Arguing Smart: Defeating Assisted Suicide & Euthanasia Before it Gets Started

A Presentation by Margaret Dore

October 20, 2012

Course Description:

In 2010, assisted suicide advocates targeted the US state of Idaho for legalization of assisted suicide, which they termed “aid in dying.” Their legal director owned a home there and was in the state actively meeting people, talking to newspapers and otherwise drumming up support. The legal director had also got an article published in The Advocate, the official publication of the Idaho State Bar Association. And then she was defeated by nine well-placed letters.

This course will discuss what constitutes assisted suicide and euthanasia. The course will give an overview of assisted suicide and euthanasia in the US and Canada. The course will explain how assisted suicide laws in Oregon and Washington work and how they are a recipe for elder abuse. The course will discuss the pro-assisted suicide/euthanasia game plan and how it can be defeated with a strategy and a long term commitment to win.

Course Materials

1. Margaret K. Dore, US Canada Assisted Suicide/Euthanasia Overview, as of April 19, 2012 ............................................ 1

2. Margaret K. Dore, "'Death with Dignity': What Do We Advise Our Clients?," King County Bar Association, Bar Bulletin, May 2009 ............ 5


5. Letters to the Editor, The Advocate, the official publication of the Idaho State Bar Association, Vol. 52, No. 9, pp.15-17 (September 2010) ............. 14


10. William Toffler MD, “What People Mean When They Say They Want to Die,” Choice is an Illusion,  ............................................28

11. The Playbook  ..............................................................30

* * *

Margaret Dore is a lawyer in Washington State USA where assisted suicide is legal. She is also President of Choice is an Illusion, a non-profit corporation opposed to assisted suicide and euthanasia.

Ms. Dore has been licensed to practice law since 1986. Her practice has included elder law and appeals. She is a former Law Clerk to the Washington State Supreme Court. She has several published court cases and many published scholarly articles.

Ms. Dore’s viewpoint is that people should be in control of their own fates, but that assisted suicide laws do not deliver. This year, she had an editorial published in the NY Times: “Assisted Suicide: A Recipe for Elder Abuse.”

For more information see www.margaretfordore.com and www.choiceillusion.org
US Canada

Assisted Suicide/Euthanasia Overview

As of April 19, 2012

Prepared by Margaret Dore

www.choiceillusion.org

1. Assisted Suicide

Assisted suicide means that someone provides the means and/or information for another person to commit suicide. When a physician is involved, the practice is physician-assisted suicide.1

2. Euthanasia

Euthanasia means “the administration of a lethal agent by another person to a patient”2

Euthanasia is also known as “mercy killing.”3

3. The Oregon and Washington Laws

In Oregon, physician-assisted suicide was legalized in 1997.4 Passage was via a ballot measure, which is similar to a referendum in Canada.5 In Washington, a similar law was passed via another ballot measure in 2008 and went into effect in 2009.6 No such law has made it through the scrutiny of a legislature despite more than 100 attempts.

________________________________________________________________


2 See e.g., AMA Code of Medical Ethics, Opinion 2.21, available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion221.page?# ;

3 See e.g., http://education.yahoo.com/reference/dictionary/entry/mercy%20killing (defining “mercy killing” as “euthanasia”).


5 Id.

6 Id.
4. **A Recipe for Elder Abuse**

The Washington and Oregon laws are a recipe for elder abuse. The most obvious reason is due to a lack of oversight when the lethal dose is administered. For example, there are no witnesses required at the death; the death is allowed to occur in private. With this situation, the opportunity is created for an heir, or some other person who will benefit from the patient’s death, to administer the lethal dose to the patient without his consent. Even if he struggled, who would know?

5. **Canadian Proposals**

In 2010, the Canadian Parliament defeated Bill C-384, which would have legalized assisted suicide and euthanasia in Canada.8 The vote was 228 to 59.9

In Canada, there are now two court cases seeking to legalize assisted suicide, physician-assisted suicide and/or euthanasia: (1) the Carter case in BC; and (2) the Leblanc case in Quebec.10 These cases seek to protect physicians, family members and other people who assist a patient’s death via constitutional protection under the Canadian Charter of Rights and Freedoms and/or by legalizing assisted suicide and/or euthanasia as a medical procedure.11 In both Carter and Leblanc, the scenario proposed would allow the death to occur in private without witnesses.12 Even if the person struggled, who would know?

Gloria Taylor is a plaintiff in the Carter case.

6. **Patients are Not Necessarily Dying**

---

7 See e.g., this article about a bill similar to the Oregon and Washington acts, which details some of the protections available for assisting persons. Margaret Dore, “A Doctor & Heir Protection Bill,” April 11, 2012, available at http://www.massagainstassistedsuicide.org/2012/04/doctor-heir-protection-bill.html


9 Id.


11 Id.

12 Id.
The Oregon and Washington laws are restricted to patients predicted to have less than six months to live. Such persons are not necessarily dying. Doctors can be wrong. Moreover, treatment can lead to recovery. Consider Jeanette Hall, who was diagnosed with cancer and given six months to a year to live. She was adamant that she would “do” Oregon’s law, but her doctor, Ken Stevens, convinced her to be treated. She is still alive. That was nearly 12 years ago.

In Canada, the Carter and Leblanc cases are not limited to people predicted to have less than 6 months to live.

7. Empowering the Healthcare System

In Oregon, patients desiring treatment under the Oregon Health Plan have been offered assisted suicide instead.

The most well known cases involve Barbara Wagner and Randy Stroup. Each wanted treatment. The Plan denied their requests and steered them to suicide by offering to pay for their suicides. Neither Wagner nor Stroup saw this scenario as a celebration of their "autonomy" and/or "choice." Wagner said: “I’m not ready to die.” Stroup said: “This is my life they’re playing with.”


14 See Jeanette Hall, Letter to the editor, “She pushed for legal right to die, and - thankfully - was rebuffed, Boston Globe, October 4, 2011 (“I am so happy to be alive!), available at http://www.boston.com/bostonglobe/editorial_opinion/letters/articles/;


15 See above articles about the Carter and Leblanc cases.


17 Id.

18 Id.

19 Id.

20 KATU TV at note 16.

21 ABC News at note 16.
Wagner and Stroup were steered to suicide. Moreover, it was the Oregon Health Plan, a
government entity, doing the steering.

If assisted suicide/euthanasia is legalized in Canada, the Canadian health care system will
be similarly empowered.

8. **A “Wedge” Issue**

In Washington State, where assisted suicide was legalized three years ago, there is
already a discussion to expand our law to direct euthanasia for non-terminal people.22  Indeed,
last month, there was a column describing reader suggestions for euthanasia for people unable to
afford care, which would be on an involuntary basis for people who want to live.23

9. **Suicide Contagion**

Oregon's suicide rate, which excludes suicides under its physician-assisted suicide law,
has been "increasing significantly" since 2000.24 Just three years prior, Oregon legalized
physician-assisted suicide. This increased suicide rate is consistent with a suicide contagion. In
other words, legalizing one type of suicide encouraged other suicides. In Canada, preventing
suicide is a significant public health issue.

---

22  See  Brian Faller, "Perhaps it's time to expand Washington's Death with Dignity Act, The Olympian, November
washingtons.html

23  See Jerry Large, "Planning for old age at a premium," The Seattle Times, March 8, 2012 at
http://seattletimes.nwsource.com/text/2017693023.html ("After Monday's column, some readers were
unsympathetic, a few suggested that if you couldn't save enough money to see you through your old age, you
shouldn't expect society to bail you out. At least a couple mentioned euthanasia as a solution.")

Division, September 2010, page 6, ("Deaths relating to the death with Dignity Act (physician-assisted suicides) are
not classified as suicides by Oregon law and therefore excluded from this report"), available at
http://epcdocuments.files.wordpress.com/2011/10/or_suicide_report_001.pdf  See also Oregon Health Authority,
News Release, "Rising suicide rate in Oregon reaches higher than national average," September 9, 2010, ("suicide
rates have been increasing significantly since 2000") available at
What Do We Advise Our Clients?

By Margaret Dore

A client wants to know about the new Death with Dignity Act, which legalizes physician-assisted suicide in Washington. Do you take the politically correct path and agree that it's the best thing since sliced bread? Or do you do your job as a lawyer and tell him that the Act has problems and that he may want to take steps to protect himself?

Patient “Control” is an Illusion

The new act was passed by the voters as Initiative 1000 and has now been codified as Chapter 70.245 RCW.

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

How the Act Works

The Act requires an application process to obtain the lethal dose, which includes a written request form with two required witnesses. The Act allows one of these witnesses to be the patient’s heir. The Act also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient's heir. This does not promote patient choice; it invites coercion.

Interested witness

By comparison, when a will is signed, having an heir as one of witnesses creates a presumption of undue influence. The probate statute provides that when one of the two required witnesses is a taker under the will, there is a

Originally published in the May 2009 issue of the King County Bar Association Bar Bulletin. Reprinted with permission of the King County Bar Association.
rebuttable presumption that the taker/witness “procured the gift by duress, menace, fraud, or undue influence.”

Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons. Indeed, no one is required to be present. The Act does not state that “only” the patient may administer the lethal dose; it provides that the patient “self-administer” the dose.

“Self-administer”

In an Orwellian twist, the term “self-administer” does not mean that administration will necessarily be by the patient. “Self-administer” is instead defined as the act of ingesting. The Act states, “Self-administer’ means a qualified patient’s act of ingesting medication to end his or her life.”

In other words, someone else putting the lethal dose in the patient’s mouth qualifies as “self-administration.” Someone else putting the lethal dose in a feeding tube or IV nutrition bag also would qualify. “Self-administer” means that someone else can administer the lethal dose to the patient.

No witnesses at the death

If, for the purpose of argument, “self-administer” means that only the patient can administer the lethal dose himself, the patient still is vulnerable to the actions of other people, due to the lack of required witnesses at the death.

With no witnesses present, someone else can administer the lethal dose without the patient’s consent. Indeed, someone could use an alternate method, such as suffocation. Even if the patient struggled, who would know? The lethal dose request would provide an alibi.

This situation is especially significant for patients with money. A California case states, “Financial reasons [are] an all too common motivation for killing someone.” Without disinterested witnesses, the patient’s control over the “time, place and manner” of his death, is not guaranteed.

If one of your clients is considering a “Death with Dignity” decision, it is prudent to be sure that they are aware of the Act’s gaps.

What to Tell Clients

1. Signing the form will lead to a loss of control

By signing the form, the client is taking an official position that if he dies suddenly, no questions should be asked. The client will be unprotected against others in the event he changes his mind after the lethal prescription is filled and decides that he wants to live. This would seem especially important for clients with money. There is, regardless, a loss of control.

2. Reality check

The Act applies to adults determined by an “attending physician” and a “consulting physician” to have a disease expected to produce death within six months. But what if the doctors are wrong? This is the point of a recent article in The Seattle Weekly: Even patients with cancer can live years beyond expectations. The article states:

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

Conclusion

As lawyers, we often advise our clients of worst-case scenarios. This is our obligation regardless of whether it is politically correct to do so. The Death with Dignity Act is not necessarily about dignity or choice. It also can enable people to pressure others to an early death or even cause it. The Act also may encourage patients with years to live to give up hope. We should advise our clients accordingly.

Margaret Dore is a Seattle attorney admitted to practice in 1986. She is the immediate past chair of the Elder Law Committee of the ABA Family Law Section. She is a former chair of what is now the King County Bar Association Guardianship and Elder Law Section. For more information, visit her website at www.margaretdore.com.

1 The Act was passed by the voters in November as Initiative 1000 and has now been codified as RCW chapter 70.245.

2 I-1000 color pamphlet, “Paid for by Yes! on 1000.”

3 RCW 70.245.030 and .220 state that one of two required witnesses to the lethal-dose request form cannot be the patient’s heir or other person who will benefit from the patient’s death; the other may be.

4 id.

5 RCW 70.245.010(3) allows someone else to talk for the patient during the lethal-dose request process; for example, there is no prohibition against this person being the patient’s heir or other person who will benefit from the patient’s death. The only requirement is that the person doing the talking be “familiar with the patient’s manner of communicating.”

6 RCW 11.88.160(2).

7 RCW 70.245.010(12).

8 People v. Stuart, 67 Cal. Rptr. 3rd 129, 143 (2007).

9 RCW 70.245.010(11) & (13).


11 id.
Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

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

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

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

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

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

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

* * *

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


[8] See Bill Status S1070, last entry.
AID IN DYING: LAW, GEOGRAPHY AND STANDARD OF CARE IN IDAHO

Kathryn L. Tucker
Compassion & Choices
Christine Salmi
Perkins Coie, LLP

MERIDIAN -- An elderly couple is dead after shots were fired in a Meridian home Sunday evening.

Ada County Coroner says 87-year-old Robert Emerson shot and killed his wife, 90-year-old Olive Emerson, and then turned the gun on himself.

Meridian Police say investigators were told by family members that Robert and Olive were both suffering from terminal cancer.

Introduction

The news report above reflects a tragedy that arises when terminally ill patients feel trapped in a dying process they find unbearable, yet don’t feel they can turn to their physician to obtain a prescription for medication that can be consumed to bring about a peaceful death.

Idaho law empowers citizens with broad autonomy over medical decisions, including specifically decisions relating to end of life care. However, Idaho has no legislation either permitting or prohibiting the end of life option known as “aid in dying.” Having the option of aid in dying provides comfort to terminally ill patients even if they do not consume the medication to bring about death. The experience in Oregon, where aid in dying has been affirmatively legal for a dozen years, reflects this: roughly one-third of the patients who obtain the medication each year do not go on to ingest it. They are comforted by this option, but die of their underlying disease. Oregon’s data also tells us much about why patients choose aid in dying: loss of autonomy, loss of dignity, and decreasing ability to participate in activities that made life enjoyable are the most frequently mentioned reasons.

This article reviews the law in Idaho governing end-of-life care, the law and practice in the surrounding states, and the possible implications for Idaho of being situated among states that affirmatively permit aid in dying. It is time for Idaho to join the surrounding states by including aid in dying among end-of-life options available for patients with terminal illnesses. This article posits that Idaho can do so under the current state of the law by incorporating this intervention into medical practice subject to the standard of care.

Idaho law governing end of life care

Idaho statutes include The Medical Consent and Natural Death Act (MC-NDA), I.C. §§ 39-4501 to -4515. This statute empowers citizens to refuse or direct withdrawal of life-prolonging medical treatment. In enacting this statute, the Idaho Legislature set forth the following policy statements:

(1) The legislature recognizes the established common law and the fundamental right of adult persons to control the decisions relating to the rendering of their medical care, including the decision to have lifesustaining procedures withheld or withdrawn.

(2) In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of this state shall recognize the right of a competent person to have his or her wishes for medical treatment and for the withdrawal of artificial life-sustaining procedures carried out even though...
that person is no longer able to communicate with the physician.⁴

The MCNDA includes a provison stating that this Act “does not make legal, and in no way condones, euthanasia, mercy killing, or assisted suicide or permits an affirmative or deliberate act or omission to end life, other than to allow the natural process of dying.”⁵

This raises the question whether aid in dying could fall within this exclusion. Those who consider the act of allowing a dying patient to ingest medication to achieve a peaceful death a form of suicide would argue that it does. Others who recognize that the choice of a dying patient for a peaceful death is something fundamentally different from suicide would argue that this exclusion does not apply to aid in dying.⁶ In any event, the statute does not contain a prohibition against aid in dying.

A critical analysis of the law in Idaho supports the contention that Idaho patients should be able to access aid in dying because there is no logical distinction between a terminally-ill patient’s right to refuse life-sustaining treatment and such patient’s right to have access to medication which the patient could ingest to bring about a peaceful death.

One might argue that aid in dying could be prosecuted under Idaho’s criminal statute, I.C. § 18-4014, which provides, in part:

Every person who, with intent to kill, administers or causes or procures to be administered, to another, any poison or other noxious or destructive substance or liquid, but by which death is not caused, is punishable by imprisonment in the state prison not less than ten (10) years, and the imprisonment may be extended to life.⁷

However, this statute only applies if the patient does not die. A patient who ingests medication prescribed by their physician for aid in dying will almost certainly achieve the desired death.⁸ If the patient does achieve the desired death, an aggressive prosecutor might argue that the physician could be prosecuted for homicide. This situation was recently addressed in Montana, and the Montana Supreme Court squarely rejected the possibility of a homicide charge being brought against a physician who provided aid in dying.⁹

Based on this landscape, Idaho physicians should feel safe to provide aid in dying to their competent, terminally-ill patients, free of fear of criminal prosecu-

The Montana Supreme Court squarely rejected the possibility of a homicide charge being brought against a physician who provided aid in dying.

Aid in dying in surrounding states
Oregon
Oregonians approved the passage of the Oregon Death with Dignity Act (Dignity Act) in 1994.¹¹ The Dignity Act allows a mentally-competent, terminally-ill patient to obtain medication from his or her physician, which the patient can consume to bring about a peaceful death.¹² The experience in Oregon demonstrates that when this option is available, it does not place patients at risk, as those who oppose aid in dying have advocated.¹³ Oregon’s experience has caused even staunch opponents to admit that continued opposition to such a law can only be based on moral or religious grounds.⁴

The option of aid in dying has not been unwillingly forced upon those who are poor, uneducated, uninsured, or otherwise disadvantaged.¹⁵ In fact, those with a baccalaureate degree or higher were 7.9 times more likely than those without a high school diploma to choose aid in dying.¹⁶ One hundred percent of patients opting for aid in dying had private health insurance, Medicare, or Medicaid, and were overwhelmingly enrolled in hospice care.¹⁷ Furthermore, during the first 12 years in which it was a legal option, only 460 Oregonians chose it.¹⁸ Terminally ill adults who chose this option in 2009 represented 19 deaths for every 10,000 Oregonians who died that year. Roughly one-third of those patients who complete the process of seeking medications under the Dignity Act do not go on to consume the medications.¹⁹

Simultaneously, Oregon doctors increased efforts to improve their ability to provide adequate end-of-life care, including increasing their knowledge of pain medication usage for the terminally ill, becoming more informed at recognizing depression and other conditions that could impair decision making, and referring their patients to hospice programs with greater frequency.²⁰ The option of aid in dying also has psychological benefits for terminally ill patients. The availability of the option gives a terminally-ill patient autonomy, control, and choice, which physicians in Oregon have identified as the predominant motivational factors behind the decision to request assistance in dying.²¹

Washington
Washington passed a Dignity Act virtually identical to Oregon’s in November 2008.²² The Washington Department of Health publishes information about the types and quantities of forms received under the Dignity Act on its website²³ and updates this information weekly.²⁴ The Department of Health also publishes an annual report that includes information on how many prescriptions are written under the Act, and how many people ingest the prescribed medication. The first annual report includes data from March 2009 through December 31, 2009.²⁵ Statistical reports will be completed annually thereafter.

Montana
Montana recognizes the right of its citizens to choose aid in dying through a decision of the Montana Supreme Court. In Baxter v. State, Robert Baxter, a 75-year-old U.S. Marine veteran and long-haul truck driver dying of lymphocytic leukemia, sued the State to establish his right to choose aid in dying.²⁶ Baxter was married, with four grown children, and was fiercely independent; he wanted the option for a peaceful death on his own terms if his suffering became unbearable.²⁷ Additional plaintiffs included four Montana physicians who treat patients with termi-
nal illnesses and Compassion & Choices, the national non-profit organization that advocates on behalf of terminally ill persons.28

The plaintiffs challenged the application of Montana’s homicide statute to a physician providing a prescription to a terminally-ill, mentally-competent patient for medication that the patient could consume to bring about a peaceful death if he found his dying process unbearable.29 The case invoked the Montana State Constitution’s guarantees of privacy and dignity.30 Commentators speculated that constitutional claims of this nature had a good chance of success given the state constitution’s text and the body of law construing these provisions, which was robustly protective of individual decision-making.31

Plaintiffs asserted an alternative argument that under the consent as a defense doctrine, a doctor who provided aid in dying could not be subject to prosecution for homicide.32 The patient would have consented to the physician’s assistance in precipitating the patient’s death and there was no public policy reason to deny the consent defense under these circumstances.33 The plaintiffs in Baxter had the advantage of being able to point to many years of data from Oregon’s implementation of its statute affirmatively making aid in dying legal, which made clear that risks to patients do not arise when patients have the option to choose aid in dying.34 The argument—that risks will still be present if aid in dying is an option—had been central to the states’ efforts to prevent courts from finding a right to choose this intervention.35

On December 5, 2008, the Montana State District Court issued summary judgment in favor of the Plaintiffs, holding that the state constitution’s Individual Dignity Clause and the stringent right of privacy are “intertwined insofar as they apply to Plaintiffs’ assertion that competent terminal patients have the constitutional right to determine the timing of their death and to obtain physician assistance in doing so.”36 The district court further concluded that “[t]he decision as to whether to continue life for a few additional months when death is imminent certainly is one of personal autonomy and privacy.”37 In an odd synchronicity, Plaintiff Bob Baxter died the same day the lower court ruling was issued. The State appealed.

The Supreme Court held 5-2 that terminally ill Montanans have the right to choose aid in dying under state law.38 The court declined to reach the constitutional issues.39 Instead, it resolved the case on the alternative ground under the consent defense to the homicide statute, finding:

“no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy.”40

. . . [A] physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient himself can give effect to his life-ending decision, or not, as the case may be. Each stage of the physician-patient interaction is private, civil, and compassionate. The physician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient’s subsequent private decision whether to take the medicine does not breach public peace or endanger others. . . .

. . . There is thus no indication in the homicide statutes that physician aid in dying—in which a terminally ill patient elects and consents to taking possession of a quantity of medicine from a physician that, if he chooses to take it, will cause his own death—is against public policy.

. . . The Rights of the Terminally Ill Act very clearly provides that terminally ill patients are entitled to autonomous, end-of-life decisions, even if enforcement of those decisions involves direct acts by a physician. Furthermore, there is no indication in the Rights of the Terminally Ill Act that an additional means of giving effect to a patient’s decision—in which the patient, without any direct assistance, chooses the time of his own death—is against public policy.41

Montana has not enacted statutes with specific requirements governing provision of aid in dying.42 Accordingly, the limitations of the laws in Oregon and Washington do not apply in Montana, although certain boundaries recognized by the Court are similar to the Oregon and Washington requirements; all three states require that the patient be terminally ill, mentally competent, and that the physician involvement be limited to providing a prescription that the patient can self-administer.

Aid in dying in Idaho should be governed by the standard of care

Most medical care is not governed by statute or court decision, but is instead governed by the standard of care.43 In determining the standard of care, Idaho courts apply an objective community standard test that looks at what a similarly situated practitioner in the local community would do, taking into account his or her training, experience, and fields of medical specialization.44

Oregon’s, Washington’s and Montana’s practices of affirmatively permitting mentally competent, terminally ill patients to choose aid in dying will appropriately influence the standard of care in Idaho. Idaho is particularly well situated to be the first state that adopts this approach, given that it has no legislation specifically addressing the matter and is surrounded by states where the practice is now an established option available to patients dying of terminal illnesses.

Conclusion

Most Americans “believe a person has a moral right to end their life if they are suffering great pain and have no hope of improvement.”45 It is critically important that patients can turn to their physician for aid in dying. When a patient does not feel able to discuss the desire for aid in dying with his or her physician or cannot find a physician willing to provide it, the patient may seek assistance in precipitating death from a family member or loved one. Tragically, these incidents often involve a violent means to death, such as gunshot.
Cases of this nature appear with disturbing frequency in the newspapers, as noted at the outset of this article. However, should aid in dying emerge as an end-of-life option in Idaho, it is hopeful that such tragedies can be avoided in the future.

About the Authors

Kathryn L. Tucker is Director of Legal Affairs for Compassion & Choices. She was co-counsel to the plaintiffs in Baxter v. State, discussed in this article. Ms. Tucker previously practiced with Perkins Coie, LLP, and teaches Law, Medicine and Ethics at the End of Life at the University of Washington, Seattle University, Lewis and Clark, and Loyola Schools of Law. She can be reached at ktucker@compassionandchoices.org.

Christine Salmi practices commercial litigation with the Boise office of Perkins Coie, LLP. Ms. Salmi provided research and editing support for this article.

Endnotes
3 See id.
10 Concerns about possible criminal prosecution are the primary reason physicians fear providing aid in dying. Another concern is that professional disciplinary action can be taken against a physician for providing such care.
17 Id. at 23.
18 Annual Reports, supra note 12, Year 12 – 2009 Summary (2010).
19 Id.
24 Id., Forms Received, http://www.doh.wa.gov/dwda/formsreceived.htm (last visited Apr. 6, 2010).
26 224 P.3d at 1214.
27 Id. at 1224.
28 Id. at 1214.
29 Id.
30 Mont. Const. art. II, §§ 4, 10.
33 Id.
37 Id.
38 Baxter, 224 P.3d at 1222.
39 Id. at 1216.
40 Id. at 1215.
41 Id. at 1217-18.
Legislature rejected euthanasia

Dear Editor:

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

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

Montana doesn’t permit it

Dear Editor:

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

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

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

Senator Greg Hinkle
Thompson Falls, MT

Heirs will abuse older people

Dear Editor:

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

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

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

Do not be deceived.

Representative Nancy Elliott
Merrimack, New Hampshire

No assisted suicide in Idaho

To the Editor:

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

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

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

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

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

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

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

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

Wrong article for The Advocate

Dear Editor:

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

According to your website: “The Advocate features articles written by attorneys on topics of interest to members of the legal community.” Kathryn L. Tucker is not an Idaho attorney. She is an extremely well-paid political activist stirring up controversy through her erroneous rhetoric. I find it extremely difficult to believe that this subject matter would be of interest to the majority of your readers. Which leads me to ask why publish such an article? Are you using your position as editor to help promote your own political agenda?

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

Doctors not always right

Dear Editor:

I live in Idaho, but formerly lived in Washington state where assisted suicide is legal. I was appalled to see Kathryn Tucker’s article promoting “aid in dying,” which is not only a euphemism for assisted suicide, but euthanasia. Indeed, in 1991, an “aid in dying” law was proposed in Washington State, which would have legalized direct euthanasia “performed in person by a physician.” Legalizing these practices is bad public policy for many reasons. One personal to me is that doctors are not always right. In 2005, I was diagnosed with a rare form of terminal endocrine cancer. This, along with having contracted Parkinson’s disease, has made for a challenging life. Like most people, I sought a second opinion from the premier hospital in the nation that treats this form of cancer, M.D. Anderson, in Houston. But they refused to even see me, indicating they thought it was hopeless. Now five years later, it’s obvious they were wrong.

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

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

Chris Carlson
Medimont, ID

Article’s lousy legal analysis

Dear Editor:

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

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

Robert Moody
Boise, ID

Oregon’s law doesn’t work

Dear Editor:

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

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

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

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

In other words, they were likely people with money. Was it really their “choice?” Preserve choice in Idaho. Reject assisted suicide.

Robin Sipe
Eagle, ID

Oregon mistake cost lives

Dear Editor:

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

patients on the Oregon Health Plan (Medicaid).

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

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

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

Kenneth Stevens, MD
Sherwood, OR

Let the Lawyer Referral Service send clients your way.

Many people who need an attorney don’t know what kind of attorney or where to look. The LRS matches clients with participating attorneys.

Did You Know?
• Over 4,000 people call the LRS service yearly
• 1,000+ people use the online LRS monthly
• Your name is available to both online and call-in LRS clients

To learn how to sign-up for LRS contact Kyme Graziano at (208) 334-4500.
**AID IN DYING: NOT LEGAL IN IDAHO; NOT ABOUT CHOICE**

Margaret K. Dore  
*Law Offices of Margaret K. Dore, P.S.*

“Those who believe that legalizing euthanasia and/or assisted-suicide will assure their ‘choice,’ are naive.”  
-William Reichel, MD  
*Coeur d’Alene Press  
June 30, 2010*

### Introduction

Last month, *The Advocate* ran an article by Kathryn Tucker, Director of Legal Affairs for Compassion & Choices, a successor organization to the Hemlock Society. Tucker argued that “aid in dying” is legal in Idaho such that “physicians should feel safe to provide [it]” and that this option will give patients “choice.”

“Aid in dying” is a euphemism for euthanasia and physician-assisted suicide. Tucker’s article appears to be limited to physician-assisted suicide. Regardless, an Idaho doctor who undertakes such practice is subject to criminal and civil liability. It is also untrue that legalization will assure patient choice.

### Physician-assisted suicide

The American Medical Association (AMA) defines physician-assisted suicide, as follows:

“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).”

The AMA rejects assisted suicide. Assisted suicide is also opposed by disability rights groups such as the Disability Rights Education and Defense Fund, and Not Dead Yet.

### Most states and Canada do not allow assisted suicide

The vast majority of states to consider assisted suicide, have rejected it. This year, New Hampshire and Canada rejected it by wide margins.

There are just two states where assisted suicide is legal: Oregon and Washington. These states have statutes, which give doctors immunity from criminal and civil liability. In Montana, there is a court decision, which gives doctors a potential defense to criminal prosecution, but does not legalize assisted suicide by giving doctors criminal and civil immunity.

### Not what the voters were promised

The Oregon and Washington acts were passed via initiatives in which voters were promised that their “choice” would be assured. Both acts, however, have significant gaps so that patient choice is not assured. For example, neither act requires witnesses at the death. Without disinterested witnesses, the opportunity is created for someone to administer the lethal dose to the patient without his consent. Even if he struggled, who would know?

Oregon and Washington are also “Don’t Ask, Don’t Tell” states. Required official forms and reports do not ask about or report on whether the patient consented at the time of death. Consent at the time of death is also not required by the language of the acts themselves. Once again and contrary to marketing rhetoric, patient “choice” is not assured.

### New Hampshire

In January 2010, an assisted suicide bill was defeated in the New Hampshire House of Representatives, 242 to 113. The major reason was elder abuse. New Hampshire Representative Nancy Elliott states: “These acts empower heirs and others to pressure and abuse older people to cut short their lives. This is especially an issue when the older person has money. There is no assisted-suicide bill that you can write to correct this huge problem.”

### Patients are not necessarily dying

Oregon and Washington’s acts apply to “terminal” patients, defined as having no more than six months to live. Such patients are not necessarily dying. Doctor prognoses can be wrong. Moreover, treatment can lead to recovery. Oregon resident, Jeanette Hall, who was diagnosed with cancer and told that she had six months to a year to live, stated:

I wanted to do our law and I wanted my doctor to help me. Instead, he encouraged me to not give up and ultimately I decided to fight. I had both chemotherapy and radiation...

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

### Expanded definitions of “terminal”

Compassion & Choices has proposed expanded definitions of terminal for the purpose of assisted suicide laws, which, if enacted, will cause these laws to apply to people who are clearly not dying. This was the case with the New Hampshire bill described above. When originally introduced, it contained the following definition of “terminal condition”:

Julie Brown of Seattle holds a sign she used at a protest against a Washington law that allows assistance for suicide.
XIII. “Terminal condition” means an incurable and irreversible condition, for the end stage of which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death.22

Commentator Stephen Drake explains the definition’s ramifications, as follows: “[T]erminality is defined as having a condition that is irreversible and will result in a premature death. My partner [a motorized wheelchair user] would fit that definition. Many people I work with also fit the definition… None of them are dying.”23

In Montana, Compassion & Choices proposed another broad definition of “terminally ill adult patient,” as follows: “[A]n adult who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time.”24 Attorney Theresa Schrempp and doctor Richard Wonderly provide this analysis:25

[The] definition is broad enough to include an 18 year old who is insulin dependent or dependent on kidney dialysis, or a young adult with stable HIV/AIDS. Each of these patients could live for decades with appropriate medical treatment. Yet, they are “terminally ill” according to the definition promoted by [Compassion & Choices].

It’s not about choice

Once a patient is labeled “terminal,” the argument can be made that his treatment should be denied in favor of someone more deserving.26 This has happened in Oregon where patients labeled “terminal” have not only been denied coverage for treatment, they have been offered coverage for assisted suicide instead.27 The most well known case involves Barbara Wagner, who had lung cancer.28 The Oregon Health Plan refused to pay for a drug to possibly prolong her life and offered to pay for her assisted suicide instead.29

After Wagner’s death, Compassion & Choices’ president, Barbara Coombs Lee, published an editorial in The Oregonian arguing against Wagner’s choice to try and beat her cancer.30 Coombs Lee also defended the Oregon Health Plan and argued for a public policy change to discourage people from seeking cures.31

This editorial, combined with Compassion & Choices’ expanded definitions of terminal, provide a glimpse into Compassion & Choices’ true agenda: It’s not the promotion of personal choice.

In Idaho, assisted suicide is prohibited by the common law

Criminal Liability

The Idaho Code provides that when there is no statute governing a matter, the common law of England applies.32 “At common law, an aider and abettor [of suicide] was guilty of murder…”33

Prior to 1994, there were no statutes in Idaho addressing assisted suicide. Assisted suicide was prohibited by the common law and chargeable as murder.

In 1994, the Idaho Legislature passed an act to establish procedures for Do Not Resuscitate Orders.34 As part of this act, the legislature included a provision that assisted suicide was not being made legal. The provision stated: “This act does not make legal and in no way condones, mercy killing, assisted suicide or euthanasia.”35

In 2001 and 2007, the provision was re-codified.36 Now part of the Medical Consent and Natural Death Act, it states: “This chapter does not make legal, and in no way condones, euthanasia, mercy killing, or assisted suicide or permit an affirmative or deliberate act or omission to end life, other than to allow the natural process of dying.”37

Per the above provision and common law, assisted suicide remains a crime in Idaho. Assisted suicide can also be statutorily charged as murder. Idaho Code § 18-4001 defines “murder” as the “unlawful killing of a human being . . . with malice aforethought,” while Idaho Code § 18-4002 states that “malice” is a “deliberate intention unlawfully to take away the life of a fellow creature.”38 With assisted suicide prohibited by common law and not subsequently made legal, a doctor who assists a suicide with “deliberate intention” is guilty of such unlawful killing. He can be statutorily charged with murder.

Civil liability

In 2009, the Idaho Supreme Court decided Cramer v. Slater, which states that doctors “can be held liable for [a] patient’s suicide.”39 In Cramer, doctors negligently informed a patient about his HIV/AIDS status, which allegedly caused him to commit suicide.40 Tucker does not address Cramer. She argues instead that Idaho doctors are free to perform assisted suicide due to the law in Oregon, Washington and Montana.41

Ignoring for the moment that assisted suicide is not actually legal in Montana, this is like saying that because a brothel is legal in Nevada, the same brothel is legal in Utah. This is obviously not the case. Tucker also argues that the above provision in the Medical Consent and Natural Death Act does not prohibit “aid in dying” because aid in dying is not “suicide.”42 She made a similar argument as counsel for the plaintiffs in Blick v. Connecticut.43 The Court disagreed and dismissed the case.44 Judge Aurigemma stated:

[T]he legislature intended the statute to apply to physicians who assist a suicide and intended the term “suicide” to include self-killing by those who are suffering from unbearable terminal illness. The language and legislative history of § 53a-56 compel the conclusion that the defendants [state’s attorneys] would not be acting in excess of their authority if they prosecuted the plaintiffs under § 53a-56 for providing “aid in dying.”45

Tucker concludes her article by holding out assisted suicide as a solution to murder-suicide in elderly couples. According to Donna Cohen, an expert on murder-suicide, the typical case involves a depressed, controlling husband who shoots his ill wife: “The wife does not want to die and is often shot in her sleep. If she was awake at the time, there are usually signs that she tried to defend herself.”46 If assisted suicide were legal, the husband, not wanting to die, would still be a victim.

Conclusion

Physician-assisted suicide is not legal in Idaho. A doctor who engages in such practice is subject to criminal and civil liability.
Endnotes


2  Kathryn Tucker & Christine Salmi, Aid in Dying: Law, Geography and Standard of Care in Idaho, 53 THE ADVOCATE: OFFICIAL PUBLICATION OF THE IDAHO STATE BAR No. 8, 42-45, 45 (2010); IAN DOWBIGGIN, A CONCISE HISTORY OF EUTHANASIA 129 (2007)(The Hemlock Society was formed in 1980 and “dedicated to the decriminalization of assisted suicide and active voluntary euthanasia”); id. at 146 (In 2003, Hemlock changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices.)

3  Tucker, Aid in Dying, at 43.


6  Int’l Task Force, cited at note 4 (“Between January 1996 and June 2009, there were 113 legislative proposals in 24 states.”) All were either defeated, tabled for the session, or languished with no action taken.).


8  See OR. REV. STAT. § 127.800-995 (2005); WASH. REV.CODE ANN. § 70.245.010-904 (2009).


11  OR. REV. STAT. § 127.800-995 (2005); WASH. REV.CODE ANN. § 70.245.010-904 (2009).

On March 5, 2010, demonstrators protest Washington Assisted Suicid Act in front of the University of Washington Hospital in Seattle while several TV stations interview Eileen Geller.

12  See also ALL of the University of Washington Hospital in Seattle while several TV stations interview Eileen Geller.
LETTERS TO THE EDITOR

Dutch law allows euthanasia

Dear Editor:

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

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

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

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

William Reichel, M.D.
Georgetown University
Washington DC

Article deserves clarification

Dear Editor:

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

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

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

Doctors should embrace aid in dying

Dear Editor:

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

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

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

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

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

Tom Archie, MD
Hailey, ID

Elder abuse a growing problem

Dear Editor:

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

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

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

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

Alex Schadenberg
Euthanasia Prevention Coalition
London ON, Canada
Don’t follow Oregon’s lead:
Say no to assisted suicide

Dear Editor:

I am an internal medicine doctor, practicing in Oregon where assisted suicide is legal. I write in support of Margaret Dore’s article, Aid in Dying: Not Legal in Idaho; Not About Choice. I would also like to share a story about one of my patients.

I was caring for a 76 year-old man who came in with a sore on his arm. The sore was ultimately diagnosed as a malignant melanoma, and I referred him to two cancer specialists for evaluation and therapy. I had known this patient and his wife for over a decade. He was an avid hiker, a popular hobby here in Oregon. As he went through his therapy, he became less able to do this activity, becoming depressed, which was documented in his chart.

During this time, my patient expressed a wish for doctor-assisted suicide to one of the cancer specialists. Rather than taking the time and effort to address the question of depression, or ask me to talk with him as his primary care physician and as someone who knew him, the specialist called me and asked me to be the “second opinion” for his suicide. She told me that barbiturate overdoses “work very well” for patients like this, and that she had done this many times before.

I told her that assisted-suicide was not appropriate for this patient and that I did NOT concur. I was very concerned about my patient’s mental state, and I told her that addressing his underlying issues would be better than simply giving him a lethal prescription. Unfortunately, my concerns were ignored, and approximately two weeks later my patient was dead from an overdose prescribed by this doctor. His death certificate, filled out by this doctor, listed the cause of death as melanoma.

The public record is not accurate. My patient did not die from his cancer, but at the hands of a once-trusted colleague. This experience has affected me, my practice, and my understanding of what it means to be a physician.

What happened to this patient, who was weak and vulnerable, raises several important questions that I have had to answer, and that the citizens of Idaho should also consider:

- If assisted suicide is made legal in Idaho, will you be able to trust your doctors, insurers and HMOs to give you and your family members the best care? I referred my patient to specialty care, to a doctor I trusted, and the outcome turned out to be fatal.

- How will financial issues affect your choices? In Oregon, patients under the Oregon Health Plan have been denied coverage for treatment and offered coverage for suicide instead. See e.g. KATU TV story and video at http://www.katu.com/home/video/26119539.html (about Barbara Wagner). Do you want this to be your choice?

- If your doctor and/or HMO favors assisted suicide, will they let you know about all possible options or will they simply encourage you to kill yourself? The latter option will often involve often less actual work for the doctor and save the HMO money.

In most states, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient received was a lethal prescription, intended to kill him.

Is this where you want to go? Please learn the real lesson from Oregon.

Despite all of the so-called safeguards in our assisted suicide law, numerous instances of coercion, inappropriate selection, botched attempts, and active euthanasia have been documented in the public record.

Protect yourselves and your families. Don’t let legalized assisted suicide come to Idaho.

Charles J. Bentz MD
Oregon Health & Sciences University
Portland, OR

Do you have clients with
TAX PROBLEMS?
MARTELLE LAW OFFICE, P.A.
represents clients with Federal and State tax problems

- OFFERS IN COMPROMISE
- APPEALS
- BANKRUPTCY DISCHARGE
- INNOCENT SPOUSE
- INSTALLMENT PLANS
- PENALTY ABATEMENT
- TAX COURT REPRESENTATION
- TAX RETURN PREPARATION

MARTELLE LAW OFFICE, P.A.
208-938-8500
873 East State Street
Eagle, ID 83616
E-mail:attorney@martellelaw.com
www.martellelaw.com

Your legal staffing resource for part-time and full-time employees.

We are accepting applications and resumes from experienced paralegals and other professional office staff.

Contact Merrily Munther
or Mary Lou Brewton-Belveau
at (208) 344-4566
info@idaholegalstaffing.com

Accepting referrals for arbitration and mediation services

GEORGE D. CAREY
P.O. Box 171391
Boise, Idaho 83717
Telephone: (208) 866-0186
Email: gcdgdc@yahoo.com
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

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 Moyer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.
"There's always a little triumph," Bud chimes in. "I made it for another day."

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

Then 75, "he became old almost overnight," Heidi says. Still, Bud was put on medications that kept him going—long enough to have a stroke five years later, kidney failure the year after that, and then the onset of severe chest pain known as angina. "It was scary," says Heidi, who found herself struggling at 3 a.m. to find Bud's veins so she could inject the morphine that the doctor had given Bud for the pain.

Heidi is a petite blond nurse with a raucous laugh. She's 20 years younger than her husband, whom she met at a military hospital, and shares his cigar-smoking habit. Bud was a high-flying psychiatrist in the '80s when he became the U.S. Assistant Secretary of Defense, responsible for all Armed Forces health activities.

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

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

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

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

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

When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the Journal of the American Medical Association.
Given these two studies, it’s no surprise that in Oregon some people who got a prescription for lethal medication on the basis of a six-month prognosis have lived longer. Of the 341 people who put themselves to death as of 2007 (the latest statistics available), 17 did so between six months and two years after getting their prescription, according to state epidemiologist Katrina Hedberg. Of course, there’s no telling how long any of the 341 would have lived had they not killed themselves. The Department of Health does not record how long people have lived after getting prescriptions they do not use, so there’s no telling, either, whether those 200 people outlived their prognosis. Compassion & Choices of Oregon, which independently keeps data on the people whom it helps navigate the law, says some have lived as long as eight years after first inquiring about the process (although it doesn’t track whether they ever received the medication and a six-month prognosis).

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

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

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

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

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

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

**Randy Niedzielski** reached that point in the summer of 2006, according to his wife Nancy. Diagnosed with brain cancer in 2000, the onetime Lynnwood property manager had been through several rounds of chemotherapy and had lived years longer than the norm. But the cancer cells had come back in an even more virulent form and had spread to his muscle system. "He would have these bizarre muscle contractions," Nancy recalls. "His feet would go into a cone shape. His arms would twist in weird angles." Or his chest would of its own volition go into what Nancy calls a "tent position," rising up from his arms. "He'd just be screaming in pain."
Randy would have liked to move to Oregon to take advantage of the Death With Dignity Act there, according to Nancy. But he didn't have time to establish residency as required. That was about six weeks before his death.

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

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

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

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

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

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

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

nshapiro@seattleweekly.com
What People Mean

What People Mean When They Say They Want to Die

(originally published as a Statement for the BBC)

by William Toffler, MD

There has been a profound shift in attitude in my state since the voters of Oregon narrowly embraced assisted suicide 11 years ago. A shift that, I believe, has been detrimental to our patients, degraded the quality of medical care, and compromised the integrity of my profession.

Since assisted suicide has become an option, I have had at least a dozen patients discuss this option with me in my practice. Most of the patients who have broached this issue weren't even terminal. One of my first encounters with this kind of request came from a patient with a progressive form of multiple sclerosis. He was in a wheelchair yet lived a very active life. In fact, he was a general contractor and quite productive. While I was seeing him, I asked him about how it affected his life. He acknowledged that multiple sclerosis was a major challenge and told me that if he got too much worse, he might want to "just end it." It sounds like you are telling me this because you might ultimately want assistance with your own assisted suicide- if things got a worse," I said. He nodded affirmatively, and seemed relieved that I seemed to really understand.

I told him that I could readily understand his fear and his frustration and even his belief that assisted suicide might be a good option for him. At the same time, I told him that should he become sicker or weaker, I would work to give him the best care and support available. I told him that no matter how debilitated he might become, that, at least to me, his life was, and would always be, inherently valuable. As such, I would not recommend, nor could I participate in his assisted-suicide. He simply said, "Thank you."

The truth is that we are not islands. How physicians respond to the patient's request has a profound effect, not only on a patient's
choices, but also on their view of themselves and their inherent worth.

When a patient says, "I want to die"; it may simply mean, "I feel useless."

When a patient says, "I don't want to be a burden"; it may really be a question, "Am I a burden?"

When a patient says, "I've lived a long life already"; they may really be saying, "I'm tired. I can't keep going."

And, finally, when a patient says, "I might as well be dead"; they may really be saying, "No one cares about me."

Many studies show that assisted suicide requests are almost always for psychological or social reasons. In Oregon there has never been any documented case of assisted suicide used because there was actual untreatable pain.[6] As such, assisted suicide has been totally unnecessary in Oregon.

Sadly, the legislation passed in Oregon does not require that the patient have unbearable suffering, or any suffering for that matter. The actual Oregon experience has been a far cry from the televised images and advertisements that seduced the public to embrace assisted suicide. In statewide television ads in 1994, a woman named Patty Rosen claimed to have killed her daughter with an overdose of barbiturates because of intractable cancer pain.[7] This claim was later challenged and shown to be false. Yet, even if it had been true, it would be an indication of inadequate medical care- not an indication for assisted suicide.

Astonishingly, there is not even inquiry about the potential gain to family members of the so-called "suicide" of a "loved one." This could be in the form of an inheritance, a life insurance policy, or, perhaps even simple freedom from previous care responsibilities.

Most problematic for me has been the change in attitude within the healthcare system itself. People with serious illnesses are sometimes fearful of the motives of doctors or consultants. Last year, a patient with bladder cancer contacted me. She was concerned that an oncologist might be one of the "death doctors." She questioned his motives—particularly when she obtained a second opinion from another oncologist which was more sanguine about her prognosis and treatment options. Whether one or the other consultant is correct or not, such fears were never an issue before assisted suicide was legalized.

In Oregon, I regularly receive notices that many important services and drugs for my patients—even some pain medications—won't be paid for by the State health plan. At the same time, assisted suicide is fully covered and sanctioned by the State of Oregon and by our collective tax dollars.12)

I urge UK leaders to reject the seductive siren of assisted suicide. Oregon has tasted the bitter pill of barbiturate overdoses and many now know that our legislation is hopelessly flawed. I believe Great Britain, the birthplace of Dame Cicely Saunders, and the Hospice movement, a model to the rest of the world, deserves better. On May 12, 2006 the Physicians-Assisted Suicide Bill was defeated in the United Kingdom (UK) Parliament House of Lords 148 – 100 vote. http://www.pccef.org/whoweare/memberviewpoints.htm
This is a reworked excerpt from a memo I wrote in 2009. I realize that it’s a casual presentation. I hope that it’s nonetheless helpful. The reference to “I-1000” is the name of Washington’s law before it was codified as RCW 70.245.010 et. seq.

A. The Playbook

In 2008, in Washington state USA, the “Yes” campaign followed a playbook, which is now being used throughout the United States and Canada. A good summary of its main themes is found in this excerpt from a Compassion & Choices’ brief, as follows:

This case presents the question of whether a mentally competent, terminally ill patient who is facing an exceptionally painful or difficult death has the right to obtain a prescription for medication from a cooperating doctor which the patient can self-administer to bring about a peaceful death.

The patient - and the patient alone - has the choice to use or not use the drugs: to advance, incrementally, the timing of a death which is about to occur from the underlying disease in any event, in order to avoid prolonged suffering that has become unbearable to the individual; or to take comfort from the right to choose, but allow the medication to go unused. (Spacing Changed).


People are often willing to accept legalization of assisted suicide when presented with these themes, which are false and misleading. See below.
1. **Death is not necessarily imminent**

As set forth above, the brief refers to “a death which is about to occur from the underlying disease in any event.” It is, however, not true that death would necessarily be imminent. This is the point of a *Seattle Weekly* article published after the Washington election: Even patients with cancer can live years beyond expectations.¹

Compassion & Choices has also been pushing for broader definitions of “terminal.” For example, in Montana, Compassion & Choices proposed this definition of “terminal”:

The term “terminally ill adult patient”, as used in the complaint, means a person 18 years of age or older who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time. (Emphasis added).²

With this definition, an 18 year old with diabetes who is insulin dependent, could have years, if not decades, to live.

---

¹ The article states:

Since the day [the patient] was given two to four months to live, [she] has gone with her children on a series of vacations . . . .

“We almost lost her because she was having too much fun, not from cancer” [her son chuckles].


² Plaintiffs’ Interrogatory Answer # 4, attached to Plaintiffs’ Brief in Support of Motion for Summary Judgment.
But, “without the administration of life-sustaining treatment,” such person could be facing death “within a relatively short time.” He or she would be “terminal” under the above definition.\(^3\)

Once someone is labeled “terminal,” the door is open to allowing comfort care only, not “treatment.” However and regardless, the deaths at issue are not necessarily imminent; the people at issue are not necessarily “dying.”

2. **Washington’s law allows a patient to be killed without consent**

The Compassion & Choices’ brief also includes the affirmative claim: “The patient - and the patient alone - has the choice to use or not use the drugs.” A similar claim was featured in the Washington State election:

> Only the patient - and no one else - may administer the medication [lethal dose].

Color Pamphlet, Paid for by Yes! on 1000.

These claims are untrue. Washington’s law and the other death with dignity proposals allow someone else to administer the lethal dose. See below.

3. **“Self-administer”**

The brief fails to disclose that the term “self-administer” doesn’t necessarily mean that administration will be by the

---

\(^3\) See Opinion letter from Attorney Theresa Schrempp and Dr. Richard Wonderly at [http://www.euthanasiaprevention.on.ca/ConnMemo02.pdf](http://www.euthanasiaprevention.on.ca/ConnMemo02.pdf)
patient. I-1000, now codified as RCW 70.245.010(12), defines self-administer as the “act of ingesting.” With this definition, someone else putting the lethal dose in the patient’s mouth (or feeding tube or IV nutrition bag) qualifies as “self-administration.”

4. **Patient consent is not required at death**

The brief also fails to disclose that the patient’s consent is not required when the lethal dose is administered. Without a right to consent at the time of administration, there is no right to choose the “timing, means and/or manner of one’s death” - a claim often made by proponents of assisted suicide and euthanasia.

5. **Patient competency is not required at death**

The brief also fails to disclose that the patient is not required to be competent, capable or even aware when the lethal dose is administered. Once again, the patient would not necessarily be doing the choosing.

6. **Killing without consent is permissible if done**

---

4 For more detail regarding this point, see: Margaret Dore, “‘Death with Dignity’: What do we tell our clients?” May 2009.

5 See Entire Text of I-1000, now codified at Chapter 70.245 RCW.

6 This is especially true for persons who plan, in the words of the brief, to “take comfort from the right to choose, but allow the medication to go unused.” Without a right to consent when the lethal dose is administered, such persons could be in for a big surprise. Also, the “right to rescind” does not change this result.

7 See: I-1000/Chapter 70.245 RCW, in its entirety.
according to I-1000

Killing another person is homicide. I-1000 and other death with dignity acts, however, allow this result as long as the actions taken are according to the acts. For example, I-1000 states:

Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. (Emphasis added).

I-1000, §18(1)/RCW 70.245.180(1).

7. No witnesses

If for the purpose of argument, I-1000 does not “allow” killing without consent, patients are still vulnerable to the actions of other people. This is because there are no required witnesses at the death.

Without disinterested witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi, as would regulations that require prosecutors and others to treat

---

8 Cf. RCW 9A.32.010 (defining “homicide”); RCW 9A.32.020 (regarding premeditation); and RCW 9A.32.030 (defining “murder”).

9 For more detail regarding this point, see: Margaret Dore, “‘Death with Dignity’: What do we tell our clients,?” May 2009. (Attached at A-17 through A-26).

10 See: I-1000/Chapter 70.245 RCW, in its entirety.

11 The drugs used (Seconal and Nembutal) are water and alcohol soluble and therefore injectable while someone is sleeping. See product inserts.
the death as “natural.”12 The patient’s death without his consent would be the perfect crime. So much for “choice.”

8. Motive

The above scenario would seem especially significant for patients with money. A California case, People v. Stuart, 67 Cal Rptr. 3rd 129, 143 (2007), states:

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

* * *