TO THE HOUSE OF REPRESENTATIVES:

The Committee on Human Services to which was referred Senate Bill No. 77 entitled “An act relating to patient choice and control at end of life” respectfully reports that it has considered the same and recommends that the House propose to the Senate that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 18 V.S.A. chapter 113 is added to read:

CHAPTER 113. RIGHTS OF QUALIFIED PATIENTS SUFFERING A TERMINAL CONDITION

§ 5281. DEFINITIONS

As used in this chapter:

(1) “Capable” means that in the opinion of a court or in the opinion of the patient’s prescribing physician, consulting physician, psychiatrist, psychologist, or clinical social worker, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.

(2) “Consulting physician” means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient’s illness and who is willing to participate in the provision.
to a qualified patient of medication to hasten his or her death in accordance

with this chapter.

(3) "Dispense" means to prepare and deliver pursuant to a lawful order

of a physician a prescription drug in a suitable container appropriately labeled

for subsequent use by a patient entitled to receive the prescription drug. The
term shall not include the actual administration of a prescription drug to the

patient.

(4) "Evaluation" means a consultation between a psychiatrist,

psychologist, or clinical social worker licensed in Vermont and a patient for

the purpose of confirming that the patient:

(A) is capable; and

(B) does not have impaired judgment.

(5) "Good faith" means objective good faith.

(6) "Health care facility" shall have the same meaning as in section

9432 of this title.

(7) "Health care provider" means a person, partnership, corporation,

facility, or institution, licensed or certified or authorized by law to administer

health care or dispense medication in the ordinary course of business or

practice of a profession.

(8) "Hospice care" means a program of care and support provided by a

Medicare-certified hospice provider to help an individual with a terminal
condition to live comfortably by providing palliative care, including effective
pain and symptom management. Hospice care may include services provided
by an interdisciplinary team that are intended to address the physical,
emotional, psychosocial, and spiritual needs of the individual and his or her
family.

(9) "Impaired judgment" means that a person does not sufficiently
appreciate the relevant facts necessary to make an informed decision.

(10) "Informed decision" means a decision by a patient to request and
obtain a prescription for medication to be self-administered to hasten his or her
death based on the patient's understanding and appreciation of the relevant
facts that was made after the patient was fully informed by the prescribing
physician of all the following:

(A) the patient's medical diagnosis;

(B) the patient's prognosis, including an acknowledgement that the
physician's prediction of the patient's life expectancy is an estimate based on
the physician's best medical judgment and is not a guarantee of the actual time
remaining in the patient's life, and that the patient may live longer than the
time predicted;

(C) the range of treatment options appropriate for the patient and the
patient's diagnosis;
(D) if the patient is not enrolled in hospice care, all feasible
end-of-life services, including palliative care, comfort care, hospice care, and
pain control;

(E) the range of possible results, including potential risks associated
with taking the medication to be prescribed; and

(F) the probable result of taking the medication to be prescribed.

(11) “Palliative care” shall have the same meaning as in section 2 of this
title.

(12) “Patient” means a person who is 18 years of age or older, a resident
of Vermont, and under the care of a physician.

(13) “Physician” means a physician licensed pursuant to 26 V.S.A.
chapter 23 or 33.

(14) “Prescribing physician” means the physician whom the patient has
designated to have primary responsibility for the care of the patient pursuant to
this chapter and who is willing to participate in the provision to a qualified
patient of medication to hasten his or her death in accordance with this chapter.

(15)(A) “Qualified patient” means a patient who:

(i) is capable;

(ii) is physically able to self-administer medication;

(iii) has executed an advance directive in accordance with chapter

231 of this title:
(iv) is enrolled in hospice care or has been informed of all feasible end-of-life services pursuant to subdivision 5283(3)(D) of this title; and

(v) has satisfied the requirements of this chapter in order to obtain a prescription for medication to hasten his or her death.

(B) An individual shall not qualify under the provisions of this chapter solely because of age or disability.

(16) “Terminal condition” means an incurable and irreversible disease which would, within reasonable medical judgment, result in death within six months.

§ 5282. REQUESTS FOR MEDICATION

(a) In order to qualify under this chapter:

(1) A patient who is capable, who has been determined by the prescribing physician and consulting physician to be suffering from a terminal condition, and who has voluntarily expressed a wish to hasten the dying process may request medication to be self-administered for the purpose of hastening his or her death in accordance with this chapter.

(2) A patient shall have made an oral request and a written request and shall have reaffirmed the oral request to his or her prescribing physician not less than 15 days after the initial oral request. At the time the patient makes the second oral request, the prescribing physician shall offer the patient an opportunity to rescind the request.
(b) Oral requests for medication by the patient under this chapter shall be made in the physical presence of the prescribing physician.

(c) A written request for medication shall be signed and dated by the patient and witnessed by at least two persons, at least 18 years of age, who, in the presence of the patient, sign and affirm that the patient appears to understand the nature of the document and to be free from duress or undue influence at the time the request was signed. Neither witness shall be any of the following persons:

(1) the patient’s prescribing physician, consulting physician, or any person who has conducted an evaluation of the patient pursuant to section 5285 of this title;

(2) a person who knows that he or she is a relative of the patient by blood, civil marriage, civil union, or adoption;

(3) a person who at the time the request is signed knows that he or she would be entitled upon the patient’s death to any portion of the estate or assets of the patient under any will or trust, by operation of law, or by contract; or

(4) an owner, operator, or employee of a health care facility, nursing home, or residential care facility where the patient is receiving medical treatment or is a resident.

(d) A person who knowingly fails to comply with the requirements in subsection (c) of this section is subject to prosecution under 13 V.S.A. § 2004.
(e) The written request shall be completed only after the patient has been examined by a consulting physician as required under section 5283 of this title.

(f)(1) Under no circumstances shall a guardian or conservator be permitted to act on behalf of a ward for purposes of this chapter.

(2) Under no circumstances shall an agent under an advance directive be permitted to act on behalf of a principal for purposes of this chapter.

§ 5283. PRESCRIBING PHYSICIAN; DUTIES

The prescribing physician shall perform all the following:

(1) determine whether a patient:

(A) is suffering a terminal condition, based on the prescribing physician’s physical examination of the patient and review of the patient’s relevant medical records;

(B) is capable;

(C) has executed an advance directive in accordance with chapter 231 of this title;

(D) is enrolled in hospice care;

(E) is making an informed decision; and

(F) has made a voluntary request for medication to hasten his or her death;

(2) require proof of Vermont residency, which may be shown by:

(A) a Vermont driver’s license or photo identification card;
(B) proof of Vermont voter’s registration; or

(C) a Vermont resident personal income tax return for the most recent tax year;

(3) inform the patient in person, both verbally and in writing, of all the following:

(A) the patient’s medical diagnosis;

(B) the patient’s prognosis, including an acknowledgement that the physician’s prediction of the patient’s life expectancy is an estimate based on the physician’s best medical judgment and is not a guarantee of the actual time remaining in the patient’s life, and that the patient may live longer than the time predicted;

(C) the range of treatment options appropriate for the patient and the patient’s diagnosis;

(D) if the patient is not enrolled in hospice care, all feasible end-of-life services, including palliative care, comfort care, hospice care, and pain control;

(E) the range of possible results, including potential risks associated with taking the medication to be prescribed; and

(F) the probable result of taking the medication to be prescribed;
(4) refer the patient to a consulting physician for medical confirmation of the diagnosis, prognosis, and a determination that the patient is capable and is acting voluntarily;

(5) verify that the patient does not have impaired judgment or refer the patient for an evaluation under section 5285 of this chapter;

(6) with the patient's consent, consult with the patient's primary care physician, if the patient has one;

(7) recommend that the patient notify the next of kin or someone with whom the patient has a significant relationship;

(8) counsel the patient about the importance of ensuring that another individual is present when the patient takes the medication prescribed pursuant to this chapter and the importance of not taking the medication in a public place;

(9)(A) inform the patient that the patient has an opportunity to rescind the request at any time and in any manner; and

(B) offer the patient an opportunity to rescind after the patient's second oral request;

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

(11) fulfill the medical record documentation requirements of section 5290 of this title;
(12) ensure that all required steps are carried out in accordance with this chapter prior to writing a prescription for medication to hasten death; and

(13)(A) dispense medication directly, including ancillary medication intended to facilitate the desired effect while minimizing the patient’s discomfort, provided the prescribing physician is licensed to dispense medication in Vermont, has a current Drug Enforcement Administration certificate, and complies with any applicable administrative rules; or

(B) with the patient’s written consent:

(i) contact a pharmacist and inform the pharmacist of the prescription; and

(ii) deliver the written prescription personally or by mail or facsimile to the pharmacist, who will dispense the medication to the patient, the prescribing physician, or an expressly identified agent of the patient.

§ 5284. MEDICAL CONSULTATION REQUIRED

Before a patient is qualified in accordance with this chapter, a consulting physician shall physically examine the patient, review the patient’s relevant medical records, and confirm in writing the prescribing physician’s diagnosis that the patient is suffering from a terminal condition and verify that the patient is capable, is acting voluntarily, and has made an informed decision. The consulting physician shall either verify that the patient does not have impaired
judgment or refer the patient for an evaluation under section 5285 of this chapter.

§ 5285. REFERRAL FOR EVALUATION

If, in the opinion of the prescribing physician or the consulting physician, a patient may have impaired judgment, either physician shall refer the patient for an evaluation. A medication to end the patient’s life shall not be prescribed until the person conducting the evaluation determines that the patient is capable and does not have impaired judgment.

§ 5286. INFORMED DECISION

A person shall not receive a prescription for medication to hasten his or her death unless the patient has made an informed decision. Immediately prior to writing a prescription for medication in accordance with this chapter, the prescribing physician shall verify that the patient is making an informed decision.

§ 5287. RECOMMENDED NOTIFICATION

The prescribing physician shall recommend that the patient notify the patient’s next of kin or someone with whom the patient has a significant relationship of the patient’s request for medication in accordance with this chapter. A patient who declines or is unable to notify the next of kin or the person with whom the patient has a significant relationship shall not be refused medication in accordance with this chapter.
§ 5288. RIGHT TO RESCIND

A patient may rescind the request for medication in accordance with this chapter at any time and in any manner regardless of the patient’s mental state. A prescription for medication under this chapter shall not be written without the prescribing physician’s offering the patient an opportunity to rescind the request.

§ 5289. WAITING PERIOD

The prescribing physician shall write a prescription no less than 48 hours after the last to occur of the following events:

(1) the patient’s written request for medication to hasten his or her death;

(2) the patient’s second oral request; or

(3) the prescribing physician’s offering the patient an opportunity to rescind the request.

§ 5290. MEDICAL RECORD DOCUMENTATION

(a) The following shall be documented and filed in the patient’s medical record:

(1) the date, time, and wording of all oral requests of the patient for medication to hasten his or her death;

(2) all written requests by a patient for medication to hasten his or her death;
(3) the prescribing physician’s diagnosis, prognosis, and basis for the
determination that the patient is capable, is acting voluntarily, and has made an
informed decision;

(4) the consulting physician’s diagnosis, prognosis, and verification,
pursuant to section 5284 of this title, that the patient is capable, is acting
voluntarily, and has made an informed decision;

(5) a copy of the patient’s advance directive;

(6) the prescribing physician’s attestation that the patient was enrolled in
hospice care at the time of the patient’s oral and written requests for
medication to hasten his or her death or that the prescribing physician informed
the patient of all feasible end-of-life services;

(7) the prescribing physician’s and consulting physician’s verifications
that the patient either does not have impaired judgment or that the prescribing
or consulting physician, or both, referred the patient for an evaluation pursuant
to section 5285 of this title and the person conducting the evaluation has
determined that the patient does not have impaired judgment;

(8) a report of the outcome and determinations made during any
evaluation which the patient may have received;

(9) the date, time, and wording of the prescribing physician’s offer to
the patient to rescind the request for medication at the time of the patient’s
second oral request; and
(10) a note by the prescribing physician indicating that all requirements under this chapter have been satisfied and describing all of the steps taken to carry out the request, including a notation of the medication prescribed.

(b) Medical records compiled pursuant to this chapter shall be subject to discovery only if the court finds that the records are:

(1) necessary to resolve issues of compliance with or limitations on actions under this chapter; or

(2) essential to proving individual cases of civil or criminal liability and are otherwise unavailable.

§ 5291. REPORTING REQUIREMENT

(a) The Department of Health shall require:

(1) that any physician who writes a prescription pursuant to this chapter promptly file a report with the Department covering all the prerequisites for writing a prescription under this chapter; and

(2) physicians to report on an annual basis the number of written requests for medication received pursuant to this chapter, regardless of whether a prescription was actually written in each instance.

(b) The Department shall review annually the medical records of qualified patients who hastened their deaths in accordance with this chapter during the previous year.
(c) The Department shall adopt rules pursuant to 3 V.S.A. chapter 25 to facilitate the collection of information regarding compliance with this chapter and to enable the Department to report information as required by subsection (d) of this section. Individually identifiable health information collected under this chapter, as well as reports filed pursuant to subdivision (a)(1) of this section, are confidential and are exempt from public inspection and copying under the Public Records Act.

(d) The Department shall generate, and make available to the public to the extent that doing so would not reasonably be expected to violate the privacy of any person, an annual statistical report of information collected under subsections (a) and (b) of this section, including:

(1) demographic information regarding qualified patients who hastened their deaths in accordance with this chapter, including the underlying illness and the type of health insurance or other health coverage, if any;

(2) any reasons given by qualified patients for their use of medication to hasten their deaths in accordance with this chapter, including whether patients expressed concerns about:

(A) being a burden to family or caregivers;

(B) the financial implications of treatment; and

(C) inadequate pain control.
(3) information regarding physicians prescribing medication in accordance with this chapter, including physicians' compliance with the requirements of this chapter;

(4) the number of qualified patients who did not take the medication prescribed pursuant to this chapter and died of other causes; and

(5) the length of time between when a patient ingested the medication and when death occurred and the number of instances in which medication was taken by a qualified patient to hasten death but failed to have the intended effect.

§ 5292. SAFE DISPOSAL OF UNUSED MEDICATIONS

The Department of Health shall adopt rules providing for the safe disposal of unused medications prescribed under this chapter.

(1) The Department initially shall adopt rules under this section as emergency rules pursuant to 3 V.S.A. § 844. The General Assembly determines that adoption of emergency rules pursuant to this subdivision is necessary to address an imminent peril to public health and safety.

(2) Contemporaneously with the initial adoption of emergency rules under subdivision (1) of this section, the Department shall propose permanent rules under this section for adoption pursuant to 3 V.S.A. §§ 836–843. The Department subsequently may revise these rules in accordance with the Vermont Administrative Procedure Act.
§ 5293. PROHIBITIONS: CONTRACT CONSTRUCTION: INSURANCE POLICIES

(a) A provision in a contract, will, trust, or other agreement, whether written or oral, shall not be valid to the extent the provision would affect whether a person may make or rescind a request for medication to hasten his or her death in accordance with this chapter.

(a) The sale, procurement, or issue of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request by a person for medication to hasten his or her death in accordance with this chapter or the act by a qualified patient to hasten his or her death pursuant to this chapter. Neither shall a qualified patient’s act of ingesting medication to hasten his or her death have an effect on a life, health, or accident insurance or annuity policy.

(b) The sale, procurement, or issue of any medical malpractice insurance policy or the rate charged for the policy shall not be conditioned upon or affected by whether the physician is willing or unwilling to participate in the provision to a qualified patient of medication to hasten his or her death in accordance with this chapter.
§ 5294. LIMITATIONS ON ACTIONS

(a) A person shall not be subject to civil or criminal liability or professional disciplinary action for actions taken in good faith reliance on the provisions of this chapter. This includes being present when a qualified patient takes the prescribed medication to hasten his or her death in accordance with this chapter.

(b) This includes A person shall not be subject to civil or criminal liability or professional disciplinary action solely for being present when a qualified patient takes prescribed medication to hasten his or her death in accordance with this chapter.

(c) A health care provider shall not subject a person to discipline, suspension, loss of license, loss of privileges, or other penalty for actions taken in good faith reliance on the provisions of this chapter or refusals to act under this chapter.

(d) The provision by a prescribing physician of medication in good faith reliance on the provisions of this chapter shall not constitute patient neglect for any purpose of law.

(e) A request by a patient for medication under this chapter shall not provide the sole basis for the appointment of a guardian or conservator.

(f) A health care provider shall not be under any duty, whether by contract, by statute, or by any other legal requirement, to participate in the
provision to a qualified patient of medication to hasten his or her death in accordance with this chapter.

(2) If a health care provider is unable or unwilling to carry out a patient’s request in accordance with this chapter and the patient transfers his or her care to a new health care provider, the previous health care provider, upon request, shall transfer a copy of the patient’s relevant medical records to the new health care provider.

(3) A decision by a health care provider not to participate in the provision of medication to a qualified patient shall not constitute the abandonment of the patient or unprofessional conduct under 26 V.S.A. § 1354.

(g) This section shall not be construed to limit civil or criminal liability for gross negligence, recklessness, or intentional misconduct.

§ 5295. HEALTH CARE FACILITY EXCEPTION

Notwithstanding any other provision of law to the contrary, a health care facility may prohibit a prescribing physician from writing a prescription for medication under this chapter for a patient who is a resident in its facility and intends to use the medication on the facility’s premises, provided the facility has notified the prescribing physician in writing of its policy with regard to the prescriptions. Notwithstanding subsection 5294(b) of this title, any health care provider who violates a policy established by a health care facility under this section may be subject to sanctions otherwise allowable under law or contract.
§ 5296. LIABILITIES AND PENALTIES

(a) With the exception of the limitations on actions established by section 5294 of this title and with the exception of the provisions of section 5298 of this title, nothing in this chapter shall be construed to limit liability for civil damages resulting from negligent conduct or intentional misconduct by any person.

(b) With the exception of the limitations on actions established by section 5294 of this title and with the exception of the provisions of section 5298 of this title, nothing in this chapter [in 13 V.S.A. § 2312 shall be construed to limit criminal prosecution under any other provision of law.

(c) A healthcare provider is subject to review and disciplinary action by the appropriate licensing entity for failing to act in accordance with this chapter, provided such failure is not in good faith.

§ 5297. FORM OF THE WRITTEN REQUEST

A written request for medication as authorized by this chapter shall be substantially in the following form:

REQUEST FOR MEDICATION TO HASTEN MY DEATH

I, ______________________, am an adult of sound mind.

I am suffering from ______________________, which my prescribing physician has determined is a terminal disease and which has been confirmed by a consulting physician.
I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, and the expected result. I am enrolled in hospice care and have completed an advance directive.

I have been informed of all feasible end-of-life services or am enrolled in hospice care.

I request that my prescribing physician prescribe medication that will hasten my death.

INITIAL ONE:

I have informed my family or others with whom I have a significant relationship of my decision and taken their opinions into consideration.

I have decided not to inform my family or others with whom I have a significant relationship of my decision.

I have no family or others with whom I have a significant relationship to inform of my decision.

I understand that I have the right to change my mind at any time.

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

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

AFFIRMATION OF WITNESSES

We affirm that, to the best of our knowledge and belief:

(1) the person signing this request:

   (A) is personally known to us or has provided proof of identity;
   (B) signed this request in our presence;
   (C) appears to understand the nature of the document and to be free

from duress or undue influence at the time the request was signed; and

(2) that neither of us:

   (A) is under 18 years of age;
   (B) is a relative (by blood, civil marriage, civil union, or adoption) of

the person signing this request;

   (C) is the patient's prescribing physician, consulting physician, or a

person who has conducted an evaluation of the patient pursuant to 18 V.S.A.
§ 5285;

   (D) is entitled to any portion of the person's assets or estate upon

death; or

   (E) owns, operates, or is employed at a health care facility where the

person is a patient or resident.

Witness 1/Date __________________________

Witness 2/Date __________________________
NOTE: A knowingly false affirmation by a witness may result in criminal penalties.

§ 5298. STATUTORY CONSTRUCTION

Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Action taken in accordance with this chapter shall not be construed for any purpose to constitute suicide, assisted suicide, mercy killing, or homicide under the law. This section shall not be construed to conflict with section 1553 of the Patient Protection and Affordable Health Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

§ 5299. NO EFFECT ON PALLIATIVE SEDATION

This chapter shall not limit or otherwise affect the provision, administration, or receipt of palliative sedation consistent with accepted medical standards.

Sec. 2. 13 V.S.A. § 2312 is added to read:

§ 2312. VIOLATION OF PATIENT CHOICE AND CONTROL AT END OF LIFE ACT

A person who violates 18 V.S.A. chapter 113 with the intent to cause the death of a patient as defined in subdivision 5281(11) of that title may be prosecuted under chapter 53 of this title (homicide).

Sec. 2. 13 V.S.A. § 2004 is added to read:
§ 2004. FALSE WITNESSING

A person who knowingly violates the requirements of 18 V.S.A. § 5282(c) shall be imprisoned for not more than 10 years or fined not more than $2,000.00, or both.

Sec. 3. EFFECTIVE DATES

This act shall take effect on September 1, 2013, except that 18 V.S.A. § 5292 (rules for safe disposal of unused medications) in Sec. 1 of this act shall take effect on passage. The Department of Health shall ensure that emergency rules adopted under Sec. 1 of this act, 18 V.S.A. § 5292, are in effect on or before September 1, 2013.

(Committee vote:___)

_____________________
Representative

FOR THE COMMITTEE
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.

http://www.seattleweekly.com/content/printVersion/553991/
Her experience underscores the difficulty doctors have in forecasting how long patients have to live—a difficulty that is about to become even more pertinent as the Washington Death With Dignity Act takes effect March 4. The law, passed by initiative last November and modeled closely on a 14-year-old law in Oregon, makes Washington the only other state in the country to allow terminally ill patients to obtain lethal medication. As in Oregon, the law is tightly linked to a prognosis: Two doctors must say a patient has six months or less to live before such medication can be prescribed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thomas Preston, a retired cardiologist who serves as medical director of Compassion & Choices of Washington, says he has in mind a different kind of speech: "You have to understand that this 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

http://www.seattleweekly.com/content/printVersion/553991/
AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

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

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

3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for cancer. I understand that he had referred her to me.
4. At our first meeting, Jeanette told me plainly that she did not want to be treated and that was going to "do" our law, i.e., kill herself with a lethal dose of barbiturates. It was very much a settled decision.

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

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

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

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

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

Attached hereto at page SI-1.

Affidavit of Kenneth Stevens, Jr., MD - page 2
F:\ASE Files\Leblanc\Kenneth Stevens MD Affidavit.wpd
9. Under the Oregon Health Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient's treatment. For example, patients with cancer are denied treatment if they have a "less than 24 months median survival with treatment" and fit other criteria. This is the Plan's "Guideline Note 12." (Attached hereto at page GN-4).

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

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

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

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

Affidavit of Kenneth Stevens, Jr., MD - page 3
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14. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Canada, your government health plan could follow a similar pattern. If so, the plan will pay for a patient to die, but not to live.

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

NAME: Jessica Borgo

A notary in and for the State of Oregon

ADDRESS: 16100 Southwest 10th St

EXPIRY OF COMMISSION: Aug 30, 2015

PLACE SEAL HERE:

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

Affidavit of Kenneth Stevens, Jr., MD - page 4
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STATEMENTS OF INTENT FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

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

4-16-2012
GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

b) Suspected Crohn's disease: upper and lower endoscopy, small bowel follow through

2) Radiological evidence of lack of stricture
3) Only covered once during any episode of illness
4) FDA approved devices must be used
5) Patency capsule should not be used prior to procedure

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

A) CSF are not indicated for primary prophylaxis of febrile neutropenia unless the primary chemotherapeutic regimen is known to produce febrile neutropenia at least 20% of the time. CSF should be considered when the primary chemotherapeutic regimen is known to produce febrile neutropenia 10-20% of the time; however, if the risk is due to the chemotherapeutic regimen, other alternatives such as the use of less myelosuppressive chemotherapy or dose reduction should be explored in this situation.

B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cells), where no disease free benefits have been documented using dose maintenance and CSF.

C) CSF are not indicated in patients who are acutely neutropenic but afebrile.

D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <100/mcl, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.

E) CSF are not indicated to increase chemotherapy dose-intensity or schedule, except in cases where improved outcome from such increased intensity has been documented in a clinical trial.

F) CSF (other than pegfilgrastim) are indicated in the setting of autologous progenitor cell transplantation, to mobilize peripheral blood progenitor cells, and after their infusion.

G) CSF are NOT indicated in patients receiving concomitant chemotherapy and radiation therapy.

H) There is no evidence of clinical benefit in the routine, continuous use of CSF in myelodysplastic syndromes. CSF may be indicated for some patients with severe neutropenia and recurrent infections, but should be used only if significant response is documented.

I) CSF is indicated for treatment of cyclic, congenital and idiopathic neutropenia.

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


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

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

Treatment with intent to prolong survival is not a covered service for patients with any of the following:
- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.

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

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

4-16-2012
GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE (CONT'D)

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

   Lines 76,195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

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

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

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

   Lines 89,384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

   Lines 1,3,4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

   Line 58

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

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

   Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

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

Ventricular assist devices are not covered for destination therapy.

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

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

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

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

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

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

   • Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
   • Head and neck cancer when initial MRI or CT is equivocal
AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO ASSISTED SUICIDE AND EUTHANASIA

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

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

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

3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the
time. By then, I had twitching in both hands, which were also getting weaker. At some point, I lost the ability to grip in my hands. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor’s prescription and support, I would have taken that opportunity.

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

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

AFFIDAVIT OF JOHN NORTON- Page 2
SWORN BEFORE ME at
MASSACHUSETTS, USA
on, AUGUST 15th, 2012

NAME: HEIDI PRZYNASKI
A notary in and for the
State of Washington, MASSACHUSETTS

ADDRESS: 85 MAIN ST
Florence, MA 01062
EXPIRY OF COMMISSION: JUNE 22, 2018

PLACE SEAL HERE:

[Signature]

JOHN NORTON

AFFIDAVIT OF JOHN NORTON- Page 3
AFFIDAVIT OF JEANETTE HALL
OPPOSING ASSISTED SUICIDE

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

1. I live in Oregon where physician-assisted suicide is legal. Our law was enacted in 1997 via a ballot initiative that I voted for.

2. In 2000, I was diagnosed with cancer and told that I had 6 months to a year to live. I knew that our law had passed, but I didn’t know exactly how to go about doing it. I tried to ask my doctor, Ken Stevens MD, but he didn’t really answer me. In hindsight, he was stalling me.

3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!
4. This July, it was 12 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 17th day of August 2012

Jeanette Hall

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

NAME: Jeanette Hall
A notary in and for the State of Oregon

ADDRESS: 157105 SW 11th Pkwy
Tigard, OR 97224
EXPIRY OF COMMISSION: September 28, 2015
PLACE SEAL HERE:

OFFICIAL SEAL
SHEENA MARIE LESLIE
NOTARY PUBLIC - OREGON
COMMISSION NO. 462203
MY COMMISSION EXPIRES SEPTEMBER 28, 2015

Affidavit of Jeanette Hall - Page 2
A little-known but very serious social problem: elders and people with disabilities are, as a group, at high risk for violence, abuse and exploitation. National studies document that about 1 in 20 elders are victims of violence and abuse. In Vermont, where the elder population is about 75,000, this would translate into 3,750 probable new cases each year. It is believed that only about one out of five of these cases ever gets reported.

Another little-known fact: Family members cause more than half of all reported abuse in later life. Shame, dependence on the abuser, fear of retribution, and isolation from the community are significant obstacles that discourage elders from reporting these crimes. When the abuse is reported, police, prosecutors and others in the justice system want to do the right thing, but many do not fully understand the unique risks faced by these victims, best practices for the investigation and prosecution of these crimes, or how to accommodate the special needs of victims once their cases have entered the justice system.

You are invited to explore this section of our website, which offers the perspectives of both local and national agencies and advocates who are engaged in addressing issues of elder abuse, neglect and mistreatment. You will also find resources, statistics, and materials that the Vermont Center for Crime Victim Services has developed specifically for this campaign.

For more information about the campaign, or to receive copies of materials, contact Barbara Whitchurch at the Vermont Center for Crime Victim Services, (802) 241-4334, bwhitchurch@ccvs.state.vt.us or Karen Vastine at the Vermont Network Against Domestic Violence and Sexual Assault, (802) 223-1302.

This project was supported by Grant No. 98-VF-GX-K003 awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.
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 defending 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 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. (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
Oregon Public Health Division

Oregon's Death with Dignity Act--2012

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2012 are listed below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and deaths that occurred as a result of ingesting prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of January 14, 2013. For more detail, please view the figures and tables on our web site: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2012

- As of January 14, 2013, prescriptions for lethal medications were written for 115 people during 2012 under the provisions of the DWDA, compared to 114 during 2011 (Figure 1). At the time of this report, there were 77 known DWDA deaths during 2012. This corresponds to 23.5 DWDA deaths per 10,000 total deaths.¹

¹ Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2011 (32,731), the most recent year for which final death data is available.

• Since the law was passed in 1997, a total of 1,050 people have had DWDA prescriptions written and 673 patients have died from ingesting medications prescribed under the DWDA.

• Of the 115 patients for whom DWDA prescriptions were written during 2012, 67 (58.3%) ingested the medication; 66 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion.

• Eleven (11) patients with prescriptions written during the previous year (2011) died after ingesting the medication during 2012.

• Twenty-three (23) of the 115 patients who received DWDA prescriptions during 2012 did not take the medications and subsequently died of other causes.

• Ingestion status is unknown for 25 patients who were prescribed DWDA medications in 2012. Fourteen (14) of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received. For the remaining 11 patients, both death and ingestion status are pending (Figure 2).

• Of the 77 DWDA deaths during 2012, most (67.5%) were aged 65 years or older; the median age was 69 years. As in previous years, most were white (97.4%), well-educated (42.9% had a least a baccalaureate degree), and had cancer (75.3%).

• Most (97.4%) patients died at home; and most (97.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, all (100.0%) had some form of health care insurance, although the number of patients who had private insurance (51.4%) was lower in 2012 than in previous years (66.2%), and the number of patients who had only Medicare or Medicaid insurance was higher than in previous years (48.6% compared to 32.1%).

• As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (93.5%), decreasing ability to participate in activities that made life enjoyable (92.2%), and loss of dignity (77.9%).

• Two of the 77 DWDA patients who died during 2012 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for seven patients (9.1%) during 2012 compared to 17.3% in previous years.

• A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 11 of the 77 DWDA deaths during 2012. Among those 11 patients, time from ingestion until death ranged from 10 minutes to 3.5 hours.
Sixty-one (61) physicians wrote the 115 prescriptions provided during 2012 (range 1-10 prescriptions per physician).

During 2012, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

**Figure 2: Summary of DWDA prescriptions written and medications ingested in 2012, as of January 14, 2013**

- 115 people had prescriptions written during 2012
- 11 people with prescriptions written in previous years ingested medication during 2012
- 67 ingested medication
- 23 did not ingest medication and subsequently died from other causes
- 25 ingestion status unknown
- 78 ingested medication
- 77 died from ingesting medication
- 1 regained consciousness after ingesting medication; died of underlying illness
- 14 died, ingestion status is pending receipt of follow-up questionnaires
- 11 death and ingestion status pending
Table 1. Characteristics and end-of-life care of 673 DWDA patients who have died from ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012

<table>
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<th>Characteristics</th>
<th>2012 (N=77)</th>
<th>1998-2011 (N=596)</th>
<th>Total (N=673)</th>
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<td><strong>Sex</strong></td>
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<td>39 (50.6)</td>
<td>308 (51.7)</td>
<td>347 (51.6)</td>
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<tr>
<td>Female (%)</td>
<td>38 (49.4)</td>
<td>288 (48.3)</td>
<td>326 (48.4)</td>
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<td>45-54 (%)</td>
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<td>44 (7.4)</td>
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<td>55-64 (%)</td>
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<td>123 (20.6)</td>
<td>139 (20.7)</td>
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<td>65-74 (%)</td>
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<td>75-84 (%)</td>
<td>18 (23.4)</td>
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<td>Other (%)</td>
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<td><strong>Marital Status</strong></td>
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<td>Never married (%)</td>
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<td>Divorced (%)</td>
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<td>152 (22.8)</td>
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<td>148 (25.0)</td>
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<td>297 (44.5)</td>
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References:

1. Includes 13 with no known gender.
2. Includes 13 with no known marital status.
3. Includes 3 with unknown county residence.
4. Includes 3 with unknown hospice enrollment status.
5. Includes 3 with unknown insurance status.
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<td>Loss of dignity (%)</td>
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<td>446 (62.0)</td>
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<td>Losing control of bodily functions (%)</td>
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<td>Financial implications of treatment (%)</td>
<td>3 (3.9)</td>
<td>15 (2.5)</td>
<td>18 (2.7)</td>
</tr>
<tr>
<td><strong>Health-care provider present</strong></td>
<td>(N=77)</td>
<td>(N=526)</td>
<td>(N=603)</td>
</tr>
<tr>
<td>When medication was ingested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician</td>
<td>8</td>
<td>100</td>
<td>108</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
<td>4</td>
<td>231</td>
<td>235</td>
</tr>
<tr>
<td>No provider</td>
<td>1</td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>Unknown</td>
<td>64</td>
<td>123</td>
<td>187</td>
</tr>
<tr>
<td>At time of death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician (%)</td>
<td>7 (9.1)</td>
<td>89 (17.3)</td>
<td>96 (16.2)</td>
</tr>
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<td>Other provider, prescribing physician not present (%)</td>
<td>4 (5.2)</td>
<td>254 (49.4)</td>
<td>258 (43.7)</td>
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<tr>
<td>No provider (%)</td>
<td>66 (85.7)</td>
<td>171 (33.3)</td>
<td>237 (40.1)</td>
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<tr>
<td>Unknown</td>
<td>0</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td><strong>Complications</strong></td>
<td>(N=77)</td>
<td>(N=596)</td>
<td>(N=673)</td>
</tr>
<tr>
<td>Regurgitated</td>
<td>0</td>
<td>22</td>
<td>22</td>
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<tr>
<td>Seizures</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>None</td>
<td>11</td>
<td>463</td>
<td>474</td>
</tr>
<tr>
<td>Unknown</td>
<td>66</td>
<td>111</td>
<td>177</td>
</tr>
<tr>
<td><strong>Other outcomes</strong></td>
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<tr>
<td>Regained consciousness after ingesting DWDA medications</td>
<td>1</td>
<td>5</td>
<td>6</td>
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### Characteristics

<table>
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<tr>
<th>Timing of DWDA event</th>
<th>2012 (N=77)</th>
<th>1998-2011 (N=596)</th>
<th>Total (N=673)</th>
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<tr>
<td><strong>Duration (weeks) of patient-physician relationship</strong>&lt;sup&gt;14&lt;/sup&gt;</td>
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<tr>
<td>Median</td>
<td>19</td>
<td>12</td>
<td>12</td>
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<tr>
<td>Range</td>
<td>0-1640</td>
<td>0-1905</td>
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<tr>
<td>Number of patients with information available</td>
<td>77</td>
<td>594</td>
<td>671</td>
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<tr>
<td>Number of patients with information unknown</td>
<td>0</td>
<td>2</td>
<td>2</td>
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<tr>
<td><strong>Duration (days) between 1st request and death</strong></td>
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<td></td>
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<tr>
<td>Median</td>
<td>47</td>
<td>46</td>
<td>46</td>
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<tr>
<td>Range</td>
<td>16-388</td>
<td>15-1009</td>
<td>15-1009</td>
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<tr>
<td>Number of patients with information available</td>
<td>77</td>
<td>596</td>
<td>673</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Minutes between ingestion and unconsciousness</strong>&lt;sup&gt;11&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Range</td>
<td>3-15</td>
<td>1-38</td>
<td>1-38</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>11</td>
<td>462</td>
<td>473</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>66</td>
<td>134</td>
<td>200</td>
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<tr>
<td><strong>Minutes between ingestion and death</strong>&lt;sup&gt;11&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>Median</td>
<td>20</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Range (minutes - hours)</td>
<td>10min-3.5hrs</td>
<td>1min-104hrs</td>
<td>1min-104hrs</td>
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<tr>
<td>Number of patients with information available</td>
<td>11</td>
<td>467</td>
<td>478</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>66</td>
<td>129</td>
<td>195</td>
</tr>
</tbody>
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1. Unknowns are excluded when calculating percentages.
2. Includes Oregon Registered Domestic Partnerships.
4. Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.
5. Private insurance category includes those with private insurance alone or in combination with other insurance.
6. Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.
7. First recorded beginning in 2001. Since then, 24 patients (4.0%) have chosen not to inform their families, and 11 patients (1.8%) have had no family to inform. There was one unknown case in 2002, two in 2005, and one in 2009.
8. Other includes combinations of secobarbital, pentobarbital, and/or morphine.
9. Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.
11. The data shown are for 2001-2012 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.
12. A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.
13. There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.
14. Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.
Death Drugs Cause Uproar in Oregon
By SUSAN DONALDSON JAMES
Aug. 6, 2008 —

Terminally Ill Denied Drugs for Life, But Can Opt for Suicide

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

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

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

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

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

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

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

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

Letter's Impact 'Devastating'

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

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

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

A lifelong smoker, she was diagnosed with lung cancer in 2005 and quit. The state-run Oregon Health Plan generously paid for thousands of dollars worth of chemotherapy, radiation, a special bed and a wheelchair, according to Wagner.
The cancer went into remission, but in May, Wagner found it had returned. Her oncologist prescribed the drug Tarceva to slow its growth, giving her another four to six months to live.

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

A 2005 New England Journal of Medicine study found the drug erlotinib, marketed as Tarceva, does marginally improve survival for patients with advanced non-small cell lung cancer who had completed standard chemotherapy.

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

"It's been tough," said her daughter, Susie May, who burst into tears while talking to ABCNews.com. "I was the first person my mom called when she got the letter," said May, 42. "While I was telling her, 'Mom, it will be ok,' I was crying, but trying to stay brave for her."

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

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

Playing With 'My Life'

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

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

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

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

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

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

The health plan takes "no position" on the physician-assisted suicide law, according to spokesman Jim Sellers.
The terminally ill who qualify can receive pain medication, comfort and hospice care, "no matter what the cost," he said.

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

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

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

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

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

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

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

"The reason is that hospice care, where most patients are at the end of life is relatively inexpensive," Anne Martens, spokesman for Washington's Death With Dignity Initiative, told ABCNews.com.

But even those who support liberal death laws say Wagner's predicament is reflective of insurance attitudes nationwide.

Case Is Not Unique

"Her case is hardly unique," said Michigan lawyer Geoffrey Fieger, who defended Dr. Jack Kevorkian's crusade to legalize physician-assisted deaths. "In the rest of the country insurance companies are making these decisions and are not paying for suicide," Fieger told ABCNews.com. "Involuntary choices are foisted on people all the time by virtue of denials."

"I am surprised there hasn't been a revolt in this country," he said. "It happens every day and people are helpless."

Indeed, one executive suffering from a rare and potentially fatal form of liver cancer is fighting his insurance company for coverage. Oncologists from a major teaching hospital in New York City have prescribed Sutent -- a medication that costs about $4,000 a month and could extend his life expectancy.

"Most of my objections are that some second rate guy on the staff of the insurance company is second-guessing one of the foremost authorities and trumping his judgment," said the 57-year-old executive,
who didn't want his name used to protect his privacy.

"I am fortunate to have the financial resources and the ability to fight these people who would rather these you die," he told ABCNews.com.

Dr. Jonathan Groner, clinical professor of surgery at OSU College of Medicine and Public Health in Columbus, Ohio, said some patients may want to prolong their lives for a life-cycle event, like a birth or wedding.

"A course of chemo would not cure, but would subdue the cancer long enough to be meaningful," he told ABCNEWS.com. "There are many people with slow-growing but nonetheless metastatic cancer for whom death, while inevitable, is many years away."

"The problem with the Oregon plan is it sounds like administrators, not physicians, are making treatment decisions," he said. "And if a patient can get assisted death paid for but not cancer treatment, the choice is obvious."

Derek Humphry, founder of the Hemlock Society and author of "Final Exit," who helped write the Oregon Death With Dignity Law, said only about 30 people a year choose an assisted death, which must be approved by two doctors.

"It's purely optional and the patient and doctor can walk away from it," the 78-year-old told ABCNEWS.com. "It's not the mad rush our enemies predicted and for our residents it has worked out well."

His own wife, Jean, was diagnosed with fast-growing breast cancer in 1975 and asked him to help find drugs to help her die. At 42, she chose to take them and ended her life.

Humphry says the Oregon Health Plan's approach to coverage is sound.

"People cling to life and look for every sort of crazy cure to keep alive and usually they are better off not to have done it," he said.

Meanwhile Wagner has faith in her medicine, not assisted death. Now, at the request of her doctor, the pharmaceutical company Genentech is giving her Tarceva free of charge for one year.

"The doctor did say it would put a lid on the cancer and I am hopeful," she said.

Wagner's daughter Susie May says her mother is a fighter. "I think we all knew that this is her last hope," she said.

Even Wagner's ex-husband, Dennis Wagner of Springfield, has weighed in on the ethical dilemma.

"My reaction is pretty typical," he told ABCNews.com. "I am sick and tired of the dollar being the bottom line of everything. We need to put human life above the dollar."

Rana Senol of ABC News Research contributed to this report.
Letter noting assisted suicide raises questions


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

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

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

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

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

An unfortunate interpretation?

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

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

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

He said the state has a financial incentive to offer death instead of life: Chemotherapy drugs such as Tarceva cost $4,000 a month while drugs for assisted suicide cost less than $100.
Saha said state health officials do not consider whether it is cheaper for someone in the health plan to die than live. But he admitted they must consider the state's limited dollars when dealing with a case such as Wagner's.

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

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

Health plan hasn't evolved?

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

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

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

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

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

However, her doctors contacted the pharmaceutical company, Genentech, which agreed to give her the medication without charging her. But doctors told us, that is unusual for a company to give away such an expensive medication.
Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

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ARTICLE INFO

Article history:
Received 2 August 2010
Received in revised form 7 December 2010
Accepted 11 December 2010
Available online 11 February 2011

Keywords:
Assisted suicide
Euthanasia
Complicated grief
Posttraumatic stress disorder
Depression

ABSTRACT

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

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

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

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

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1. Introduction

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

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50,000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 6,000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient's home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient's home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.

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"He made the mistake of asking for information about assisted suicide"

Dear Board of Medical Examiners:

We are disturbed to hear that the Board has been asked to legalize assisted suicide in Montana. We are writing to express our extreme objection to this development.

Our brother, Wes Olfort, recently died in Washington State where assisted suicide is legal. When he was first admitted to the hospital, he made the mistake of asking for information about assisted suicide. We say a mistake, because this set off a chain of events that interfered with his care and caused him unnecessary stress in what turned out to be the last months of his life.

By asking the question, he was given a "palliative care" consult by a doctor who heavily and continually pressured him to give up on treatment before he was ready to do so. It got so bad that Wes actually became fearful of this doctor and asked us and a friend to not leave him alone with her.

Justified or not, Wes was afraid that the doctor would do something to him or have him sign something if she would find him alone. In fact, even though he was on heavy doses of narcotic pain medications and not in a clear state of mind to sign documents without someone to advocate for him, this palliative care MD actually did try to get him to sign a DNR or "Do Not Resuscitate" form without his Durable POA or any family member present. Fortunately, his close friend / POA arrived at that moment in time to stop this from happening.

Some of the other doctors and staff members seemed to also write Wes off once they learned that he had asked about assisted suicide.

We object to any move by this Board to legalize assisted suicide in Montana.

We also question whether this Board would have the authority to do so. Thank you.

Ron Olfort
"I was afraid to leave my husband alone"

Letter from Oregon resident, Kathryn Judson, Published in the Hawaii Free Press, February 15, 2011. To view the original letter, click here and scroll down towards the bottom of the page.

When my husband was seriously ill several years ago, I collapsed in a half-exhausted heap in a chair once I got him into the doctor’s office, relieved that we were going to get badly needed help (or so I thought).

To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. ‘Think of what it will spare your wife, we need to think of her’ he said, as a clincher.

Now, if the doctor had wanted to say ‘I don’t see any way I can help you, knowing what I know, and having the skills I have’ that would have been one thing. If he’d wanted to opine that certain treatments weren’t worth it as far as he could see, that would be one thing. But he was tempting my husband to commit suicide. And that is something different.

I was indignant that the doctor was not only trying to decide what was best for David, but also what was supposedly best for me (without even consulting me, no less).

We got a different doctor, and David lived another five years or so. But after that nightmare in the first doctor’s office, and encounters with a ‘death with dignity’ inclined nurse, I was afraid to leave my husband alone again with doctors and nurses, for fear they’d morph from care providers to enemies, with no one around to stop them.

It’s not a good thing, wondering who you can trust in a hospital or clinic. I hope you are spared this in Hawaii.

Kathryn Judson, Oregon

Tuesday, January 15, 2013

Legal physician-assisted suicide encourages people with many quality years left to throw away their lives.

Legalization is a recipe for elder abuse.

In Oregon, legalization has empowered the Oregon Health Plan to steer citizens to suicide.

In Oregon, other suicides have increased with legalization.

In Washington, the only other state with legal assisted suicide, there have been proposals to expand that law to direct euthanasia of non-terminal people.

For more information, go to Quick Facts About Assisted Suicide.

Senator Shockley Speaks Against Assisted Suicide; warns of abuse by heirs

Click on photo to see video

A Recipe for Elder Abuse
Planning for old age at a premium

By Jerry Large
Seattle Times staff columnist

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

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

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

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

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

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

The only certainty is that nothing is universally true.

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

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.

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

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

If you are somewhere in the middle, you may want what the rich have, but be able to afford only what the poor get — and only until your money runs out, and then Medicaid will step in.
Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

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

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

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

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

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

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

The report also included the following findings:

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

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

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

Methods, data sources and limitations

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

Executive Summary

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

Key Findings

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

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

Suicide rates among women ages 45-64 rose 55 percent from 8.2 per 100,000 in 2000 to 12.2 per 100,000 in 2007.

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

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

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

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

The number of suicides in each month varies. But there was not a clear seasonal pattern.
Suicides in Oregon
Trends and Risk Factors

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


Oregon suicide report,
issued in September 2010. Data