out of good intentions has little, if any, bearing on an objective view of her legal and moral culpability under the circumstances. It is reasonable to conclude an adult child who takes it upon herself to commit the "mercy killing" of a very elderly parent based only on that parent's "apparent wishes" has abused a position of trust and committed a very serious crime. A court is not required to conclude such an act rests on a higher moral plane than any other killing. Indeed, to do so would potentially expose some of the most vulnerable in our society to the grave danger of being killed by "loved ones," however compassionate they may be, who are unable to resist a temptation that dovetails with their financial self-interest, as the record suggests may have been the case here. The trial court acted within its discretion in rejecting any arguments that defendant's motivations reduced her moral culpability, including because, as the trial court stated, defendant's killing of her mother was "perhaps the most extreme form that elder abuse can take."

C. Defendant's "Provocation and Duress" Argument

[11] Regarding rule 4.413(c)(2)(A), defendant



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RCW 11.12.160

Interested witness — Effect on will.

(1) An interested witness to a will is one who would receive a gift under the will.

(2) A will or any of its provisions is not invalid because it is signed by an interested witness. Unless there are at least two other subscribing witnesses to the will who are not interested witnesses, the fact that the will makes a gift to a subscribing witness creates a rebuttable presumption that the witness procured the gift by duress, menace, fraud, or undue influence.

(3) If the presumption established under subsection (2) of this section applies and the interested witness fails to rebut it, the interested witness shall take so much of the gift as does not exceed the share of the estate that would be distributed to the witness if the will were not established.

(4) The presumption established under subsection (2) of this section has no effect other than that stated in subsection (3) of this section.

[1994 c 221 § 16; 1965 c 145 § 11.12.160. Prior: 1917 c 156 § 38; RRS § 1408; prior: Code 1881 § 1331; 1863 p 209 § 67; 1860 p 171 § 34.]

Notes:

Effective dates -- 1994 c 221: See note following RCW [11.94.070](#).

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ingest definition

in·gest (in jĕst')

transitive verb

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

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

Related Forms:

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

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in·gest (ĭn-jĕst')

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

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

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

Related Forms:

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

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Opinion 2.21 - Euthanasia

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

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

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

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

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



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Opinion 2.211 - Physician-Assisted Suicide

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

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

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

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



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Death Drugs Cause Uproar in Oregon

Aug. 6, 2008

By SUSAN DONALDSON JAMES

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

The 64-year-old Oregon woman, whose lung cancer had been in remission, learned the disease had returned and would likely kill her. Her last hope was a \$4,000-a-month drug that her doctor prescribed for her, but the insurance company refused to pay.

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

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

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

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

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

Letter's Impact 'Devastating'

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

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

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

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

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

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

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

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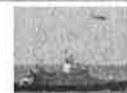
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Letter noting assisted suicide raises questions

By Susan Harding and KATU Web Staff | Published: Jul 30, 2008 at 6:30 PM PDT (2008-07-31T1:30:0Z) | Last Updated: Oct 30, 2013 at 7:35 AM PDT (2013-10-30T14:35:0Z)



Barbara Wagner

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

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

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

Instead, the letter said, the plan would pay for comfort care, including "physician aid in dying,"

better known as assisted suicide.

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

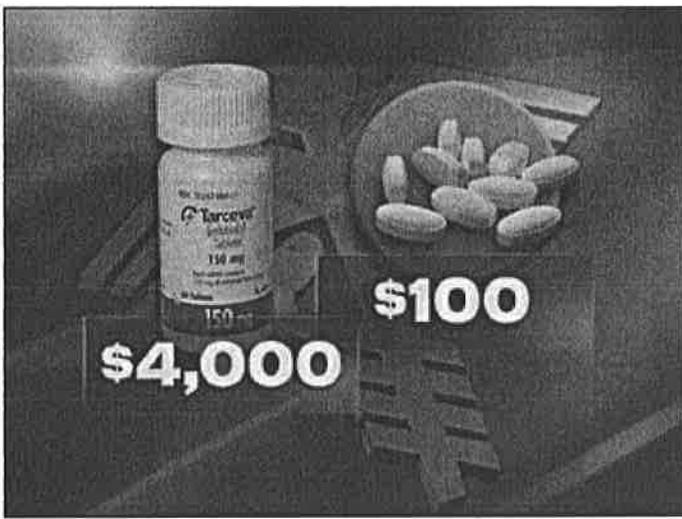
An unfortunate interpretation?

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

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

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

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



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

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

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

Health plan hasn't evolved?

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

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

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

"We are looking at today's ... 2008 treatment, but we're using 1993 standards," Fryefield said.

"When the Oregon Health Plan was created, it was 15 years ago, and there were not all the chemotherapy drugs that there are today."

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

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

Sensationalizing a sad case cheats the public of sound debate

Posted by rattig November 29, 2008 19:30PM

In the crucial period leading up to Washington State's vote on an Oregon-style Death with Dignity law, this newspaper published a story featuring Barbara Wagner. A sensational story, an easy media "gotcha" on Oregon's Medicaid program, it completely missed the deeper questions crucial to public understanding of end-of-life care and our national healthcare debate.



Barbara Coombs Lee

*President of Compassion & Choices
criticizing Wagner's
"Choice"*

Readers will recall Wagner as a 64-year-old Springfield resident with end stage lung cancer, a life-long smoker enrolled in the Oregon Health Plan (OHP). Over several years the OHP had paid for extensive cancer treatment and it continued to pay for Wagner's healthcare until her death.

When it became clear that first and second-line therapies had failed and her prognosis was grim, Ms. Wagner's oncologist recommended a costly, third-line cancer drug called Tarceva. Research indicates that 8 percent of advanced lung cancers respond to Tarceva, with a chance to extend life from an average of 4 months to 6 months. The likelihood of no response to the drug is 92 percent, yet 19 percent of patients develop toxic side effects like diarrhea and rash. Based on the low indicators of effectiveness, Oregon Health Plan denied coverage.

The irresistible ingredients of sensationalism included a distraught patient, a doctor deeply opposed to Death with Dignity and an insensitive letter of payment denial. The media was called in and the rest is history.

As a publicly funded service, Oregon Health Plan aims to do the greatest good it can. It assigns a high priority to preventive care, health maintenance, and treatments that offer a near-certain cure. Elective, cosmetic or ineffective, "futile" care is not covered. Futile care is defined as any treatment without at least a 5 percent chance of 5 year survival. "We can't cover everything for everyone," said the medical director of OHP.

"Taxpayer dollars are limited for publicly funded programs. We try to come up with policies that provide the most good for the most people."

Defends the health plan, not Wagner's choice

The OHP letter denying one ineffective treatment did not close the door on all care. It included a long list of appropriate end-of-life care that OHP would pay for, including hospice, medical equipment, palliative services and state-of-the-art pain and symptom management. Yes, the list included medication prescribed under the Oregon Death with Dignity Act. The media juxtaposed denial of Tarceva with coverage for aid in dying in a sensational, emotional manner, suggesting the two were related. Many stories ensued about supposedly callous bureaucrats refusing to prolong life but agreeing to shorten it. It made for a catchy story ... but not truthful journalism.

Was it true that Ms. Wagner was harmed in any manner? Or that Tarceva was an efficacious option?

Ms. Wagner received Tarceva, anyway, when the drug's manufacturer, Genentech, responding to the media firestorm and provided it at no cost. News stories never mentioned that when Wagner bet on the remote chance to prolong life, she probably turned her back on hospice care, widely recognized as the gold standard for end-of-life care. Sadly, it turned out Tarceva didn't help Wagner and she lived only a short time after starting the drug.

While the media widely reported OHP's denial of this expensive experimental treatment, we worry the media missed the important issues inherent in the story.

What do patients like Wagner really understand about the "last hope" treatments their doctors offer? Do doctors inform patients of the true statistical chance these therapies will prolong life, or the chance of toxic side effects that diminish the quality of the short life that remains? Might Wagner have been better served, and perhaps even lived longer, if her doctors had referred her to hospice instead of recommending a drug so toxic and so unlikely to extend her life? How many times do patients lose out on the real hope and comfort hospice offers because they are encouraged to grasp for the small hope of largely ineffective chemotherapy? Do financial incentives play a role in whether physicians recommend long-shot chemotherapy instead of comprehensive comfort care?

While the OHP decision was closely scrutinized, there was no scrutiny of realistic options considered or not considered and the decision-making process. The burning health policy question is whether we inadvertently encourage patients to act against their own self interest, chase an unattainable dream of cure, and foreclose the path of acceptance that curative care has been exhausted and the time for comfort care is at hand. Such encouragement serves neither patients, families, nor the public.

Barbara Roberts, Oregon's wise and gentle former governor, tells in her first book the story of how she and her husband Frank reacted to the news that he had entered the terminal stage of prostate cancer. She describes how immediately after disclosing the grim prognosis, the doctor announced he was setting up an appointment for chemotherapy! Frank asked two crucial questions, "Will this treatment extend my life?" and "For how long." And when the answers, balanced against the likely toxic side effects, didn't add up to how Frank envisioned his last days on earth, he declined the doctor's recommended treatment.

Roberts writes that chemotherapy seemed, "a medical misjudgment encouraged by a culture in denial and a medical profession equally in denial and unwilling to treat death as normal." Frank said "no" to treatment. But he said "yes" to life and began the "hard work of acceptance" of what it means to be mortal.

In order for society to overcome its collective denial of mortality, we desperately need a public dialogue that shuns superficial sensationalism and leads us to, and through, the hard questions. We're Oregonians. We can handle it.

X *Coombs Lee is president of the group Compassion & Choices.*

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LetDocDecide says...

My wife was diagnosed with Stage IIIb lung cancer (which really should have been stage IV) in April 2006. The diagnosing surgeon announced that there was no hope, and that my wife would only live a short time. In fact, the prognosis for my wife suggested she had a 1%-2% chance of surviving 2 years. Thankfully, we had an ambitious Oncologist that thought the surgeon's opinion was wrong.

While it is easy to armchair quarterback the appropriateness of health care treatments. You can be the one that tells my 8 and 10 year old sons that their mother should not receive Tarceva because it is an "experimental treatment". The efficacy of all chemotherapy treatments are ALL poor. The first line chemo treatment (carboplatin/Paclitaxel) that my wife received had only a 35% likelihood of a positive response. That was 2 years and 8 months ago and she is still kicking. Her response to Tarceva has been an exceptional one, resulting in a significant reduction of the size and number of tumors in her remaining right lung. After a 3rd tier chemo treatment failed 3 months ago, Tarceva is probably the only reason she is spending Christmas day with me and my boys. In fact, I expect that she will continue having a positive response to the Tarceva for at least a couple of months. Anyone with a loved one with a terminal disease would appreciate the added time.

On the topic of cost and side effects, the side-effects of Tarceva (rash and diarrhea) are nothing compared to the side effects of the Taxane or platinum chemotherapy drugs (severe anemia, reduced white blood counts and platelet levels, severe nausea, body PAIN, etc..).

In addition to these benefits, the cost of Tarceva (about \$4000/month) is NOT HIGHER than the cost of chemotherapy (about \$8000 per treatment every 3 weeks). It is expensive to treat cancer, period. It is unclear to me whether the author of this news story is appealing for the denial of all cancer treatments, or just Tarceva. If that is the case, they can tell the family of the next Stage IIIb/IV lung cancer patient that treatment is not worth the cost. What the hell, perhaps we should just Euthanize all cancer patients at the time of diagnosis to save a little money.

I believe that the spiralling costs of health care are not caused by the compassionate treatment of those with terminal diseases. The real culprits are 1) the fact that too many individuals that have no health insurance use emergency care at a huge cost premium over preventative care; 2) People have had no incentive to use healthy lifestyles as a preventative; 3) Many people with insurance are not smart shoppers when it comes to health care. This leads to people having expensive diagnostic procedures like MRI and CT scans inappropriately.

We need to wake up, do a little research into the available treatments for our ailments, and determine if the increased public cost for not insuring everyone and using more preventative health care.

Respectfully
Bob

Posted on 12/25/08 at 12:16AM
Footer



Barbara Coombs Lee

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Barbara Coombs Lee is President of Compassion & Choices, a nonprofit organization dedicated to expanding and protecting the rights of the terminally ill. She practiced as a nurse and physician assistant for 25 years before beginning a career in law and health policy. Since then she has devoted her professional life to individual choice and empowerment in health care. As a private attorney, as counsel to the Oregon State Senate, as a managed care executive and finally as Chief Petitioner for Oregon's Death with Dignity Act, she has championed initiatives that enable individuals to consider a full range of choices and be full participants in their health care decisions.

There is no info on Twitter for this entry for that keyword

Blog Entries by Barbara Coombs Lee

Five States Give Patients Choice

Posted September 27, 2010 | 11:33 AM (EST)

"There's nothing more we can do." For too long, for too many, medical professionals have used these words when they believe they cannot cure their patients. Facing, as each of us must, the nearness of death, terminally ill patients too often speak of abandonment by...

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Medical Society of New York Fights Palliative Care Information Act Despite Mounting Evidence

[2 Comments](#) | Posted September 3, 2010 | 04:33 PM (EST)

The ink of Governor Paterson's signature is barely dry on New York's Palliative Care Information Act (PCIA), drafted and sponsored by Compassion & Choices and its New York affiliate, yet evidence mounts daily for its vast and dramatic impact on end-of-life care. I predict this bill...

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New York's Palliative Care Information Act: A Sea Change in End-of-Life Care

[2 Comments](#) | Posted August 19, 2010 | 07:01 PM (EST)

Word came Sunday night from Compassion & Choices New York that Governor Paterson had signed our bill, the Palliative Care Information Act, (PCIA) and it would take effect in 180 days. Hooray!! We hope and trust this event marks the beginning of the end for endemic medical habits that...

[Read Post](#)

Compassion & Choices Membership: Something to be Proud Of

Posted July 14, 2010 | 03:15 PM (EST)

Recently Capitol Hill staffers pulled Compassion & Choices into federal politics, suggesting the new Administrator of the Centers for Medicare and Medicaid Services, Donald Berwick, should be called before Congress to answer accusations that he is a member, or affiliated somehow with C&C. "Are you now,..."



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MetLife®

March 17, 2009 09:00 AM Eastern Daylight Time

Financial Abuse Costs Elders More Than \$2.6 Billion Annually, According to MetLife Mature Market Institute Study, Though Four in Five Cases Are Not Reported

Family Members and Caregivers are Responsible in 55% of Cases

Related Costs Reach into the Tens of Millions

Prevention Tips Available for Older Americans and Their Families

WESTPORT, Conn.--(BUSINESS WIRE)--Elder financial abuse costs older Americans more than \$2.6 billion per year and is most often perpetrated by family members and caregivers, according to a new report released by the MetLife Mature Market Institute (MMI) entitled, *Broken Trust: Elders, Family and Finances*, which is accompanied by tip sheets for older adults and families on how to prevent such issues. The report, produced in conjunction with the National Committee for the Prevention of Elder Abuse (NCPEA) and Virginia Polytechnic Institute and State University, states up to one million older Americans may be targeted yearly and that related costs like health care, social services, investigations, legal fees, prosecution, lost income and assets reach tens of millions of dollars annually. The study indicates that for each case of abuse reported, there are an estimated four or more that go unreported. The economic downturn may increase vulnerability. Family members and caregivers are the culprits in 55% of cases, although financial losses are higher with investment fraud scams.

The National Adult Protective Services Association (NAPSA) suggests that the "typical" victim of elder financial abuse is between the ages of 70 and 89, white, female, frail and cognitively impaired. She is trusting of others and may be lonely or isolated, although reports show that there is a very diverse population of victims.

"Elder financial abuse has been called the 'crime of the 21st century,'" said Sandra Timmermann, Ed.D., director of the MetLife Mature Market Institute. "With the present state of the economy, older Americans are at a greater risk than ever of having their financial security threatened. And, for every dollar lost to theft and abuse, there are still more related costs associated with stress and health care and the intervention of social service, investigative and legal entities.

"This is also a growing problem made greater by the increase in the number of older Americans as targets, the relative wealth of this group, a change in family structure and the availability of technology that may make such abuse somewhat easier," said Timmermann.

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"Sadly, family members and caregivers tend to financially exploit their elderly relatives more often than strangers. Community service providers and other professionals agree, however, that reported cases represent only the very 'tip of the iceberg.' Scholars and practitioners speculate that, like perpetrators of other types of elder abuse, family members who exploit their elders are dependent upon them financially and their actions may be influenced by other problems such as alcohol and drug abuse. In addition, some family members feel a sense of entitlement and believe that they have a right to the money and material goods their parents or older relatives have accumulated," Timmermann added.

Pamela B. Teaster, Ph.D., NCPEA president, said the data provided through the National Center on Elder Abuse daily newsfeed proved invaluable. "The feed tracks media reports of elder abuse through Google and Yahoo Alerts, a process that scans billions of Web pages," said Teaster. "Not only were we able to put a face on the information reported in the primary literature, but more importantly, we had real-time information on financial elder abuse and information from numerous reporting sources," she said.

The 2006 national *Survey of State Adult Protective Services* revealed that victims range in estimated number from a low of 100,000 to a high of one million a year. It is believed that these numbers will grow with the aging population and their increasing net worth.

Elder financial abuse takes many forms, including, but not limited to: fraud (coupon, telemarketing, mail); repair and contracting scams; "sweetheart scams;" false/fraudulent advice from loan officers, stock brokers, insurance salespersons, accountants and bank officials; undue influence; illegal viatical settlements; abuse of powers of attorney and guardianship; identity theft; Internet "phishing;" failure to fulfill contracted health care services; and Medicare and Medicaid fraud.

The report states that the justice and social services systems are often inadequately trained, staffed and funded to address elder financial abuse. Further, at times it is difficult to determine whether financial abuse occurred or if one unwittingly or knowingly made a poor financial decision. Generally under state jurisdiction, most states mention financial exploitation in their statutes, although what it constitutes, who is covered and who is accountable vary as widely as do the remedies. A bill before Congress since 2002, The Elder Justice Act, would increase awareness of elder abuse, neglect and exploitation at the national level and would train individuals from various disciplines, combat elder abuse and prosecute cases. An additional measure would create an Elder Justice Coordinating Council.

Underreporting is attributed to fear of government interference, parents protecting their children and family members; embarrassment and self-blame; a lack of realization that abuse has occurred; fear of being placed in a facility; fear of harm from the perpetrator; and a belief that nothing will be done or more money will be lost.

Additional facts:

- Reports vary as to whether women or men are more vulnerable to financial abuse, but loneliness and isolation clearly leave one more

exposed to theft. The average victim of elder abuse is a woman over the age of 75 who lives alone (48% of women over the age of 75, according to the Administration on Aging). Men are reported to be particularly vulnerable to the "sweetheart scam."

- 60% of substantiated Adult Protective Services (APS) cases of elder abuse involve an adult child; sons are 2.5 times more likely than other family members to take advantage of parents.
- In addition to the obvious financial loss, long-term effects include credit problems, health issues, depression and the loss of independence.
- Signs of abuse include indications of intimidation by or fear of a caregiver, isolation from family and friends, disheveled appearance, anxiety about finances, new "best friends" and missing belongings.
- Elder financial abuse can be prevented by the following: 1) education about one's rights and about the various types of consumer fraud and scams; 2) Financial conservatorship and/or power of attorney for those who are vulnerable; 3) Assignment of responsibility to a trusted outside person, if children are a concern; 4) Additional media attention for this issue; 5) Training financial professionals to properly assist older customers; 6) Assistance from social services, medical/nursing personnel, government agencies; 7) Reporting suspected cases of financial abuse to local authorities.

Methodology

Leading researchers from the National Center for the Prevention of Elder Abuse (NCPEA), Virginia Polytechnic Institute and State University (Virginia Tech) reviewed all Newsfeed articles from April through June 2008 from the Administration on Aging's National Center on Elder Abuse (NCEA), a newly established database which tracks media reports of elder abuse through Google and Yahoo Alerts scanning billions of web pages. The researchers also searched 12 electronic databases that index academic journals containing primary literature on elder abuse from 1998 through June 2008 to provide the basis for this analysis. They found 168 articles from journals in the social science, medical and legal disciplines. At the same time, they conducted a database search of organizational and trade magazines published from 2005 to 2008 to find mentions of elder financial abuse by business and private-sector professionals (e.g., bankers, financial planners, insurance agents) who frequently interact with older adults. That search resulted in 110 articles on this topic.

National Committee for the Prevention of Elder Abuse

The National Committee for the Prevention of Elder Abuse (NCPEA) is an association of researchers, practitioners, educators and advocates dedicated to protecting the safety, security and dignity of America's most vulnerable citizens. It was established in 1988 to achieve a clearer understanding of abuse and provide direction and leadership to prevent it. The Committee is one of six partners that make up the National Center on Elder Abuse, which is funded by Congress to serve as the nation's clearinghouse on information and materials on abuse and neglect. To learn



The MetLife Study of Elder Financial Abuse

Crimes of Occasion, Desperation, and Predation Against America's Elders

The study is a follow-up of MetLife's 2009 *"Broken Trust: Elders, Family, and Finances"* and examines the prevalence and impact of elder financial abuse in America today. It demonstrates how these crimes continue to decimate incomes, impact the health and well-being of its victims, and fracture families. Yet it still is underreported, under-recognized, and under-prosecuted.

[Download the Study](#)

Key Findings

- Instances of fraud perpetrated by strangers comprised 51% of articles related to elder financial abuse, followed by family, friends, and neighbors (34%), the business sector (12%), and Medicare and Medicaid fraud (4%).
- Medicare and Medicaid fraud resulted in the highest average loss per case in that category.
- Women were twice as likely as men to be victims of elder financial abuse, with most being between the ages of 80 and 89, living alone, and requiring some level of help with either health care or home maintenance.

Methodology

Graphics

- Nearly 60% of perpetrators were men, mostly between the ages of 30 and 59.
- Dollar losses over the holidays due to family, friends, and neighbor perpetrators were overall higher than any other category due to number of instances, although the highest average dollar loss per individual was from business perpetrators.

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The MetLife Study of Elder Financial Abuse

Crimes of Occasion, Desperation, and Predation Against America's Elders



Overview

In 2009, the MetLife Mature Market Institute, in collaboration with the National Committee for the Prevention of Elder Abuse (NCPEA), and the Center for Gerontology at Virginia Tech, released a groundbreaking study to provide a comprehensive understanding of the extent and implications of elder financial abuse. The study, *Broken Trust: Elders, Family, and Finances*, consisted of a review of the scholarly and professional literature and an in-depth analysis of National Center on Elder Abuse (NCEA) newsfeed articles from April through June 2008. It was designed to provide easily accessible and well-researched information specifically focused on the problem of elder financial abuse.

In 2010, to further examine the impact of elder financial abuse on the lives of seniors nationwide, the Institute again partnered with leading researchers, Dr. Karen A. Roberto at Virginia Tech and Dr. Pamela B. Teaster at the University of Kentucky, in consultation with NCPEA. The team expanded its analysis of research published in the scholarly literature and again gathered articles from the National Center on Elder Abuse newsfeed. In addition, several individuals whose stories appeared in the 2008 newsfeeds were contacted and asked to share subsequent information about their situations. Newsfeed articles were analyzed from April through June 2010. An additional subset was collected during the 2010 holiday period (November 2010 through January 2011) to determine if instances of elder financial abuse increase during this time when family and friends are in greater proximity and with greater frequency. *The MetLife Study of Elder Financial Abuse: Crimes of Occasion, Desperation, and Predation Against America's Elders* further illuminates the widening problem of elder financial abuse.

Key Findings

- The annual financial loss by victims of elder financial abuse is estimated to be at least \$2.9 billion dollars, a 12% increase from the \$2.6 billion estimated in 2008.
- Instances of fraud perpetrated by strangers comprised 51% of the articles. Reports of elder financial abuse by family, friends, and neighbors came in second, with 34% of the news articles followed by reports of exploitation within the business sector (12%) and Medicare and Medicaid fraud (4%).
- Medicare and Medicaid fraud resulted in the highest average loss to victims (\$38,263,136) in that category followed by fraud by business and industry (\$6,219,496), family, friends, and neighbors (\$145,768), and fraud by strangers (\$95,156).

- Women were nearly twice as likely to be victims of elder financial abuse as men. Most victims were between the ages of 80 to 89, lived alone, and required some level of help with either health care or home maintenance.
- Nearly 60% of perpetrators were males. Most male perpetrators were between the ages of 30 and 59, while most female perpetrators were between the ages of 30 and 49. Perpetrators who were strangers often targeted victims with visible vulnerabilities (e.g., limited mobility, displays of confusion, being or living alone).
- Dollar losses over the holidays due to family, friend, and neighbor perpetrators were overall higher than any other category, likely owing to sheer numbers of instances, although the average number of dollars lost per individual instance was highest from business perpetrators.

Methodology

The MetLife Mature Market Institute, in partnership with Virginia Tech, the University of Kentucky, and NCEA conducted a study to determine the extent and consequences of elder financial abuse. Newsfeed articles, collected daily by the National Association of Adult Protective Services (NAPSA) through an initiative funded by the National Center on Elder Abuse (NCEA), served as a primary source of information. This newsfeed database tracks media reports of all types of elder abuse through Google and Yahoo Alerts, which scanned billions of Web pages. In order to compare to findings presented in *Broken Trust: Elders, Family, and Finances* (2009), articles on elder financial abuse were gathered from April through June 2010. Over the time period, the scans identified 389 unduplicated articles on elder financial abuse of any type from a total of 1,248 articles cited. Of those, 314 (81%) reported specific instances of financial abuse and provided information on victims and/or perpetrators. An additional 354 cases were identified in the newsfeed database between November 2010 and January 2011 for the holiday period analysis.

For More Information

The MetLife Study of Elder Financial Abuse, The Essentials: Preventing Elder Abuse, Tips: Preventing Elder Abuse for Older Americans, and Tips: Preventing Elder Abuse for Family Caregivers may be downloaded from www.MatureMarketInstitute.com. They can also be ordered by writing to: MetLife Mature Market Institute, 57 Greens Farms Road, Westport, CT 06880.



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NEWS RELEASE

Date: Sept. 9, 2010

Contact: Christine Stone, Oregon Public Health Information Officer; 971-673-1282, desk; 503-602-8027, cell; christine.i.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.

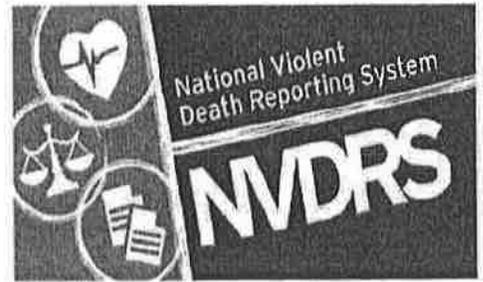
There are likely many reasons for the state's rising suicide rate, according to Millet. The single most identifiable risk factor associated with suicide is depression. Many people can manage their depression; however, stress and crisis can overwhelm their ability to cope successfully.

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.



OREGON

Public Health Division

**Suicides in Oregon:
Trends and Risk Factors
-2012 Report-**

Oregon Violent Death Reporting System
Injury and Violence Prevention Program
Center for Prevention and Health Promotion



*Excerpts
printed
2/9/14*

Executive Summary

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

Key Findings

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

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

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

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

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

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

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

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

Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year^{1,2}. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts^{3,4}. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon³. The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars^{3,4,5}. The loss to families and communities broadens the impact of each death.

The
cost
\$

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

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

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

³ Oregon Vital Statistics Annual Report, Vol. 2, 2010. Oregon Health Authority.

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

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

⁶ Maris R.W., Berman A.L., Silverman A.M. (2000). Comprehensive Textbook of suicidology. New York: The Guilford Press. (p378)

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 Y87.0¹. 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.

Mortality data from 1981 to 2010 are from Web-based Injury Statistics Query and Reporting System (WISQARS) of the Centers of Disease Control and Prevention². This system contains information from death certificates filed in state vital statistics offices.

The ORVDRS is a statewide, active surveillance system that collects detailed information on all homicides, suicides, deaths of undetermined intent, deaths resulting from legal intervention, and deaths related to unintentional firearm injuries¹. ORVDRS obtains data from Oregon medical examiners, local police agencies, death certificates, and the Homicide Incident Tracking System. All available data are reviewed, coded, and stored in the National Violent Death Reporting System. Details regarding NVDRS procedures and coding are available at <http://www.cdc.gov/ncipc/profiles/nvdrs/publications.htm>.

Rates were calculated according to death counts and bridged-race postcensal estimates released by the National Center for Health Statistics (NCHS)³. The age-adjusted rate was adjusted to the 2000 standard million. Because of limited death counts in some categories, some rates might not be statistically reliable or stable; use caution with regard to those categories with fewer than 20 deaths.

A three-year moving average of age-specific suicide death rates was computed to smooth fluctuations from one year to another. The trend in rates was tested by using Poisson regression analysis. $P < 0.05$ is considered significant.

When comparing rates, 95 percent confidence intervals were calculated. If the 95 percent confidence intervals do not overlap, then the difference is considered to be statistically significant at the 0.05-level⁴. A Chi-square test was used to test the difference on proportion (percentage) in the studying groups.

¹ 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.

² The Centers for Disease control and Prevention. WISQARS. http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html. Accessed on Sept 26, 2012.

³ National Center for Health Statistics. U.S. Census Population with Bridged-race Categories (vintage 2010 postcensal estimates): http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm#vintage2010. Accessed on June. 20, 2012.

⁴ Miniffo AM, Anderson RN, Fingerhut LA et al, Deaths: Injury, 2002. *National Vital Statistics Reports*, 2006; Vol. 54, No. 10



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Original article

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

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ABSTRACT

Background: Despite continuing political, legal and moral debate on the subject, assisted suicide is permitted in only a few countries worldwide. However, few studies have examined the impact that witnessing assisted suicide has on the mental health of family members or close friends.

Methods: A cross-sectional survey of 85 family members or close friends who were present at an assisted suicide was conducted in December 2007. Full or partial Post-Traumatic Distress Disorder (PTSD; Impact of Event Scale–Revised), depression and anxiety symptoms (Brief Symptom Inventory) and complicated grief (Inventory of Complicated Grief) were assessed at 14 to 24 months post-loss.

Results: Of the 85 participants, 13% met the criteria for full PTSD (cut-off ≥ 35), 6.5% met the criteria for subthreshold PTSD (cut-off ≥ 25), and 4.9% met the criteria for complicated grief. The prevalence of depression was 16%; the prevalence of anxiety was 6%.

Conclusion: A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although there seemed to be no complications in the grief process, about 20% of respondents experienced full or subthreshold PTSD related to the loss of a close person through assisted suicide.

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1. Introduction

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

organisations offer personal guidance to members suffering from diseases with "poor outcome" or experiencing "unbearable suffering" who wish to die.

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

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