TO: The New Jersey Senate
FROM: Margaret Dore, Esq., MBA
RE: Vote "No" on A2270(3R) (Physician-Assisted Suicide, Assisted Suicide & Euthanasia)
DATE: December 3, 2014

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I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal. Our law is based on a similar law in Oregon. Both laws are similar to the proposed bill, which is the third reprint of A2270. The bill is titled "Aid in Dying for the Terminally Ill Act."2

"Aid in Dying" is a euphemism for assisted suicide and euthanasia. The term also implies that the proposed bill is limited to people who are dying, which is untrue. The bill, despite its having been substantially amended, legalizes assisted suicide and euthanasia for people who may have years, even decades, to live. If New Jersey follows Washington State’s interpretation of its similar law, death investigations in New Jersey will be eliminated other than to certify deaths as "Natural." The cause of death on the death certificate will be falsified. Other problems are discussed below. I urge you to reject this measure.

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1 I am a former Law Clerk to the Washington State Supreme Court and to the Washington State Court of Appeals. I worked for a year with the United States Department of Justice. I am a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. I am President of Choice is an Illusion, a 501(c)(4) non-profit human rights organization opposed to assisted suicide and euthanasia. For more information, please see www.margaretdore.com and www.choiceillusion.org

2 A copy of the third reprint of A2270 is attached hereto at A-1 through A-21.

3 The term, "aid in dying" means euthanasia. See, for example, the 1989 Model Aid-in-Dying Act using the following link, with the letters "euthan" (for euthanasia) at http://www.uiowa.edu/~sfklaw/euthan.html
II. FACTUAL AND LEGAL BACKGROUND

A. Physician-Assisted Suicide, Assisted Suicide and Euthanasia

The American Medical Association defines “physician-assisted suicide” as occurring when “a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act.”4 “Assisted suicide” is a general term in which the aiding person is not necessarily a physician. “Euthanasia,” by contrast, is the direct administration of a lethal agent with the intent to cause another person’s death.5 “Euthanasia” is also known as “mercy killing.”6

The American Medical Association rejects physician-assisted suicide and euthanasia, stating they are:

fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.7

B. Withholding or Withdrawing Treatment

Withholding or withdrawing treatment (“pulling the plug”) is not assisted suicide or euthanasia. The purpose is to remove

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4 The AMA Code of Medical Ethics, Opinion 2.211 - Physician-Assisted Suicide. (Attached at A-22).


7 AMA Code of Ethics, Opinions 2.211 and 2.21, supra at footnotes 4 & 5.
treatment as opposed to an intent to kill the patient. More importantly, the patient does not necessarily die. Consider this excerpt from an article in Washington state regarding a man removed from a ventilator:

[I]nstead of dying as expected, the man slowly began to get better.  

C. Most States Have Rejected Assisted Suicide and/or Euthanasia

The vast majority of states to consider legalizing assisted suicide and/or euthanasia have rejected it. Indeed, this year in New Hampshire, the Democrat-controlled House of Representatives defeated a bill similar to A2270. The vote was 219 to 66. In the last three years, four states have strengthened their laws against assisted suicide. These states are: Arizona, Idaho, Georgia and Louisiana.

There are also three states where assisted suicide is legal:

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

10 See New Hampshire House Leadership page listing Democrats as Speaker of the House (Rep Norelli) and Majority Leader (Rep Shurtleff). (Attached A-30). See also Shurtleff's bio page at A-31 (showing his membership in the Democratic party). See also "Live Free or Die. New Hampshire Obliterates Oregon-style Death with Dignity Act!," Choice is an Illusion, March 6, 2014, http://www.choiceillusion.org/2014/03/live-free-or-die-new-hampshire.html

11 See HB 1325 Roll Call, voting 219 to 66 "yea" to defeat the bill as "ITL" (inexpedient to legislate). (Attached at A-32).
Oregon, Washington and Vermont. Oregon's law was enacted by a ballot measure in 1997. Washington's law was enacted by another ballot measure in 2008 and went into effect in 2009. Vermont's law was enacted by its legislature in 2013. No one, however, has died under that law and opponents are calling for a repeal. In New Mexico, there is a district court opinion legalizing "aid in dying" (assisted suicide and euthanasia). That case is on appeal. Moreover and contrary to claims made by suicide proponents, assisted suicide is not legal in Montana.

III. THE BILL.

A. "Eligible" Patients May Have Years, Even Decades, to Live.

The Third Reprint of A2270 applies to "terminal" patients,
meaning those predicted to have six months or less to live.\textsuperscript{17}

Such persons may, however, actually have years or even decades to live, i.e., unless this bill passes and they commit suicide or are euthanized thereunder. This is true for at least three reasons:

1. If New Jersey follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for persons with chronic conditions such as diabetes.

The proposed bill states:

"Terminal ill" means that the patient is in the terminal stage of an irreversibly fatal illness, disease, or condition with a prognosis, based upon reasonable medical certainty, of a life expectancy of six months or less.\textsuperscript{18}

Oregon's law has a similar definition, as follows:

"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.\textsuperscript{19}

In Oregon, this similar definition is interpreted to include chronic conditions such as insulin dependent diabetes.\textsuperscript{20} Oregon

\textsuperscript{17} See Third reprint, § 3. (Attached at A-5).
\textsuperscript{18} Id.
\textsuperscript{19} Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-40.
\textsuperscript{20} See Oregon's annual assisted suicide report for 2013, attached hereto at A-41 to A-47. "Chronic lower respiratory disease" and "diabetes" are listed at A-46 & A-47, respectively.
doctor, William Toffler, explains:

Our law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions... Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live.21

If New Jersey enacts the proposed bill and follows Oregon’s interpretation of “terminal disease,” assisted suicide and euthanasia will be legalized for people in New Jersey with chronic conditions such as diabetes. Dr. Toffler states:

Such persons, with treatment, could otherwise have years or even decades to live.22

2. New Jersey’s “rule of lenity” will require that the definition of “terminally ill” be interpreted to include chronic conditions such as diabetes.

In New Jersey, courts rely on the “rule of lenity” to interpret criminal statutes, which yield “more than one plausible interpretation.” State v. Shelley, 205 N.J. 320, 324, 15 A.3d 818 (2011). Per the rule, an ambiguous criminal statute “must” be interpreted in favor of the defendant. (Id.)

With this situation, a doctor who uses the bill will not be criminally liable if he assists the suicide of an otherwise


22 Id.
healthy, 18 year old diabetic dependent on insulin. This is because the bill’s definition of “terminally ill” can at least plausibly be interpreted to include diabetes. Indeed, Oregon already uses this interpretation. As noted by Dr. Toffler:

Such persons, with treatment, could otherwise have years or even decades to live.”

3. Predictions of life expectancy can be wrong.

Patients may also have years to live because predicting life expectancy is not an exact science. Consider John Norton who was diagnosed with ALS. He was told that he would get progressively worse (be paralyzed) and die in three to five years. Instead, the disease progression stopped on its own. In a 2012 affidavit, at age 74, he states:

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.

Affidavit of John Norton, attached at A-60, ¶ 5.

B. If the Bill Is Enacted, There Will Be Pressure to Expand “Eligibility.”

If A2270 is enacted, there will be pressure to expand “eligibility.” I say this due to what’s been happening with

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hospice and our experience here in Washington State regarding assisted suicide and euthanasia.

1. Hospice

Hospice has a six months to live eligibility criteria. In August, the Washington Post reported that there "appears to be a surge in hospices enrolling patients who aren’t close to death." This practice is resulting in the overdose deaths of non-dying people.

2. Washington State

In Washington State, our law went into effect in 2009. Since then, we have had informal proposals to expand our law to non-terminal people. For example, there was a column in the Seattle Times, which is our largest paper, with a suggestion of euthanasia as a solution for people who didn’t have enough money for their old age. So, if you worked hard all your life, paid taxes and then your pension plan went broke, this is how society would pay you back, with non-voluntary or involuntary euthanasia?

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26 Id.

27 See Jerry Large, “Planning for old age at a premium,” The Seattle Times, March 8, 2012 (“After Monday’s column, . . . a few [readers] 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.”) (Emphasis added). (Attached at A-62).
Prior to passing our law, I never heard anyone talk like this.

C. How the Bill Works.

A2270 has an application process to obtain the lethal dose, which includes a written lethal dose request form.\(^{28}\)

Once the lethal dose is issued by the pharmacy, there is no oversight.\(^{29}\) The death is not required to be witnessed by disinterested persons.\(^{30}\) Indeed, no one is required to be present.\(^{31}\)

D. Specific Problems with the Bill.

The bill implies that its provisions are “entirely voluntary.” For example, § 2.c. states:

> The public welfare requires . . . a defined and safeguarded process . . . which will: . . . ensure that the process is entirely voluntary on the part of all participants, including patients . . . \(^{32}\)

This comforting thought is an illusion and propaganda when compared to what the third reprint actually says and does.

Please consider some of the bill’s specific problems discussed

\(^{28}\) The lethal dose request form can be viewed at A2270, §20. (A-15 to A-17)

\(^{29}\) See A2270 in its entirety. (Attached at A-1 through A-21).

\(^{30}\) Id.

\(^{31}\) Id.

\(^{32}\) A2270, § 2, line 41, attached at A-2.
below.

1. No witnesses at the death.

The third reprint of A2270 does not require witnesses at the death.\(^{33}\) Without disinterested witnesses, the opportunity is created for someone else to administer the lethal dose to the patient without her consent.\(^{34}\) Even if she struggled, who would know? This situation is especially significant for people with money. A California case, *People v. Stuart*, 67 Cal.Rptr.3d 129, 143 (2007), states:

> [F]inancial considerations [are] an all too common motivation for killing someone.\(^{35}\)

Without disinterested witnesses, the patient’s voluntary action is not guaranteed.

2. Adding witnesses will not fix the problem.

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

\(^{33}\) See A2270 in its entirety, attached hereto at A-1 to A-21.

\(^{34}\) The drugs used for assisted suicide in Oregon and Washington, Secobarbital and Pentobarbital (Nembutal), are water soluble, such that they can be injected without consent, for example, to a sleeping person. See “Secobarbital Sodium Capsules, Drugs.Com, at [http://www.drugs.com/pro/secobarbital-sodium.html](http://www.drugs.com/pro/secobarbital-sodium.html) and [http://www.drugs.com/pro/nembutal.html](http://www.drugs.com/pro/nembutal.html) See also Oregon’s report, page 6, attached at A-46 (listing these drugs).

\(^{35}\) In *People v. Stuart*, the daughter had killed mother with a pillow.
3. Witnesses can be coercive.

Witnesses can also be coercive. Consider Oregon resident Lovelle Svart, who threw herself an “exit party,” during which time she danced the polka with George Eighmey of Compassion & Choices. The party was reported in the Seattle Times, which wrote an article implying that she was in control. At the end of the party, however, when it was time for her to die, the paper also reported this exchange between her and Eighmey, which took place in front of ten people:

"Is this what you want?"

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

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

"Yes."37

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

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

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

4. **Someone else is allowed to speak for the patient during the lethal dose request process.**

Under A2270, a patient requesting a lethal dose is required to be “capable.” This is, however, a relaxed standard in which someone else is allowed to speak for the patient. Moreover, the speaking person does not have to be the patient’s designated agent such as an attorney-in-fact under a power of attorney. The only requirement is that the speaking person be “familiar with the patient’s manner of communicating.” The third reprint of A2270 states:

"Capable" means having the capacity to make health care decisions and to communicate them to a health care provider, including 
communication through persons familiar with the patient’s manner of communicating . . . 
(Emphasis added).

Being “familiar with the patient’s manner of communicating” is a very minimal standard. Consider, for example, a doctor’s assistant who is familiar with a patient’s “manner of communicating” in Spanish, but does not herself understand

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38 A2270, § 4.b, attached at A-5, line 25.
39 A2270, § 3, attached at A-3, lines 24-27.
Spanish. That, however, would be good enough. Indeed, the doctor’s janitor could speak for the patient as long as he was "familiar with the patient’s manner of communicating."

5. **The term "self-administer," allows someone else to administer the lethal dose to the patient.**

Proponents may claim that patients under A2270 are, nonetheless, in control due to a requirement of "self-administration." A2270, however, only says that a patient "may" self-administer a lethal dose. There is no provision that administration of the lethal dose "must" be by self-administration. A2270 also defines "self-administer" as the patient’s "act of ingesting." § 3 says:

"Self-administer" means a qualified terminally ill patient’s act of ingesting medication that has been prescribed pursuant to [this bill] . . . (Emphasis added).

A2270 does not define "ingesting." Dictionary definitions include:

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

With these definitions, someone else putting the lethal dose in the patient’s mouth qualifies as self-administration because the patient will thereby be "swallowing" the lethal dose, i.e.,

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40 See Bill A2270 in its entirety, attached hereeto at A-1 to A-21.

41 § 3 at a-4, lines 44-45, to A-5, lines 1-2.

42 Webster’s New World College Dictionary, ingest. (Attached at A-63).
“ingesting” it. Someone else placing a medication patch on the patient’s arm will also qualify because the patient will thereby be “absorbing” the lethal dose, i.e., “ingesting” it. Someone else turning on lethal gas will qualify because the patient will thereby be “inhaling” the lethal dose, i.e., “ingesting” it.

With “self-administer” defined as mere ingestion, someone else is allowed to administer the lethal dose to the patient.

6. A2270 legalizes physician-assisted suicide and assisted suicide.

A2270 allows a patient to ingest a lethal dose prescribed by a physician. This is “physician-assisted suicide.” The AMA Code of Medical Ethics, Opinion 2.211 states:

Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act . . . .

Attached at A-22.

A2270 also allows the active participation of non-physicians such as the patient’s heirs. See e.g., the bill’s lethal dose request form, which allows one of two witnesses on the form to be the patient’s heir. (Attached hereto at A-16 to A-17). With this situation, the general term, “assisted suicide,” is also appropriate. A2270 thus legalizes both physician-assisted suicide and assisted suicide generally.
7. **A2270 legalizes euthanasia.**

As discussed above (Section III.D.5.), the bill’s definition of “self-administer,” allows someone else to administer the lethal dose to the patient. With this situation, A2270 legalizes “euthanasia” under generally accepted medical terminology. The AMA Code of Medical Ethics, Opinion 2.21, states:

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

8. **A2270 does not prohibit involuntary administration of the lethal dose without patient consent.**

A2270 does not require that the patient be capable or even aware when the lethal dose is administered. There is also no language requiring the patient’s consent at the time of administration. Similarly, there is no criminal penalty for administering a lethal dose to a patient without his consent.

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43 Attached hereto at A-23.

44 A2270 addresses whether the patient is "competent" or "capable" in conjunction with the lethal dose request, not later at the time of administration. See: §§ 2.a., 3., 4.b., 5.a., 6.a.(1), 6.a.(4), 7.c., 11.c.(3) & (4), and 20 (regarding “sound mind”).

45 A2270 requires that a determination of whether a patient is acting "voluntarily" be made in conjunction with the lethal dose request, not later. See: §§ 4.c., 5.a., 6.a.(1), 6.a.(4), 7.c., 11.c.(3) & (4), and 20 (regarding making the request “voluntarily”).

46 See, for example, §18, which provides criminal penalties, none of which apply to administration of a lethal dose without consent. §18 states:

a. A person who, without authorization of the patient, and with the intent or effect of causing the patient’s death, willfully alters or forges a request for medication pursuant to [this bill] or conceals or destroys a rescission of that request is guilty of a crime of the second degree.
9. The patient's promised control over the time, place and manner of his death is an illusion.

Proponents may argue that patient consent is, nonetheless, required at the time of administration because a patient may rescind the request for the lethal dose "at any time." A provision that a patient may rescind the request is not, however, the same thing as a requirement that the patient give consent to administration. Consider, for example, a patient who signed up for the lethal dose "just-in-case," which is a scenario promoted by assisted suicide/euthanasia proponents. If such patient would later become incompetent, be sedated, or simply be sleeping, she would not have the ability to rescind. Moreover, without a consent requirement, the act implies that administration of the lethal

b. A person who coerces or exerts undue influence on a patient to request medication pursuant to [this bill] or to destroy a rescission of a request is guilty of a crime of the third degree.

c. Theft of medication prescribed to a qualified terminally ill patient pursuant to [this bill] shall constitute an offense involving theft of a controlled dangerous substance as set forth in N.J.S.2C:20-2.

d. Nothing in [this bill] shall limit liability for civil damages resulting from the negligence or intentional misconduct of any person.

e. The penalties set forth in this section shall not preclude the imposition of any other criminal penalty applicable under law for conduct that is inconsistent with the provisions of [this bill].

47 A2270, § 10.b., attached hereto at A-9, lines 43-45.
dose can nonetheless go forward. To the extent this point is ambiguous, the rule of lenity would resolve it in favor of the potential accused, i.e., a doctor, a nurse or family member who administered the lethal dose.

Without a right of consent, the patient’s promised control over the time, place and manner of his or her death is an illusion.

10. **A2270 lacks transparency and accountability.**
   
a. **Record keeping is private.**

   A2270 provides that a doctor’s compliance with its provisions be tracked in the patient’s medical record, which is a private document protected by HIPPA.\(^{48}\)

   b. **If New Jersey follows Washington State’s interpretation of language similar to A2270, death investigations by the medical examiner will be eliminated other than to certify the deaths as “Natural”; the cause of death will be falsified.**

   A2270 states:

   Any action taken in accordance with the provisions of [this bill] shall not constitute patient abuse or neglect, suicide, assisted suicide, mercy killing, or homicide under any law of this State."\(^{49}\)

   In Washington State, similar language has been interpreted

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\(^{48}\) See Bill A2270, § 11.d., attached at A-10.

\(^{49}\) §17.a.(2), at A-13, line 42.
to require the Medical Examiner to certify the manner of death as "Natural" as long as Washington's death with dignity act was used, i.e., regardless of the specific facts of the case.\textsuperscript{50} In addition, the death certificate is not to contain any language indicating that the act was used."\textsuperscript{51} Prohibited words include "suicide", "mercy killing" and "euthanasia."\textsuperscript{52}

If New Jersey enacts A2270 and follows Washington's lead, there will be a similar result in which death investigations are effectively eliminated and the death certificate is falsified to eliminate the true cause of death, which is a lethal dose of medication. There will be a lack of transparency regarding specific deaths and also a lack of transparency for the purpose of later review should anyone want to know how the law is working in practice.

A smaller point, vital statistics regarding disease survival rates will also be distorted (and artificially pushed downward).

\textsuperscript{50} See Washington State Department of Health "Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with the Death with Dignity Act," (Attached hereto as A-64).

\textsuperscript{51} Id.

\textsuperscript{52} Id.
c. The Division of Consumer Affairs is without power to investigate other than to "request" a report; No disclosure of identifying information is permitted.

A2270 provides for reporting by prescribing health care professionals to the Division of Consumer Affairs.\textsuperscript{53} This is for the purpose of an annual statistical report to the public.\textsuperscript{54} The Division is given no powers of investigation or enforcement, i.e., other than to "request" a report.\textsuperscript{55} Moreover, any information collected "that contains material or data that could be used to identify an individual patient or health care professional shall not be included under materials available to public inspection."\textsuperscript{56} Once again, there is a lack transparency and accountability regarding this bill.

IV. THE OREGON AND WASHINGTON EXPERIENCE

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

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

\textsuperscript{53} A2270, § 13, at A-11, line 32, to A-12, line 24.
\textsuperscript{54} § 13(3) at A-12, lines 5-9.
\textsuperscript{55} Id.
\textsuperscript{56} A-12, lines 16-19.
[All] the protections end after the prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is [voluntarily administered]

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

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

If A2270 is passed, health care providers and insurers in New Jersey will be able to follow Oregon’s lead to steer patients to suicide. Consider the case of Oregon resident, Barbara Wagner. In 2008, the Oregon Health Plan offered to cover her assisted suicide instead of a drug to possibly cure her cancer.

"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."  

With the Oregon Health Plan’s letter, Wagner was steered to suicide. The drug’s manufacturer subsequently agreed to provide

\[57\]  

\[58\]  
Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (Excerpt attached at A-66)
the drug.\textsuperscript{59} She nonetheless died a short time later.

To learn more about steerage to suicide in Oregon, See: the affidavit of Kenneth Stevens, MD (attached hereto at A-49 to A-58, describing how the Oregon Health Plan works); and Bradley Williams, "Assisted suicide is not legal, not the answer," August 21, 2014 (attached at A-65, regarding Compassion & Choices’ true mission to discourage patient cures).

\textbf{C. Oregon’s Annual Report for 2013 is Consistent with Financial Elder Abuse and the "Barbara Wagner" Scenario}

According to Oregon’s most recent annual assisted suicide report for 2013, most of the people who died from a lethal dose were white, aged 65 or older, and well-educated.\textsuperscript{60} People with these attributes are typically well off, i.e., the middle class and above.

The report implies that these deaths were voluntary, stating that Oregon's act "allows" residents to obtain a lethal dose.\textsuperscript{61} There is nothing in the report, however, that actually says that the deaths were voluntary.\textsuperscript{62} Older well-off people are, regardless, in a vulnerable demographic for abuse and

\textsuperscript{59} "Letter noting assisted suicide raises questions," KATU TV, July 30, 2008. (Attached at A-68)

\textsuperscript{60} Report, page 2, attached hereto at A-42, last full paragraph.

\textsuperscript{61} Id., page 1, attached hereto at A-41.

\textsuperscript{62} Report, pages 1-7, starting at A-41.
exploitation. This includes murder. A 2009 MetLife Mature
Market Institute Study states:

Elders' vulnerabilities and larger net worth
make them a prime target for financial abuse
. . . Victims may even be murdered by
perpetrators who just want their funds and
See them as an easy mark.63

The Oregon report, in which most of the people dying under
the act were older and well-off, is consistent with financial
er elder abuse. The report, which also describes patients on
Medicaid, is consistent with the “Barbara Wagner” scenario.

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

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

Oregon's assisted suicide act went into
effect “in late 1997.”64

63 The MetLife Study can be viewed at this link:

64 Oregon's assisted suicide report for 2013, attached at A-41.
By 2000, Oregon's regular suicide rate was "increasing significantly."\(^{65}\) 

By 2007, Oregon's regular suicide rate was 35% above the national average.\(^{66}\) 

By 2010, Oregon's regular suicide rate was 41% above the national average.\(^{67}\) 

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

The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.\(^{68}\)

Oregon is the only state where there has been legalization of assisted suicide long enough to have statistics over time. The enormous cost of increased (regular) suicides in Oregon, positively correlated to physician-assisted suicide legalization, is a significant factor for this body to consider regarding A2270, which seeks to legalize physician-assisted suicide in New Jersey.


\(^{66}\) Attached at A-72

\(^{67}\) Attached at A-75.

\(^{68}\) Attached at A-76.
E. Legal Assisted Suicide can be Traumatic for Family Members as well as Patients.

1. The Swiss study.

In 2012, a study was released in Switzerland, addressing trauma suffered by persons who witnessed an assisted suicide.69 The study found that 1 out of 5 family members or friends present at an assisted suicide were traumatized.70 These persons:

[E]xperienced full or sub-threshold PTSD [Post Traumatic Stress Disorder] related to the loss of a close person through assisted suicide.71

2. My cases involving the Oregon and Washington assisted suicide laws.

I have had two clients whose fathers signed up for the lethal dose.72 In the first case, one side of the family wanted the father to take the lethal dose, while the other did not. The father spent the last months of his life caught in the middle and traumatized over whether or not he should kill himself. My

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70 Id.

71 Id.

client, his adult daughter, was also traumatized. The father did not take the lethal dose and died a natural death.

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

F. Pain is Not the Issue.

The current Oregon assisted suicide report for 2013 lists "concerns" as to why the people who ingested the lethal dose signed up to do so.\textsuperscript{73} Per the report, there were 20 patients who had a concern about: "inadequate pain control."\textsuperscript{74} This is 20 people out of 32,475 total deaths in Oregon.\textsuperscript{75} Regardless, there was no claim that any one of these 20 patients was actually in pain.\textsuperscript{76} Pain is not the issue.

V. CONCLUSION

If the Third Reprint of A2270 is enacted, assisted suicide, physician-assisted suicide and euthanasia will become law for

\textsuperscript{73} Oregon Report, page 6, attached hereto at A-46.

\textsuperscript{74} Id.

\textsuperscript{75} Report, p.2, at A-42, fn 1 (total Oregon deaths in 2012 was 32,475)

\textsuperscript{76} See entire Oregon report at A-41 to A-47.
people with years, even decades to live. These persons will include young adults with chronic conditions such as diabetes. These persons will include older people with money, under a law that allows their heirs to actively participate in their getting the lethal dose and which has no oversight over administration of the lethal dose. Even if the person struggled, who would know?

If New Jersey follows Washington State’s interpretation of language similar to the Third Reprint, death investigations by the medical examiner will be eliminated other than to certify the deaths as “Natural.” The death certificate will be falsified. There will be a pronounced lack of transparency and accountability.

I urge you to reject this measure.

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Law Offices of Margaret K. Dore, P.S.
Choice is an Illusion, an 501(c)(4) nonprofit organization opposed to assisted suicide and euthanasia
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www.choiceillusion.org
1001 4th Avenue, 44th Floor
Seattle, WA 98154
206 389 1754 main reception line
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Sponsored by:
Assemblyman JOHN J. BURZICHELLI
District 3 (Cumberland, Gloucester and Salem)
Assemblyman TIMOTHY J. EUSTACE
District 38 (Bergen and Passaic)

Co-Sponsored by:
Assemblymen Cryan, McKeon, Assemblywoman Jasey and Assemblyman Wilson

SYNOPSIS
"Aid in Dying for the Terminally Ill Act"; permits qualified terminally ill patient to self-administer medication to end life in humane and dignified manner.

CURRENT VERSION OF TEXT
As amended by the General Assembly on June 23, 2014.

(Sponsorship Updated As Of: 6/6/2014)

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. (New section) Sections 1 through 21 of this act P.L. 45 shall be known and may be cited as the "New Jersey Death with Dignity Act."

2. (New section) The Legislature finds and declares that:

a. The public welfare requires a defined and safeguarded process, with procedural safeguards to protect the interests of patients and health care providers, by which a patient who is an adult New Jersey resident with the capacity to make health care decisions, and who has been determined by that individual’s attending physician and consulting physician to be suffering from a terminal disease that will cause death within six months, may obtain medication that the patient may self-administer to end his life in a humane and dignified manner.

b. Statistics from other states that have enacted laws to provide compassionate aid in dying for terminally ill patients indicate that the great majority of patients who requested medication under the laws of those states, including more than 90% of patients in Oregon since 1998 and between 72% and 86% of patients in Washington in each year since 2009, were enrolled in hospice care at the time of death, suggesting that those patients had availed themselves of available treatment and comfort care options available to them at the time they requested compassionate aid in dying.

c. The public welfare requires that such a process be entirely voluntary on the part of all participants, including the patient, the
patient's physicians, and any other health care provider furnishing
services or care to the patient in a defined and safeguarded process in
order to effectuate the purposes of this act, which will:

(1) guide health care providers and patient advocates who
provide support to dying patients;
(2) assist capable, terminally ill patients who request
compassionate aid in dying;
(3) protect vulnerable adults from abuse; and
(4) ensure that the process is entirely voluntary on the part of all
participants, including patients and those health care providers that
are providing care to dying patients;

This act is in the public interest and is necessary for
the welfare of the State and its residents, and it is intended that it
be liberally construed to effectuate its purposes.

3. (New section) As used in this act:

“Adult” means an individual who is 18 years of age or older.

“Attending physician” means a physician licensed pursuant to Title 45 of the Revised Statutes who has primary responsibility for the treatment and care of a qualified terminally ill patient and treatment of the patient's terminal illness, disease, or condition.

“Capable” means having the capacity to make health care decisions and to communicate them to a health care professional, including communication through persons familiar with the patient's manner of communicating if those persons are available.

“Consulting physician” means a physician licensed pursuant to Title 45 of the Revised Statutes who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's illness, disease, or condition.

“Counseling” means one or more consultations as necessary between a psychiatrist or psychologist licensed pursuant to Title 45 of the Revised Statutes and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

“Health care facility” means a health care facility licensed pursuant to P.L. 1971, c. 136 (C.26:2H-1 et seq.)

“Health care professional” means a person licensed to practice a health care profession pursuant to Title 45 of the Revised Statutes.

“Health care provider” means a health care professional or
health care facility.

“Informed decision” means a decision by a qualified terminally
ill patient to request and obtain a prescription for medication that
the qualified patient may choose to self-administer to end the
patient's life in a humane and dignified manner, which is based on
an appreciation of the relevant facts and after being fully informed
by the attending physician of:
(1) the patient's medical diagnosis;
(2) the patient's prognosis;
(3) the potential risks associated with taking the medication to
be prescribed;
(4) the probable result of taking the medication to be prescribed;
and
(5) the feasible alternatives to taking the medication, including,
but not limited to, additional treatment opportunities, palliative
care, comfort care, hospice care, and pain control.
"Medically confirmed" means that the medical opinion of the
attending physician has been confirmed pursuant to section 7 of
P.L. , c. (C.) (pending before the Legislature as this bill)²
by a consulting physician who has examined the patient and the
patient's relevant medical records.
²("Participating in this act" or "participation in this act")
"Participate in this act"² means to perform the duties of an
attending physician or consulting physician, a psychiatrist or
psychologist providing counseling, or a pharmacist dispensing
medication, a health care provider² in accordance with the
provisions of this act P.L., c. (C.) (pending before
the Legislature as this bill)², but does not include: making an initial
determination that a patient has a terminal disease is terminally
ill² and informing the patient of the medical prognosis; providing
information about the provisions of this act P.L., c. (C.)
(pending before the Legislature as this bill)² to a patient upon the
patient's request; or providing a patient, upon the patient's request,
with a referral to another physician health care provider².
"Patient" means a person who is under the care of a physician.
"Physician" means a doctor of medicine or osteopathy licensed
to practice medicine in New Jersey by the State Board of Medical
Examiners.²
"Qualified terminally ill² patient" means a capable adult who is
a resident of New Jersey and has satisfied the requirements of this
act in order² to obtain a prescription for medication that the
qualified patient may self-administer to end the patient's life in a
humane and dignified manner pursuant to P.L., c. (C.)
(pending before the Legislature as this bill)². A person shall not be
considered to be a qualified terminally ill² patient solely because
of the person's age or disability or a diagnosis of any specific
illness, disease, or condition².
"Self-administer" means a qualified terminally ill² patient's act
of ingesting medication to end that individual's life in a humane
and dignified manner[ that has been prescribed pursuant to P.L. [C. (pending before the Legislature as this bill)]

2 [“Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in a patient’s death within six months.] 3

“Terminal illness” means that the patient is in the terminal stage of an irreversibly fatal illness, disease, or condition. A determination of a specific life expectancy is not required as a precondition for a diagnosis that the patient is “terminally ill,” but a prognosis, based upon reasonable medical certainty, of a life expectancy of six months or less, with or without the provision of life-sustaining treatment, shall be deemed to constitute evidence that the patient is “terminally ill” for the purposes of P.L. [C. (pending before the Legislature as this bill)]

4. (New section) A terminally ill patient may make a written request for medication that the patient may choose to self-administer in order to end that individual’s life in a humane and dignified manner in accordance with the provisions of this act pursuant to P.L. [C. (pending before the Legislature as this bill)] if the patient:

a. is an adult resident of New Jersey as demonstrated pursuant to section 11 of P.L. [C. (pending before the Legislature as this bill)];

b. is capable and has been determined by the patient’s attending physician and a consulting physician to be suffering from a terminal disease; and

c. has voluntarily expressed a wish to receive a prescription for medication pursuant to P.L. [C. (pending before the Legislature as this bill)];

5. (New section) a. A valid written request for medication under this act shall be in substantially the form set forth in section 20 of this act (pending before the Legislature as this bill), signed and dated by the patient and witnessed by at least two individuals who, in the patient’s presence, attest that, to the best of their knowledge and belief, the patient is capable and is acting voluntarily to sign the request.

b. At least one of the witnesses shall be a person who is not:

(1) a relative of the patient by blood, marriage, or adoption;

(2) at the time the request is signed, entitled to any portion of the patient’s estate of the qualified patient’s estate upon the patient’s death under any will or by operation of law; and

[Page of paper with handwritten notes]
6. (New section) a. The attending physician shall ensure that all appropriate steps are carried out in accordance with the provisions of this act before writing a prescription for medication to enable a qualified terminally ill patient to end the patient’s life in a humane and dignified manner, for which purpose the physician may choose to self-administer pursuant to P.L. c. (pending before the Legislature as this bill), including such actions as are necessary to:

(1) make the initial determination of whether a patient [has a terminal disease] is terminally ill, is capable, and has voluntarily made the request for medication pursuant to P.L. c. (pending before the Legislature as this bill);

(2) require that the patient demonstrate New Jersey residency pursuant to section 11 of P.L. c. (pending before the Legislature as this bill);

(3) inform the patient of: the patient’s medical diagnosis and prognosis; the potential risks associated with taking the medication to be prescribed; the probable result of taking the medication; and the feasible alternatives to taking the medication, including, but not limited to, additional treatment opportunities, palliative care, comfort care, hospice care, and pain control;

(4) refer the patient to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the patient is capable and acting voluntarily;

(5) refer the patient for counseling, if appropriate, pursuant to this act section 8 of P.L. c. (pending before the Legislature as this bill);

(6) recommend that the patient participate in a consultation concerning additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options for the patient, and provide the patient with a referral to a health care professional qualified to discuss these options with the patient;
advice the patient about the importance of having another person present when the patient chooses to self-administer medication prescribed under this act and of not taking the medication in a public place; inform the patient of the patient's opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind the request at the end of the 15-day waiting period required by this act; and of not taking the medication in a public place; to verify, immediately before writing the prescription for medication under this act, that the patient is making an informed decision to request the medication; and to fulfill the medical record documentation requirements of this act.

b. The attending physician shall:
   (1) dispense medication directly, including ancillary medication intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under law to dispense and has a current federal Drug Enforcement Administration certificate of registration; or
   (2) with the patient's written consent:
      (a) contact a pharmacist to inform the latter of the prescription; and
      (b) transmit the written prescription personally, by mail, or by permissible electronic communication to the pharmacist, who shall dispense the medication directly to either the patient, the attending physician, or an expressly identified agent of the patient.

Medication dispensed pursuant to this subsection shall not be dispensed to the patient by mail or other form of courier.

7. (New section) A person shall not be considered a qualified patient until a consulting physician has:
   a. examined that patient and the patient's relevant medical records;
   b. confirmed, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease;
c. verified that the person patient is capable, is acting voluntarily, and has made an informed decision to request medication to end the person's life in a humane and dignified manner that, if prescribed, the patient may choose to self-administer pursuant to P.L. c. (pending before the Legislature as this bill).

8. (New section) If, in the opinion of the attending physician or the consulting physician, a patient requesting medication that the patient may choose to self-administer pursuant to P.L. c. (pending before the Legislature as this bill) may not be capable because the patient may be suffering from have a psychiatric or psychological disorder or depression that causes impaired judgment, the physician shall refer the patient to a licensed psychiatrist or psychologist for counseling to determine whether the patient is capable. A consulting physician who refers a patient to a licensed psychiatrist or psychologist for counseling pursuant to this subsection shall provide written notice of the referral to the attending physician. Medication to end a patient's life in a humane and dignified manner shall not be prescribed unless the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

b. If a patient has been referred to a licensed psychiatrist or psychologist for counseling pursuant to subsection a. of this section, the attending physician shall not write a prescription for medication that the patient may choose to self-administer pursuant to P.L. c. (pending before the Legislature as this bill) unless the attending physician has been notified in writing by the licensed psychiatrist or psychologist of that individual's determination that the patient is capable.

9. (New section) A patient shall not receive a prescription for medication to end the patient's life in a humane and dignified manner unless the patient has made an informed decision. Immediately before writing a prescription for medication pursuant to this act, the attending physician shall verify that the patient is making an informed decision.

10. (New section) A qualified terminally ill patient shall not receive a prescription for medication to end the patient's life in a humane and dignified manner that the patient may choose to self-administer pursuant to P.L. c. (pending before the Legislature as this bill) unless the attending physician has recommended that the patient notify the patient's next of kin of
the patient’s request for medication [pursuant to this act], except that a patient who declines or is unable to notify the patient’s next of kin shall not have the request for medication denied for that reason.

[11.] 10. (New section) a. In order to receive a prescription for medication that a qualified patient may self-administer to end the patient’s life in a humane and dignified manner, the patient shall make an oral request and a written request for the medication, and reiterate the oral request to the patient’s attending physician at least 15 days after making the initial oral request. At the time the patient makes a second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

(1) At least 15 days shall elapse between the patient’s initial oral request and the writing of a prescription pursuant to this act.

(2) At least 48 hours shall elapse between the time the patient signs the written request and the writing of a prescription pursuant to this act. In order to receive a prescription for medication that a qualified terminally ill patient may choose to self-administer pursuant to P.L. 2047, c. 2 (pending before the Legislature as this bill), the patient shall make two oral requests and one written request for the medication to the patient’s attending physician, subject to the following requirements:

(1) at least 15 days shall elapse between the initial oral request and the second oral request;

(2) at the time the patient makes a second oral request, the attending physician shall offer the patient an opportunity to rescind the request;

(3) the patient may submit the written request to the attending physician when the patient makes the initial oral request or at any time thereafter;

(4) the written request shall meet the requirements of section 5 of P.L. 2047, c. 2 (pending before the Legislature as this bill);

(5) at least 15 days shall elapse between the patient’s initial oral request and the writing of a prescription pursuant to P.L. 2047, c. 2 (pending before the Legislature as this bill); and

(6) at least 48 hours shall elapse between the attending physician’s receipt of the patient’s written request and the writing of a prescription pursuant to P.L. 2047, c. 2 (pending before the Legislature as this bill).

b. A qualified 2[terminally ill] patient may rescind the request at any time and in any manner without regard to the patient’s mental state. 2[The attending physician shall not write a prescription for medication pursuant to this act without offering the patient an opportunity to rescind the request.]
At the time the patient makes an initial oral request for medication that the patient may choose to self-administer pursuant to P.L., c. (C.) (pending before the Legislature as this bill), the patient's attending physician shall recommend to the patient that the patient participate in a consultation concerning additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options, and provide the patient with a referral to a health care professional qualified to discuss these options with the patient. If the patient chooses to participate in such consultation, the consultation shall include, to the extent the patient consents to share such information, consideration of: the patient's terminal illness; the patient's prognosis; current and past courses of treatment prescribed for the patient in connection with the patient's terminal illness, including the results of any such treatment; and any palliative care, comfort care, hospice care, and pain control treatment the patient is currently receiving or has received in the past.

The attending physician shall ensure that the following items shall be documented in the patient's medical record for the purposes of this act:

1. the determination that the patient is a qualified terminally ill patient and the basis for that determination;
2. the oral requests and the written requests by the patient to the attending physician for medication to end the patient's life in a humane and dignified manner that the patient may choose to self-administer pursuant to P.L., c. (C.) (pending before the Legislature as this bill);
3. the attending physician's diagnosis and prognosis, and determination that the patient is capable, is acting voluntarily, and has made an informed decision;
4. the consulting physician's diagnosis and prognosis, and verification that the patient is capable, is acting voluntarily, and has made an informed decision;
5. a report of the outcome and determinations made during counseling of the patient pursuant to this act;
6. if applicable, a report of the determination made by a licensed psychiatrist or psychologist as to whether the patient is capable pursuant to section 8 of P.L., c. (C.) (pending before the Legislature as this bill);
7. the attending physician's recommendation that the patient participate in a consultation concerning additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options; the referral provided to the patient with a referral to a health care professional qualified to discuss these options with the patient; an indication as to whether the patient participated in the consultation; and an indication as to whether the patient is currently
receiving palliative care, comfort care, hospice care, or pain control
treatments;

(7) the attending physician's offer to the patient to rescind the
patient's request at the time of the patient's second oral request; and

(8) a note by the attending physician indicating that all
requirements under (this act) P.L. , c. (C. ) (pending
before the Legislature as this bill) have been met and indicating the
steps taken to carry out the patient's request for medication,
including a notation of the medication prescribed.

A request for medication pursuant to (this act) P.L. , c. (C. ) (pending before the Legislature
as this bill) shall not be granted unless the qualified terminally ill
patient has documented that individual's New Jersey residency by
furnishing to the attending physician a copy of one of the following
as applies to that individual:

a. a driver's license or non-driver identification card issued by
the New Jersey Motor Vehicle Commission;
b. proof that the person is registered to vote in New Jersey;
c. a New Jersey resident gross income tax return filed for the
most recent tax year; or
d. any other government record that the attending physician
reasonably believes to demonstrate the individual's current
residency in this State.

Any medication dispensed pursuant
this act that is not self-administered by a qualified patient
P.L. , c. (C. ) (pending before the Legislature as this bill)
that a qualified terminally ill patient chooses not to self-administer
shall be disposed of by lawful means.

The Director of the Division of
Consumer Affairs in the Department of Law and Public Safety shall
require that a health care professional report the following
information to the division on a form and in a manner prescribed by
regulation of the director, in consultation with the Commissioner
of Health:

(1) No later than 30 days after the dispensing of medication
pursuant to (this act) P.L. , c. (C. ) (pending before the
Legislature as this bill), the health care professional who dispensed
the medication shall file a copy of the dispensing record with the
division, and shall otherwise facilitate the collection of such
information as the director may require regarding compliance with
any other government record that the attending physician
reasonably believes to demonstrate the individual's current
residency in this State.
(2) No later than 30 days after the date of the qualified terminally ill patient’s death, the attending physician who prescribed the medication shall transmit to the division such documentation of the patient’s death as the director shall require.

(3) In the event that anyone required to report information to the division pursuant to P.L. 1963, c. 404 (pending before the Legislature as this bill) provides an inadequate or incomplete report, the division shall contact the person to request a complete report.

(4) To the maximum extent practicable and consistent with the purposes of this section, the division shall seek to coordinate the process for reporting information pursuant to this subsection with the process for reporting prescription monitoring information by a pharmacy permit holder pursuant to sections 25 through 30 of P.L. 2001, c. 404 (C. 47: 1A-1 et seq.) and P.L. 2001, c. 404 (C. 47: 1A-5 et al.).

b. Any information collected pursuant to subsection a. of this section that contains material or data that could be used to identify an individual patient or health care professional shall not be included under materials available to public inspection pursuant to P.L. 1963, c. 73 (C. 47: 1A-1 et seq.) and P.L. 2001, c. 404 (C. 47: 1A-5 et al.).

c. The division shall prepare and make available to the public on its Internet website an annual statistical report of information collected pursuant to subsection a. of this section.

(5) [15.] A. (New section) a. A provision in a contract, will, insurance policy, annuity, or other agreement, written or oral, made on or after the effective date of P.L. 2007, c. 244 (C. 45: 1-45 through C. 45: 1-50), shall not be valid to the extent that the provision would condition or restrict a person’s decision to make or rescind a request for medication to end the person’s life in a humane and dignified manner pursuant to P.L. 2001, c. 404 (pending before the Legislature as this bill).

b. An obligation owing under a contract, will, insurance policy, annuity, or other agreement, made before the effective date of P.L. 2001, c. 404 (pending before the Legislature as this bill), shall not be affected by the provisions of P.L. 2001, c. 404 (pending before the Legislature as this bill); a person’s making or rescinding a request for medication to end the person’s life in a humane and dignified manner pursuant to P.L. 2001, c. 404 (pending before the Legislature as this bill), or any other action taken pursuant to P.L. 2001, c. 404 (pending before the Legislature as this bill).

c. On or after the effective date of P.L. 2001, c. 404 (pending before the Legislature as this bill),
procurement or issuance of a life, health, or accident insurance
policy or annuity or the premium or rate charged for the policy
or annuity shall not be conditioned upon or otherwise take into
account the making or rescinding of a request for medication
pursuant to this act (pending before the Legislature as this bill) by any person.

15. (New section) Nothing in this act (pending before the Legislature as this bill) shall
be construed to:

a. authorize a physician or any other person to end a patient's
life by lethal injection, active euthanasia, or mercy killing or any
act that constitutes assisted suicide under any law of this State;
or

b. lower the applicable standard of care to be provided by a
health care professional who participates in this act (pending before the Legislature as this bill).

16. (New section) A person shall not be authorized to take any
action on behalf of a patient for the purposes of this act (pending before the Legislature as this bill) by virtue of that
person's designation as a guardian pursuant to N.J.S.3B:12-1 et seq., a conservator pursuant to N.J.S.3B:13A-1 et seq., a health care representative pursuant to P.L.1991, c.201 (C.26:2H-53 et seq.), or a patient's representative pursuant to P.L.2011, c.145 (C.26:2H-129 et al.), except for communicating the patient's health care decisions
to a health care provider if the patient so requests.

17. (New section) a. (1) Except as provided in section 19
of this act (pending before the Legislature as this bill), a person shall not be subject to civil or criminal liability or
professional disciplinary action for any action taken in compliance
with the provisions of this act (pending before the Legislature as this bill), including being present when a
qualified patient takes self-administers medication to end the patient's life in a humane and dignified
manner prescribed pursuant to this act (pending before the Legislature as this bill). A person who
substantially complies in good faith with the provisions of this act (pending before the Legislature as this bill) shall be deemed to be in compliance with its provisions.

(2) Any action taken in accordance with the provisions of this act (pending before the Legislature as this bill) shall not constitute patient abuse or neglect suicide,
2l assisted suicide, mercy killing, or homicide under any 2[criminal]\^2
2 law of this State.
3 (3) A patient's request for, or the provision of, medication in
4 compliance with the provisions of 2[this act]\ P.L. , c. (C. )
5 (pending before the Legislature as this bill)\^2 shall not 2[constitute
6 neglect for any purpose of law or]\^2 provide the sole basis for the
7 appointment of a guardian or conservator.
8 b. Any action taken by a health care professional to participate
9 in 2[this act]\ P.L. , c. (C. ) (pending before the
10 Legislature as this bill)\^2 shall be voluntary on the part of that
11 individual. If a health care professional is unable or unwilling to
12 carry out a patient's request under 2[this act]\ P.L. , c. (C. )
13 (pending before the Legislature as this bill)\^2, and the patient
14 transfers 2[this] the patient's\^2 care to a new health care professional
15 or health care facility\^2, the prior health care professional shall
16 transfer, upon request, a copy of the patient's relevant records to the
17 new health care professional or health care facility\^2.
18
19 18. (New section) a. A person who, without authorization of
20 the patient, 2and with the intent or effect of causing the patient's
21 death,\^2 willfully alters or forges a request for medication pursuant
22 to 2[this act]\ P.L. , c. (C. ) (pending before the
23 Legislature as this bill)\^2 or conceals or destroys a rescission of that
24 request 2[with the intent or effect of causing the patient's death]\^2, is
25 guilty of a crime of the second degree.
26 b. A person who coerces or exerts undue influence on a patient
27 to request medication 2[to end the patient's life,] pursuant to
28 P.L. , c. (C. ) (pending before the Legislature as this bill)\^2
29 or to destroy a rescission of a request 2[.\]\^2 is guilty of a crime of
30 the third degree.
31 c. 2Theft of medication prescribed to a qualified terminally ill
32 patient pursuant to P.L. , c. (C. ) (pending before the
33 Legislature as this bill) shall constitute an offense involving theft of
34 a controlled dangerous substance as set forth in N.J.S.2C:20-2.
35 d. 2Nothing in 2[this act]\ P.L. , c. (C. ) (pending
36 before the Legislature as this bill)\^2 shall limit liability for civil
37 damages resulting from the negligence or intentional misconduct of
38 any person.
39 2[d.] 2 The penalties set forth in this section shall not
40 preclude the imposition of any other criminal penalty applicable
41 under law for conduct that is inconsistent with the provisions of
42 2[this act]\ P.L. , c. (C. ) (pending before the Legislature
43 as this bill)\^2.

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14
19. (New section) Any governmental entity that incurs costs resulting from a person terminating his life qualified terminally pursuant to this act P.L., c. (pending before the Legislature as this bill) in a public place has a claim against the estate of the person patient to recover those costs and reasonable attorneys' fees related to enforcing the claim.

20. (New section) A written request for a medication as authorized by this act P.L., c. (pending before the Legislature as this bill) shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, .................., am an adult of sound mind and a resident of New Jersey.

I am suffering from .................., which my attending physician has determined is a terminal illness, disease or condition and which has been medically 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, the expected result, and the feasible alternatives, including palliative care, comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and to contact any pharmacist as necessary to fill the prescription.

INITIAL ONE:

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

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

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

INITIAL ALL THAT APPLY:

...... My attending physician has recommended that I participate in a consultation concerning additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options, and provided me with a referral to a health care professional qualified to discuss these options with me.
I have participated in a consultation concerning additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options.

I am currently receiving palliative care, comfort care, or hospice care.

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

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

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

Signed: .

Dated: .

DECLARATION OF WITNESSES

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

Witness 1 Witness 2
Initials Initials

1. Is personally known to us or has provided proof of identity.
2. Signed this request in our presence on the date of the person's signature.
3. Appears to be of sound mind and not under duress, fraud, or undue influence.
4. Is not a patient for whom either of us is the attending physician.

Printed Name of Witness 1: .
Signature of Witness 1/Date: .

Printed Name of Witness 2: .
Signature of Witness 2/Date: .

NOTE: At least one witness shall not be a relative by blood, marriage, or adoption of the person signing this request, shall not be
entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. If the patient is a resident of a long-term care facility, one of the witnesses shall be an individual designated by the facility.

21. (New section) The Director of the Division of Consumer Affairs in the Department of Law and Public Safety, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of [this act] P.L. , c. (C. ) (pending before the Legislature as this bill), including the required reporting of information to the division by health care professionals pursuant to section [14] 13 of [this act] P.L. , c. (C. ) (pending before the Legislature as this bill).

22. (New section) The State Board of Medical Examiners, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L. , c. (C. ) (pending before the Legislature as this bill) concerning the duties of a licensed physician pursuant thereto.

23. (New section) The New Jersey State Board of Pharmacy, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L. , c. (C. ) (pending before the Legislature as this bill) concerning the duties of a licensed pharmacist pursuant thereto.

24 New section) The State Board of Psychological Examiners, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L. , c. (C. ) (pending before the Legislature as this bill) concerning the duties of a licensed psychologist pursuant thereto.

25. (New section) a. As used in this section:
   "Health care facility" or "facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).
   "Health care professional" means a person licensed to practice a health care profession pursuant to Title 45 of the Revised Statutes.
   b. [A health care facility may adopt a written policy to prohibit a health care professional from taking] (1) The existing policies and procedures utilized by a health care facility shall, to the maximum extent possible, govern the taking of any action by a
health care professional\(^2\) pursuant to sections 1 through 20 of P.L., c. (C.) (pending before the Legislature as this bill) on the premises owned by, or under the direct control of, the facility\(^2\).

\(^2\) If the facility has given prior written notice of the written policy to all health care professionals with privileges to practice on those premises, except as otherwise prescribed by regulation of the Commissioner of Health pursuant to paragraph (4) of this subsection.

(2) Any action taken by a health care facility to participate in P.L., c. (C.) (pending before the Legislature as this bill) shall be voluntary on the part of the facility.

(3) A health care facility shall not be subject to a licensure enforcement action by the Department of Health for any action taken in compliance with the provisions of P.L., c. (C.) (pending before the Legislature as this bill).

(4) The Commissioner of Health, pursuant to the “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L., c. (C.) (pending before the Legislature as this bill), concerning their application to a health care facility and any action taken by a health care professional on the premises owned by, or under the direct control of, the facility\(^2\).

\(^2\)(5)\(^2\) The provisions of this subsection shall not preclude a health care facility or a health care professional from providing to a patient any health care services to which the provisions of sections 1 through 20 of P.L., c. (C.) (pending before the Legislature as this bill) do not apply.

\(^2\)A health care professional who violates a written policy as set forth in subsection b. of this section, after being notified in writing of that policy, is subject to such of the following actions as the health care facility deems appropriate:

(1) the loss of privileges or membership, or other sanctions provided under the medical staff bylaws, policies, and procedures of the facility if the health care professional is a member of the medical staff at the facility and takes the prohibited action while on the premises of that facility, but not including the private medical office of a physician or other provider; and

(2) the termination of a lease or other contract for the occupancy of real property or other nonmonetary remedy provided by the lease or contract if the health care professional takes the prohibited action while on the premises of the health care facility or on property that is owned by or under the direct control of the facility; provided, however, that no lease or other contract made on or after the effective date of this act shall authorize or permit any nonmonetary remedy for taking the prohibited action in the form of loss or
restriction of medical staff privileges or exclusion from a managed
health care provider network; or

(3) the termination of a contract or other nonmonetary remedy
provided by contract if the health care professional takes the
prohibited action while acting in the course and scope of that
individual’s capacity as an employee or independent contractor of
the health care facility, except that nothing in this subparagraph
shall preclude:

(a) a health care professional from taking the prohibited action
while acting outside the course and scope of that individual’s
capacity as an employee or independent contractor; or

(b) a patient from contracting with the patient’s attending
physician and consulting physician to act outside the course and
scope of either physician’s capacity as an employee or independent
contractor of the health care facility.

(4) A health care facility shall follow all otherwise applicable
due process and other procedures that the facility may have in place
relating to the imposition of sanctions on a health care
professional.

read as follows:

1. a. Any person who is licensed in the State of New Jersey to
practice psychology, psychiatry, medicine, nursing, clinical social
work, or marriage counseling, whether or not compensation is
received or expected, is immune from any civil liability for a
patient's violent act against another person or against himself unless
the practitioner has incurred a duty to warn and protect the potential
victim as set forth in subsection b. of this section and fails to
 discharge that duty as set forth in subsection c. of this section.

b. A duty to warn and protect is incurred when the following
conditions exist:

(1) The patient has communicated to that practitioner a threat of
imminent, serious physical violence against a readily identifiable
individual or against himself and the circumstances are such that a
reasonable professional in the practitioner's area of expertise would
believe the patient intended to carry out the threat; or

(2) The circumstances are such that a reasonable professional in
the practitioner's area of expertise would believe the patient
intended to carry out an act of imminent, serious physical violence
against a readily identifiable individual or against himself.

A duty to warn and protect shall not be incurred when a qualified
patient requests medication that the patient may
choose to self-administer in order to end the patient's life in a
humane and dignified manner in accordance with the provisions
of P.L. 1976, c. 300 (pending before the Legislature as this bill).

c. A licensed practitioner of psychology, psychiatry, medicine,
nursing, clinical social work, or marriage counseling shall discharge
the duty to warn and protect as set forth in subsection b. of this
section by doing any one or more of the following:
(1) Arranging for the patient to be admitted voluntarily to a
psychiatric unit of a general hospital, a short-term care facility, a
special psychiatric hospital, or a psychiatric facility, under the
provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);
(2) Initiating procedures for involuntary commitment to
treatment of the patient to an outpatient treatment provider, a short-
term care facility, a special psychiatric hospital 2,2 or a psychiatric
facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et
seq.);
(3) Advising a local law enforcement authority of the patient's
threat and the identity of the intended victim;
(4) Warning the intended victim of the threat, or, in the case of
an intended victim who is under the age of 18, warning the parent
or guardian of the intended victim; or
(5) If the patient is under the age of 18 and threatens to commit
suicide or bodily injury upon himself, warning the parent or
guardian of the patient.

24. A practitioner who is licensed in the State of New Jersey to
practice psychology, psychiatry, medicine, nursing, clinical social
work, or marriage counseling who, in complying with subsection c.
of this section, discloses a privileged communication, is immune
from civil liability in regard to that disclosure.

25 (cf. P.L.2009, c.112, s.21)

27. N.J.S.2C:11-6 is amended to read as follows:
28 2C:11-6. Aiding Suicide. A person who purposely aids
another to commit suicide is guilty of a crime of the second degree
if his conduct causes such suicide or an attempted suicide, and
otherwise of a crime of the fourth degree. Any action taken in
accordance with the provisions of P.L. c. (C.) (pending
before the Legislature as this bill) shall not constitute suicide or
assisted suicide.
29 (cf. P.L.1978, c.95, s.2C:11-6)

28. This act shall be submitted to the people for their approval
or rejection at the next general election to be held at least 70 days
following the date of its enactment for the purpose of complying
with Article II, Section I, paragraph 2 of the New Jersey
Constitution.]

29. This voter referendum shall be submitted to the people in
the following manner and form:
There shall be printed on each official ballot to be used at the
general election, the following:
a. In every municipality in which voting machines are not used, a legend which shall immediately precede the question as follows:

If you favor the proposition printed below make a cross (X), plus (+), or check (✓) in the square opposite the word "Yes." If you are opposed thereto make a cross (X), plus (+) or check (✓) in the square opposite the word "No."

b. In every municipality the following question:

| YES | AUTHORIZATION TO ALLOW CERTAIN PERSONS TO USE MEDICATION TO END THEIR LIFE IN A HUMANE AND DIGNIFIED WAY
Do you approve allowing an adult who is able to make health care decisions and has a terminal disease that will cause death within six months to use a prescribed drug to end his life in a humane and dignified way?

| NO | INTERPRETIVE STATEMENT
Voter approval of P. L., c. (C. ) (pending before the Legislature as this bill) will permit an adult who is able to make health care decisions and has a terminal disease that will cause death within six months to use a prescribed drug to end his life in a humane and dignified way. |

[30.] 28. This act shall take effect on the first day of the [third] fourth month next following [voter approval of this act at the designated general election] the date of enactment, but the Director of the Division of Consumer Affairs in the Department of Law and Public Safety, the Commissioner of Health, the State Board of Medical Examiners, the New Jersey State Board of Pharmacy, and the State Board of Psychological Examiners may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.
Opinion 2.211 - Physician-Assisted Suicide

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

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

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

Opinion 2.21 - Euthanasia

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

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

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

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

Terminal Uncertainty

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

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

The doctor gave Clayton two to four months to live. That was almost four years ago.

Prodded by a son who lives in Seattle, Clayton sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center. Too weak to endure the toxicity of chemotherapy, she started with radiation, which at first made her even weaker but eventually built her strength.

Given dodgy prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called pemetrexate.

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

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

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

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

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

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

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

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

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

Sadly, Christakis' research has shown that his mother was an exception. In 2000, Christakis published a study in the British Medical Journal that followed 500 patients admitted to hospice programs in Chicago. He found that only 20 percent of the patients died approximately when their doctors had predicted. Unfortunately, most died sooner. "By and large, the physicians were overly optimistic," says Christakis.
In the world of hospice care, this finding is disturbing because it indicates that many patients aren't being referred early enough to take full advantage of services that might ease their final months. "That's what has frustrated hospices for decades," says Wayne McCormick, medical director of Providence Hospice of Seattle, explaining that hospice staff frequently don't get enough time with patients to do their best work.

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

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

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

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

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

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

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

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

**Every morning** when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.
"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 Christakias study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the Journal of the American Medical Association.
Given these two studies, it's no surprise that in Oregon some people who got a prescription for lethal medication on the basis of a six-month prognosis have lived longer. Of the 341 people who put themselves to death as of 2007 (the latest statistics available), 17 did so between six months and two years after getting their prescription, according to state epidemiologist Katrina Hedberg. Of course, there's no telling how long any of the 341 would have lived had they not killed themselves. The Department of Health does not record how long people have lived after getting prescriptions they do not use, so there's no telling, either, whether those 200 people outlived their prognosis. Compassion & Choices of Oregon, which independently keeps data on the people whom it helps navigate the law, says some have lived as long as eight years after first inquiring about the process (although it doesn't track whether they ever received the medication and a six-month prognosis).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

nshapiro@seattleweekly.com
Speaker of the House

State Rep. Terie Norelli was elected Speaker of the House for the 2013-2014 biennium on December 5, 2012.

The Speaker's duties are varied. Not only does the Speaker preside over a House session (preserving order while enforcing and interpreting the House parliamentary rules), it is also the Speaker's responsibility to make committee appointments and refer more than 1,000 bills to the appropriate committee for review. The only time the Speaker votes is to break a tie.

Majority and Minority Leaders

The primary responsibilities of the Majority and Minority leaders are: to organize and develop party positions; to provide channels of communications between the party and the Speaker and work closely with the various groups within their party. The Majority Leader is Rep. Steve Shurtleff of Concord. Rep. Gene Chandler of Bartlett serves as the Minority Leader.
**State of New Hampshire**

**House of Representatives**

<table>
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<tr>
<th>NH General Court</th>
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<th>Contact Us</th>
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</thead>
</table>

### Representative Stephen Shurtleff (d)

**Merrimack- District 11**  
**Seat #: 2001**  
**Incumbent**

**Home Address:**  
11 Vinton Dr  
Penacook, NH 03303-1583  
**Phone:** (603) 753-4563  
**Email:** steve.shurtleff@leg.state.nh.us

**More:**

#### House Committee Information

- **Committee Name:**
  - LEGISLATIVE ADMIN. SUBCOMMITTEE - ENROLLED B. RULES CRIMINAL JUSTICE AND PUBLIC SAFETY

- **Position:**
  - Member
  - V Chairman
  - Member

- **Telephone:**
  - 271-3529
  - 271-3661
  - 271-3419

- **Committee Function:**
  - N/A

#### Personal Website:

- N/A

#### Personal Biography:

- N/A

#### Local Government Involvement:

- N/A

#### Miscellaneous Information:

- N/A

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107 North Main Street, Concord, New Hampshire, 03301, (603) 271-3661
HB1325 Roll Calls

Bill Title: relative to death with dignity for certain persons suffering from a terminal condition.

LSR#: 2528  Body: H  Local Govt: N  Chapter#: none  Gen Status: HOUSE

House Roll Calls:

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<td>03/06/2014</td>
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<td>219</td>
<td>66</td>
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</table>

Senate Roll Calls:

No Rolls Calls Made by the Senate.

Disclaimer: "ITL" Inexpedient to legislate (Bill dead).
Opponents of Vermont’s physician-assisted suicide law are calling on legislators and the governor to place a moratorium on the prescription of life-ending drugs.

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

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

Mahoney and other opponents said the bill doesn’t have proper patient protections to ensure that people with disabilities or diminished capacity are not coerced into ending their lives, or to safeguard against the diversion of the drugs.

Sen. Claire Ayer, D-Addison, who helped shepherd the bill into law last session, said the opponents’ concerns are a rehash of the points they raised before.

“I don’t hear anything new,” she said. “I think that we’ve settled these issues.”
N.M. official appeals 'right to die' ruling - KFDA - NewsChannel 10 /... http://www.newschannel10.com/story/24968237/nm-official-appeals-r...

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

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

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

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

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

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

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

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Montana judge hears assisted suicide arguments

HELENA - The issue of physician assisted suicide was in court Tuesday.

Montanans Against Assisted Suicide[http://www.montanansagainsta ssistedsuicide.org/] is arguing that a policy position by the Montana Board of Medical Examiners[http://bsd.dli.mt.gov/license/bsd_boards/med_board/board_pag] implies that physician assisted suicide may be legal.
A lawyer for the Board says that the position - since rescinded, says no such thing. Michael Fanning says the group bringing the lawsuit has no real case is trying to force the issue to the Montana Supreme Court.

The position paper, written in response to doctor inquiries, said that the board would handle complaints related to assisted suicide on a case-by-case basis as it would other cases.

Margaret Dore, an attorney for MAAS, said the paper overstepped the Board's authority and implied to many that assisted suicide was legal in Montana.

"They are a board that is comprised of 11 doctors and two members of the public," she said. "It has no expertise to be making a pronouncement, that aid in dying is legal in Montana. That's the role of the legislature or a court and they are neither."

She said that such an understanding had huge implications in devaluing the lives of the sick and elderly.

That position paper - in response to the lawsuit - has since been rescinded by the Board and scrubbed from its website. But Dore said court action was still needed to prevent the Board from reinstating such a position.

She repeatedly asked District Judge Mike Menahan to weigh in on a Montana Supreme Court ruling known as Baxter, that envisions potential defenses to doctors charged with homicide for assisting with suicide.

But Menahan said it wasn't the role of a district judge to rule on a Montana Supreme Court order.

Michael Fanning, an attorney for the Board, said MAAS had no standing to bring the lawsuit, has suffered no damages from the Board's rescinded position and was simply jockeying to get the case before the Montana Supreme Court in hopes of overturning the Baxter ruling.

"This most certainly is a political question, a philosophical question or an academic debate, but it is not a lawsuit," he said. "In fact, this is a feigned case. It was contrived simply to bring this matter before you."

Menahan did not immediately rule on the case.

**COMMENTS**
Montanans Against Assisted Suicide (MAAS) appeals Montana Medical Board lawsuit. MAAS seeks permanent removal of a position statement that wrongly implies that assisted suicide is legal in Montana; appeal will also allow MAAS to continue its ongoing challenge to Montana's assisted suicide case, Baxter v. State.

"The only reason the Board of Medical Examiners abandoned their position paper was to get rid of our lawsuit," said Margaret Dore, Attorney for MAAS. "That's not good enough. They're just going to come back again with a new angle in the future that they hope will get around the legislature. The position paper was a significant 'toe in the door' to the attempted backdoor legalization of assisted suicide in Montana. The Board will attempt to do it again using another angle."

Appeal will also allow MAAS to continue its ongoing challenge to the decision in Baxter v. State, which suicide proponents claim legalized assisted suicide in Montana. A MTN News article describes the situation, as follows:

[The] position paper - in response to the lawsuit - has since been rescinded by the Board and scrubbed from its website. But [MAAS's attorney, Margaret] Dore said court action was still needed to prevent the Board from reinstating such a position.

She repeatedly asked District Judge Mike Menahan to weigh in on a Montana Supreme Court ruling known as Baxter, that envisions potential defenses to doctors charged with homicide for assisting with suicide.*

Problems with legalizing assisted suicide include that it encourages people with years to live, to throw away their lives. Legalization also creates new opportunities for elder abuse, for example, when there is an inheritance involved. In Oregon, legalization has enabled that state's health plan (Medicaid) to offer the "treatment" of suicide in lieu of desired treatments (to improve the quality of life, to extend life or to cure).**

For Bradley Williams, President of MAAS, preventing assisted suicide legalization is up front and personal. He says, "I'm 64 years old. I don't want a doctor or anyone else telling me or my wife that we should go kill ourselves."
MAAS is a single issue group that welcome everyone opposed to assisted-suicide regardless of their views on other issues. In 2013, MAAS and its allies easily defeated Senate Bill 220, which had sought to legalize assisted suicide in Montana. MAAS's own bill, HB 505, which had sought to reverse Baxter's holding and give prosecutors a lower sentencing option, passed the House, but was defeated by four votes in the Senate before it was tabled.

* To view a copy of the MTV News article, go here: http://www.kxlf.com/news/montana-judge-hears-assisted-suicide-arguments/

** To view a copy of "Quick Facts Against Assisted Suicide," go here: http://www.montanansagainstassistedsuicide.org/p/quick-facts-about-assisted-suicide.html

###
SB 220 Defeated

On February 13, 2013, an Oregon-style assisted suicide bill, SB 220, was defeated and tabled in the Senate Judiciary Committee’s executive session.

The vote to defeat SB 220 was 7 to 5.

The vote to table it was 9 to 3.

* For a legal and policy analysis of the defeated bill, SB 220, see this link: http://maasd documents.files.wordpress.com/2013/02/mt no-on-sb-220_0011.pdf

** To view the bill’s information page, go here.

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Jeanette Hall, 12 years after her doctor talked her out of physician-assisted suicide in Oregon - Click photo to read her story.

Voices From Oregon and Washington Where Assisted Suicide is Legal

- "I was afraid to leave my husband alone"
- "This is how society will pay you back? With non-voluntary or involuntary euthanasia?"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "It wasn’t the father saying that he wanted to die"
- "He made the mistake of asking about assisted suicide"

Law Enforcement Viewpoint Against Assisted Suicide

Some healthcare providers already misuse and/or abuse palliative care. If assisted suicide is made legal, providers will have even more power to abuse patients and/or take away patient choice. To learn more, click here.

To see our doctor ad, please go here.

Click on the banner to see website

Print our handouts
Oregon Revised Statute

Chapter 127

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.897, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

Please browse this page or download the statute for printing. (Read the statute at https://www.oregonlegislature.gov)

127.800 s.1.01. Definitions.

The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

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

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

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, 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.

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

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

(6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(a) His or her medical diagnosis;

(b) His or her prognosis;

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

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

(e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

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

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

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1996 c.3 s.1.01; 1999 c.423 s.1]

(Writeen Request for Medication to End One's Life in a Humane and Dignified Manner)

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 s.2.01; 1999 c.423 s.2]

127.810 s.2.02. Form of the written request.
Oregon’s Death with Dignity Act--2013

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

Figure 1:
Oregon DWDA Prescription Recipients and Deaths*, 1998-2013

*As of January 22, 2014
• As of January 22, 2014, prescriptions for lethal medications were written for 122 people during 2013 under the provisions of the DWDA, compared to 116 during 2012 (Figure 1). At the time of this report, there were 71 known DWDA deaths during 2013. This corresponds to 21.9 DWDA deaths per 10,000 total deaths.¹

• Since the law was passed in 1997, a total of 1,173 people have had DWDA prescriptions written and 752 patients have died from ingesting medications prescribed under the DWDA.

• Of the 122 patients for whom DWDA prescriptions were written during 2013, 63 (51.6%) ingested and died from the medication. Eight (8) patients with prescriptions written during the previous years (2011 and 2012) died after ingesting the medication during 2013, for a total of 71 DWDA deaths.

• Twenty-eight (28) of the 122 patients who received DWDA prescriptions during 2013 did not take the medications and subsequently died of other causes.

• Ingestion status is unknown for 31 patients who were prescribed DWDA medications in 2013. Seven (7) of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received. For the remaining 24 patients, both death and ingestion status are pending (Figure 2).

• Of the 71 DWDA deaths during 2013, most (69.0%) were aged 65 years or older; the median age was 71 years (42 years – 96 years). As in previous years, most were white (94.4%), well-educated (53.5% had at least a baccalaureate degree), and had cancer (64.8%). In 2013, fewer patients had cancer (64.8%) compared to previous years (80.4%), and more patients had chronic lower respiratory disease (9.9%), and other underlying illnesses (16.9%).

• Most (97.2%) DWDA patients died at home, and most (85.7%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, most (96.7%) had some form of

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

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

- As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (93.0%), decreasing ability to participate in activities that made life enjoyable (88.7%), and loss of dignity (73.2%).

- Two of the 71 DWDA patients who died during 2013 were referred for formal psychiatric or psychological evaluation.

- Prescribing physicians were present at the time of death for eight patients (11.4%) during 2013 compared to 16.5% in previous years.

- A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 11 of the 71 DWDA deaths during 2013. Among those 11 patients, time from ingestion until death ranged from 5 minutes to 5.6 hours.

- Sixty-two (62) physicians wrote the 122 prescriptions provided during 2013 (range 1-10 prescriptions per physician).

- During 2013, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.
Figure 2: Summary of DWDA Prescriptions Written and Medications Ingested in 2013, as of January 22, 2014

- 122 people had prescriptions written during 2013
  - 8 people with prescriptions written in previous years ingested medication during 2013
    - 71 ingested medication
      - 71 died from ingesting medication
      - 0 regained consciousness after ingesting medication; died of underlying illness
    - 63 ingested medication
    - 28 did not ingest medication and subsequently died from other causes
    - 31 ingestion status unknown
      - 7 died, ingestion status is pending receipt of follow-up questionnaires
      - 24 death and ingestion status pending
### Table 1. Characteristics and End-of-life Care of 752 DWDA Patients who Died from Ingesting a Lethal Dose of Medication as of January 17, 2014, Oregon, 1998-2013

<table>
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<tr>
<th>Characteristics</th>
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<th>1998-2012 (N=681)</th>
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<td><strong>Sex</strong></td>
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<tr>
<td>Male (%)</td>
<td>44 (62.0)</td>
<td>352 (51.7)</td>
<td>396 (52.7)</td>
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<tr>
<td>Female (%)</td>
<td>27 (38.0)</td>
<td>329 (48.3)</td>
<td>355 (47.3)</td>
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<td><strong>Age</strong></td>
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<td>18-34 (%)</td>
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<td>35-44 (%)</td>
<td>1 (1.4)</td>
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<td>16 (2.1)</td>
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<td>45-54 (%)</td>
<td>6 (8.5)</td>
<td>52 (7.6)</td>
<td>58 (7.7)</td>
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<td>55-64 (%)</td>
<td>15 (21.1)</td>
<td>141 (20.7)</td>
<td>156 (20.7)</td>
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<td>65-74 (%)</td>
<td>23 (32.4)</td>
<td>194 (28.5)</td>
<td>217 (28.9)</td>
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<td>75-84 (%)</td>
<td>17 (23.9)</td>
<td>189 (27.8)</td>
<td>206 (27.4)</td>
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<td>85+ (%)</td>
<td>9 (12.7)</td>
<td>84 (12.3)</td>
<td>93 (12.4)</td>
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<td><strong>Median years (range)</strong></td>
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<td>71 (29-96)</td>
<td>71 (25-96)</td>
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<tr>
<td><strong>Race</strong></td>
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<tr>
<td>White (%)</td>
<td>67 (94.4)</td>
<td>662 (97.6)</td>
<td>729 (97.3)</td>
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<td>African American (%)</td>
<td>0 (0.0)</td>
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<td>American Indian (%)</td>
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<td>Pacific Islander (%)</td>
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<td>1 (0.1)</td>
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<td>Other (%)</td>
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<td>Two or more races (%)</td>
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<td>Hispanic (%)</td>
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<td><strong>Marital Status</strong></td>
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<td>Married (%)</td>
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<td>Widowed (%)</td>
<td>13 (18.3)</td>
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<td>Never married (%)</td>
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<td>55 (8.1)</td>
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<td>Divorced (%)</td>
<td>14 (19.7)</td>
<td>155 (22.9)</td>
<td>169 (22.6)</td>
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<td><strong>Educational Attainment</strong></td>
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<tr>
<td>Less than high school (%)</td>
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<td>42 (6.2)</td>
<td>44 (5.9)</td>
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<td>High school graduate (%)</td>
<td>10 (14.1)</td>
<td>154 (22.8)</td>
<td>164 (22.0)</td>
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<tr>
<td>Some college (%)</td>
<td>21 (29.6)</td>
<td>177 (26.2)</td>
<td>198 (26.5)</td>
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<tr>
<td>Baccalaureate or higher (%)</td>
<td>38 (53.5)</td>
<td>303 (44.8)</td>
<td>341 (45.6)</td>
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<tr>
<td><strong>Unknown</strong></td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
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<tr>
<td>Metro counties (%)</td>
<td>25 (35.2)</td>
<td>289 (42.6)</td>
<td>314 (41.9)</td>
</tr>
<tr>
<td>Coastal counties (%)</td>
<td>5 (7.0)</td>
<td>51 (7.5)</td>
<td>56 (7.5)</td>
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<tr>
<td>Other western counties (%)</td>
<td>33 (46.5)</td>
<td>292 (43.1)</td>
<td>325 (43.4)</td>
</tr>
<tr>
<td>East of the Cascades (%)</td>
<td>8 (11.3)</td>
<td>46 (6.8)</td>
<td>54 (7.2)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>End of life care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled (%)</td>
<td>60 (85.7)</td>
<td>593 (90.5)</td>
<td>653 (90.1)</td>
</tr>
<tr>
<td>Not enrolled (%)</td>
<td>10 (14.3)</td>
<td>62 (9.5)</td>
<td>72 (9.9)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>1</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private (%)</td>
<td>27 (43.5)</td>
<td>424 (64.7)</td>
<td>451 (62.9)</td>
</tr>
<tr>
<td>Medicare, Medicaid or Other Governmental (%)</td>
<td>33 (53.2)</td>
<td>221 (33.7)</td>
<td>254 (35.4)</td>
</tr>
<tr>
<td>None (%)</td>
<td>2 (3.2)</td>
<td>10 (1.5)</td>
<td>12 (1.7)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>9</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>Characteristics</td>
<td>2013 (N=71)</td>
<td>1998-2012 (N=681)</td>
<td>Total (N=752)</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------</td>
<td>-------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Underlying Illness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasms (%)</td>
<td>46 (64.8)</td>
<td>545 (80.4)</td>
<td>591 (78.9)</td>
</tr>
<tr>
<td>Lung and bronchus (%)</td>
<td>10 (14.1)</td>
<td>129 (19.0)</td>
<td>139 (18.6)</td>
</tr>
<tr>
<td>Breast (%)</td>
<td>1 (1.4)</td>
<td>56 (8.3)</td>
<td>57 (7.6)</td>
</tr>
<tr>
<td>Colon (%)</td>
<td>6 (8.5)</td>
<td>43 (6.3)</td>
<td>49 (6.5)</td>
</tr>
<tr>
<td>Pancreas (%)</td>
<td>2 (2.8)</td>
<td>45 (6.6)</td>
<td>47 (6.3)</td>
</tr>
<tr>
<td>Prostate (%)</td>
<td>2 (2.8)</td>
<td>31 (4.6)</td>
<td>33 (4.4)</td>
</tr>
<tr>
<td>Ovary (%)</td>
<td>1 (1.4)</td>
<td>27 (4.0)</td>
<td>28 (3.7)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>24 (33.8)</td>
<td>214 (31.6)</td>
<td>238 (31.8)</td>
</tr>
<tr>
<td>Amyotrophic lateral sclerosis (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic lower respiratory disease (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS (%)</td>
<td>0 (0.0)</td>
<td>9 (1.3)</td>
<td>9 (1.2)</td>
</tr>
<tr>
<td>Other Illnesses (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DWDA process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>2 (2.8)</td>
<td>42 (6.2)</td>
<td>44 (5.9)</td>
</tr>
<tr>
<td>Patient informed family of decision (%)</td>
<td>62 (91.2)</td>
<td>570 (93.9)</td>
<td>632 (93.8)</td>
</tr>
<tr>
<td>Patient died at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home (patient, family or friend) (%)</td>
<td>69 (97.2)</td>
<td>645 (95.1)</td>
<td>714 (95.3)</td>
</tr>
<tr>
<td>Long term care, assisted living or foster care facility (%)</td>
<td>2 (2.8)</td>
<td>27 (4.0)</td>
<td>29 (3.9)</td>
</tr>
<tr>
<td>Hospital (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>0 (0.0)</td>
<td>5 (0.7)</td>
<td>5 (0.7)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lethal medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secobarbital (%)</td>
<td>7 (9.9)</td>
<td>396 (58.1)</td>
<td>403 (53.6)</td>
</tr>
<tr>
<td>Pentobarbital (%)</td>
<td>64 (90.1)</td>
<td>278 (40.8)</td>
<td>342 (45.5)</td>
</tr>
<tr>
<td><strong>Other (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>End of life concerns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Losing autonomy (%)</td>
<td>66 (93.0)</td>
<td>618 (91.3)</td>
<td>684 (91.4)</td>
</tr>
<tr>
<td>Less able to engage in activities making life enjoyable (%)</td>
<td>63 (88.7)</td>
<td>602 (88.9)</td>
<td>665 (88.9)</td>
</tr>
<tr>
<td>Loss of dignity (%)</td>
<td>52 (73.2)</td>
<td>452 (81.9)</td>
<td>504 (80.9)</td>
</tr>
<tr>
<td>Losing control of bodily functions (%)</td>
<td>26 (36.6)</td>
<td>350 (51.7)</td>
<td>376 (50.3)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>36 (49.3)</td>
<td>264 (39.0)</td>
<td>299 (40.0)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it (%)</td>
<td>20 (28.2)</td>
<td>157 (23.2)</td>
<td>177 (23.7)</td>
</tr>
<tr>
<td>Financial implications of treatment (%)</td>
<td>4 (5.6)</td>
<td>18 (2.7)</td>
<td>22 (2.9)</td>
</tr>
<tr>
<td><strong>Health-care provider present</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When medication was ingested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician (%)</td>
<td>8 (8.3)</td>
<td>111 (16.4)</td>
<td>119</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present (%)</td>
<td>3 (3.2)</td>
<td>235 (34.1)</td>
<td>238</td>
</tr>
<tr>
<td>No provider (%)</td>
<td>3 (3.2)</td>
<td>73 (10.7)</td>
<td>76</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>57 (63.4)</td>
<td>192 (28.4)</td>
<td>249</td>
</tr>
<tr>
<td>At time of death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician (%)</td>
<td>8 (11.4)</td>
<td>99 (14.0)</td>
<td>107 (16.0)</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present (%)</td>
<td>5 (7.1)</td>
<td>258 (37.6)</td>
<td>263 (39.3)</td>
</tr>
<tr>
<td>No provider (%)</td>
<td>57 (81.4)</td>
<td>242 (34.4)</td>
<td>299 (44.7)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complications <strong>17</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regurgitated</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Seizures</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>10</td>
<td>477 (70.3)</td>
<td>487</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>59 (29.7)</td>
<td>182 (29.7)</td>
<td>241</td>
</tr>
<tr>
<td>Other outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regained consciousness after ingesting DWDA medications <strong>13</strong></td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
There are these deaths. There are very few, because the number of unknowns.

1. Unknowns are included when calculating percentages.
2. Includes Oregon Registered Domestic Partnerships.
3. Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.
4. Private insurance category includes those with private insurance alone or in combination with other insurance.
5. 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.
6. Includes 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.
7. First recorded beginning in 2001. Since then, 31 patients (4.6%) have chosen not to inform their families, and 12 patients (1.8%) have had family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and three in 2013.
8. 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 2001-2013 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.
12. A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.
13. There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years’ annual reports on our website [http://www.healthoregon.org/dwd] for more detail on these deaths.
14. Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.
Dear Editor,

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

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

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

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

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

To read a commentary on the most recent Oregon government assisted-suicide report, which lists chronic conditions as the "underlying illness" justifying assisted suicide, please go here: http://www.noassistedsuicideconnecticut.org/2014/02/oregons-new-assisted-suicide-report.html

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

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

William L. Toffler
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
503-494-5322
503-494-8573 (patient care)
503-494-4496 (fax)
toffler@ohsu.edu
KENNETH STEVENS, MD, being first duly sworn on oath, deposes and says as follows:

1. I am a doctor in Oregon 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. On December 5, 2011, I submitted a letter to the Board of Medical Examiners, which is attached hereto as Exhibit A.

3. The instant affidavit updates that letter to reflect current Oregon practice. Specifically, the “five year, five percent” rule described in my letter has been replaced with the prioritization scheme described below.

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

5. 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.

6. 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.

7. 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.
8. 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 thirteen years.

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

10. Today, for patients under the Oregon Health Plan (Medicaid), there are also financial incentives to commit suicide. One incentive is that 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 as Exhibit B, page SI-1.

11. Under the Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient’s treatment. As an 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 as Exhibit B, page GN-4).

12. 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.

13. 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.

14. 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.

15. 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.

16. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Montana, your government health plan could follow a similar pattern. Private health plans could also follow this pattern. If so, these plans would pay for you and/or your family to die, but not to live.
FURTHER AFFIANT SAYETH NOT.

[Signature]
KENNETH STEVENS, JR., MD.

SUBSCRIBED AND SWORN TO before me this ___ day of October, 2013.

[Signature]
Sheri A. Acker
Printed Name
Notary Public for the State of Oregon
Residing at Hillsboro, OR
My Commission Expires 09/03/16
FURTHER AFFIANT SAYETH NOT.

KENNETH STEVENS, JR., MD.

SUBSCRIBED AND SWORN TO before me this 16 day of October, 2013.

SHERI A ACKER
Printed Name
Notary Public for the State
of Oregon
Residing at Hillsboro, OR
My Commission Expires 9/3/2014
From: Kenneth Stevens [mailto:kenndhstevensjr@gmail.com]
Sent: Monday, December 05, 2011 10:52 PM
To: Marquand, Ian; Connor, Maggle; DL1 BSD Medical Examiners; bbddburke@gmail.com
Subject: Physician assisted suicide dangers

Re: Physician-Assisted Suicide: A Danger to Patients; Don't Let Patients be Steered to Suicide

Dear Montana Medical Examiner Board member:

I understand that the Montana Medical Examiner Board will be voting on physician-assisted suicide. I have been a cancer doctor in Oregon for more than 40 years. The combination of assisted-suicide legalization and prioritized medical care based on prognosis has created a danger for my patients on the Oregon Health Plan (Medicaid).

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

Under our law, a patient is not supposed to be eligible for voluntary suicide until they are deemed to have six months or less to live. In the well publicized cases of Barbara Wagner and Randy Stroup, neither of them had such diagnoses, nor had they asked for suicide. The Plan, nonetheless, offered them suicide.

In Oregon, the mere presence of legal assisted-suicide steers patients to suicide even when there is not an issue of coverage. One of my patients was adamant she would use the law. I convinced her to be treated. Eleven years later she is thrilled to be alive. Please, don’t let assisted suicide come to Montana.


Kenneth R. Stevens, Jr., MD
13680 SW Morgan Rd Sherwood, OR 97140
Professor Emeritus and former Chair, Radiation Oncology Department, Oregon Health & Science University, Portland, Oregon
503 625 5044 503 481 8410

Appendix, Tab 6, Affidavit of Kenneth Stevens, MD
STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.
GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES


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 cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.

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

D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic granulocyte or colony stimulating factor (CSF) and high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with asplenia, severe neutropenia with absolute neutrophil count <100/μl, 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/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

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

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

The Health Evidence Review Commission is reluctant to place a strict $/QALY (quality adjusted life-year) or $/LYS (life-year saved) requirement on end-of-life treatments, as such measurements are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when determining 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 NOTES FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

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 cleanings 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.
SWORN BEFORE ME at
MASSACHUSETTS, USA
on, AUGUST 16th, 2012

NAME: HEROI PRZYNSKI
A notary in and for the
State of Washington MASSACHUSETTS

ADDRESS: 35 MAIN ST
Florence, MA 01062

EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

JOHN NORTON

AFFIDAVIT OF JOHN NORTON - Page 3
Planning for old age at a premium

Preparing for long-term care is difficult — even for those who can afford insurance plans.

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.

Insurance for long-term care is supposed to provide some security for people who are not quite...
ingest - Definition of ingest at YourDictionary.com

Dictiionary Home » Dictionary Definitions » ingest
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- Thesaurus Synonyms
- Sentence Examples

**ingest definition**

**ingest (in jest')**

*transitive verb*

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

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

Related Forms:
- *ingestion in-ges'-tion noun*
- *ingestive in-ges'-tive adjective*

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**ingest (in-jest')**

*transitive verb* *ingest-ed, ingest-ing, ingest-s*

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

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

Related Forms:
- *ingest'-ible adjective*
- *ingestion in-ges'-tion noun*
- *ingestive in-ges'-tive adjective*


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http://www.yourdictionary.com/ingest
Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys:
Compliance with the Death with Dignity Act

Washington's Death with Dignity Act (RCW 70.245) states that "...the patient's death certificate...shall list the underlying terminal disease as the cause of death." The act also states that, "Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law."

If you know the decedent used the Death with Dignity Act, you must comply with the strict requirements of the law when completing the death record:

1. The underlying terminal disease must be listed as the cause of death.
2. The manner of death must be marked as "Natural."
3. The cause of death section may not contain any language that indicates that the Death with Dignity Act was used, such as:
   a. Suicide
   b. Assisted suicide
   c. Physician-assisted suicide
   d. Death with Dignity
   e. I-1000
   f. Mercy killing
   g. Euthanasia
   h. Secobarbital or Seconal
   i. Pentobarbital or Nembutal

The Washington State Registrar will reject any death certificate that does not properly adhere to the requirements of the Death with Dignity Act.1 If a death certificate contains any reference to actions that might indicate use of the act, the Local Registrar and Funeral Director will be instructed, under RCW 70.58.030, to obtain a correction from the medical certifier before a permit to proceed with disposition will be issued.

Call the Department of Health's Center for Health Statistics (360-236-4307) for guidance on how to proceed if you have any questions regarding compliance with cause of death reporting under the Death with Dignity Act.

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1 Under state law, the State Registrar of Vital Statistics "shall prepare and issue such detailed instruction as may be required to secure the uniform observance of its provisions and the maintenance of a perfect system of registration. ... The State Registrar shall carefully examine the certificates received monthly from the local registrars, county auditors, and clerks of the court and, if any are incomplete or unsatisfactory, the State Registrar shall require such further information to be furnished as may be necessary to make the record complete and satisfactory." RCW 43.70.160.

Revised April 8, 2009
Assisted suicide is not legal, not the answer

By BRADLEY WILLIAMS

I take exception to the opinion by two members of the former Hemlock Society, now known as “Compassion & Choices.” The opinion of July 25 implies that assisted suicide is legal in Montana, which is not true.

I am the president of Montanans Against Assisted Suicide. We are in litigation against the Montana Medical Examiners Board. As part of that litigation, we got the board to remove a position paper from its website implying that assisted suicide is legal. Assisted suicide is not legal.

The “treatment” of suicide
As part of our litigation with the board, we also obtained an affidavit from Dr. Ken Stevens, of Oregon, which is one of the few states in which assisted suicide is legal. His affidavit describes how, in Oregon, the state’s Medicaid program uses legal assisted suicide to steer patients to suicide. This is through coverage incentives. The program will not necessarily cover a treatment to cure a disease or to extend a patient’s life. The program will cover the patient’s suicide. In other words, with legal assisted suicide, desired treatments are displaced with the “treatment” of suicide.

Backing the establishment
The former Hemlock Society, Compassion & Choices, touts itself as the great promoter of individual choice. But if you take a closer look, its actual mission is to back the medical-government establishment.

Consider the well-publicized case of Oregon cancer patient Barbara Wagner. In 2008, Oregon’s Medicaid program declined to cover “Tarceva,” a cancer drug recommended by her doctor, and offered to cover her suicide instead, terming it “aid in dying.” Wagner was devastated.

“It was horrible,” Wagner told ABCNews.com. The drug’s manufacturer subsequently gave Tarceva to Wagner without charge. She, nonetheless, died a short time later.

I recently asked Stevens about Tarceva. He told me that some of his patients had taken it and that for some of them it was beneficial. This was in terms of survival and better quality of life. He also told me that it can be difficult to know how a particular cancer patient will do on a particular cancer drug. He said that there are always some patients who live longer than expected, sometimes 10 or even 20 years longer, depending on the type of cancer. He said, “This is because there are always some people who beat the odds.” Barbara Wagner had wanted to be one of those people.

After Wagner’s death, Compassion & Choices stepped forward to show its true colors. Specifically, its president, Barbara Coombs Lee, published an opinion in Oregon’s largest paper taking issue with Wagner’s choice to try and live. Coombs Lee argued that Wagner should have instead given up hope and accepted her pending death. But, this was not Wagner’s choice.

In a KATU TV interview (katu.com/news/specialreports/26119530.html), Wagner had said: “I’m not ready, I’m not ready to die... I’ve got things I’d still like to do.”

A public policy to discourage cures
Coombs Lee’s opinion piece also argued for a public policy change to discourage people from seeking cures. This would presumably be through coverage incentives. For example, she said: “The burning public policy question is whether we inadvertently encourage patients to act against their own self-interest, chase an unattainable dream of cure, and foreclose the path of acceptance that curative care has been exhausted.”

Coombs Lee is a former “managed care executive.” See (maasdocuments.files.wordpress.com/2014/08/coombslee bio.pdf)
Your choice is not assured by their legislation. Don’t be fooled by their double-speak.

Bradley Williams is president of Montanans Against Assisted Suicide (montanansagainstassistedsuicide.org), a grassroots group and a Montana nonprofit public benefit association. MAAS welcomes everyone opposed to assisted suicide regardless of their views on other issues.

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.

— Oregon cancer patient Barbara Wagner who was denied Tarceva cancer drug by Oregon’s Medicaid program, but was offered coverage for “aid in dying” suicide instead
Death Drugs Cause Uproar in Oregon
Aug. 6, 2008
By SUSAN DONALDSON JAMES

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

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 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 get 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 bad 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.
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.
NEWS RELEASE

Date: Sept. 9, 2010

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

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

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

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

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

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

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

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

The report also included the following findings:

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

Oregon Health Authority
Suicides in Oregon
Trends and Risk Factors

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


Executive Summary

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

Key Findings

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

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

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

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

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

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

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

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

Suicide is an important public health problem in Oregon. Each year there are more than 500 Oregonians who die 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 death on death certificates. Suicide was considered with code of X60-84 and Y87.0. Deaths related to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore are excluded from this report.


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

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

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

Key Findings

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

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

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

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

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

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

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

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

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars. 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 2010 and 2003 to 2010 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Original article

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

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ABSTRACT

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

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

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

Conclusion: A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although these 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 50000 members, and between 100 and 150 people die each year with the organisation’s assistance. In comparison, Dignitas has about 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient’s home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient’s home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.

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