Attachments

Margaret Dore Memo

Vote NO on SF 1880

Prepared for the

Minnesota Legislature

dated

June 25, 2015
A bill for an act relating to health; adopting compassionate care for terminally ill patients; proposing coding for new law in Minnesota Statutes, chapter 145.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [145.871] COMPASSIONATE CARE.

Subd. 1. Citation. This section may be cited as the "Minnesota Compassionate Care Act of 2015."

Subd. 2. Definitions. (a) For purposes of this section, the following terms have the meanings given.

(b) "Adult" means a person who is 18 years of age or older.

(c) "Aid in dying" means the medical practice of a physician prescribing medication to a qualified patient who is terminally ill, which medication a qualified patient may self-administer to bring about the patient's own death.

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

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

(f) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's terminal illness.
(g) "Counseling" means one or more consultations as necessary between a 
psychiatrist or a psychologist and a patient for the purpose of determining that the patient 
is competent and not suffering from depression or any other psychiatric or psychological 
disorder that causes impaired judgment.

(h) "Health care provider" means a person licensed, certified, or otherwise authorized 
or permitted by law to administer health care or dispense medication in the ordinary 
course of business or practice of a profession, including but not limited to a physician, 
psychiatrist, psychologist, or pharmacist.

(i) "Health care facility" means a hospital, residential care home, nursing home, 
or rest home.

(j) "Informed decision" means a decision by a qualified patient to request and obtain 
a prescription for medication that the qualified patient may self-administer for aid in 
dying, that is based on an understanding and acknowledgment of the relevant facts and 
after being fully informed by the attending physician of:

(1) the patient's medical diagnosis and prognosis;

(2) the potential risks associated with self-administering the medication to be 
    prescribed;

(3) the probable result of taking the medication to be prescribed;

(4) the feasible alternatives and health care treatment options, including but not 
    limited to palliative care.

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

(l) "Palliative care" means health care centered on a terminally ill patient and the 
patient's family that:

(1) optimizes the patient's quality of life by anticipating, preventing, and treating the 
    patient's suffering throughout the continuum of the patient's terminal illness;

(2) addresses the physical, emotional, social, and spiritual needs of the patient;

(3) facilitates patient autonomy, the patient's access to information, and patient 
    choice; and

(4) includes but is not limited to discussions between the patient and a health care 
    provider concerning the patient's goals for treatment options available to the patient, 
    including hospice care and comprehensive pain and symptom management.

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

(n) "Pharmacist" means a person licensed under chapter 151.
(o) "Physician" means a person licensed to practice medicine and surgery under chapter 147.

(p) "Psychiatrist" means a psychiatrist licensed under chapter 147.

(q) "Psychologist" means a psychologist licensed under section 148.907.

(r) "Qualified patient" means a competent adult who is a resident of Minnesota, has a terminal illness, and has satisfied the requirements of this section in order to obtain aid in dying.

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

(t) "Terminal illness" means the final stage of an incurable and irreversible medical condition that an attending physician anticipates, within reasonable medical judgment, will produce a patient's death within six months.

Subd. 3. Request for aid in dying. (a) A person who:

(1) is an adult;

(2) is competent;

(3) is a resident of Minnesota;

(4) has been determined by the person's attending physician to have a terminal illness; and

(5) has voluntarily expressed a wish to receive aid in dying

may request aid in dying by making two written requests pursuant to subdivisions 4 and 5.

(b) A person is not a qualified patient under this section based solely on age, disability, or any specific illness.

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

Subd. 4. Signed, written requests required. (a) A patient wishing to receive aid in dying shall submit two written requests to the patient's attending physician in substantially the form in subdivision 5. A valid written request for aid in dying under this section shall be signed and dated by the patient. Each request shall be witnessed by at least two persons who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is: (1) of sound mind; and (2) acting voluntarily and not being coerced to sign the request. The patient's second written request for aid in dying shall be submitted no earlier than 15 days after the patient submits the first request.

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

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

(d) If the patient is a resident of a residential care home, nursing home, or skilled
nursing facility at the time the written request is made, one of the witnesses shall be a
person designated by the home or facility.

Subd. 5. Request form. A request for aid in dying as authorized by this section
shall be in substantially the following form:

REQUEST FOR MEDICATION TO AID IN DYING

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

I am a resident of Minnesota.

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

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

I request that my attending physician prescribe medication that I may self-administer
for aid in dying. I authorize my attending physician to contact a pharmacist to fill the
prescription for the medication, upon my request.

INITIAL ONE:

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

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

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

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

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

I make this request voluntarily and without reservation, and I accept full
responsibility for my decision to request aid in dying.

Signed: .......

Dated: .......
DECLARATION OF WITNESSES

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

Witness 1 .......  Witness 2 .......

Initials ......... Initials .......

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

Printed Name of Witness 1 ..............
Signature of Witness 1 .............. Date ..............
Printed Name of Witness 2 ..............
Signature of Witness 2 .............. Date ..............

Subd. 6. Opportunity to rescind request. (a) A qualified patient may rescind the patient's request for aid in dying at any time and in any manner without regard to the patient's mental state.

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

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

Subd. 7. Physician responsibilities. When an attending physician is presented with a patient's first written request for aid in dying under this section, the attending physician shall:

1. make a determination that the patient:
   (i) is an adult;
   (ii) has a terminal illness;
   (iii) is competent; and
   (iv) has voluntarily requested aid in dying;
2. require the patient to demonstrate residency in this state by presenting:
   (i) Minnesota driver's license;
   (ii) a valid voter registration record authorizing the patient to vote in this state;
   (iii) evidence that the patient owns or leases property in this state; or
(iv) any other government-issued document that the attending physician reasonably believes demonstrates that the patient is a current resident of this state;

(3) ensure that the patient is making an informed decision by informing the patient of:

(i) the patient's medical diagnosis;

(ii) the patient's prognosis;

(iii) the potential risks associated with self-administering the medication to be prescribed for aid in dying;

(iv) the probable result of self-administering the medication to be prescribed for aid in dying, and

(v) the feasible alternatives and health care treatment options including, but not limited to, palliative care; and

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

Subd. 8. **Qualified patient.** In order for a patient to be found to be a qualified patient for the purposes of this section, a consulting physician shall:

(1) examine the patient and the patient's relevant medical records;

(2) confirm, in writing, the attending physician's diagnosis that the patient has a terminal illness;

(3) verify that the patient is competent, is acting voluntarily, and has made an informed decision to request aid in dying, and

(4) refer the patient for counseling, if required in accordance with subdivision 9.

Subd. 9. **Medical determination on competency.** (a) If, in the medical opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological condition or depression that is causing impaired judgment, either the attending or consulting physician shall refer the patient for counseling to determine whether the patient is competent to request aid in dying.

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

Subd. 10. **Process.** (a) After an attending physician and a consulting physician determine that a patient is a qualified patient, and after the qualified patient submits a second request for aid in dying according to subdivision 4, the attending physician shall:
(1) recommend to the qualified patient that the patient notify the patient's next of
kin of the patient's request for aid in dying and inform the qualified patient that failure
to do so shall not be a basis for the denial of the request;
(2) counsel the qualified patient concerning the importance of:
   (i) having another person present when the qualified patient self-administers the
   medication prescribed for aid in dying; and
   (ii) not taking the medication in a public place;
(3) inform the qualified patient that the patient may rescind the patient's request for
aid in dying at any time and in any manner;
(4) verify, immediately before writing the prescription for medication for aid in
dying, that the qualified patient is making an informed decision;
(5) fulfill the medical record documentation requirements in subdivision 11; and
(6)(i) dispense medications, including ancillary medications intended to facilitate the
desired effect to minimize the qualified patient's discomfort, if the attending physician is
authorized to dispense such medication, to the qualified patient; or
   (ii) upon the qualified patient's request and with the qualified patient's written consent;
      (A) contact a pharmacist and inform the pharmacist of the prescription; and
      (B) deliver the written prescription personally, by mail, by facsimile, or by another
electronic method that is permitted by the pharmacy to the pharmacist, who shall dispense
the medications directly to the qualified patient, the attending physician, or an expressly
identified agent of the qualified patient.
(b) The attending physician may sign the qualified patient's death certificate that
shall list the underlying terminal illness as the cause of death.

Subd. 11. Medical record. With respect to a request by a qualified patient for aid in
dying, the attending physician shall ensure that the following items are documented or
filed in the qualified patient's medical record:
(1) the basis for determining that the qualified patient requesting aid in dying is an
adult and is a resident of the state;
(2) all oral requests by a qualified patient for medication for aid in dying;
(3) all written requests by a qualified patient for medication for aid in dying;
(4) the attending physician's diagnosis of the qualified patient's terminal illness and
prognosis, and a determination that the qualified patient is competent, is acting voluntarily,
and has made an informed decision to request aid in dying;
(5) the consulting physician's confirmation of the qualified patient's diagnosis and
prognosis, and confirmation that the qualified patient is competent, is acting voluntarily,
and has made an informed decision to request aid in dying.
(6) a report of the outcome and determinations made during counseling, if counseling
was recommended and provided as required by subdivision 9;
(7) documentation of the attending physician's offer to the qualified patient to rescind
the patient's request for aid in dying at the time the attending physician writes the qualified
patient a prescription for medication for aid in dying; and
(8) a statement by the attending physician indicating that all requirements under this
section have been met and indicating the steps taken to carry out the qualified patient's
request for aid in dying, including the medication prescribed.

Subd. 12. Use of records. Records or information collected or maintained under
this section shall not be subject to subpoena or discovery or introduced into evidence in
any judicial or administrative proceeding except to resolve matters concerning compliance
with this section, or as otherwise specifically provided by law.

Subd. 13. Disposing of medication. Any person in possession of medication
prescribed for aid in dying that has not been self-administered must dispose of the
medication.

Subd. 14. Contract, will, or other instrument. (a) Any provision in a contract,
will, insurance policy, annuity, or other agreement, whether written or oral, that is entered
into on or after October 1, 2015, that would affect whether a person may make or rescind a
request for aid in dying is not valid.
(b) Any obligation owing under any currently existing contract shall not be
conditioned or affected by the making or rescinding of a request for aid in dying.
(c) On and after the effective date of this section, the sale, procurement, or issuance
of any life, health, or accident insurance or annuity policy or the rate charged for any
such policy shall not be conditioned upon or affected by the making or rescinding of a
request for aid in dying.
(d) A qualified patient's act of requesting aid in dying or self-administering
medication prescribed for aid in dying shall not:
(1) affect a life, health, or accident insurance or annuity policy, or benefits payable
under the policy;
(2) be grounds for eviction from a person's place of residence or a basis for
discrimination in the terms, conditions, or privileges of sale or rental of a dwelling or in
the provision of services or facilities because of the patient's request for aid in dying;
(3) provide the sole basis for the appointment of a conservator or guardian; or
(4) constitute suicide for any purpose.

Subd. 15. Participate in provision of medication. (a) As used in this section,
"participate in the provision of medication" means to perform the duties of an attending
physician or consulting physician, a psychiatrist, a psychologist, or a pharmacist according
to subdivisions 2 to 10, and does not include:

(1) making an initial diagnosis of a patient's terminal illness;

(2) informing a patient of the patient's medical diagnosis or prognosis;

(3) informing a patient concerning the provisions of this section, upon the patient's
request; or

(4) referring a patient to another health care provider for aid in dying.

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

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

(d) A health care facility may adopt written policies prohibiting a health care
provider associated with the health care facility from participating in the provision of
medication to a patient for aid in dying, provided the facility provides written notice
of the policy and any sanctions for violation of the policy to the health care provider.

Notwithstanding the provisions of this paragraph or any policies adopted according to this
paragraph, a qualified health care provider may:

(1) diagnose a patient with a terminal illness;

(2) inform a patient of the patient's medical prognosis;

(3) provide a patient with information concerning the provisions of this section,
upon a patient's request;

(4) refer a patient to another health care facility or health care provider;

(5) transfer a patient's medical records to a health care provider or health care
facility as requested by a patient; or

(6) participate in the provision of medication for aid in dying when the health care
provider is acting outside the scope of the provider's employment or contract with a health
care facility that prohibits participation in the provision of the medication.

Subd. 16. Criminal act. (a) Any person who without authorization of a patient
wilfully alters or forges a request for aid in dying, as described in subdivisions 4 and 5, or
conceals or destroys a rescission of a request for aid in dying with the intent or effect of
causing the patient's death, is guilty of attempted murder or murder.

(b) Any person who coerces or exerts undue influence on a patient to complete a
request for aid in dying, as described in subdivisions 4 and 5, or coerces or exerts undue
influence on a patient to destroy a rescission of the request with the intent or effect of
caus[ing the patient's death, is guilty of attempted murder or murder.

Subd. 17. Aid in dying. (a) Nothing in this section authorizes a physician or any
other person to end a patient's life by lethal injection, mercy killing, assisting a suicide,
or any other active euthanasia.

(b) Any action taken according to this section does not constitute causing or assisting
another person to commit suicide.

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

Subd. 18. Civil damages. This section does not limit liability for civil damages
resulting from negligent conduct or intentional misconduct by any person.

Subd. 19. Criminal prosecution. Nothing in this section precludes criminal
prosecution under any provision of law for conduct that is inconsistent with this section.
Opinion 2.211 - Physician-Assisted Suicide

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

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

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

Opinion 2.21 - Euthanasia

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

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

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

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

Terminal Uncertainty

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

By Nina Shapiro
published: January 14, 2009

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

That was almost four years ago.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 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.

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2014, as of February 2, 2015

155 people had prescriptions written during 2014

- 11 people with prescriptions written in previous years ingested medication during 2014
- 94 ingested medication
- 37 did not ingest medication and subsequently died from other causes
- 24 ingestion and death status unknown
- 105 ingested medication
- 105 died from ingesting medication
- 0 regained consciousness after ingesting medication; died of underlying illness
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>
</tr>
<tr>
<td><strong>Age at death (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-34 (%)</td>
<td>1 (1.0)</td>
<td>6 (0.8)</td>
<td>7 (0.8)</td>
</tr>
<tr>
<td>35-44 (%)</td>
<td>2 (1.9)</td>
<td>16 (2.1)</td>
<td>18 (2.1)</td>
</tr>
<tr>
<td>45-54 (%)</td>
<td>3 (2.9)</td>
<td>58 (7.7)</td>
<td>61 (7.1)</td>
</tr>
<tr>
<td>55-64 (%)</td>
<td>28 (26.7)</td>
<td>156 (20.7)</td>
<td>184 (21.4)</td>
</tr>
<tr>
<td>65-74 (%)</td>
<td>29 (27.6)</td>
<td>218 (28.9)</td>
<td>247 (28.8)</td>
</tr>
<tr>
<td>75-84 (%)</td>
<td>23 (21.9)</td>
<td>206 (27.3)</td>
<td>229 (26.7)</td>
</tr>
<tr>
<td>85+ (%)</td>
<td>19 (18.1)</td>
<td>94 (12.5)</td>
<td>113 (13.2)</td>
</tr>
<tr>
<td><strong>Median years (range)</strong></td>
<td>72 (29-96)</td>
<td>71 (25-96)</td>
<td>71 (25-96)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (%)</td>
<td>100 (95.2)</td>
<td>731 (97.3)</td>
<td>831 (97.1)</td>
</tr>
<tr>
<td>African American (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>American Indian (%)</td>
<td>0 (0.0)</td>
<td>2 (0.3)</td>
<td>2 (0.2)</td>
</tr>
<tr>
<td>Asian (%)</td>
<td>1 (1.0)</td>
<td>8 (1.1)</td>
<td>9 (1.1)</td>
</tr>
<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>
</tr>
<tr>
<td>Two or more races (%)</td>
<td>1 (1.0)</td>
<td>2 (0.3)</td>
<td>3 (0.4)</td>
</tr>
<tr>
<td>Hispanic (%)</td>
<td>1 (1.0)</td>
<td>5 (0.7)</td>
<td>6 (0.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married (%)</td>
<td>48 (45.7)</td>
<td>347 (46.2)</td>
<td>395 (46.1)</td>
</tr>
<tr>
<td>Widowed (%)</td>
<td>26 (24.8)</td>
<td>172 (22.9)</td>
<td>198 (23.1)</td>
</tr>
<tr>
<td>Never married (%)</td>
<td>6 (5.7)</td>
<td>63 (8.4)</td>
<td>69 (8.1)</td>
</tr>
<tr>
<td>Divorced (%)</td>
<td>25 (23.8)</td>
<td>169 (22.5)</td>
<td>194 (22.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school (%)</td>
<td>6 (5.7)</td>
<td>45 (6.0)</td>
<td>51 (6.0)</td>
</tr>
<tr>
<td>High school graduate (%)</td>
<td>23 (21.9)</td>
<td>164 (21.9)</td>
<td>187 (21.9)</td>
</tr>
<tr>
<td>Some college (%)</td>
<td>26 (24.8)</td>
<td>198 (26.4)</td>
<td>224 (26.2)</td>
</tr>
<tr>
<td>Baccalaureate or higher (%)</td>
<td>50 (47.6)</td>
<td>342 (45.7)</td>
<td>392 (45.9)</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro counties (%) ^3</td>
<td>46 (44.7)</td>
<td>315 (41.9)</td>
<td>361 (42.3)</td>
</tr>
<tr>
<td>Coastal counties (%)</td>
<td>6 (5.8)</td>
<td>57 (7.6)</td>
<td>63 (7.4)</td>
</tr>
<tr>
<td>Other western counties (%)</td>
<td>40 (38.8)</td>
<td>325 (43.3)</td>
<td>365 (42.7)</td>
</tr>
<tr>
<td>East of the Cascades (%)</td>
<td>11 (10.7)</td>
<td>54 (7.2)</td>
<td>65 (7.6)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>End of life care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrolled (%)</td>
<td>93 (93.0)</td>
<td>654 (90.0)</td>
<td>747 (90.3)</td>
</tr>
<tr>
<td>Not enrolled (%)</td>
<td>7 (7.0)</td>
<td>73 (10.0)</td>
<td>80 (9.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>5</td>
<td>27</td>
<td>32</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private (%)</td>
<td>37 (39.8)</td>
<td>452 (62.9)</td>
<td>489 (60.2)</td>
</tr>
<tr>
<td>Medicare, Medicaid or Other Governmental (%)</td>
<td>56 (60.2)</td>
<td>255 (35.5)</td>
<td>311 (38.3)</td>
</tr>
<tr>
<td>None (%)</td>
<td>0 (0.0)</td>
<td>12 (1.7)</td>
<td>12 (1.5)</td>
</tr>
<tr>
<td>Unknown</td>
<td>12</td>
<td>35</td>
<td>47</td>
</tr>
<tr>
<td>Characteristics</td>
<td>2014 (N=105)</td>
<td>1998-2013 (N=754)</td>
<td>Total (N=859)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------</td>
<td>------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Underlying Illness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant neoplasms (%)</td>
<td>72 (68.6%)</td>
<td>596 (79.4%)</td>
<td>668 (78.0%)</td>
</tr>
<tr>
<td>Lung and bronchus (%)</td>
<td>16 (15.2%)</td>
<td>139 (18.5%)</td>
<td>155 (18.1%)</td>
</tr>
<tr>
<td>Breast (%)</td>
<td>7 (6.7%)</td>
<td>57 (7.6%)</td>
<td>64 (7.5%)</td>
</tr>
<tr>
<td>Colon (%)</td>
<td>5 (4.8%)</td>
<td>49 (6.5%)</td>
<td>54 (6.3%)</td>
</tr>
<tr>
<td>Pancreas (%)</td>
<td>9 (8.6%)</td>
<td>47 (6.3%)</td>
<td>56 (6.5%)</td>
</tr>
<tr>
<td>Prostate (%)</td>
<td>2 (1.9%)</td>
<td>33 (4.4%)</td>
<td>35 (4.1%)</td>
</tr>
<tr>
<td>Ovary (%)</td>
<td>5 (4.8%)</td>
<td>28 (3.7%)</td>
<td>33 (3.9%)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>28 (26.7%)</td>
<td>243 (32.4%)</td>
<td>271 (31.7%)</td>
</tr>
<tr>
<td>Amyotrophic lateral sclerosis (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic lower respiratory disease (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other illnesses (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DWDA process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>3 (2.9%)</td>
<td>44 (5.9%)</td>
<td>47 (5.5%)</td>
</tr>
<tr>
<td>Patient informed family of decision (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<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>Unknown</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 (70.3%)</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 (31.4%)</td>
<td>178 (23.7%)</td>
<td>211 (24.7%)</td>
</tr>
<tr>
<td>Financial implications of treatment (%)</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>Unknown</td>
<td>81</td>
<td>251</td>
<td>332</td>
</tr>
<tr>
<td>At time of death</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>Unknown</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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reigned consciousness after ingesting DWDA medications</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
### Characteristics

<table>
<thead>
<tr>
<th>Timing of DWDA event</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration (weeks) of patient-physician relationship</strong>&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><strong>Number of patients with information available</strong></td>
<td>105</td>
<td>752</td>
<td>857</td>
</tr>
<tr>
<td><strong>Number of patients with information unknown</strong></td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Duration (days) between 1st request and death</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</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><strong>Number of patients with information available</strong></td>
<td>105</td>
<td>754</td>
<td>859</td>
</tr>
<tr>
<td><strong>Number of patients with information unknown</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Minutes between ingestion and unconsciousness</strong>&lt;sup&gt;1,12&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><strong>Number of patients with information available</strong></td>
<td>20</td>
<td>487</td>
<td>507</td>
</tr>
<tr>
<td><strong>Number of patients with information unknown</strong></td>
<td>85</td>
<td>267</td>
<td>352</td>
</tr>
<tr>
<td><strong>Minutes between ingestion and death</strong>&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><strong>Number of patients with information available</strong></td>
<td>20</td>
<td>492</td>
<td>512</td>
</tr>
<tr>
<td><strong>Number of patients with information unknown</strong></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 2001. Since then, 37 patients (4.7%) have chosen not to inform their families, and 16 patients (2.0%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 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 6 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.
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.

---

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.
Sawyer Arraigned on State Fraud Charges

Judge Sets Plea Entry for Sept. 6

News sources
BEND, Ore.

Former Bend real estate broker Tami Sawyer was arraigned Thursday on state charges of criminal mistreatment and aggravated theft, four days after her arrest at Portland International Airport.

Sawyer was taken into custody by Port of Portland police after arriving on a flight back from Mexico, where she was allowed to go and check on rental property.

She appeared before Deschutes County Circuit Judge Wells Ashby, who continued her bond at $50,000 but set no travel restrictions, prosecutors said.

Ashby said she can travel outside of Oregon but has to sign and submit a waiver of extradition, should that be needed.

Sawyer faces charges of first-degree criminal mistreatment and aggravated theft, accused of selling Thomas Middleton's home and pocketing the proceeds.

The judge set her next court appearance for Sept. 6 at 8:30 a.m., when she is scheduled to enter a plea.

Sawyer and husband Kevin are scheduled for trial in December on federal fraud and money-laundering charges.

Former Bend real estate broker Tami Sawyer was arrested Sunday night at Portland International Airport on a Deschutes County warrant issued late last week after her indictment on felony charges of criminal mistreatment and aggravated theft.

Sawyer, 48, was booked into the Multnomah County Jail around 9 p.m. Sunday, about a half-hour after her arrest, reportedly having just flown back to Oregon after a judge agreed to let her go check on rental property that she and husband Kevin own in Cabo San Lucas, Mexico.

Deschutes County Circuit Judge Alta Brady signed an arrest warrant with $50,000 bail last Thursday, two days after she was indicted on a first-degree criminal mistreatment charge that alleges she took custody of Thomas Middleton, a dependent or elderly person, for the purpose of fraud.

The first-degree aggravated theft charge alleges that in October 2008, Sawyer stole more than $50,000 from the Thomas Middleton Revocable Trust.

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.
The death of Victorino Noval at Kaiser Permanente - Victorino Noval Kaiser victim and Hector A. Noval his Personal Representative and son

Kaiser hospital ignored the power of attorney of Victorino Noval and terminally extubated him. 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. - See more at: http://lawmedconsultant.com/3019/lawsuit-sisters-have-hospital-kill-multi-millionaire-father-for-inheritence/#sthash.e1PIGxaQ.dpuf

Mr. Noval wanted to live and Kaiser records indicate that Mr. Noval who had developed pneumonia was recovering and would be returning home and would be going back to work. Instead the staff was lied to by the daughter who convinced them that Hector, the son of Victorino was in agreement with her. This was not true and Kaiser did not verify the statement. Instead Kaiser terminally extubated him and he died within minutes from lack of oxygen and a morphine overdose. The sibling who lied to Kaiser inherited several million dollars.

Background information on the children of Victorino Noval: http://legalstuff.kaiserpapers.org/background-victorino-noval-children.html

Medical Expert Opinion as to cause of death of Victorino Noval: http://legalstuff.kaiserpapers.org/james-f-lineback.html

CASE SUMMARY PREPARED BY JAMES F LINEBACK, M.D. http://legalstuff.kaiserpapers.org/james-f-lineback-2.html

Mr. Hector Noval immediately contacted criminal investigating authorities and also filed suit against Kaiser. Kaiser staff have indicated that they wish to assert their right to Fifth Amendment privilege against incrimination to avoid providing testimony which they believe may incriminate them. The arbitrator has billed over $100,000.00 to date to Kaiser. Court filings are below in order by most recent date of filing:

April 24, 2015 - Answer to Complaint for Physical Elder Abuse - Case No. 30-2012-00620923 Unlimited Civil

Defendants Lourdes Frost ("Frost") and Tania Noval ("Noval"), for themselves, and for no other Defendant, answer the "Complaint for Physical Elder Abuse, etc. filed by Hector Noval on or about December 28, 2012. http://legalstuff.kaiserpapers.org/pdfs/frost-noval-Answer to Complaint.pdf


December 2014 - Declaration of Casey Young, Esq. in Support of Reply to Opposition to Petition to Vacate Arbitration Note: Respondent's (Kaiser) Notice of Motion and Motion for Summary Judgment, or in the Alternative for Summary Adjudication is included in this document as Exhibit 2.

http://legalstuff.kaiserpapers.org/victorino-noval.html
Preventing Abuse and Exploitation: A Personal Shift in Focus. An article about guardianship, elder abuse and assisted suicide.


By Margaret K. Dore, Esq., MBA
The Voice of Experience, American Bar Association
Volume 25, No. 4, Winter 2014

I graduated from law school in 1986. I first worked for the courts and then for the United States Department of Justice. After that, I worked for other lawyers, and then, in 1994, I officially started my own practice in Washington State. Like many lawyers with a new practice, I signed up for court-appointed work in the guardianship/probate context. This was mostly guardian ad litem work. Once in awhile, I was appointed as an attorney for a proposed ward, termed an “alleged incapacitated person.” In other states, a guardianship might be called a “conservatorship” or an “interdiction.” A guardian ad litem might be called a “court visitor.”

My Guardianship Cases

Most of my guardianship cases were straightforward. There would typically be an elderly person who could no longer handle his or her affairs. I would be the guardian ad litem. My job would be to determine whether the person needed a guardian, and if that were the case, to recommend a person or agency to fill that role.

My work also included private pay cases with moderate estates. With these cases, I would sometimes see financial abuse and exploitation. For example, there was an elderly woman whose nephew took her to the bank each week to obtain a large cash withdrawal. She had dementia, but she could pass as “competent” to get the money. In another case, “an old friend from 30 years ago” took “Jim,” a 90 year old man, to lunch. The friend invited Jim to live with him in exchange for making the friend sole beneficiary of his will. Jim agreed. The will was executed and he went to live with the friend in a nearby town. A guardianship was started and I was appointed guardian ad litem. I drove to the friend’s house, which was dilapidated. Jim did not seem to have his own room. I asked him if he would like to go home. He said “yes” and got in my car. He was not incompetent, but he had allowed someone else to take advantage of him. In another case, there was a disabled man whose caregiver had used his credit card to remodel her home. He too was competent, but he had been unable to protect himself.

In those first few years, I loved my guardianship cases. I had been close to my grandmother and enjoyed working with older people. I met guardians and other people who genuinely wanted to help others.

But then I got a case involving a competent man who had been railroaded into guardianship. The guardian, a company, refused to let him out. The guardian also appeared to be churning the case, i.e., causing conflict and then billing for work to respond to the
"Choice" Is An Illusion: Preventing Abuse and Exploitation: A Personal Shift in Focus. An article about guardianship, elder abuse and assisted suicide.

NO ASSISTED SUICIDE

Demonstration at University of Washington Hospital - Seattle WA

MAINT SITE ARCHIVE

► 2015 (29)
► 2014 (68)
► December 2014 (2)
► November 2014 (5)
► October 2014 (8)
► September 2014 (6)
► August 2014 (6)
► July 2014 (5)
► June 2014 (3)
► May 2014 (1)
► April 2014 (4)
► March 2014 (10)
► February 2014 (7)

Concerns about assisted suicide include hiding mal...
Not Dead Yet: "American Bar Association Newsletter...
New Swiss Study Misses the Obvious: Wealthy Older...
Montana Group Appeals Medical Examiner Board Lawsuit...
Margaret Dore writes the New Hampshire Judiciary C...
Dr. Toffler writes the New Hampshire Judiciary Comm...
Preventing Abuse and Exploitation: A

The MetLife Studies

In 2009, the MetLife Mature Market Institute released its landmark study on elder financial abuse. See www.metlife.com/assets/caq/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf The estimated financial loss by victims in the United States was $2.6 billion per year.

The study also explained that perpetrators are often family members, some of whom feel themselves "entitled" to the elder's assets. The study states that perpetrators start out with small crimes, such as stealing jewelry and bank checks, before moving on to larger items or coercing elders to sign over the deeds to their homes, change their wills or liquidate their assets.

In 2011, MetLife released another study available at www.metlife.com/assets/caq/mmi/publications/studies/2011/mmi-elder-financial-abuse.pdf, which described how financial abuse can be a catalyst for other types of abuse and which was illustrated by the following example. "A woman barely came away with her life after her caretaker of four years stole money from her and pushed her wheelchair in front of a train. After the incident the woman said, "We were so good of friends ... I'm so hurt that I can't stop crying."

Failure to Report

A big reason that elder abuse and exploitation are prevalent is that victims do not report. This failure to report can be for many reasons. A mother being abused by her son might not want him to go to jail. She might also be humiliated, ashamed or embarrassed about what's happening. She might be legitimately afraid that if she reveals the abuse, she will be put under guardianship.

The statistics that I've seen on unreported cases vary, from only 2 in 4 cases being reported, to one in 20 cases. Elder abuse and exploitation are, regardless, a largely uncontrolled problem.

A New Development: Legalized Assisted Suicide

Another development relevant to abuse and exploitation is the ongoing push to legalize assisted suicide and euthanasia in the United States. "Assisted suicide" means that someone provides the means and/or information for another person to commit suicide. If the assisting person is a physician who prescribes a lethal dose, a more precise term is "physician-assisted suicide." "Euthanasia," by contrast, is direct administration of a lethal agent with the intent to cause another person's death.

In the United States, physician-assisted suicide is legal in three states: Oregon, Washington and Vermont. Eligible patients are required to be "terminal," which means having less than six months to live. Such patients, however, are not necessarily dying. One reason is because expectations of life expectancy can be wrong. Treatment can also lead to recovery. I have a friend who was talked out of using Oregon's law in 2000. Her doctor, who did not believe in assisted suicide, convinced her to be treated instead. She is still alive today, 13 years later.

oversight over administration of the lethal dose. Even if the patient struggled, who would know? See here.

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

Jurisdictions without legal assisted suicide already have a significant problem with palliative care abuse by some doctors and nurses. 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 Leaks 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

A-30

On, the law was enacted by a ballot measure in 1997. Vermont’s law was passed by another measure in 2008 and went into effect in 2009. Vermont’s law was enacted on May 20, 2013. All three laws are a recipe for abuse. One reason is that they allow someone else to talk for the patient during the lethal dose request process. Moreover, once the lethal dose is issued by the pharmacy, there is no oversight over administration. Even if the patient struggled, who would know? [See e.g., http://www.choiceillusion.org/2013/11/quick-facts-about-assisted-suicide_11.html]

Here in Washington state, we have already had informal proposals to expand our law to non-terminal people. The first time I saw this was in a newspaper article in 2011. More recently, there was a newspaper column suggesting euthanasia “if you couldn’t save enough money to see yourself through your old age,” which would be involuntary euthanasia. Prior to our law being passed, I never heard anyone talk like this.


My Cases Involving the Oregon and Washington Assisted Suicide Laws

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

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

Conclusion

In my guardianship cases, people were financially abused and sometimes treated terribly, but nobody died and sometimes we were able to make their lives much better. With legal assisted suicide, the abuse is final. Don’t make Washington’s mistake.

Margaret K. Dore (margaretodore@margaretodore.com) JD, MBA, is an attorney in private practice in Washington State where assisted suicide is legal. She is a former Law Clerk to the Washington State Supreme Court and the Washington State Court of Appeals. She worked for a year with the U.S. Department of Justice and is president of Choice Is an Illusion, www.choiceillusion.org, a nonprofit corporation opposed to assisted suicide and euthanasia.

Labels: euthanasia, Guardianship Abuse; Elder abuse; Margaret Dore, Oregon, physician-assisted suicide, Vermont, Washington

Links to this post

Create a Link

Newer Post Home Older Post

©2015 Choice Is an Illusion, a nonprofit organization. All rights reserved. Powered by Blogger.
Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

B. Wagner a,⁎, J. Müller b, A. Maercker c

a University Clinic for Psychotherapy and Psychosomatic Medicine, University Hospital Leipzig, Semmelweisstr. 10, 04103 Leipzig, Germany
b Department of Psychiatry, University Hospital Zurich, Cullenstr. 8, 8091 Zurich, Switzerland
c Department of Psychopathology and Clinical Intervention, University of Zurich, Irzammühlestr. 14/17, 8050 Zurich, Switzerland

ARTICLE INFO

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

Keywords:
Assisted suicide
Euthanasia
Complicated grief
Posttraumatic stress disorder
Depression

ABSTRACT

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

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

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

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

© 2010 Elsevier Masson SAS. All rights reserved.

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-servicing 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 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient's home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient's home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.
Oregon Revised Statute

Chapter 127

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

Please browse this page or download the statute for printing - (or read the statute at https://www.leg.state.or.us)

127.800 s.1.01. Definitions.

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

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

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

(3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

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

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

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

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

(a) His or her medical diagnosis;

(b) His or her prognosis;

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

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

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

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

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

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

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

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 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...
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.
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 16, 2012

NAME: HEIDI PRZYNCKI

A notary in and for the
State of Washington MASSACHUSETTS

ADDRESS: 35 MAUI ST
Pompeii, MA 01062
EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

HEIDI PRZYNCKI
NOTARY PUBLIC

A-37
THE UNDERSIGNED, being first duly sworn under oath, states:

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

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

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

Affidavit of Jeanette Hall - Page 1
4. This July, it was 12 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 17th day of August 2012

Jeanette Hall

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

NAME: Jeanette Hall

A notary in and for the State of Oregon

ADDRESS: 15405 SW Illium Ave Portland, OR 97224

EXPIRY OF COMMISSION: September 29, 2015

PLACE SEAL HERE:

OFFICIAL SEAL
SHEENA MARIE LESLIE
NOTARY PUBLIC - OREGON
COMMISSION NO. 462203
MY COMMISSION EXPIRED SEPTEMBER 29, 2015
In Re SB 128

DECLARATION OF KENNETH STEVENS, MD

I, Kenneth Stevens, declare the following under penalty of perjury.

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 published articles in medical journals and written chapters for books on medical topics. This has been for both a national and international audience. I work in both hospital and clinical settings. I have treated thousands of patients with cancer.

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

3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for

Affidavit of Kenneth Stevens, Jr., MD - page 1
cancer. I understand that he had referred her to me.

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

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

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

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

8. 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.
9. Finally, I have been asked to comment on generally accepted medical practice regarding the administration of prescription drugs to a patient.

10. Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer prescription drugs to a patient. Common examples of persons acting under the direction of a doctor, include: nurses and other healthcare professionals who act under the direction of a doctor to administer drugs to a patient in a hospital setting; parents who act under the direction of a doctor to administer drugs to their children in a home setting; and adult children who act under the direction of a doctor to administer drugs to their parents in a home setting.

Signed under penalty of perjury, this 14th day of June 2015

Kenneth Stevens, Jr., MD
Sherwood, Oregon
Planning for old age at a premium

Preparing for longterm 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
Arizona Strengthens its Law Against Assisted Suicide

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.

Monday, May 5, 2014

Links to this post
Create a Link

Labels: assisted suicide
“CHOICE” IS AN ILLUSION
A human rights organization working to keep assisted suicide and euthanasia out of your state, and out of your life.

Idaho Home  Idaho Strengthens Law  Idaho Bar Articles  Letters to the Editor

CLICK HERE to return to main site

MONDAY, JULY 4, 2011
Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

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

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

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

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

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

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

---

[3] Iowa existing civil law included Cramer v. Slater, 146 Idaho 868, 878, 204 P.3d 508 (2009), which states that doctors “can be held liable for [a] patient’s suicide.” Existing law also included a common law crime in which an “ aider and abettor” of suicide is guilty of murder. Assisted suicide can also be statutorily charged as murder. See Margaret K. Dore, “Aid in Dying: Not Legal in Idaho; Not About Choice,” The Advocate, official publication of the Idaho State Bar, Vol. 52, No. 9, pages 18-20, September 2010 (describing existing law prior to the new bill’s enactment); and The Hon. Robert E. Bakes, retired Chief Justice of the Idaho Supreme Court, Letter to the Editor, “Legislature rejected euthanasia,” The Advocate, September 2010 (In both the Idaho criminal statutes as well as I.C.6-1012, the Idaho legislature has rejected physician-assisted suicide”). Entire issue, available here: http://www.isb.idaho.gov/pdf/advocate/issues/adv10sep.pdf
2011-2012 Regular Session - HB 1114
Homicide; offering to assist in commission of suicide; repeal certain provisions

Sponsored By
(1) Setzler, Ed 35th
(4) Pak, B.J. 102nd
(2) Golick, Rich 34th
(5) Lindsey, Edward 54th
(3) Ramsey, Matt 72nd
(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 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 8:57 a.m.
Last Modified: Tuesday, April 24, 2012 at 8:57 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.

Reader comments posted to this article may be published in our print edition. All rights reserved. Copyrighted material may not be re-published without permission. Links are encouraged.
Ingest definition

Ingest (in jest')

Transitive verb

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

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

Related Forms:

- Ingestion in-ges'tion noun
- Ingestive in-ges'tive adjective

Ingest (in-jest')

Transitive verb Ingest-ed, Ingest-ing, Ingests

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

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

Related Forms:

- Ingest'i-ble adjective
- Ingestion in-ges'tion noun
- Ingestive in-ges'tive adjective

Rate this Article

- Print
- E-mail
- Link/Cite
- Bookmark

http://www.yourdictionary.com/ingest

11/4/2010