AMENDED IN SENATE MARCH 17, 2015

SENATE BILL No. 128

Introduced by Senators Wolk and Monning
(Principal coauthors: Senators Jackson and Leno)
(Principal coauthor: Assembly Member Eggman)
(Coauthors: Senators Block, Hall, Hancock, Hernandez, Hill,
McGuire, and Wieckowski)
(Coauthors: Assembly Members Chu, Cooper, Frazier, Cristina Garcia,
Quirk, Rendon, and Mark Stone) Mark Stone)

January 20, 2015

An act to add Part 1.85 (commencing with Section 443) to Division 1 of the Health and Safety Code, relating to end of life.

LEGISLATIVE COUNSEL'S DIGEST

SB 128, as amended, Wolk. End of life.

Existing law authorizes an adult to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of his or her incapacity pursuant to a power of attorney for health care.

This bill would enact the End of Life Option Act authorizing an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal illness, as defined, to make a request for medication prescribed pursuant to these provisions for the purpose of ending his or her life. The bill would establish the procedures for making these requests. The bill would also establish the forms to request aid-in-dying medication and under specified circumstances an interpreter declaration to be signed subject to penalty of perjury, thereby imposing a crime and state-mandated local program.
This bill would prohibit a provision in a contract, will, or other agreement, or in a health care service plan contract, or health benefit plan contract, from being conditioned upon or affected by a person making or rescinding a request for the above-described medication. The bill would prohibit the sale, procurement, or issuance of any life, health, or accident insurance or annuity policy, or the rate charged for any policy, from being conditioned upon or affected by the request.

This bill would provide immunity from civil or criminal liability or professional disciplinary action for participating in good faith compliance with the act. *Act, and would specify that the immunities and prohibitions on sanctions of a health care provider are solely reserved for conduct provided for by the bill. The bill would provide that participation in activities authorized pursuant to this bill shall be voluntary.

This bill would make it a felony to knowingly alter or forge a request for medication to end an individual's life without his or her authorization or to conceal or destroy a rescission of a request for medication, if it is done with the intent or effect of causing the individual's death. The bill would make it a felony to knowingly coerce or exert undue influence on an individual to request medication for the purpose of ending his or her life or to destroy a rescission of a request. By creating a new crime, the bill would impose a state-mandated local program. The bill would provide that nothing in its provisions be construed to authorize ending a patient's life by lethal injection, mercy killing, or active euthanasia, and would provide that action taken in accordance with the act shall not constitute, among others, suicide or homicide.

This bill would require the State Department of Public Health to adopt regulations regarding the collection of information to determine the use of and compliance with the act, and would require the department to annually review a sample of certain records and make a statistical report of the information collected.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.
This bill would provide that no reimbursement is required by this act for a specified reason.


The people of the State of California do enact as follows:

SECTION 1. Part 1.85 (commencing with Section 443) is added to Division 1 of the Health and Safety Code, to read:

PART 1.85. END OF LIFE OPTION ACT

443. This part shall be known and may be cited as the End of Life Option Act.

443.1. As used in this part, the following definitions shall apply:

(a) "Adult" means an individual 18 years of age or older.

(b) "Aid-in-dying medication" means medication determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal illness.

(c) "Attending physician" means the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal illness.

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

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

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

(g) "Department" means the State Department of Public Health.
(h) “Health care provider” or “provider” means a person licensed, certified, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession, including, but not limited to, physicians, doctors of osteopathy, and pharmacists. “Health care provider” or “provider” includes a health care facility as identified in Section 1250.

(i) “Informed decision” means a decision by a terminally ill individual to request and obtain a prescription for medication that the individual may self-administer to end the individual’s life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

1. The individual’s medical diagnosis and prognosis.
2. The potential risks associated with taking the medication to be prescribed.
3. The probable result of taking the medication to be prescribed.
4. The possibility that the individual may choose not to obtain the medication or may obtain the medication but may decide not to take it.
5. The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

(j) “Medically confirmed” means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual’s relevant medical records.

(k) “Physician” means a doctor of medicine or osteopathy currently licensed to practice medicine in this state.

(l) “Public place” means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.

(m) “Qualified individual” means a competent adult who is a resident of California and has satisfied the requirements of this part in order to obtain a prescription for medication to end his or her life.

(n) “Self-administer” means a qualified individual’s affirmative, conscious, and physical act of using the medication to bring about his or her own death.
(o) "Terminal illness" means an incurable and irreversible illness that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

443.2. (a) A competent, qualified individual who is a terminally ill adult may make a request to receive a prescription for aid-in-dying medication if all of the following conditions are satisfied:

(1) The qualified individual’s attending physician has determined the individual to be suffering from a terminal illness.

(2) The qualified individual has voluntarily expressed the wish to receive a prescription for aid-in-dying medication.

(3) The qualified individual is a resident of California and is able to establish residency through any of the following means:

(A) Possession of a California driver-license: license or other identification issued by the State of California.

(B) Registration to vote in California.

(C) Evidence that the person owns or leases property in California.

(D) Filing of a California tax return for the most recent tax year.

(4) The qualified individual documents his or her request pursuant to the requirements set forth in Section 443.3.

(b) A person may not qualify under the provisions of this part solely because of age or disability.

(c) A request for a prescription for aid-in-dying medication under this part shall not be made on behalf of the patient through a power of attorney, an advance health care directive, or a conservator.

443.3. (a) A qualified individual wishing to receive a prescription for aid-in-dying medication pursuant to this part shall submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician.

(b) A valid written request for aid-in-dying medication under subdivision (a) shall meet all of the following conditions:

(1) The request shall be in substantially the form described in Section 443.9.

(2) The request shall be signed and dated by the qualified individual seeking the medication.

(3) The request shall be witnessed by at least two other adult persons who, in the presence of the qualified individual, shall attest
that to the best of their knowledge and belief the qualified
individual is all of the following:
(A) Competent.
(B) Acting voluntarily.
(C) Not being coerced to sign the request.
(e) **At most, Only** one of the two witnesses at the time the written
request is signed may:
(1) Be related to the qualified individual by blood, marriage, or
adoption or be entitled to a portion of the person’s estate upon
death, but not both. **death.**
(2) Own, operate, or be employed at a health care facility where
the qualified individual is receiving medical treatment or resides.
(d) The attending physician of the qualified individual shall not
be one of the witnesses required pursuant to paragraph (3) of
subdivision (b).

443.4. (a) A qualified individual may at any time rescind his
or her request for aid-in-dying medication without regard to the
qualified individual’s mental state.
(b) A prescription for aid-in-dying medication provided under
this part may not be written without the attending physician
offering the qualified individual an opportunity to rescind the
request.

443.5. (a) Before prescribing aid-in-dying medication, the
attending physician shall do all of the following:
(1) Make the initial determination of all of the following:
(A) Whether the requesting adult is competent.
(B) Whether the requesting adult has a terminal illness.
(C) Whether the requesting adult has voluntarily made the
request for aid-in-dying medication pursuant to Sections 443.2
and 443.3.
(D) Whether the requesting adult is a qualified individual
pursuant to subdivision (m) of Section 443.1.
(2) Ensure the qualified individual is making an informed
decision by discussing with him or her all of the following:
(A) His or her medical diagnosis and prognosis.
(B) The potential risks associated with taking the aid-in-dying
medication to be prescribed.
(C) The probable result of taking the aid-in-dying medication
to be prescribed.
(D) The possibility that he or she may choose to obtain the medication but not take it.

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

(3) Refer the qualified individual to a consulting physician for medical confirmation of the diagnosis, prognosis, and for a determination that the qualified individual is competent and has complied with the provisions of this part.

(4) Refer the qualified individual for counseling if appropriate.

(5) Ensure that the qualified individual’s request does not arise from coercion or undue influence by another person.

(6) Counsel the qualified individual about the importance of all of the following:

(A) Having another person present when he or she takes the aid-in-dying medication prescribed pursuant to this part.

(B) Not taking the aid-in-dying medication in a public place.

(7) Inform the qualified individual that he or she may rescind the request for aid-in-dying medication at any time and in any manner.

(8) Offer the qualified individual an opportunity to rescind the request for medication before prescribing the aid-in-dying medication.

(9) Verify, immediately prior to writing the prescription for medication, that the qualified individual is making an informed decision.

(10) Ensure that all appropriate steps are carried out in accordance with this part before writing a prescription for aid-in-dying medication.

(11) Fulfill the record documentation that may be required under Section 443.16.

(b) If the conditions set forth in subdivision (a) are satisfied, the attending physician may deliver the aid-in-dying medication in any of the following ways:

(1) Dispense aid-in-dying medications directly, including ancillary medication intended to minimize the qualified individual’s discomfort, if the attending physician meets all of the following criteria:
(A) Is registered as a dispensing physician with the Medical Board of California. Is authorized to dispense medicine under California law.

(B) Has a current United States Drug Enforcement Administration (USDEA) certificate.

(C) Complies with any applicable administrative rule or regulation.

(2) With the qualified individual’s written consent, the attending physician may contact a pharmacist, inform the pharmacist of the prescriptions, and deliver the written prescriptions personally, by mail, or electronically to the pharmacist, who shall may dispense the medications to the qualified individual, the attending physician, or a person expressly designated by the qualified individual and with the designation delivered to the pharmacist in writing or verbally.

(c) Delivery of the dispensed medication to the qualified individual, the attending physician, or a person expressly designated by the qualified individual may be made by: personal delivery, United Parcel Service, United States Postal Service, Federal Express, or by messenger service.

443.6. Prior to a qualified individual obtaining aid-in-dying medication from the attending physician, the consulting physician shall perform all of the following:

(a) Examine the qualified individual and his or her relevant medical records.

(b) Confirm in writing the attending physician’s diagnosis and prognosis.

(c) Verify, in the opinion of the consulting physician, that the qualified individual is competent, acting voluntarily, and has made an informed decision.

(d) Fulfill the record documentation that may be required under Section 443.16.

443.7. (a) Unless otherwise prohibited by law, the attending physician may sign the qualified individual’s death certificate.

(b) The cause of death listed on an individual’s death certificate who uses aid-in-dying medication shall be the underlying terminal illness.

443.8. A qualified individual may not receive a prescription for aid-in-dying medication pursuant to this part, unless he or she has made an informed decision. Immediately before writing a
prescription for aid-in-dying medication under this part, the
attending physician shall verify that the individual is making an
informed decision.

443.9. (a) A request for aid-in-dying medication as authorized
by this part 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 the state \textit{State} of California.
I am suffering from .............., which my attending physician has determined
is in its terminal phase and which has been medically confirmed.
I have been fully informed of my diagnosis and prognosis, the nature of the
aid-in-dying medication to be prescribed and potential associated risks, the
expected result, and the feasible alternatives or additional treatment
opportunities, including comfort care, hospice care, palliative care, and pain
control.
I request that my attending physician prescribe medication that will end my
life in a humane and dignified manner if I choose to take it, and I authorize
my attending physician to contact any pharmacist about my request.
INITIAL ONE:

........... I have informed one or more members of my family of my decision
and taken their opinions into consideration.
........... I have decided not to inform my family of my decision.
........... I have no family to inform of my decision.
I understand that I have the right to rescind this request at any time.
I understand the full import of this request and I expect to die if I take the
aid-in-dying medication to be prescribed. I further understand that although
most deaths occur within three hours, my death may take longer, and my My
attending physician has counseled me about this possibility: \textit{the possibility that my death may not be immediately upon the consumption of the medication.}
I make this request voluntarily and without reservation: voluntarily, without
reservation, and without being coerced.

Signed:........................
Dated:..........................,

DECLARATION OF WITNESSES
We declare that the person signing this request:
(a) is personally known to us or has provided proof of identity;
(b) signed this request in our presence;
(c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and
(d) is not an individual for whom either of us is the attending physician.

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate or be employed at a health care facility where the person is a patient or resident.

(b) (1) The written language of the request shall be written in the same translated language as any conversations, consultations, or interpreted conversations or consultations between a patient and his or her attending or consulting physicians.

(2) Notwithstanding paragraph (1), the written request may be prepared in English even where the conversations or consultations or interpreted conversations or consultations where conducted in a language other than English if the English language form includes an attached interpreter's declaration that is signed under penalty of perjury. The interpreter's declaration shall state words to the effect that:

I (INSERT NAME OF INTERPRETER), am fluent in English and (INSERT TARGET LANGUAGE).

On (insert date) at approximately at (insert time), I read the "Request for Medication to End My Life" to (insert name of individual/patient) in (insert target language).

Mr./Ms. (insert name of patient/qualified individual) affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and (insert target language) and further declare under penalty of perjury that the foregoing is true and correct.

Executed at (insert city, county, and state) on (insert day of month) of (insert month), (insert year).

X Interpreter signature
X Interpreter printed name
X Interpreter address
(3) An interpreter provided by paragraph (2) shall not be related to the qualified individual by blood, marriage, or adoption or be entitled to a portion of the person's estate upon death. An interpreter provided by paragraph (2) shall be qualified as described in subparagraph (H) of paragraph (2) of subdivision (c) of Section 1300.67.04 of Title 28 of the California Code of Regulations.

443.10. (a) A provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for aid-in-dying medication, is not valid.

443.11. (a) The sale, procurement, or issuance of a life, health, accident insurance or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for a policy or plan contract may not be conditioned upon or affected by a person making or rescinding a request for aid-in-dying medication.

(b) Notwithstanding any other law, a qualified individual's act of self-administering aid-in-dying medication may not have an effect upon a life, health, or accident insurance or annuity policy other than that of a natural death from the underlying illness.

443.12. (a) Notwithstanding any other law, a person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this part, including an individual who is present when a qualified individual self-administers the prescribed aid-in-dying medication.

(b) A health care provider or professional organization or association may not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this part.

(c) A request by an individual to an attending physician or to a pharmacist to dispense aid-in-dying medication or provide aid-in-dying medication in good faith compliance with the provisions of this part does not constitute neglect or elder abuse for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.
(d) (1) Participation in activities authorized pursuant to this part shall be voluntary. A person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to this part is not required to take any action in support of a patient's decision under this part, except as otherwise required by law. 

(2) If a health care provider is unable or unwilling to carry out an individual's request under this part and the individual transfers care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the individual's relevant medical records to the new health care provider. 

(e) Nothing in this part shall prevent a health care provider from providing an individual with health care services that do not constitute participation in this part.

443.13. A health care provider may not be sanctioned for any of the following:

(a) Making an initial determination pursuant to the standard of care that an individual has a terminal illness and informing him or her of the medical prognosis. 

(b) Providing information about the End of Life Option Act to a patient upon the request of the individual. 

(c) Providing an individual, upon request, with a referral to another physician. 

(d) Contracting with an individual to act outside the course and scope of the provider's capacity as an employee or independent contractor of a health care provider that prohibits activities under this part. 

(e) Notwithstanding any contrary provision in this section, the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions taken pursuant to this part and those health care providers may be sanctioned for conduct and actions not included and provided for in this part if the conduct and actions do not comply with the standards and practices set forth by the Medical Board of California.

443.14. (a) Knowingly altering or forging a request for medication to end an individual's life without his or her authorization or concealing or destroying a rescission of a request for medication is punishable as a felony if the act is done with the intent or effect of causing the individual's death.
(b) Knowingly coercing or exerting undue influence on an individual to request medication for the purpose of ending his or her life or to destroy a rescission of a request is punishable as a felony.

(c) For purposes of this section, “knowingly” has the meaning provided in Section 7 of the Penal Code.

(d) Nothing in this section limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(e) The penalties in this section do not preclude criminal penalties applicable under any law for conduct inconsistent with the provisions of this part.

443.15. Nothing in this part may be construed to authorize a physician or any other person to end an individual’s life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, mercy killing, homicide, or elder abuse under the law.

443.16. (a) The State Public Health Officer, in consultation with the State Department of Social Services, shall adopt regulations establishing reporting requirements for physicians and pharmacists pursuant to this part.

(b) The reporting requirements shall be designed to collect information to determine utilization and compliance with this part. The information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient’s family, and any medical provider or pharmacist involved with the patient under the provisions of this part.

(c) Based on the information collected, the department shall provide an annual compliance and utilization statistical report aggregated by age, gender, race, ethnicity, and primary language spoken at home and other data the department may determine relevant. The department shall make the report public within 30 days of completion of each annual report.

443.17. A person who has custody or control of any unused aid-in-dying medication prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying medication for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means.
443.18. Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section 443.16 to the Health and Safety Code, imposes a limitation on the public’s right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

(a) Any limitation to public access to personally identifiable patient data collected pursuant to Section 443.16 of the Health and Safety Code as proposed to be added by this act is necessary to protect the privacy rights of the patient and his or her family.

(b) The interests in protecting the privacy rights of the patient and his or her family in this situation strongly outweigh the public interest in having access to personally identifiable data relating to services.

(c) The statistical report to be made available to the public pursuant to subdivision (c) of Section 443.16 of the Health and Safety Code is sufficient to satisfy the public’s right to access.

SEC. 3. The provisions of this part are severable. If any provision of this part or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
ATTORNEYS FOR PETITIONER

MONTANA FIRST JUDICIAL DISTRICT COURT,
LEWIS AND CLARK COUNTY

MONTANANS AGAINST ASSISTED SUICIDE, a Montana Nonprofit Public Benefit Corporation,

PETITIONER,

vs.

BOARD OF MEDICAL EXAMINERS,
MONTANA DEPARTMENT OF LABOR & INDUSTRY,

RESPONDENT.

STATE OF OREGON )
COUNTY OF Washington)

JEANETTE HALL, being first duly sworn on oath, deposes and says as follows:

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

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

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

4. This last July, it was 13 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

FURTHER AFFIANT SAYETH NOT.

/\ see attached signature page

JEANETTE HALL

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

/\ Norma Andrade
Printed Name
Notary Public for the State of Oregon
Residing at Tigard
My Commission Expires 08/19/14
didn’t know exactly how to go about doing it. I tried to ask my doctor, Ken Stevens MD, but he didn’t really answer me. In hindsight, he was stalling me.

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

4. This last July, it was 13 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

FURTHER AFFIANT SAYETH NOT.

Jeanette Hall

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

Norma Andrade

Printed Name
Notary Public for the State of Oregon
Residing at Tigard
My Commission Expires August 19, 2016
consented to defendant's acts, we are satisfied from our independent research that defendant's actions should not be treated in effect as assisting a suicide. Our Supreme Court rejected an "assisted suicide" argument in People v. Matlock (1959) 51 Cal.2d 682, 336 P.2d 505 (Matlock), stating "'where a person actually performs, or actively assists in performing, the overt act resulting in death, such as shooting or stabbing the victim, administering the poison, or holding one under water until death takes place by drowning, his act constitutes murder, and it is wholly immaterial whether this act is committed pursuant to an agreement with the victim..."' (id. at p. 694, 336 P.2d 505, followed in People v. Cleaves (1991) 229 Cal.App.3d 367, 376–377, 280 Cal.Rptr. 146; but see In re Joseph G. (1983) 34 Cal.3d 429, 194 Cal.Rptr. 163, 667 P.2d 1176 [making an exception to Matlock's murder rule when one of two people engaged in a simultaneous suicide effort actively employs the single instrumentality involved].)

B. Defendant's "Unusual Case" Argument

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

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

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

C. Defendant's "Provocation and Duress" Argument

§ 1250.4 Medical director of health care facilities in department of corrections and youth authority; investigation and report of contagious or infectious diseases; examination of inmates; refusal to comply; involuntary testing and treatment; tuberculosis; AIDS or HIV

(a) As used in this section:

(1) "Department" means the Department of Corrections or the Department of the Youth Authority.

(2) "Communicable, contagious, or infectious disease" means any disease that is capable of being transmitted from person to person with or without contact and as established by the State Department of Health Services pursuant to Section 120130, and Section 2500 et seq. of Title 17 of the California Code of Regulations.

(3) "Inmate or ward" means any person incarcerated within the jurisdiction of the Department of Corrections or the Department of the Youth Authority, with the exception of a person on parole.

(4) "Institution" means any state prison, camp, center, office, or other facility under the jurisdiction of the Department of Corrections or the Department of the Youth Authority.

(5) "Medical director," "chief of medical services," or "chief medical officer" means the medical officer, acting medical officer, medical director, or the physician designated by the department to act in that capacity, who is responsible for directing the medical treatment programs and medical services for all health services and services supporting the health services provided in the institution.

(b) Each health care facility in the Department of Corrections and in the Department of the Youth Authority shall have a medical director in charge of the health care services of that facility who shall be a physician and surgeon licensed to practice in California and who shall be appointed by the directors of the departments. The medical director shall direct the medical treatment programs for all health services and services supporting the health services provided in the facility.

(c) The medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, shall use every available means to ascertain the existence of, and to immediately investigate, all reported or suspected cases of any communicable, contagious, or infectious disease and to ascertain the source or sources of the infections and prevent the spread of the disease. In carrying out these investigations, the medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, is hereby invested with full powers of inspection, examination, and quarantine or isolation of all inmates or wards known to be, or reasonably suspected to be, infected with a communicable,
contagious, or infectious disease.

(d) The medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, shall order an inmate or ward to receive an examination or test, or may order an inmate or ward to receive treatment if the medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, has reasonable suspicion that the inmate or ward has, has had, or has been exposed to a communicable, contagious, or infectious disease and the medical director, chief of medical services, chief medical officer, or the physician designated by the department to act in that capacity, has reasonable grounds to believe that it is necessary for the preservation and protection of staff and inmates or wards.

(e) Notwithstanding Section 2600 or 2601 of the Penal Code, or any other provision of law, any inmate or ward who refuses to submit to an examination, test, or treatment for any communicable, contagious, or infectious disease or who refuses treatment for any communicable, contagious, or infectious disease, or who, after notice, violates, or refuses or neglects to conform to any rule, order, guideline, or regulation prescribed by the department with regard to communicable disease control shall be tested involuntarily and may be treated involuntarily. This inmate or ward shall be subject to disciplinary action as described in Title 15 of the California Code of Regulations.

(f) This section shall not apply to HIV or AIDS. Testing, treatment, counseling, prevention, education, or other procedures dealing with HIV and AIDS shall be conducted as prescribed in Title 8 (commencing with Section 7500) of Part 3 of the Penal Code.

(g) This section shall not apply to tuberculosis. Tuberculosis shall be addressed as prescribed in Title 8.7 (commencing with Section 7570) of the Penal Code.

CREDIT(S)


HISTORICAL AND STATUTORY NOTES

2008 Main Volume

Legislative findings, declaration and intent relating to Stats.1996, c. 1023 (S.B.1497), see Historical and Statutory Notes under Business and Professions Code § 690.

Subordination of legislation by Stats.1996, c. 1023 (S.B.1497), see Historical and Statutory Notes under Business and Professions Code § 690.

Former Notes

Former § 1250.4, added by Stats.1984, c. 1627, § 1, operative July 1, 1985, stated legislative findings that freestanding skilled nursing facilities provide services for progressively disabled persons, and was repealed by Stats.1987, c. 382, § 1.

West's Ann. Cal. Health & Safety Code § 1250.4, CA HLTH & S § 1250.4

## IN THIS ISSUE

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bishops Attack Autonomy</td>
<td>1</td>
</tr>
<tr>
<td>Long-Term Care Education</td>
<td>1</td>
</tr>
<tr>
<td>Robb Report</td>
<td>2</td>
</tr>
<tr>
<td>Remembering Frans Wery</td>
<td>3</td>
</tr>
<tr>
<td>Essay Contest Winners</td>
<td>3</td>
</tr>
<tr>
<td>Welcome to New People</td>
<td>4</td>
</tr>
<tr>
<td>Compassion in Action</td>
<td>5</td>
</tr>
<tr>
<td>Introducing Our Medical Directors</td>
<td>6</td>
</tr>
<tr>
<td>Consider a Bequest</td>
<td>7</td>
</tr>
<tr>
<td>CSV Spotlight</td>
<td>8</td>
</tr>
<tr>
<td>Research Roundup</td>
<td>9</td>
</tr>
</tbody>
</table>

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### Derek Humphry to be Keynote Speaker at 2011 Annual Meeting

This year our keynote speaker will be Derek Humphry, the author of *Final Exit* and the founder of the Hemlock Society USA in 1980. Derek is generally considered to be the father of the modern movement for choice at the end of life in America.

Derek is a British journalist and author who has lived in the United States since 1978, the same year he published the book *Jean's Way* describing his first wife's final years of suffering from cancer and his part in helping her to die peacefully. The public response to the book caused him to start the Hemlock Society USA in 1980 from his garage in Santa Monica. Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion In Dying to become Compassion & Choices.

In 1991 he published *Final Exit*. Much to his surprise, it became the national #1 bestseller within six months. Since then it has been translated into 12 languages and is now in its fourth edition.

Although not affiliated with – and sometimes even at odds with – Compassion & Choices, Derek is still actively involved in the movement. Always interesting and sometimes controversial, Derek will provide our supporters and their guests with his perspective about the evolution of the movement for choice at the end of life in America.

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**Save the Date!**

Sat., October 22, 2011, 1-3 p.m.

University Unitarian Church
6556 35th Ave NE
Seattle, WA 98115-7393
His mind was keen, his grin infectious. His passions were politics and sports. He read voraciously. His humor was prankish, his wit razor-sharp.

Born and raised in Eugene, he adored his parents and four brothers. He graduated from South Eugene High School and the University of Michigan.

For years, he struggled through bouts of pain and fatigue that defied medical diagnosis and left him depressed about his inability to carry on normal daily activities and fearful that he would never regain normal health.

He had dreams, ambitions, accomplishments and, say many who knew him, vast potential.

But three months ago, in the throes of a flu that upended a period of relatively good health, Nick Klonoski took his own life.

He had just turned 29.

Klonoski did not use any of the commonly known methods of suicide. Instead, he employed a "helium hood kit" that he ordered by mail from a two-person company in Southern California.

The small, white box, measuring 10 by 7 by 3 inches and decorated with a butterfly, holds a brown paper packet, its edges zigzagged with pinking shears and stitched shut on a sewing machine. Inside the packet is a clear plastic bag with an elasticized band sewn to the open end, to slip over the head and fit snugly around the neck. The box also contains clear plastic tubing, for hooking up tanks of lethal helium gas.

Manufactured and sold by The Gladd Group, the helium hood kit has no other use than to assist a person contemplating suicide. It costs $60, payable only by cash or check. According to Manta, an online business networking site where small-business owners can share information, The Gladd Group has two employees and estimated annual sales of $98,000 - equal to the price of 1,633 kits.

Selling a "suicide kit" - coupled with detailed instructions from another right-to-suicide organization on where to buy it and how to use it - raises complex legal, ethical and emotional questions about what constitutes helping another person to take his or her own life. Assisting
another person's suicide via the law in most states, including Oregon. But definitions of aiding, promoting, encouraging or assisting are not legally precise.

No one to date has been prosecuted for selling a helium hood kit in the United States. Many police agencies, medical examiners, district attorneys and legislators know little or nothing about the kits, although now that he is aware of them, state Sen. Floyd Prozanski, D-Eugene, says he's drafting a bill to outlaw their sale.

The right-to-suicide movement argues that disseminating how-to information about suicide and selling the kits that facilitate the act are protected by the free speech clause of the First Amendment in the U.S. Constitution.

On the afternoon he died, Klonoski drove to a party goods store not far from his family's Eugene home. A store receipt police found in his room shows that at 2:16 p.m., he signed for rental of a large tank of helium. Returning home, with the rest of his family out of the house for the afternoon - all five brothers had gathered at the family home for the holidays - he followed the instructions for using the helium hood kit as detailed in "Final Exit," a book written by longtime pro-suicide activist and longtime Lane County resident, Derek Humphry. He died in his bedroom before his family returned.

Jake Klonoski, at 30 the oldest of the Klonoski brothers, found his next-younger brother's body after Nick didn't respond to attempts to call him to dinner.

"I know Nick was vulnerable because of the health issues he had been dealing with for years, but he wasn't terminally ill, and he seemed to have been getting better until the flu thing happened," Jake Klonoski said. "He had family and many friends to help him through the bad times and then enjoy the good times with him. Now I know there also are people out there ready to persuade people like Nick to give up."

Nearly 1,000 people, including a former governor and a busload of colleagues from one of his many political projects, packed Temple Beth Israel's huge sanctuary - the only place large enough to accommodate the crowd on a cold sunny afternoon in early January - to honor Nick Klonoski's life. Although the family is not Jewish, his brothers wore yarmulkes, bright yellow imprinted with the blue emblem of the University of Michigan, in his honor. Speakers laughed and cried as they chronicled his intellectual brilliance and mischievous nature, and mourned the loss of his immense possibilities.

Overwhelmed by his death, his mother, U.S. District Court Judge Ann Aiken, declines to speak publicly about it. His father, retired University of Oregon political science professor James Klonoski, died two years ago. But two of his brothers, Jake and Zach Klonoski, are determined to speak out, to stop what they consider illegal and immoral assisted suicide.

"The company that sells this kit obviously is purposely targeting a vulnerable group," said Jake Klonoski, a law student at Stanford University. "They made money off my brother, they gave him the tools to take his own life without knowing him, without knowing anything about him. For $60, they blew his life apart. It breaks my heart."

When it comes to promoting an American's right to die by suicide, all roads lead to Derek Humphry. He describes himself in an online autobiography as "a journalist and author who has spent the last 30 years campaigning for lawful physician-assisted dying to be an option for the
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 care 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
published: January 14, 2009

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

That was almost four years ago.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On the other hand, 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 chimed 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 these attacks will be or whether patients will be able to survive them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

nshapiro@seattleweekly.com
DENVER (AP) —

Colorado lawmakers rejected a proposal to give dying patients the option to seek doctors' help ending their lives, concluding a long day of emotional testimony from more than 100 people.

For one lawmaker who voted no, the issue was personal. Tearfully telling her colleagues she was a cancer survivor, Democratic Rep. Dianne Primavera recalled how a doctor told her she wouldn't live more than five years.

But she found a doctor who gave her a different opinion.

"And he took me in his care, and I am here today 28 years later," she said.
“Choice” Is An Illusion: Arizona Strengthens Its Law Against Assisted Suicide

MONDAY, MAY 5, 2014

Arizona Strengthens Its Law Against Assisted Suicide

http://www.kansascity.com/2014/04/30/4993778/brewer-signs-bill-targeting-assisted.html

PHOENIX — Arizona Gov. Jan Brewer has signed a bill that aims to make it easier to prosecute people who help someone commit suicide.

Republican Rep. Justin Pierce of Mesa says his bill will make it easier for attorneys to prosecute people for manslaughter for assisting in suicide by more clearly defining what it means to “assist.”

House Bill 2565 defines assisting in suicide as providing the physical means used to commit suicide, such as a gun. The bill originally also defined assisted suicide as “offering” the means to commit suicide, but a Senate amendment omitted that word.

The proposal was prompted by a difficult prosecution stemming from a 2007 assisted suicide in Maricopa County.

Brewer signed the bill on Wednesday.

Labels: assisted suicide

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HELP US HELP YOU
Choice is an Illusion gives you a voice against assisted suicide, euthanasia and palliative care abuse. Please donate now.

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MARGARET DORE BLOG
Click banner to view blog

WELCOME
Assisted suicide proponents claim that legalization will give you “choice.” But whose choice will it be?

In Oregon where assisted suicide is legal, that state’s Medicaid program uses coverage incentives to steer patients to suicide. See here.

In Oregon and Washington State, where assisted suicide is legal, there is no oversight over administration of the lethal dose. Even if the patient struggled, who would...
Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

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

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

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

The legal director’s articles included "Aid in Dying: Law, Geography and Standard of Care in Idaho," published in The Advocate, the official publication of the Idaho State Bar.[6] Responding to the editor that organization’s legal director wrote articles claiming that the practice, which she called "aid in dying," was already legal in Idaho. Compassion & Choices was formerly known as the Hemlock Society.[5]

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

***

[3] """Th""""en=""""x""""'=""""""""'i""""c""""i""""n""""g"""" c""""i""""v""""l"""" a""""n""""d"""" c""""r""""i""""m""""i""""n"""" l""""i""""a""""b""""i""""l""""i""""t""""y"""" o""""n"""" d""""o""""c""""t""""s"""" a""""n""""d"""" o""""t""""h""""e"""" r""""o""""s"""" w""""h""""o"""" c""""a""""u""""s"""" o""""r"""" a""""i""""d"""" a"""" s""""u""""i""""c""""e"""". """" E""""x""""i""""s""""t""""i""""n""""g"""" l""""a""""w"""" l""""a""""s"""" a""""l""""s""""o"""" c""""o""""n""""s""""t""""u""""r"


[6] Compassion & Choices was formerly known as the Hemlock Society.[5]

[7] See Margaret K. Dore, "Aid in Dying: Law, Geography and Standard of Care in Idaho," published in The Advocate, the official publication of the Idaho State Bar.[6] Responding to the editor that organization’s legal director wrote articles claiming that the practice, which she called "aid in dying," was already legal in Idaho. Compassion & Choices was formerly known as the Hemlock Society.[5]

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

Sponsored By

(1) Setzler, Ed 35th
(2) Golick, Rich 34th
(3) Ramsey, Matt 72nd
(4) Pak, B.J. 102nd
(5) Lindsey, Edward 54th
(6) Rice, Tom 51st

Sponsored In Senate By

Ligon, Jr., William 3rd

Committees

HC: Judiciary Non-Civil
SC: Judiciary

First Reader Summary

A BILL to be entitled an Act to amend Article 1 of Chapter 5 of Title 16 of the O.C.G.A., relating to homicide, so as to repeal certain provisions regarding offering to assist in the commission of a suicide; to prohibit assisted suicide; to provide for definitions; to provide for criminal penalties; to provide for certain exceptions; to provide for certain reporting requirements with respect to being convicted of assisting in a suicide; to amend Title 51 of the O.C.G.A., relating to torts, so as to provide for civil liability for wrongful death caused by assisted suicide; to provide for definitions; to provide an effective date; to repeal conflicting laws; and for other purposes.

Status History

May/01/2012 - Effective Date
May/01/2012 - Act 639
May/01/2012 - House Date Signed by Governor
Apr/10/2012 - House Sent to Governor
Mar/29/2012 - Senate Agreed House Amend or Sub
Mar/29/2012 - House Agreed Senate Amend or Sub As Amended
Mar/27/2012 - Senate Passed/Adopted By Substitute
Mar/27/2012 - Senate Third Read
Mar/22/2012 - Senate Read Second Time
Mar/22/2012 - Senate Committee Favorably Reported By Substitute
Mar/07/2012 - Senate Read and Referred
Mar/07/2012 - House Immediately Transmitted to Senate
Mar/07/2012 - House Passed/Adopted By Substitute
Mar/07/2012 - House Third Readers
Feb/28/2012 - House Committee Favorably Reported By Substitute
Feb/23/2012 - House Second Readers
Feb/22/2012 - House First Readers
Feb/21/2012 - House Hopper

Footnotes

3/7/2012 Modified Structured Rule; 3/7/2012 Immediately transmitted to Senate; 3/29/2012 House agrees to the Senate Substitute as House amended; 3/29/2012 Senate agreed to House amendment to Senate substitute
La. assisted-suicide ban strengthened

The Associated Press

Published: Tuesday, April 24, 2012 at 8:37 a.m.

Last Modified: Tuesday, April 24, 2012 at 8:37 a.m.

BATON ROUGE -- The House unanimously backed a proposal Monday to strengthen Louisiana's ban on euthanasia and assisted suicide.

House Bill 1086 by Rep. Alan Seabaugh, R-Shreveport, would spell out that someone authorized to approve medical procedures for another person may not approve any procedure that would be considered assisted suicide. That prohibition also would be extended to include surgical or medical treatment for the developmentally disabled or nursing home residents who may be unable to make their own medical decisions.

Louisiana already has a prohibition in criminal law against euthanasia and assisted suicide. But Seabaugh said he wanted to make sure it was clear in the state's medical consent law.

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Chapter 127

Note: The division headings, subdivision headings and leadlines for ORS 127.800 to 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 - (or 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 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 determined that the patient is capable and is suffering from a terminal disease and will, within six months, die as a result of that disease.

(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 which, within reasonable medical judgment, will, within six months, produce death. [1995 c.3 s.1; 1999 c.423 s.1]

(Written 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
Oregon's Death with Dignity Act—2014

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 DWDA to collect compliance information and to issue an annual report. The key findings from 2014 are presented below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of 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 February 2, 2015. For more detail, please view the figures and tables on our web site: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2014

- As of February 2, 2015, prescriptions for lethal medications were written for 155 people during 2014 under the provisions of the DWDA, compared to 121 during 2013 (Figure 1). At the time of this report, 105 people had died from ingesting the medications prescribed during 2014 under DWDA. This corresponds to 31.0 DWDA deaths per 10,000 total deaths.¹

¹ Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2013 (33,931), the most recent year for which final death data are available.

Since the law was passed in 1997, a total of 1,327 people have had DWDA prescriptions written and 859 patients have died from ingesting medications prescribed under the DWDA.

Of the 155 patients for whom DWDA prescriptions were written during 2014, 94 (60.6%) ingested the medication; all 94 patients died from ingesting the medication. No patients that ingested the medication regained consciousness.

Eleven patients with prescriptions written during the previous years (2012 and 2013) died after ingesting the medication during 2014.

Thirty-seven of the 155 patients who received DWDA prescriptions during 2014 did not take the medications and subsequently died of other causes.

Ingestion status is unknown for 24 patients who were prescribed DWDA medications in 2014. For all of the 24 patients, both death and ingestion status are pending (Figure 2).

Of the 105 DWDA deaths during 2014, most (67.6%) were aged 65 years or older. The median age at death was 72 years. As in previous years, decedents were commonly white (95.2%) and well-educated (47.6% had at least a baccalaureate degree).

While most patients had cancer, the percent of patients with cancer in 2014 (68.6%) was lower than in previous years (79.4%), and the percent with amyotrophic lateral sclerosis (ALS) was higher (16.2% in 2014, compared to 7.2% in previous years).

While similar to previous years that most patients had cancer (68.6%), this percent was lower than the average for previous years (79.4%); in contrast, the percent of patients with ALS was higher in 2014 (16.2%) than in previous years (7.2%).

Most (89.5%) patients died at home, and most (93.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, all (100.0%) had some form of health care insurance, although the number of patients who had private insurance (39.8%) was lower in 2014 than in previous years (62.9%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (60.2% compared to 35.5%).

As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (86.7%), and loss of dignity (71.4%).

Three of the 105 DWDA patients who died during 2014 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for 14 patients (13.9%) during 2014 compared to 15.9% in previous years.

A procedure revision was made 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 20 of the 105 DWDA deaths during 2014. Among those 20 patients, time from ingestion until death ranged from eleven minutes to one hour.

Eighty-three physicians wrote 155 prescriptions during 2014 (1-12 prescriptions per physician).

During 2014, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.
Table 1. Characteristics and end-of-life care of 857 DWDA patients who have died from ingesting a lethal dose of medication as of February 2, 2015, by year, Oregon, 1998-2014

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (%)</td>
<td>56 (53.3)</td>
<td>397 (52.7)</td>
<td>453 (52.7)</td>
</tr>
<tr>
<td>Female (%)</td>
<td>49 (46.7)</td>
<td>357 (47.3)</td>
<td>406 (47.3)</td>
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<tr>
<td><strong>Age at death (years)</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>18-34 (%)</td>
<td>1 (1.0)</td>
<td>6 (0.8)</td>
<td>7 (0.8)</td>
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<tr>
<td>35-44 (%)</td>
<td>2 (1.9)</td>
<td>16 (2.1)</td>
<td>18 (2.1)</td>
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<tr>
<td>45-54 (%)</td>
<td>3 (2.9)</td>
<td>58 (7.7)</td>
<td>61 (7.1)</td>
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<tr>
<td>55-64 (%)</td>
<td>28 (26.7)</td>
<td>156 (20.7)</td>
<td>184 (21.4)</td>
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<tr>
<td>65-74 (%)</td>
<td>29 (27.6)</td>
<td>218 (28.9)</td>
<td>247 (28.8)</td>
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<tr>
<td>75-84 (%)</td>
<td>23 (21.9)</td>
<td>206 (27.3)</td>
<td>229 (26.7)</td>
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<tr>
<td>85+ (%)</td>
<td>19 (18.1)</td>
<td>94 (12.5)</td>
<td>113 (13.2)</td>
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<tr>
<td><strong>Median years (range)</strong></td>
<td>72 (29-96)</td>
<td>71 (25-96)</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>100 (95.2)</td>
<td>731 (97.3)</td>
<td>831 (97.1)</td>
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<tr>
<td>African American (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
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<td>American Indian (%)</td>
<td>0 (0.0)</td>
<td>2 (0.3)</td>
<td>2 (0.2)</td>
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<td>Asian (%)</td>
<td>1 (1.0)</td>
<td>8 (1.1)</td>
<td>9 (1.1)</td>
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<tr>
<td>Pacific Islander (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>2 (1.9)</td>
<td>1 (0.1)</td>
<td>3 (0.4)</td>
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<tr>
<td>Two or more races (%)</td>
<td>1 (1.0)</td>
<td>2 (0.3)</td>
<td>3 (0.4)</td>
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<td>Hispanic (%)</td>
<td>1 (1.0)</td>
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<td>6 (0.7)</td>
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<td><strong>Marital Status</strong></td>
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<tr>
<td>Married (%)</td>
<td>48 (45.7)</td>
<td>347 (46.2)</td>
<td>395 (46.1)</td>
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<tr>
<td>Widowed (%)</td>
<td>26 (24.8)</td>
<td>172 (22.9)</td>
<td>198 (23.1)</td>
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<tr>
<td>Never married (%)</td>
<td>6 (5.7)</td>
<td>63 (8.4)</td>
<td>69 (8.1)</td>
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<td>Divorced (%)</td>
<td>25 (23.8)</td>
<td>169 (22.5)</td>
<td>194 (22.7)</td>
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<td>Unknown</td>
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<tr>
<td><strong>Education</strong></td>
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<tr>
<td>Less than high school (%)</td>
<td>6 (5.7)</td>
<td>45 (6.0)</td>
<td>51 (6.0)</td>
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<td>High school graduate (%)</td>
<td>23 (21.9)</td>
<td>164 (21.9)</td>
<td>187 (21.9)</td>
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<td>Some college (%)</td>
<td>26 (24.8)</td>
<td>198 (26.4)</td>
<td>224 (26.2)</td>
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<td>Baccalaureate or higher (%)</td>
<td>50 (47.8)</td>
<td>342 (45.7)</td>
<td>392 (45.9)</td>
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<td><strong>Residence</strong></td>
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<tr>
<td>Metro counties (%)</td>
<td>46 (44.7)</td>
<td>315 (41.9)</td>
<td>361 (42.3)</td>
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<td>Coastal counties (%)</td>
<td>6 (5.8)</td>
<td>57 (7.6)</td>
<td>63 (7.4)</td>
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<tr>
<td>Other western counties (%)</td>
<td>40 (38.8)</td>
<td>325 (43.3)</td>
<td>365 (42.7)</td>
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<td>East of the Cascades (%)</td>
<td>11 (10.7)</td>
<td>54 (7.2)</td>
<td>65 (7.6)</td>
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<td>5</td>
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<td><strong>End of life care</strong></td>
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<tr>
<td>Hospice</td>
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<tr>
<td>Enrolled (%)</td>
<td>93 (93.0)</td>
<td>654 (90.0)</td>
<td>747 (90.3)</td>
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<tr>
<td>Not enrolled (%)</td>
<td>7 (7.0)</td>
<td>73 (10.0)</td>
<td>80 (9.7)</td>
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<td><strong>Insurance</strong></td>
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<td>Private (%)</td>
<td>37 (39.8)</td>
<td>452 (62.9)</td>
<td>489 (60.2)</td>
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<td>Medicare, Medicaid or Other Governmental (%)</td>
<td>56 (60.2)</td>
<td>255 (35.5)</td>
<td>311 (38.3)</td>
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<td>None (%)</td>
<td>0 (0.0)</td>
<td>12 (1.7)</td>
<td>12 (1.5)</td>
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<td>Unknown</td>
<td>12</td>
<td>35</td>
<td>47</td>
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## Oregon Public Health Division

### Characteristics

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<tr>
<th>Characteristics</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
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<td><strong>Underlying Illness</strong></td>
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<tr>
<td>Malignant neoplasms (%)</td>
<td>72 (68.6)</td>
<td>596 (79.4)</td>
<td>668 (78.0)</td>
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<td>Lung and bronchus (%)</td>
<td>16 (15.2)</td>
<td>139 (18.5)</td>
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<td>Breast (%)</td>
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<td>Colon (%)</td>
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<td>49 (6.5)</td>
<td>54 (6.3)</td>
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<td>Pancreas (%)</td>
<td>9 (8.6)</td>
<td>47 (6.3)</td>
<td>56 (6.5)</td>
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<td>Prostate (%)</td>
<td>2 (1.9)</td>
<td>33 (4.4)</td>
<td>35 (4.1)</td>
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<td>Ovary (%)</td>
<td>5 (4.8)</td>
<td>28 (3.7)</td>
<td>33 (3.9)</td>
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<td>Other (%)</td>
<td>28 (26.7)</td>
<td>243 (32.4)</td>
<td>271 (31.7)</td>
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<td><strong>Amyotrophic lateral sclerosis (%)</strong></td>
<td>17 (16.2)</td>
<td>54 (7.2)</td>
<td>71 (8.3)</td>
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<td><strong>Chronic lower respiratory disease (%)</strong></td>
<td>4 (3.8)</td>
<td>34 (4.5)</td>
<td>38 (4.4)</td>
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<td>Heart Disease (%)</td>
<td>3 (2.9)</td>
<td>14 (1.9)</td>
<td>17 (2.0)</td>
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<td>HIV/AIDS (%)</td>
<td>0 (0.0)</td>
<td>9 (1.2)</td>
<td>9 (1.1)</td>
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<td><strong>Other Illnesses (%)</strong></td>
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<tr>
<td><strong>Unknown</strong></td>
<td>9 (8.6)</td>
<td>44 (5.9)</td>
<td>53 (6.2)</td>
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<td><strong>DWDA Process</strong></td>
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<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>3 (2.9)</td>
<td>44 (5.9)</td>
<td>47 (5.5)</td>
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<tr>
<td>Patient informed family of decision (%)</td>
<td>95 (90.5)</td>
<td>634 (83.6)</td>
<td>729 (85.2)</td>
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<tr>
<td>Patient died at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home (patient, family or friend) (%)</td>
<td>94 (89.5)</td>
<td>716 (95.3)</td>
<td>810 (94.6)</td>
</tr>
<tr>
<td>Long term care, assisted living or foster care facility (%)</td>
<td>8 (7.6)</td>
<td>29 (3.9)</td>
<td>37 (4.3)</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>3 (2.9)</td>
<td>5 (0.7)</td>
<td>8 (0.9)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>End of life concerns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Losing autonomy (%)</td>
<td>96 (91.4)</td>
<td>686 (91.5)</td>
<td>782 (91.5)</td>
</tr>
<tr>
<td>Less able to engage in activities making life enjoyable (%)</td>
<td>91 (86.7)</td>
<td>667 (88.9)</td>
<td>758 (88.7)</td>
</tr>
<tr>
<td>Loss of dignity (%)</td>
<td>75 (71.4)</td>
<td>504 (68.0)</td>
<td>579 (79.3)</td>
</tr>
<tr>
<td>Losing control of bodily functions (%)</td>
<td>52 (49.5)</td>
<td>376 (50.1)</td>
<td>428 (50.1)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>42 (40.0)</td>
<td>300 (40.0)</td>
<td>342 (40.0)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it (%)</td>
<td>33 (32.4)</td>
<td>178 (23.7)</td>
<td>211 (24.7)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>42 (40.0)</td>
<td>300 (40.0)</td>
<td>342 (40.0)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>5 (4.8)</td>
<td>22 (2.9)</td>
<td>27 (3.2)</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>14</td>
<td>119</td>
<td>133</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present (%)</td>
<td>6</td>
<td>238</td>
<td>244</td>
</tr>
<tr>
<td>No provider (%)</td>
<td>4</td>
<td>76</td>
<td>80</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>81</td>
<td>251</td>
<td>332</td>
</tr>
<tr>
<td><strong>At time of death</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician (%)</td>
<td>14 (13.9)</td>
<td>107 (15.9)</td>
<td>121 (15.7)</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present (%)</td>
<td>6</td>
<td>263 (39.2)</td>
<td>269 (34.8)</td>
</tr>
<tr>
<td>No provider (%)</td>
<td>81 (80.2)</td>
<td>301 (44.9)</td>
<td>382 (49.5)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>4</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td><strong>Complications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regurgitated (%)</td>
<td>0</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Seizures (%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other (%)</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Unknown (%)</td>
<td>20</td>
<td>487</td>
<td>507</td>
</tr>
<tr>
<td><strong>Other outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regained consciousness after ingesting DWDA medications (%)</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
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<tbody>
<tr>
<td><strong>Timing of DWDA event</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration (weeks) of patient-physician relationship&lt;sup&gt;14&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>19</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Range</td>
<td>1-1312</td>
<td>0-1905</td>
<td>0-1905</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>105</td>
<td>752</td>
<td>857</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Duration (days) between 1st request and death</td>
<td>43</td>
<td>48</td>
<td>47</td>
</tr>
<tr>
<td>Range</td>
<td>15-439</td>
<td>15-1009</td>
<td>15-1009</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>105</td>
<td>754</td>
<td>859</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Minutes between ingestion and unconsciousness&lt;sup&gt;11,12&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Range</td>
<td>2-15</td>
<td>1-38</td>
<td>1-38</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>20</td>
<td>487</td>
<td>507</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>85</td>
<td>267</td>
<td>352</td>
</tr>
<tr>
<td>Minutes between ingestion and death&lt;sup&gt;11,12&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>27</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Range (minutes - hours)</td>
<td>11mins-1hr</td>
<td>1min-104hrs</td>
<td>1min-104hrs</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>20</td>
<td>492</td>
<td>512</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>85</td>
<td>262</td>
<td>347</td>
</tr>
</tbody>
</table>

1. Unknowns are excluded when calculating percentages.
2. Includes Oregon Registered Domestic Partnerships.
4. Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.
5. Private insurance category includes those with private insurance alone or in combination with other insurance.
6. Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.
7. First recorded beginning in 2003. Since then, 37 patients (4.7%) have chosen not to inform their families, and 16 patients (2.0%) have had no family to inform. Of these, one unknown case in 2002, two in 2005, one in 2009, and three in 2013.
8. Other includes combinations of secobarbital, pentobarbital, phenobarbital, 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 2001-2014 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.
Letter to editor, New Haven Register

1 message

William Toffler <toffler@ohsu.edu>  To: "letters@nhregister.com" <letters@nhregister.com>

Sun, Feb 23, 2014 at 7:23 PM

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 to die in less than six months unless they don't receive their medications. Such persons, with treatment, could otherwise have years or even decades to live.

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 MD
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

I verified the content with Dr. Toffler.
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: Heidi PRUZYNK

A notary in and for the
State of Washington MASSACHUSETTS

ADDRESS: 85 Main St
Florence, MA 01062

EXPIRY OF COMMISSION: June 22, 2016

PLACE SEAL HERE:

[ SEAL ]

[ Affidavit of Heidi PRUZYNK ] 

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...
House Bill 3337

Sponsored by Representatives GREENLICK, LININGER, Senator STEINER HAYWARD; Representatives KENY-GUYER, READ

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor’s brief statement of the essential features of the measure as introduced.

Modifies definition of “terminal disease” in Oregon Death With Dignity Act.

A BILL FOR AN ACT

Relating to end of life decisions; amending ORS 127.800.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 127.800 is amended to read:

ORS 127.800 Definition. 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. (a) “Health care provider” means a person licensed, certified or otherwise authorized or permitted by the [law] laws 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.

(b) “Health care provider” includes a health care facility.

7. “Informed decision” means a decision made by a qualified patient, to request and obtain a prescription to end [his or her] the patient’s life in a humane and dignified manner, that is based on an appreciation of the relevant facts and is made after being fully informed by the attending physician of:

(a) [His or her] The patient’s medical diagnosis;

(b) [His or her] The patient’s 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 to taking the medication to be prescribed, including, but not
limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means that 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 Oregon Medical Board.

(11) "Qualified patient" means a capable adult patient 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] the patient’s 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] result in death within [six months] one year.

Expands eligibility for assisted suicide.
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. 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
MONTANA FIRST JUDICIAL DISTRICT COURT,
LEWIS AND CLARK COUNTY

MONTANANS AGAINST ASSISTED
SUICIDE & FOR LIVING WITH
DIGNITY, a Montana Nonprofit
Public Benefit Corporation,

PETITIONER,

vs.

BOARD OF MEDICAL EXAMINERS,
MONTANA DEPARTMENT OF LABOR &
INDUSTRY,

RESPONDENT.

STATE OF OREGON       )            }
COUNTY OF CLACKAMAS ) ss.

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, 2017, 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.

KENNETH STEVENS, JR., MD.

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

Printed Name
Notary Public for the State of Oregon
Residing at Hillsboro, OR
My Commission Expires 9/3/2014

Affidavit of Kenneth Stevens, Jr., MD - page 5
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
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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 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 of 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 99453 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 chemotherapy regimen, other alternatives such as the use of less myelosuppressive chemotherapy or dose reduction should be explored in this situation.
B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.
C) CSF are not indicated in patients who are acutely neutropenic but afebrile.
D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <1000/mL and 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 considering treatment options near the end of life. For example, in no instance can it be justified to spend $100,000 in public resources to increase an individual's expected survival by three months when hundreds of thousands of Oregonians are without any form of health insurance.

4-16-2012
GUIDELINE 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, HETEROTROPIC BONE FORMATION

Lines 89, 384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1, 3, 4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

Dental cleaning and fluoride treatments are limited to once per 12 months for adults and twice per 12 months for children up to age 19 (D1110, D1120, D1203, D1204, D1208). More frequent dental cleanings and/or fluoride treatments may be required for certain higher risk populations.

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 105, 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

4-16-2012
Death Drugs Cause Uproar in Oregon

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

By SUSAN DONALDSON JAMES

Aug. 6, 2008 —

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

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

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

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

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

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

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

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

Letter's Impact 'Devastating'

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

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

"I'm not too good today," said Wagner, a Springfield great-grandmother. "But I'm opposed to the
A lifelong smoker, she was diagnosed with lung cancer in 2005 and quit. The state-run Oregon Health Plan generously paid for thousands of dollars worth of chemotherapy, radiation, a special bed and a wheelchair, according to Wagner.

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

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

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

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

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

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

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

Playing With 'My Life'

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

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

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

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

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

The state also regularly evaluates and updates approvals for cancer treatments. "We look as exhaustively as we can with good peer review evidence," she said.
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.
Rising suicide rate in Oregon reaches higher than national average:

**World Suicide Prevention Day is September 10**

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

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

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

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

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

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

The report also included the following findings:

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

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


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 3.2 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 350 Oregonians who died by suicide and more than 1,800 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon with more deaths due to suicide among Oregonians than car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 2006 alone, self-inflicted hospitalization charges exceeded 24 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 570 million dollars. The loss to families and communities broadens the impact of each death.

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

Methods, data sources and limitations

Suicide is a death resulting from the intentional use of force against oneself. In this report, suicide deaths are identified according to International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of deaths on death certificates. Suicide was considered with codes of X60-X84 and Y87.0. Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore are excluded from this report.


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.

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

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ARTICLE INFO

Article Notes:
Received 2 August 2010
Accepted 11 December 2010
Available online 11 February 2011

Keywords:
Assisted suicide
Euthanasia
Complicated grief
Posttraumatic stress disorder
Depression

ABSTRACT

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

Methods: A cross-sectional survey of 83 family members or close friends who were present at an assisted suicide was conducted in December 2009. Full or partial Post-Traumatic Distress Disorder (PTSD); Impact of Events 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 4.5% met the criteria for complicated grief. The prevalence of depression was 16%; the prevalence of anxiety was 0%.

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

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1. Introduction

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

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

On March 26, 2013, Philip Tummarelo, a retired police Sergeant Inspector, testified before the Montana Senate Judiciary Committee on behalf of HB 505. His testimony included the Thomas Middleton case in which physician-assisted suicide had facilitated the defrauding of an elderly man. An article from KTVZ.com states:

"State and court documents show Middleton, who suffered from Lou Gehrig’s disease, moved into Sawyer’s home in July 2008, months after naming her trustee of his estate, The Bulletin reported Saturday. Middleton deeded his home to the trust and directed her to make it a rental until the real estate market improved.

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than $200,000, the documents show, and it was deposited into an account for one of Sawyer’s businesses, Starboard LLC, and $90,000 of that was transferred to two other Sawyer companies, Genesis Futures and Tami Sawyer PC.” (Emphasis added).

To read the entire article, go here: http://www.ktvz.com/news/Sawyer-Arraigned-on-State-Fraud-Charges/-/413192/619440/-/view/print/-/1w9ly3z/-/index.html
Sensationalizing a sad case cheats the public of sound debate

Posted by rattig November 29, 2008 19:30PM

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

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

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

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

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

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

Was it true that Ms. Wagner was harmed in any manner? Or that Tarceva was an efficacious option?
Sensationalizing a sad case cheats the public of sound debate - Opinion Impact - The Oregonian ...

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

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

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

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

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

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

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

Coombs Lee is president of the group Compassion & Choices.

Categories:

Comments

LetDocDecide says...

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

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

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

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

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

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

Respectfully
Bob

Posted on 12/25/08 at 12:16AM
Footer
Barbara Coombs Lee is President of Compassion & Choices, a nonprofit organization dedicated to expanding and protecting the rights of the terminally ill. She practiced as a nurse and physician assistant for 25 years before beginning a career in law and health policy. Since then she has devoted her professional life to individual choice and empowerment in health care. As a private attorney, as counsel to the Oregon State Senate, as a managed care executive and finally as Chief Petitioner for Oregon's Death with Dignity Act, she has championed initiatives that enable individuals to consider a full range of choices and be full participants in their health care decisions.

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Blog Entries by Barbara Coombs Lee

Five States Give Patients Choice

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

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

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

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

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

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

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

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

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Compassion & Choices Membership: Something to be Proud Of

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

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

http://www.huffingtonpost.com/barbara-coombs-lee/
Monday, December 1, 2014

Compassion & Choices has a New Campaign to Reduce Patient Choice: Be Careful What you Sign.

By Margaret Dore, Esq., MBA

Last week, the deceptively named euthanasia promotion group, Compassion & Choices (C & C), announced a new campaign to reduce patient choice.*

C & C wants to increase the enforceability of health care directives, but only for those that refuse treatment. C & C wants a health care provider who doesn’t follow the directive, to not get paid. The problem is that you could get stuck with what you thought that you wanted and not be allowed to change your mind. Consider this example:

You signed a health care directive stating that you do not want "artificially-provided" food and drink, for example, via an IV, nasal tube or stomach tube.

You're in an accident, which renders you unable to personally direct your health care and unable to eat and drink. The healthcare facility and the family member in charge of your care want to give you food and water through "artificial" means. The facility thinks that you will need it for a short time and then recover.

But, if the healthcare facility does this under C & C's proposal, it will not get paid.

A few years ago, the owner of an elder care facility told me about one of its residents. He was an older gentleman who was a slow eater, but he had never choked or aspirated on his food. His doctor arranged for a swallow test, which he failed. To prevent aspiration, the doctor said "Nothing by mouth." The man had previously signed a health care directive saying that he would not want artificially provided food or water. So this meant nothing at all. Moreover, the man's son sided with the doctor.

Over the next few days, the man said that he was hungry and that he wanted something to eat, until he got too weak to say anything at all.

He was not allowed to change his mind and it was a horrible awful death.

So much for compassion and choice.

About the Author

Margaret Dore is President of Choice is an Illusion, a nonprofit 501(c)(4) human rights organization opposed to assisted suicide and euthanasia. She is also an attorney in Washington State where assisted suicide is legal. See www.margaretdore.com and www.choiceillusion.org

Margaret Dore Debates Assisted Suicide

"A right to medically assisted suicide may sound compassionate and just, but beware the details when it comes to the act itself, a U.S. lawyer warned." Click on the photo to read the article.

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- WA State: Vote "Yes" on SB 5919
- Compassion & Choices has a new campaign to reduce patient choice: Be careful what you sign.
- Euthanasia without the patient's consent and over the family's objection.
- This is how society will pay you back? With non-voluntary or involuntary euthanasia?
- Dore Letter to the New Jersey Assembly
- The Brittany Maynard Case Illustrates Problems with Legal Assisted Suicide

Choice Illusion

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http://www.margaretdore.org/2014/12/compassion-choices-has-new-campaign-to.html
Be careful what you sign.

Advocate directives are dangerous when used to refuse treatment or care. It's better to leave that up to your trusted agent to make decisions in the moment. Margaret Dore is an attorney in Washington State and President of Choice is an Illusion.

* C & C's new campaign "to put a stop to unwanted medical treatment."

Published by Admin at 7:46 PM

Labels: advanced directives, Compassion and Choices, VSED

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"Choice" is an Illusion: Senator Jennifer Fielder on Compassion & Choices

SATURDAY, DECEMBER 21, 2013

Beware of Vultures: Senator Jennifer Fielder on Compassion & Choices

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

By Senator Jennifer Fielder

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

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

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

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

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

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

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

You see, there is so much money in government that almost everything in government is about the money. The usual tactic is to disguise a ploy as "the humane thing to do".

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

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

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

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

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

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Know? See here.

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

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

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

"Choice" is an illusion.

ARTICLES AGAINST ASSISTED SUICIDE

- Terminal Uncertainty
- Preventing Abuse and Exploitation: A Personal Shift in Focus
- Aid in Dying: Not Legal in Idaho; Not About Choice
- 'Death with Dignity': What Do We Advise Our Clients?
- Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice
- Assisted Suicide Report Lacks Information about Consent
- Death with Dignity: What do we Tell our Clients?

MORE WEB SITES:

MASS AGAINST ASSISTED SUICIDE

Click on the banner to learn about how we won in Massachusetts!

CONNECTICUT AGAINST ASSISTED SUICIDE

Click on the photo to view website.

KANSAS AGAINST ASSISTED SUICIDE

Click on the banner to view website.

UTAH AGAINST ASSISTED
Victorino Noval, 78, entered a Kaiser hospital in Southern California on April 28, 2010, with a diagnosis of aspiration pneumonia. He was intubated, placed on a mechanical ventilator, and sedated. His medical history included early stages of Parkinson’s, and COPD. Noval was totally independent prior to his hospitalization. He lived in his own home, drove his own car, performed his own daily living activities, managed his own finances and investments, and had an annual income of $3 Million. He was worth an estimated $6 Million. He never left the hospital alive and a lawsuit filed by his son in Riverside County, California, alleges some very serious shenanigans. And here are the highlights, according to the complaint which is available in full below:

On May 7th, 2010, despite exhibiting improvement in his pneumonia and having a positive prognosis for recovery, Kaiser staff removed Noval from his ventilator, extubated him, and then administered large doses of morphine with the sole intention being to bring about his death. They succeeded. And this was all done without consulting his son, Hector Noval, despite the fact that Kaiser had an executed durable power of attorney (DPOA) for health care naming Hector and his sister, Lourdes Frost, as co-attorneys in fact. Under California law the hospital would be required to consult with both of them regarding any medical decisions if the elder Noval was incapacitated, and would have to receive unanimous approval in order to gain consent for any changes in treatment. But Frost and her other sister, Tania Noval, apparently conspired to convince hospital staff that their father suffered from dementia, had a very poor quality of life and poor baseline health, and had made it clear he never wanted to be on mechanical ventilation for any period of time. All of this was untrue according to Hector. The motivation of the sisters? To hasten their father’s death in order to collect the inheritance.

On February 2, 2012, Hector Noval filed suit in Riverside County Superior Court naming Kaiser Foundation Hospitals, Dr. Richard Bradburne, social worker Anthony Tapia, hospital bioethics specialist Dan Wilson, and 50 unnamed “Does”, and alleging, among other things, negligence, wrongful death, fraud, elder abuse, lack of informed consent and medical battery. The details of the events alleged in the complaint are so disturbing that, if true, could give rise to criminal charges of manslaughter against the named defendants. The death of Michael Jackson at the hands of his physician pales in comparison to the death of Noval, which was consciously and purposely planned, and brought about with specific, intentional, overt, targeted actions.

According to the complaint filed with the court by Hector Noval, the following took place: On the very first day of Noval’s admission, his son Hector requested he be transferred to Cedar’s Sinai Hospital. For reason’s unknown, Kaiser refused. On May 3, Frost provided Kaiser with a copy of the DPOA, but Hector was unaware that he was named co-attorney in fact, and was also unaware of his powers and responsibilities in that role. Kaiser at no time informed Hector that they had received the DPOA, that it even existed, or that he was named as attorney in fact. Also on May 3, Frost and her sister met with defendants Bradburne and Tapia and falsely claimed that Noval had a history of “advanced” Parkinson’s Disease and that he had “declined functionally” over the past “six months,” suffering from “problems with gait and balance.” Despite being aware of the DPOA, the defendants only discussed Noval’s medical history and plan of care with the two sisters, and never approached Hector Noval, even while being aware he had come to the hospital on multiple occasions expressing an interest in being involved in the decisions regarding the care of his father.

On May 3, Dr. Bradburne also prescribed an additional 1-2 weeks of aggressive treatment for the elder Noval. Yet the next day the two sisters met again with Tapia and informed him that the entire family had discussed their father’s situation and agreed that the proper course of action should be “terminal extubation”, meaning the breathing tube should be removed, the ventilator shut off, all treatment withdrawn and Victorino Noval should be allowed to die. They went so far as to ask the social worker to call a Catholic priest to administer the last rights, which Tapia did. He also conveyed the “unanimous” wishes of the family to the other defendants.

The sisters set about convincing the hospital staff that their brother was a drug addict and suffered from mental illness. Tania Noval had a previous relationship with Tapia and it is alleged she used this existing familiarity with him to her and her sister’s advantage. He even made notations in the medical record regarding the unfavorable characterization of her brother, which were read by the other treatment providers. On May 5th when Hector came to the hospital to visit his father, Tapia, without explanation, met him at the entrance with a security guard who searched him for weapons. Tapia then took Hector to a conference room and told him “terminal extubation” was going to take place the following day, also without explanation of why the change in care was taking place. Hector again asked that his father be transferred and also that the extubation be delayed. This would be the ONLY discussion he had with hospital staff about extubation. Hector left the hospital and retained an attorney.
Thank you for your email regarding Oregon's Death with Dignity Act. For all of your questions, the answer is no. Since our office is charged with maintaining absolute confidentiality, our policy is to never release identifying information. We can neither confirm nor deny participation of any individual patient or physician. We have been contacted by law enforcement and legal representatives in the past, but have not provided identifying information of any type. To ensure confidentiality, our office does not maintain source documentation on participants.

Please let me know if you have further questions.

Thank you,
Alicia

Alicia Parkman
Mortality Research Analyst
Center for Health Statistics
Oregon Health Authority
Ph: 971-673-1150
Fax: 971-673-1201

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From: Margaret Dore [mailto:margaretdore@margaretdore.com]
Sent: Monday, January 02, 2012 5:48 PM
To: alicia.a.parkman@state.or.us
Subject: Death with Dignity Act

Thank you for answering my prior questions about Oregon's death with dignity act.

I have these follow up questions:

1. Would your office release copies of completed reporting forms, e.g., a doctor's completed "Oregon Death with Dignity Act Attending Physician Follow-up Form," in response to a civil subpoena?
2. Would your office release copies of completed reporting forms in answer to a request by law enforcement?
3. Would your office confirm to law enforcement whether a person had in fact died under Oregon's Death with Dignity Act?

Margaret Dore
Law Offices of Margaret K. Dore, P.S.
Confidentiality of Death Certificates
OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION

TO: County Vital Records Registrars and Deputies
FROM: Sharon Rice, Manager, Registration Unit Center for Health Statistics

SUBJECT: CONFIDENTIALITY—DEATH WITH DIGNITY

This memo is to insure your continued support of the Vital Records strict code of confidentiality on all birth and death certificates.

You received a memo dated November 18, 1997 from Edward Johnson, II, State Registrar. In this memo he discussed the necessity of protecting the privacy of all parties when a death occurs by means of Oregon’s death with dignity law.

I have received several calls from different counties asking for more information. After discussing these concerns with the Registrar and physicians within the Health Division the following rules will apply to all physician assisted deaths.

You will neither confirm nor deny if a death has occurred in your county. If this question is asked by employees within your own Health Department, those calls should be referred to Edward Johnson, II, State Registrar (503) 731-4109 or Katrina Hedberg, M.D. (503) 731-4024. If you are asked for information from any other source on this specific topic, those callers will be referred to Katrina Hedberg, M.D., Oregon Health Division, (503) 731-4024. Do not refer callers to me as I am not at liberty to discuss this topic, and I would only have to refer the caller again.

December 12, 1997
We will begin asking funeral directors to direct report all physicians assisted death certificates to this office thus eliminating the registration through the county office. This will assist in maintaining the confidentiality in your office. Only limited staff in records will be aware of this type of death, as these records will not be handled through regular channels. We will also be controlling the issuance of certified copies making sure the family is aware of the new abbreviated copies and recommending they receive this type of certified copy.

If the funeral home chooses to forward the death record to your office, you may forward it to this office for registration. You should not maintain a white copy of the death record for six months nor should you issue certified copies.

If you do register the death locally then you may not maintain a six-month copy of the death record. Before issuing any certified copies of the death record you will need to contact this office for special permission to do so. There are three people in this office that can grant that permission:

Edward Johnson, II—State Registrar (503) 731-4109
Carol Sanders, Manager, Certification Unit 731-4416
Sharon Rice, Manager, Registration Unit 731-4412

Since we do not anticipate a large number of these cases, the different rules for the handling, these deaths should not adversely affect your work. You may never have this type of death occur within your county.

If you haven't by now determined the seriousness of this, let me add one additional statement so you will know how seriously this matter is being taken by the State Health Division. Any staff within the Center for Health Statistics that reveals any information they are not authorized to release, will immediately be terminated. Any county vital records staff, releasing information will have their registrar-deputy registrar commissions immediately revoked, thus eliminating you from having any contact with vital records within your county.

Remember if you are asked if any physician assisted deaths have occurred in your county you may neither confirm nor deny their occurrence. This may put you in a difficult position if you are being asked from Personnel within your own health department. Again, you will need to explain that you have been told you are not to discuss this topic with anyone, and refer the caller as mentioned earlier in this memo.
CAIRO, Egypt — The boys’ deaths — scattered in the United States, in Yemen, in Turkey and elsewhere in seemingly isolated horror — had one thing in common: They hanged themselves after watching televised images of Saddam Hussein’s execution.

Officials and relatives say the children appeared to be mimicking the former dictator’s Dec. 30 hanging, shown both on a sanitized Iraqi government tape and explicit clandestine videos that popped up on Web sites and some TV channels.

The leaked videos, apparently taken by cell phone cameras, set off international outrage over the raucous scene at Saddam’s execution, but some experts are more concerned about the images of the deposed Iraqi leader dropping through the gallows floor and his body swinging at the end of a rope.

The experts say such graphic images can severely affect youngsters who do not yet understand the consequences of death and violence — especially because Saddam’s death received intense international attention.

“They see how it’s done, but they don’t think it’s horrific, and they’re more likely to imitate it,” said Hisham Ramy, an associate professor of psychiatry at Ain Shams University in Cairo.

From Texas to Turkey

A day after Saddam’s execution, a 10-year-old boy in Texas hanged himself from a bunk bed after watching a news report on the execution. Police in the Houston suburb of Webster said the boy, Sergio Pelico, tied a slipknot around his neck while on the bed but had not meant to kill himself.

“I don’t think he thought it was real,” Julio Gustavo, Sergio’s uncle, said afterward. “They showed them putting the noose around his neck and everything. Why show that on TV?”

Something similar occurred in Turkey, where 12-year-old Alisen Akti hanged himself Wednesday from a bunk bed after watching TV footage. His father, Esat Akti, told a newspaper in the southeastern province of Mus that his son had been affected by the televised images.

“After watching Saddam’s execution he was constantly asking ‘How was Saddam killed?’ and ‘Did he suffer?’” Akti was quoted as saying. “These television images are responsible for my son’s death.”

Nine-year-old Mubassahr Ali, from the eastern Pakistan town of Rahim Yar Khan, died hours after Saddam when he also mimicked the ousted leader’s execution, local police official Sultan Ahmed Chaudhry said.

“The ill-fated boy used a long piece of cloth, tied it with a ceiling fan and wrapped its other end around his neck. Then he stood on a chair and fell down,” Chaudhry said.

In Yemen and Saudi Arabia

In Yemen, at least two young boys died and another was injured in apparent imitations of Saddam’s hanging.

One of the cases involved a 13-year-old junior high school student who hanged himself after watching Saddam’s execution on television, a Yemeni security official said.

When the boy’s family returned to their home outside the capital, San’a, on Wednesday, they found him hanging from a tree wearing a traditional Arab headdress, said the boy’s cousin, Yahya al-Hammadi.

In Saudi Arabia, a 12-year-old boy was found by his brother hanging from an iron door with a rope around his neck, the newspaper Okaz reported. The boy, Sultan Abdullah al-Shemmeri, lived with his family in the province of Hafir al-Batin, near the Iraqi border.

“The child was just 12 years old and didn’t really know whether the execution of Saddam was something good or bad,” a Saudi Interior Ministry official said Saturday. The official spoke on condition of anonymity because he was not authorized to speak to the press.
Others reported
Local media in Algeria and India also have reported other mimicking deaths, but these could not immediately be confirmed.

Ramy, the professor in Egypt, said children are prone to imitating violence they encounter on television, the Internet and movies, but usually they act out against another person. Mimicking a hanging or suicide is unusual, but perhaps in this case it is unsurprising, he said.

Because "some people have said Saddam is a hero and martyr and have glorified his death, this has affected children," Ramy said.

But Jasem Hajia, a child psychologist in Kuwait City, cautioned against placing all the blame on video images. "This is extreme, and I think there were physiological disorders as well with the children," Hajia said.

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Recommendations for Reporting on Suicide

Suicide is a public health issue. Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking.

Download the PDF (2 pages)

Important Points for Covering Suicide

More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.

- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

This table is scrollable by touch on mobile devices.

<table>
<thead>
<tr>
<th>Instead of This</th>
<th>Do This:</th>
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<tbody>
<tr>
<td>Big or sensationalistic headlines, or prominent placement (e.g., &quot;Kurt Cobain Used Shotgun to Commit Suicide&quot;).</td>
<td>Inform the audience without sensationalizing the suicide and minimize prominence (e.g., &quot;Kurt Cobain Dead at 27&quot;).</td>
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<tr>
<td>Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.</td>
<td>Use school/work or family photo; include hotline logo or local crisis phone numbers.</td>
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<tr>
<td>Describing recent suicides as an &quot;epidemic,&quot; &quot;skyrocketing,&quot; or other strong terms.</td>
<td>Carefully investigate the most recent CDC data and use non-sensational words like &quot;rise&quot; or &quot;higher.&quot;</td>
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<td>Describing a suicide as inexplicable or &quot;without warning.&quot;</td>
<td>Most, but not all, people who die by suicide exhibit warning signs. Include the &quot;Warning Signs&quot; and &quot;What to Do&quot; sidebar (from p. 2) in your article if possible.</td>
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<tr>
<td>&quot;John Doe left a suicide note saying...&quot;.</td>
<td>&quot;A note from the deceased was found and is being reviewed by the medical examiner.&quot;</td>
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<td>Investigating and reporting on suicide similar to reporting on crimes.</td>
<td>Report on suicide as a public health issue.</td>
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<td>Quoting/interviewing police or first responders about the causes of suicide.</td>
<td>Seek advice from suicide prevention experts.</td>
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<td>Referring to suicide as &quot;successful,&quot; &quot;unsuccessful&quot; or a &quot;failed attempt.&quot;</td>
<td>Describe as &quot;died by suicide&quot; or &quot;completed&quot; or &quot;killed him/herself.&quot;</td>
</tr>
</tbody>
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Suicide Contagion or "Copycat Suicide" occurs when one or more suicides are reported in a way