Attachments

Margaret Dore Memo

Vote No on B21-38

Submitted to the

D.C. Council Health Committee

July 24, 2015
A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To provide procedures and requirements regarding the request for and dispensation of covered medications to qualified patients seeking to die in a humane and dignified manner; to define the duties of attending physicians and consulting physicians; to provide for counseling of patients and family notification; to require informed decision-making and waiting periods; to require reporting from the Department of Health; to define the effect of the act on contracts, wills, insurance, and annuity policies; to provide for immunities, liabilities, and penalties; to provide an opt-out provision for health care providers; to provide for claims by a government for costs incurred.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the “Death with Dignity Act of 2015”.

Sec. 2. Definitions.

For purposes of this act, the term:

(1) “Adult” means an individual who has attained 18 years of age.

(2) “Attending physician” means the physician selected by, or assigned to, the patient and who has primary responsibility for the treatment and care of the patient.

(3) “Capable” means that, in the opinion of a court or the patient’s attending physician, consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers.
(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 and who is willing to participate in the provision of a covered medication to a qualified patient in accordance with this act.

(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) "Covered medication" means a medication prescribed pursuant to this act for the purpose of ending a person's life in a humane and dignified manner.

(7) "Department" means the Department of Health.

(8) "Health care provider" means a person, partnership, corporation, facility, or institution, licensed or certified or authorized by law to administer health care or dispense medication in the ordinary course of business or practice of a profession.

(9) "Informed decision" means a decision by a qualified patient to request and obtain a prescription for a covered medication 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 covered medication to be prescribed;

(D) The probable results of taking the covered medication to be prescribed; and
(E) The feasible alternatives, including comfort care, hospice care, and pain control.

(10) "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.

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

(12) "Physician" means a person authorized to practice medicine in the District of Columbia.

(13) "Qualified patient" means a capable adult who is a resident of the District of Columbia who satisfies the requirements of this act in order to obtain a prescription for a covered medication.

(14) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

Sec. 3. Requests for a covered medication.

(a) To request a covered medication, a patient shall:

(1) Make 2 oral requests, separated by at least 15 days, to an attending physician.

(2) Submit a written request, signed and dated by the patient, to the attending physician before the patient makes his or her second oral request and at least 48 hours before a covered medication may be prescribed or dispensed.

(b)(1) A written request made pursuant to subsection (a)(2) of this section shall be witnessed by at least two individuals who, in the presence of the patient, attest to the best of their
knowledge and belief the patient is capable, acting voluntarily, and not being unduly influenced
to sign the request.

(2) One of the witnesses shall be a person who is not:

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

(B) A person who at the time the request is signed, would be entitled to

any portion of the estate of the qualified patient upon death under any will or by operation of

law; or

(C) An owner, operator, or employee of a health care facility where the

qualified patient is receiving medical treatment or is a resident.

(3) The patient’s attending physician at the time of the request shall not be a

witness.

(4) If the patient is a patient in a long-term care facility at the time the written

request is made, one of the witnesses shall be an individual designated by the facility and having

the qualifications specified in the Department’s regulations.

(c) A written request made pursuant to subsection (a)(2) of this section shall be in

substantially the following form:

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

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

"I am suffering from ____________, which my attending physician has determined is a terminal
disease and which has been medically confirmed by a consulting physician.
"I have been fully informed of my diagnosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

"INITIAL ONE:

[ ] I have informed my family of my decision and taken their opinion 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 as any time.

I understand the full import of this request, and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within 3 hours of taking the medication to be prescribed, my death may take longer, and my physician has counseled me about this possibility.

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

"Signed:

"Dated:

"DECLARATION OF WITNESSES:

"We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud, or undue influence;"
(d) Is not a patient for whom either of us is the attending physician.

"Date:

"Witness 1:

"Address:

"Witness 1 signature:

"Date:

"Witness 2:

"Address:

"Witness 2 signature:

"NOTE: One witness shall not be a relative (by blood, marriage, or adoption) of the person signing this request, shall not be entitled to any portion of the person’s estate upon death and shall not own, operate, or be employed at the health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.”.

Sec. 4. Responsibilities of the attending physician.

Upon receiving a request for a covered medication pursuant to section 3, the attending physician shall:

(1) Determine that the patient:

(A) Has a terminal disease;

(B) Is capable;

(C) Has made the request voluntarily; and

(D) Is a resident of the District of Columbia;

(2) Inform the patient of:
(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking a covered medication;

(D) The probable result of taking a covered medication; and

(E) The feasible alternatives to taking a covered medication, including comfort care, hospice care, and pain control;

(4) Refer the patient to a consulting physician, who shall:

(A) Examine the patient and his or her relevant medical records to confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease;

(B) Verify, in writing, to the attending physician that the patient:

(i) Is capable;

(ii) Is acting voluntarily; and

(iii) Has made an informed decision; and

(C) Refer the patient to counseling if appropriate, pursuant to section 5;

(5) Refer the patient to counseling if appropriate, pursuant to section 5;

(6) Recommend that the patient notify next of kin of his or her decision to request a covered medication;

(7) Counsel the patient about the importance of having another person present when the patient takes a covered medication and of not taking a covered medication in a public place;

(8) Inform the patient that he or she has an opportunity to rescind a request for a covered medication at any time and in any manner;
(9) Verify, immediately prior to writing the prescription for a covered medication, that the patient is making an informed decision; and

(10) Fulfill the medical record documentation requirements of section 7.

Sec. 5. Counseling referral.

(a) If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for required counseling.

(b) No covered medication shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

Sec. 6. Dispensing a covered medication.

(a) An attending physician may not prescribe or dispense a covered medication, unless:

(1) At least 15 days have elapsed between the patient’s 2 oral requests for a covered medication pursuant to section 3(a);

(2) The patient submitted a written request for a covered medication pursuant to section 3 before making his or her second oral request;

(3) At least 48 hours have elapsed since the patient submitted a written request for a covered medication pursuant to section 3; and

(4) The attending physician offered the patient an opportunity to rescind his or her request for a covered medication immediately before prescribing or dispensing the covered medication.

(b) After the attending physician ensures that the requirements provided in subsection (a) of this section and section 4 have been satisfied, an attending physician may:
(1) Dispense a covered medication, including ancillary medications intended to minimize the patient’s discomfort, directly to the qualified patient; provided, that the attending physician is authorized to do so in the District of Columbia and has a current Drug Enforcement Administration certificate; and

(2) With the patient’s written consent:

   (A) Contact a pharmacist and inform the pharmacist of the prescription for a covered medication; and

   (B) Deliver the written prescription for a covered medication personally or by mail to the pharmacist, who will dispense the covered medication to the patient, the attending physician, or an expressly identified agent of the patient.

   (c) Notwithstanding any other provision of law, the attending physician may sign the patient’s death certificate.

Sec. 7. Medical record documentation requirements.

The following must be documented and filed in the patient’s medical record:

(1) All oral requests by a patient for a covered medication;

(2) All written requests by a patient for a covered medication;

(3) The attending physician’s diagnosis and prognosis, determination that the patient is a District resident and is capable, acting voluntarily, and has made an informed decision;

(4) The consulting physician’s diagnosis and prognosis and verification that the patient is capable, acting voluntarily, and has made an informed decision;

(5) If a patient is referred to counseling pursuant to section 5, a report of the outcome and determinations made during counseling;
(6) The attending physician’s offer to the patient to rescind his or her request before the patient makes his or her second oral request; and

(7) A note by the attending physician indicating that all requirements under this act have been met and indicating the steps taken to carry out the request, including a notation of the covered medication prescribed.

Sec. 8. Reporting requirements.

(a)(1) The Department shall annually review a sample of records maintained pursuant to this act.

(2) The Department shall require a health care provider, upon dispensing a covered medication pursuant to this act, to file a copy of the dispensing record with the Department.

(b) The Mayor shall issue regulations to facilitate the collection of information regarding compliance with this act. Except as otherwise required by law, the information collected will not be a public record and may not be made available for inspection by the public.

(c) The Department will generate and make available to the public an annual statistical report of information collected under subsection (b) of this section.

Sec. 9. Effect on construction of wills and contracts.

(a) No provision in a contract, will, or other agreement, whether written or oral, will be valid to the extent the provision would affect whether a person may make or rescind a request for a covered medication.

(b) No obligation owing under any currently existing contract may be conditioned or affected by the making or rescinding of a request, by a person, for a covered medication.

Sec. 10. Insurance and annuity policies.
The sale, procurement, or issuance of any life, health, accident insurance, or annuity policy or the rate charged for any policy may not be conditioned upon or affected by the making or rescinding of a request, by a person, for a covered medication. Neither may a qualified patient’s act of ingesting a covered medication have an effect upon a life, health, accident, insurance, or annuity policy.

Sec. 11. Immunities and liabilities.

(a) Except as provided in subsections (b), (c), (d), and (e) of this section:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for:

(A) Participating in good faith compliance with this act; or

(B) Being present when a qualified patient takes a covered medication.

(2) No professional organization or association or health care provider may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss or membership or other penalty for participating or refusing to participate in good faith compliance with this act.

(3) No request by a patient for or provision by an attending physician of a covered medication in good faith compliance with the provisions of this act shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(b) A person who, without authorization of the patient, willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient’s death shall not be immune from criminal liability under this section.
(c) A person who coerces or exerts undue influence on a patient to request a covered medication, or who prevents or destroys a rescission of such request, shall not be immune from criminal liability under this section.

(d) Nothing under this act limits liability for civil damages resulting from negligent or intentional misconduct by any person.

(e) The penalties pursuant to this act do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this act.

Sec. 12. Health care provider participation; notification; permissible sanctions.

(a) No health care provider is under any duty, whether by contract, by statute, or by any other legal requirement, to participate in the provision of a covered medication to a qualified patient. If a healthcare provider is unable or unwilling to carry out a patient’s request under this act and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient’s relevant medical records to the new health care provider.

(b) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider on the prohibiting provider’s premises from participating under this act if the prohibiting provider has notified the health care provider of the prohibiting provider’s policy regarding participating pursuant to this act. Nothing in this subsection prevents a health care provider from providing health care services to a patient that does not constitute participation under this act.

(c) Notwithstanding subsection (a) of this section or section 11, a health care provider may subject another health care provider to the following sanctions if prior to participation, the
sanctioning health care provider has notified the sanctioned provider that it prohibits

participation under this act:

(1) Loss of privileges, loss of membership, or other sanction provided pursuant to

the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the

sanctioned provider is a member of the sanctioning provider's medical staff and participates

under this act while on the premises of a health care facility of the sanctioning health care

provider, but not including the private medical office of a physician or other provider;

(2) Termination of lease or other property contract or other nonmonetary remedies

provided by lease contract, not including loss or restriction of medical staff privileges or

exclusion from a provider panel, if the sanctioned provider participates under this act while on

the premises of the sanctioning health care provider or on property that is owned by or under the

direct control of the sanctioning health care provider; or

(3) Termination of any contract or other nonmonetary remedies provided by

contract if the sanctioned provider participates pursuant to this act while acting in the course and

scope of the sanctioned provider's capacity as an employee or independent contractor of the

sanctioning health care provider. Nothing in this paragraph shall be construed to prevent:

(A) A health care provider from participating under this act while acting

outside the course and scope of the provider's capacity as an employee or independent

contractor; or

(B) A patient from contracting with his or her attending physician and

consulting physician to act outside the course and scope of the provider's capacity as an

employee or independent contractor of the sanctioning health care provider.
(d) A health care provider that imposes sanctions under subsection (c) of this section must follow all due process and other procedures that the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(e) Suspension or termination of staff membership or privileges under subsection (b) of this section is not reportable under section 513 of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.13). Action taken pursuant to sections 4, 5, 6, or 7 of this act may not be the sole basis for a report of unprofessional or dishonorable conduct under section 514 of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.14).

(f) Nothing contained in this act shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist or psychologist, or other health care provider participating under this act.

Sec. 13. Claims by governmental entity for costs incurred.

Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to this act in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim.

Sec. 14. Penalties.

(a) A person who, without authorization of the patient, willfully alters, forges, conceals, or destroys an instrument, a reinstatement or revocation of an instrument, or any other evidence or document reflecting the patient’s desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration which hastens the death of the patient commits a Class A felony.
(b) Except as provided in subsection (a) of this section, a person who, without authorization of the principal, willfully alters, forges, conceals, or destroys an instrument, a reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal’s desires and interests, with the intent or effect or affecting a health care decision shall be fined no more than the amount set forth in section 101 of the Criminal Fine Proportionality Amendment Act of 2012, effective June 11, 2013 (D.C. Law 190317; D.C. Official Code § 22-3571.01), or incarcerated for no more than 180 days, or both.

Sec. 15. Safe disposal of unused covered medications.

Pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 et seq.), the Mayor shall issue rules providing for the safe disposal of unused covered medications.

Sec. 16. Construction.

Nothing in this act may be construed to authorize a physician or any other person to end a patient’s life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this act do not constitute suicide, assisted suicide, mercy killing, or homicide, under the law.

Sec. 17. Fiscal impact.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 18. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December
24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.
Breaking the Silence on Elder Abuse

From Washington Lawyer, February 2015

By Kathryn Alfisi

The issue of elder abuse made front-page news in 2009 when famed philanthropist Brooke Astor's son, Anthony Marshall, was convicted on 14 of 16 counts for financially exploiting his mother, stealing millions of dollars from her.

A few years earlier in the District of Columbia, a similar case played out on a much smaller scale and away from the media glare.

D.C. resident Hattie Mae Goode was a housekeeper who, along with her husband, had scrimped and saved, bought a house (in which she took great pride), and wanted to be independent in her elder years. Several years after her husband died, Goode was introduced to Reginald Rogers by a mutual friend. Rogers, a lawyer, soon became indispensable to Goode, taking her to doctor appointments, to the bank, and eventually obtaining power of attorney over her.

"She trusted him to take care of her and her financial affairs, which turned out to be a very bad idea. He just cleaned her out," says Goode's niece Alma Robinson, who is executive director of the California Lawyers for the Arts.

"It was such a horrible story. This widow by herself with nobody looking after her, and then he convinces her that her family is trying to take advantage of her," Robinson says.

Cases such as Goode's and Astor's are all too common, say experts, yet the issue of elder abuse often goes unnoticed.

Vulnerable and Exploited

While statistics are hard to come by, a recent report by the U.S. Department of Justice and U.S. Department of Health and Human Services states that elder abuse—which includes physical, sexual, and psychological abuse, as well as neglect, abandonment, and financial exploitation—affects about five million Americans each year. According to the report, just one in 24 cases of elder abuse is reported to authorities.[1] (/bar-resources/publications/washington-lawyer/articles/february-2015-elder-abuse.cfm#ftnref1)

While elder abuse may not be garnering a lot of public attention, there appears to be growing sensitivity to the issue among lawyers, says David English, a professor at the University of Missouri School of Law and chair of the American Bar Association's (ABA) Commission on Law and Aging. English recalls leading an ABA program on elder abuse in 1995 that only about 10 people attended; now such programs are sold out.

Lawyers are likely seeing an increasing number of elder abuse cases for several reasons: There are now more individuals who are considered elderly; people are living longer than ever before, but are not necessarily in a state of good health; and the power of attorney is more widely used and, therefore, more likely to be abused.

In a 2003 report, the National Research Council defined elder mistreatment (both abuse and neglect) as "(a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm."[2] (/bar-resources/publications/washington-lawyer/articles/february-2015-elder-abuse.cfm#ftnref2)

The Web site of the U.S. Administration on Aging's National Center on Elder Abuse (NCEA) provides statistics and data that help to paint a picture of the problem. Citing figures from the U.S. Census Bureau, the NCEA states that people age 65 or older are expected to account for 20 percent of the country's total population by 2050. Currently, seniors 85 years old and up comprise the fastest growing segment of the U.S. population: 5.8 million as of 2010, a number that is projected to increase to 19 million people by 2050.

The NCEA also offers various findings that reveal the prevalence of elder abuse. One such finding, from the 2003 report by the National Research Council, showed that only 1 in 14 cases of elder abuse ever come to the attention of authorities.

Another finding, from a 2011 report on New York State elder abuse prevalence, revealed that major financial exploitation was self-reported at a rate of 41 per 1,000 older residents surveyed, higher than other forms of abuse.[3] (/bar-resources/publications/washington-lawyer/articles/february-2015-elder-abuse.cfm#ftnref3)
Misplaced Trust
Traci Tait often deals with elder abuse cases at her job as assistant Bar counsel with the D.C. Office of Bar Counsel. Tait handled the Goode case, which in many ways was not that different from the many cases concerning the elderly that are taken by Bar Counsel. However, the U.S. Attorney’s Office also became involved with the Goode case, and Tait ended up working collaboratively with the FBI.

The investigation into Goode’s attorney started as a cold call by Robinson, Goode’s niece, to the Office of Bar Counsel. Not wanting to jump to conclusions, Tait first suggested that Robinson take certain steps, such as taping a conversation with Rogers (with his permission) with a witness present, before filing a complaint against him. Tait also advised Robinson to file a complaint with the U.S. Attorney’s Office, which agreed to take the case.

Robinson, along with Goode’s sister, decided to fly from California to the District of Columbia when they heard that Goode was in the hospital. Once in the District, they soon became aware of how much control Rogers had over Goode’s financial affairs.

Following Tait’s advice, Robinson set up a meeting with Rogers in which he told her that the books were open and he had nothing to hide. But when Robinson and her aunt went to the bank, they discovered that Rogers had withdrawn all the remaining cash (close to $6,000) from Goode’s accounts. Meanwhile, Goode’s phone had been disconnected because the bills weren’t being paid, according to Robinson.

With Tait’s assistance, Robinson was able to terminate Rogers’ power of attorney over Goode and bring charges against him, including intentional misappropriation, within six months of Robinson’s initial call.

“The things that will get you disbarment are misappropriation, theft, and dishonesty, depending on how big the dishonesty is,” says Tait.

Goode lost more than $260,000 in savings and was able to only recover $75,000, the most money allowed from the D.C. Bar’s Clients’ Security Fund.

Despite the successful outcome of the case, the whole situation was very upsetting to Robinson.

“It was just horrible to think that someone would take advantage of her like this when she was so vulnerable,” she says.

The Silent Crime
As upsetting as the case was, at least Goode was able to see the situation resolved. Many elder abuse cases are never reported or investigated because there’s no family member or loved one involved. And the elderly often make unreliable witnesses due to dementia, making it difficult to bring a case without a third-party witness. But this is why the elderly make such easy targets.

“The elderly are an at-risk group for a lot of reasons, including, but not limited to, diminished capacity, isolation from family or other caregivers, lack of sophistication when it comes to purchasing property, financing, or using computers,” says Amy Mix of the AARP Legal Counsel for the Elderly (LCE).

Mix heads up the Consumer Fraud and Financial Abuse Unit at LCE, which works closely with the D.C. Department of Human Services’ Adult Protective Services and the Metropolitan Police Department. She has seen cases where, like with Goode, someone has convinced an elderly person to assign them the power of attorney, and then used that authority to either take the senior’s home—often a target of predatory lenders or con artists—or strip their bank accounts of all their money.

Which is what happened to an 86-year-old client of Mix whose case she had been litigating for four years. A family friend of the client had convinced her that she was in financial distress and had her sign some paperwork that ended up being a deed transferring the title to her home. The “friend” then took a mortgage out on the property and walked away with $320,000 in cash.

“A lot of defendants are family members, lots are friends, often people who befriend a senior through church or some other community group. We had a senior victim who had given her life savings away to some scammer who told her she’d won the lottery and would have to pay the taxes ahead of time,” says Mix. The scammer found the victim using information in her husband’s obituary.

There are also repeat offenders, according to Mix. “There are people who make a living off of this,” she adds.

Mary Ann Parker also works for LCE, but as an attorney for the Office of the D.C. Long Term-Care Ombudsman Program, which monitors individuals in long-term care facilities in the District, including nursing homes, group homes, and assisted living facilities, as well as people who are getting a high level of service at home through the Medicaid waiver.
Parker says the program received about 50 complaints within the last year or two concerning elder physical or sexual abuse or neglect. The complaints take a lot of investigation and, similar to financial exploitation, it can be difficult to prove that abuse or neglect had taken place.

“When you talk about a vulnerable population that might have cognitive impairment, it’s very difficult to find out if there was abuse. When you look at [elderly persons] with a big bruise on their cheek you might think that someone hit them, but it could be because their medication makes them bruise easily. They may be able to tell you or they may not,” she says.

Parker believes education and training are crucial in combating elder abuse.

“In our nursing homes and assisted living facilities we advocate for culture change, because if you’re not educating people they may not even understand it. Also, we do a lot of education with the police. We go to their roll calls now just to talk about the population, about their rights, and also what signs to look for,” she says.

**Advocating for the Elderly**

There are several national programs and initiatives intended to address the issue of elder abuse. In July 2014 the Department of Justice and Department of Health and Human Services published the “Elder Justice Roadmap” as a guide for teams, communities, states, and national entities to combat elder abuse.

The agencies sought the input of experts and stakeholders from across the country to identify and prioritize actions that direct services providers, educators, and researchers can take to help the elderly. The report also provides a roadmap for strategic investment and engagement by policy makers in the public and private sectors at the local, state, and national levels.

While many priorities were identified in the report, the top five were awareness, brain health, caregiving, economics, and resources. Awareness includes increasing public knowledge of elder abuse through a holistic, well-coordinated response in services, education, policy, and research. Brain health priority calls for research and focus on cognitive capacity and mental health.

Under caregiving, the report seeks better support and training for both paid and unpaid caregivers. Economics means quantifying the costs of elder abuse, “which is often entwined with financial incentives and comes with huge fiscal costs to victims, families, and society,” and resources means strategically investing more in services, education, and research, and expanding knowledge to reduce elder abuse.

The 15-member ABA Commission on Law and Aging examines a wide range of legal issues affecting older persons. Among its recent projects is a booklet on elder abuse for law enforcement that was created with the help of the Department of Justice.

“It’s a handy reference for law enforcement to use when they’re investigating incidents,” says English.

For another project, the commission worked with the Consumer Financial Protection Bureau to publish four fiduciary guides to help family members and others who are called to manage someone else’s money or benefits.

Although abuse can be a big problem in this area, English says sometimes it’s not intentional. “Some people really don’t have an understanding of their responsibilities as an agent or trustee,” he says.

A third project saw the commission partner with the Investor Protection Trust to create assessment-type educational materials for lawyers about elder abuse. The two groups, with the Investor Protection Institute, announced this past summer that they were launching the Elder Investment Fraud and Financial Exploitation (EIFFE) Prevention Program—Legal, which will work to develop, test, and implement a model national continuing legal education program to teach lawyers to recognize clients who may be vulnerable to financial fraud and exploitation due to mild cognitive impairment, identify signs of such abuse in their clients, and report suspected incidents to authorities.

A survey that was conducted as part of the program showed that more than nine out of 10 attorneys say elder investment fraud and financial exploitation is a “very serious” or “somewhat serious” problem. In addition, more than one out of three attorneys say they are aware that they are or may be dealing with victims of elder investment fraud and financial exploitation. Roughly nine out of 10 attorneys who responded to the survey were willing to participate in a continuing legal education program concerning this problem.

**DC TROV**

Closer to home, a new project was recently established to address elder abuse in the District. Launched in October, the District’s Collaborative Training and Response to Older Victims, or DC TROV, is a joint effort by the Network for Elderly Victim Recovery of DC (NVRDC), Adult Protective Services, the Metropolitan Police Department, LCE, the U.S. Attorney’s Office for the District of Columbia, and the DC Coalition Against Domestic Violence.
One person who is following the project closely is Bridgette Hardwood, who directs the legal, criminal, and civil legal services program at NVRDC, which is administering DC TROV.

"At the official launch, it was amazing to [hear] all the perspectives in the room and the excitement about building this coordinated response. I think it's going to be a great tool for our senior population," Hardwood says.

The three-year project was made possible by a grant from the Department of Justice's Office on Violence Against Women, with training provided by the National Clearinghouse on Abuse in Later Life.

"DC TROV was established to create a coordinated community response to . . . elder abuse in the District, and we do that through basically a very formalized collaboration with key partners that may confront this issue in different arenas," says Hardwood. "The purpose of the project is essentially to bring all these partners together and . . . train them to better reorganize and respond to elder abuse, but also to create a long, sustainable partnership where we have a streamlined approach when a case of elder abuse comes up."

In December, DC TROV trained 80 police officers on how to recognize and respond to elder abuse; more trainings are planned in early 2015. Training sessions also will be conducted for the victim services team this year.

DC TROV has been working with the District of Columbia Courts as well, building on the courts' own training on domestic violence in the elderly population. In 2014 DC TROV sent five prosecutors to a four-and-a-half day training on elder abuse, and more will likely be trained in the future.

"The long-term goal of the project is for all of these critical members of the response—law enforcement, prosecutors, judges, and victim advocates—to receive some sort of baseline training and also an advanced level of training in areas we've determined are really specific to what the community here needs," says Hardwood.

Year one of the project is focused on getting all the key partners trained, while year two is about implementation. Assessments among the elderly population and among service providers will be conducted during the first two years of the project. Money will be set aside for year three to increase the services identified in the assessments.

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Notes


Adult Abuse generally refers to mistreatment of an older person by someone who has a special relationship with the elder such as a spouse, sibling, child, friend, or caregiver. Abuse may take the form of one or all of the following: physical, financial or emotional abuse, neglect or abandonment. Abuse includes the willful infliction of serious pain or injury, unreasonable confinement, intimidation or forced sexual contact.

Abusers
Typically, the abuser is a relative, frequently an adult child of the victim. The abusers may suffer from alcohol or drug abuse. Sometimes the abusers were abused as children. The abuser may be emotionally unstable. Sometimes, the caregiver can no longer cope with a stressful situation and does not know where to turn for help.

Reporting Abuse
Many who suffer from abuse may feel ashamed and embarrassed and suffer from low self esteem. Some don't want to report their own child as an abuser. Often the abused simply fears more abuse if they report it. Others are too feeble to think clearly, or they may not realize that help is available.

You Can Help
It's up to you to break the silence. Certain people are required by law to report abusers. They are conservators and guardians, court-appointed mental retardation advocates, police officers, licensed health professionals, health care administrators and social workers. Others such as neighbors, church members, relatives, and friends may report voluntarily. Persons reporting voluntarily need not identify themselves.

Who to Call
Call the hotline at (202) 541-3950. More victims are helped by callers outside the family than in it. When you call the hotline, a social worker will assist you. The social worker will take information about your concerns and will conduct an investigation to determine if abuse, neglect, or exploitation is occurring. Sometimes medical or psychiatric care helps solve the problem. In other cases, services can be provided to victims in their homes or they can be removed from danger.

If the investigation indicates that a person is in need of protection, a variety of services may be made available to them. Social workers may arrange for counseling, legal services, emergency placement, and/or medical services.

Remember, the person you are worried about can refuse intervention. The merely eccentric will be left in peace. And your identity will be protected, because reports are confidential.
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 distress—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 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.
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.
Oregon’s Death with Dignity Act—2014

Oregon’s Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. The key findings from 2014 are presented below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of February 2, 2015. For more detail, please view the figures and tables on our web site: http://www.healthoregon.org/dwd.

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

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

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

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

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

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

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

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

Of the 105 DWDA deaths during 2014, most (67.6%) were aged 65 years or older. The median age at death was 72 years. As in previous years, decedents were commonly white (95.2%) and well-educated (47.6% had a 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
  - 94 ingested medication
  - 37 did not ingest medication and subsequently died from other causes
  - 24 ingestion and death status unknown
  - 11 people with prescriptions written in previous years ingested medication during 2014
  - 105 ingested medication
    - 0 regained consciousness after ingesting medication; died of underlying illness
    - 105 died from ingesting medication

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>
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<tr>
<td><strong>Sex</strong></td>
<td></td>
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<tr>
<td>Male (%)</td>
<td>56 (53.3)</td>
<td>397 (52.7)</td>
<td>453 (52.7)</td>
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<tr>
<td>Female (%)</td>
<td>49 (46.7)</td>
<td>357 (47.3)</td>
<td>406 (47.3)</td>
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<td><strong>Age at death (years)</strong></td>
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<td>45-54 (%)</td>
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<td>55-64 (%)</td>
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<td>65-74 (%)</td>
<td>29 (27.6)</td>
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<td>75-84 (%)</td>
<td>23 (21.9)</td>
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<td>85+ (%)</td>
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<td>Median years (range)</td>
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<td>71 (25-96)</td>
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<td><strong>Race</strong></td>
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<td>Other (%)</td>
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<td>Two or more races (%)</td>
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<td><strong>Marital Status</strong></td>
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<td>Married (%)</td>
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<td>Never married (%)</td>
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<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 (%)</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>Insurance</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>
</tbody>
</table>
### Characteristics

#### Underlying illness

<table>
<thead>
<tr>
<th>Illness</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasms (%)</td>
<td></td>
<td></td>
<td></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>17 (16.2)</td>
<td>54 (7.2)</td>
<td>71 (8.3)</td>
</tr>
<tr>
<td>Chronic lower respiratory disease (%)</td>
<td>4 (3.8)</td>
<td>34 (4.5)</td>
<td>38 (4.4)</td>
</tr>
<tr>
<td>Heart Disease (%)</td>
<td>3 (2.9)</td>
<td>14 (1.9)</td>
<td>17 (2.0)</td>
</tr>
<tr>
<td>HIV/AIDS (%)</td>
<td>0 (0.0)</td>
<td>9 (1.2)</td>
<td>9 (1.1)</td>
</tr>
<tr>
<td>Other illnesses (%)</td>
<td>9 (8.6)</td>
<td>44 (5.9)</td>
<td>53 (6.2)</td>
</tr>
<tr>
<td>Unknown</td>
<td>0 (0)</td>
<td>3 (0.7)</td>
<td>3 (0.7)</td>
</tr>
</tbody>
</table>

#### DWDA process

<table>
<thead>
<tr>
<th>Process</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<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>95 (90.5)</td>
<td>634 (93.6)</td>
<td>729 (93.2)</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 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 (0)</td>
<td>3 (0.7)</td>
<td>3 (0.7)</td>
</tr>
</tbody>
</table>

#### Lethal medication

<table>
<thead>
<tr>
<th>Medication</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pentobarbital (%)</td>
<td>41 (39.0)</td>
<td>344 (45.6)</td>
<td>385 (44.8)</td>
</tr>
<tr>
<td>Secobarbital (%)</td>
<td>63 (60.0)</td>
<td>403 (53.4)</td>
<td>466 (54.2)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>1 (1.0)</td>
<td>7 (0.9)</td>
<td>8 (0.9)</td>
</tr>
</tbody>
</table>

#### End of life concerns

<table>
<thead>
<tr>
<th>Concern</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<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 (80.6)</td>
<td>579 (79.3)</td>
</tr>
<tr>
<td>Loss of 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>43 (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>
</tbody>
</table>

#### Health-care provider present

<table>
<thead>
<tr>
<th>Provider</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=684)</th>
<th>Total (N=789)</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

#### When medication was ingested

<table>
<thead>
<tr>
<th>Provider</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<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 (5.9)</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>
</tbody>
</table>

#### Complications

<table>
<thead>
<tr>
<th>Complication</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regurgitated</td>
<td>0</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Seizures</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>20</td>
<td>487</td>
<td>507</td>
</tr>
<tr>
<td>Unknown</td>
<td>85</td>
<td>244</td>
<td>329</td>
</tr>
</tbody>
</table>

#### Other outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regained consciousness after ingesting DWDA medications</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

### Timing of DWDA event

<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>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;11,12&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Range</td>
<td>2-15</td>
<td>1-38</td>
<td>1-38</td>
</tr>
<tr>
<td><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 six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years’ annual reports on our website (http://www.healthoregon.org/dwd) for more detail on these deaths.
14. Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.


Page 6 of 6
Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

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 b Department of Psychiatry, University Hospital Zurich, Calmannstr. 8, 8091 Zurich, Switzerland
 c Department of Psychopathology and Clinical Intervention, University of Zurich, Birzmühlstr. 14/17, 8050 Zurich, Switzerland

1. Introduction

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

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation’s assistance. In comparison, Dignitas has about 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient’s home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient’s home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.
**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
conflict and/or to cause more conflict. I have an accounting background and also saw markers of embezzlement. I tried to tell the court, but the supervising commissioner didn't know much about accounting. She allowed the guardian to hire its own CPA to investigate the situation, which predictably exonerated the guardian. The guardian had many cases and if what I said had been proved true, there would have been political fallout. There were also conflicts of interest among the lawyers.

At this point, the scales began to fall from my eyes. My focus started to shift from working within the system to seeing how the system itself sometimes facilitates abuse. This led me to write articles addressing some of the system's flaws. See e.g., Margaret K. Dore, Ten Reasons People Get Railroaded into Guardianship, 21 AM. J. FAM. L. 148 (2008), available at www.margaretmdore.com/pdf/Dore_AFL_Winter08.pdf; Margaret K. Dore, The Time is Now: Guardians Should be Licensed and Regulated Under the Executive Branch, Not the Courts, WASH. ST. B. ASS'N B. NEWS, Mar. 2007 at 27-9, available at http://massdocuments.files.wordpress.com/2013/08/dore-the-time-is-now-astx.pdf

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 blank checks, before moving on to larger items or coercing elders to sign over the deeds to their homes, change their wills or liquidate their assets.

In 2011, Met Life 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 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 the 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.
Oregon's law was enacted by a ballot measure in 1997. Washington'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, 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 (margaretdore@margaretdore.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

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Authority of chapter — References to practices under this chapter — Applicable standard of care.

(1) Nothing in this chapter authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide." Consistent with RCW 70.245.010 (7), (11), and (12), 70.245.020(1), 70.245.040(1)(k), 70.245.060, 70.245.070, 70.245.090, 70.245.120 (1) and (2), 70.245.160 (1) and (2), 70.245.170, 70.245.190(1) (a) and (d), and 70.245.200 (2), state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication.

(2) Nothing contained in this chapter shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist or psychologist, or other health care provider participating under this chapter.

[2009 c 1 § 18 (Initiative Measure No. 1000, approved November 4, 2008).]
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:
   - Suicide
   - Assisted suicide
   - Physician-assisted suicide
   - Death with Dignity
   - I-1000
   - Mercy killing
   - Euthanasia
   - Secobarbital or Seconal
   - Pentobarbital or Nembutal

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

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

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1 Under state law, the State Registrar of Vital Statistics "shall prepare and issue such detailed instruction as may be required to secure the uniform observance of its provisions and the maintenance of a perfect system of registration. ... The State Registrar shall carefully examine the certificates received monthly from the local registrars, county auditors, and clerks of the court and, if any are incomplete or unsatisfactory, the State Registrar shall require such further information to be furnished as may be necessary to make the record complete and satisfactory." RCW 43.70.160.
October 27, 1997. In November 1997, a measure was placed on the general election ballot to repeal the Act. Voters chose to retain the Act by a margin of 50% to 40%.

There is no state "program" for participation in the Act. People do not "make application" to the State of Oregon or the Oregon Health Authority. It is up to qualified patients and licensed physicians to implement the Act on an individual basis. The Act requires the Oregon Health Authority to collect information about patients who participate each year and to issue an annual report.

Q: Are there any other states that have similar legislation?
A: Yes. On November 4, 2008, the State of Washington passed Initiative 1000, the state's Death with Dignity Act, which became law on March 5, 2009. Information about the Washington Death with Dignity Act can be found at http://www.dch.wa.gov/dwda.

In 2009, the Montana Supreme Court ruled that physicians may assist patients in ending their lives by prescribing lethal medications (to be self-administered by the patient), citing the state's Rights of the Terminally Ill Act. Information on the Montana Supreme Court decision can be found at http://searchcourts.mt.gov/getDocument?vid=88487FE0-2501-438A-AC31-CCEB2D37C894.

In 2013, the Vermont General Assembly passed Act 39, the state's Patient Choice and Control at End of Life Act, which was signed into law on May 20, 2013. Information about the Vermont Patient Choice and Control at End of Life Act can be found at http://healthvermont.gov/family/end_of_life_care/patient_choice.aspx.

Q: Who can participate in the Act?
A: The law states that, in order to participate, a patient must be: 1) 18 years of age or older, 2) a resident of Oregon, 3) capable of making and communicating health care decisions for him/herself, and 4) diagnosed with a terminal illness that will lead to death within six (6) months. It is up to the attending physician to determine whether these criteria have been met.

Q: Can someone who doesn't live in Oregon participate in the Act?
A: No. Only patients who establish that they are residents of Oregon can participate if they meet certain criteria.

Q: How does a patient demonstrate residency?
A: A patient must provide adequate documentation to the attending physician to verify that s/he is a current resident of Oregon. Factors demonstrating residency include, but are not limited to: an Oregon Driver License, a lease agreement or property ownership document showing that the patient rents or owns property in Oregon, an Oregon voter registration, a recent Oregon tax return, etc. It is up to the attending physician to determine whether or not the patient has adequately established residency.

Q: How long does someone have to be a resident of Oregon to participate in the Act?
A: There is no minimum residency requirement. A patient must be able to establish that s/he is currently a resident of Oregon.

Q: Can a non-resident move to Oregon in order to participate in the Act?
A: There is nothing in the law that prevents someone from doing this. However, the patient must be able to prove to the attending doctor that s/he is currently a resident of Oregon.

Q: Are participating patients reported to the State of Oregon by name?
A: The State does collect the names of patients in order to cross-check death certificates. However, the law guarantees the confidentiality of all participating patients (as well as physicians) and the Oregon Health Authority does not release this information to the public or media. The identity of participating physicians is coded, but the identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed.

Q: Who can give a patient a prescription under the Act?
A: Patients who meet certain criteria can request a prescription for lethal medication from a licensed Oregon physician. The physician must be a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) licensed to practice medicine by the Board of Medical Examiners for the State of Oregon. The physician must also be willing to participate in the Act. Physicians are not required to provide prescriptions to patients and participation is voluntary. Additionally, some health care systems (for example, a Catholic hospital or the Veterans Administration) have prohibitions against practicing the Act that physicians must abide by as terms of their employment.

Q: If a patient's doctor does not participate in the Act, how can s/he get a prescription?
A: The patient must find another M.D. or D.O. licensed to practice medicine in Oregon who is willing to participate. The Oregon Health Authority does not recommend doctors, nor can we provide the names of participating physicians or patients due to the need to protect confidentiality.

Q: If a patient's primary care doctor is located in another state, can that doctor write a prescription for the patient?
A: No. Only M.D.s or D.O.s licensed to practice medicine by the Board of Medical Examiners for the State of Oregon can write a valid prescription for lethal medication under the Act.

Q: How does a patient get a prescription from a participating physician?
A: The patient must meet certain criteria to be able to request to participate in the Act. Then, the following steps must be fulfilled:

1. The patient must make two oral requests to the attending physician, separated by at least 15 days;
2. The patient must provide a written request to the attending physician, signed in the presence of two witnesses, at least one of whom is not related to the patient;
3. The patient must have adequate residency in Oregon, which is defined as: a) being a current resident of Oregon, b) if not, having a current resident of Oregon who can provide proof of current Oregon residency, and c) being willing to move to Oregon.

Q: What is the Oregon Death with Dignity Act (DODA)?
Chapter 127

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

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

127.800 s.1.01. Definitions.

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

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

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

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

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

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

(6) "Health care provider" means a person licensed, certified or otherwise authorized 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)
Letter to editor, New Haven Register

1 message

William Toffler <toffler@ohsu.edu>                                            Sun, Feb 23, 2014 at 7:23 PM
To: "letters@nhregister.com" <letters@nhregister.com>

Dear Editor,

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

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

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

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

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

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

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

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

William L. Toffler MD  
Professor of Family Medicine  
3181 SW Sam Jackson Park Road  
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toffler@ohsu.edu
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 28th, 2012

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

ADDRESS: 35 MAIN ST
Pforoace, MA 01062
EXPIRY OF COMMISSION: JUNE 22, 2016

PLACE SEAL HERE:

[Seal]

AFFIDAVIT OF JOHN NORTON - Page 3
MONTANANS AGAINST ASSISTED SUICIDE & FOR LIVING WITH DIGNITY, a Montana Nonprofit Public Benefit Corporation,

PETITIONER,

vs.

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

RESPONDENT.

STATE OF OREGON ) ) ss.
) ) ss.
COUNTY OF CLACKAMAS )

KENNETH STEVENS, MD, being first duly sworn on oath, deposes and says as follows:

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

2. On December 5, 2011, I submitted a letter to the Board of Medical Examiners, which is attached hereto as Exhibit A.

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

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

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

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

7. I, personally, did not and do not believe in assisted suicide. I also believed that her cancer was treatable and that her prospects were good. She was not, however, interested in treatment. She had made up her mind, but she continued to see me.
8. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated and she is still alive today. Indeed, she is thrilled to be alive. It’s been thirteen years.

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

10. Today, for patients under the Oregon Health Plan (Medicaid), there are also financial incentives to commit suicide. One incentive is that the Plan covers the cost. The Plan’s “Statements of Intent for the April 1, 2012 Prioritized List of Health Services,” states:

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

Attached hereto as Exhibit B, page SI-1.

11. Under the Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient’s treatment. As an example, patients with cancer are denied treatment if they have a “less than 24 months median survival with treatment” and fit other criteria. This is the Plan’s “Guideline Note 12.” (Attached hereto as Exhibit B, page GN-4).

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

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

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

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

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

KENNETH STEVENS, JR., MD

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

SHERI A ACKER
NOTARY PUBLIC FOR THE STATE OF OREGON
RESIDING AT WILSONVILLE, OR
MY COMMISSION EXPIRES 9/3/2014
From: Kenneth Stevens [mailto:kennethstevensjr@gmail.com]
Sent: Monday, December 05, 2011 10:52 PM
To: Marquand, Ian; Connor, Maggie; DLI BSD Medical Examiners; bbddburke@gmail.com
Subject: Physician assisted suicide dangers

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

Dear Montana Medical Examiner Board member:

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

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

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

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


Kenneth R. Stevens, Jr., MD
13680 SW Morgan Rd Sherwood, OR 97140
Professor Emeritus and former Chair, Radiation Oncology Department, Oregon Health & Science University, Portland, Oregon
503 625 5044  503 481 8410
STATEMENTS OF INTENT FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S0453 for classes.
GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)
   b) Suspected Crohn's disease: upper and lower endoscopy, small bowel follow through
   2) Radiological evidence of lack of stricture
   3) Only covered once during any episode of illness
   4) FDA approved devices must be used
   5) Patency capsule should not be used prior to procedure

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES


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

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

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

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

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

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

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

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

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

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


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

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

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

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

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

4-16-2012  Page GN-4  Exhibit B A-54
GUIDELINE NOTES FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

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

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76, 195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

Lines 79, 103, 105, 125, 131, 166, 170, 196, 206, 231, 280, 314

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

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89, 384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1, 3, 4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

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

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108, 279

Ventricular assist devices are covered only in the following circumstances:

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

Ventricular assist devices are not covered for destination therapy.

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

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

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

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

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

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

• Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
• Head and neck cancer when initial MRI or CT is equivocal

4-16-2012
MONTANA FIRST JUDICIAL DISTRICT COURT, 
LEWIS AND CLARK COUNTY

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

vs.

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

STATE OF OREGON 
COUNTY OF Washington 

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

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

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

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

4. This last July, it was 13 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead.

Assisted suicide should not be legal.

FURTHER AFFIANT SAYETH NOT.

Jeanette Hall

Subscribed and sworn to before me this 16th day of October, 2013.

Norma Andrade
Notary Public for the State of Oregon
Residing at Tigard
My Commission Expires August 19, 2016
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
BEFORE THE LEGISLATURE OF THE
STATE OF CALIFORNIA

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...
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 \(\frac{14}{14}\) day of June 2015

Kenneth Stevens, Jr., MD
Sherwood, Oregon
"Choice" Is An Illusion: Arizona Strengthens Its Law Against Assisted Suicide

MONDAY, MAY 5, 2014
Arizona Strengthens Its Law Against Assisted Suicide

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

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

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

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

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

Brewer signed the bill on Wednesday.

Labels: assisted suicide

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

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MARGARET DORE BLOG
Click banner to view blog

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

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

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

By Margaret Dore

On Monday, July 4, 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 caused suicide.[3] The bill’s "Statement of Purpose" says: "This legislation will supersede existing common law and statutory law by confirming that it is illegal to cause or assist in the suicide of another."[4]

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

The legal director’s articles included "Aid in Dying: Law, Geography and Standard of Care in Idaho," published in The Advocate, the official publication of the Idaho State Bar.[6] Responding to letters to the editor that 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]

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[3] Then existing civil law included Cramer v. Slater, 146 Idaho 866, 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.").
A BILL 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.

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

The Associated Press

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

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. Reprinted material must be credited and may not be republished without permission. Links are encouraged.
Byline: Randi Bjornstad The Register-Guard

His mind was keen, his grin infectious. His passions were politics and sports. He read voraciously. His humor was prankish, his wit razor-sharp.

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

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

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

But three months ago, in the throes of a flu that upended a period of relatively good health, Nick Klonoski took his own life. He had just turned 29.

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

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

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

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

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

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

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

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

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

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

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

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

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

http://www.thefreslib.com/ /print/PrintArticle.aspx?id=256637350

A.67
This year our keynote speaker will be Derek Humphry, the author of *Final Exit* and the founder of the Hemlock Society USA in 1980. Derek is generally considered to be the father of the modern movement for choice at the end of life in America.

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

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

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

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**Save the Date!**

Sat., October 22, 2011, 1-3 p.m.
University Unitarian Church
6556 35th Ave NE
Seattle, WA 98115-7393
SPRINGFIELD, Ore. - Barbara Wagner has one wish - for more time.

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

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

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

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

An unfortunate interpretation?

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

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

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

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

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

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

**Health plan hasn't evolved?**

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

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

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

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

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

However, her doctors contacted the pharmaceutical company, Genentech, which agreed to give her the medication without charging her. But doctors told us, that is unusual for a company to give away such an expensive medication.
Barbara Coombs Lee is President of Compassion & Choices, a nonprofit organization dedicated to expanding and protecting the rights of the terminally ill. She practiced as a nurse and physician assistant for 25 years before beginning a career in law and health policy. Since then she has devoted her professional life to individual choice and empowerment in healthcare. As a private attorney, as counsel to the Oregon State Senate, as a managed care executive and finally as Chief Petitioner for Oregon's Death with Dignity Act, she has championed initiatives that enable individuals to consider a full range of choices and be full participants in their healthcare decisions.

Blog Entries by Barbara Coombs Lee

Five States Give Patients Choice
Posted September 27, 2010 | 11:33 AM (EST)

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

Read Post

Medical Society of New York Fights Palliative Care Information Act Despite Mounting Evidence
2 Comments | Posted September 3, 2010 | 04:33 PM (EST)

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

Read Post

New York's Palliative Care Information Act: A Sea Change in End-of-Life Care
2 Comments | Posted August 19, 2010 | 07:01 PM (EST)

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

Read Post

Compassion & Choices Membership: Something to be Proud Of
Posted July 14, 2010 | 03:15 PM (EST)

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

http://www.huffingtonpost.com/barbara-coombs-lee/
Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

Oregon’s suicide rate is 35 percent higher than the national average. The rate is 15.2 suicides per 100,000 people compared to the national rate of 11.3 per 100,000. (*for 2007*)

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

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

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

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

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

The report also included the following findings:

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

*Oregon Health Authority*
Suicides in Oregon
Trends and Risk Factors

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


Oregon suicide report,
issued in September 2010. Data
Executive Summary

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

Key Findings

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

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

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

Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (78.4 per 100,000). White males had the highest suicide rates among all races/ethnicity (28.8 per 100,000). Firearms were the dominant mechanism of suicide among men (62%).

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

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

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

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

Suicide is an important public health problem in Oregon. Each year there are more than 500 Oregonians who die by suicide and more than 1,800 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon with more deaths due to suicide among Oregonians than car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 2006 alone, self-inflicted hospitalization charges exceeded 24 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 570 million dollars. The loss to families and communities broadens the impact of each death.

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

Methods, data sources and limitations

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

Public Health Division

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

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

Excerpt printed 2/9/14
Executive Summary

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

Key Findings

- In 2010, the age-adjusted suicide rate among Oregonians of 17.1 per 100,000 was 41 percent higher than the national average.
- The rate of suicide among Oregonians has been increasing since 2000.
- Suicide rates among adults ages 45-64 rose approximately 50 percent from 18.1 per 100,000 in 2000 to 27.1 per 100,000 in 2010. The rate increased more among women ages 45-64 than among men of the same age during the past 10 years.
- Suicide rates among men ages 65 and older decreased approximately 15 percent from nearly 50 per 100,000 in 2000 to 43 per 100,000 in 2010.
- Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (76.1 per 100,000). Non-Hispanic white males had the highest suicide rate among all races/ethnicity (27.1 per 100,000). Firearms were the dominant mechanism of injury among men who died by suicide (62%).
- Approximately 26 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (44.6 vs. 31.5 per 100,000). Significantly higher suicide rates were identified among male veterans ages 18-24, 35-44 and 45-54 when compared to non-veteran males. Veteran suicide victims were reported to have more physical health problems than non-veteran males.
- Psychological, behavioral, and health problems co-occur and are known to increase suicide risk. Approximately 70 percent of suicide victims had a diagnosed mental disorder, alcohol and/or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, less than one third of male victims and about 60 percent of female victims were receiving treatment for mental health problems at the time of death.
- Eviction/loss of home was a factor associated with 75 deaths by suicide in 2009-2010.
Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars. The loss to families and communities broadens the impact of each death.

“Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors”. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

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Sensationalizing a sad case cheats the public of sound debate

Posted by rattig November 29, 2008 19:30PM

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

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

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

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

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

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

Was it true that Ms. Wagner was harmed in any manner? Or that Tarceva was an efficacious option?

http://blog.oregonlive.com/opinion_impact/2008/11/sensationalizing_a_sad_case_ch/print.html
Ms. Wagner received Tarceva, anyway, when the drug's manufacturer, Genentech, responding to the media firestorm and provided it at no cost. News stories never mentioned that when Wagner bet on the remote chance to prolong life, she probably turned her back on hospice care, widely recognized as the gold standard for end-of-life care. Sadly, it turned out Tarceva didn't help Wagner and she lived only a short time after starting the drug.

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

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

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

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

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

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

Coomb Lee is president of the group Compassion & Choices.

Categories:

Comments

LetDocDecide says...

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

http://blog.oregonlive.com/opinion_impact/2008/11/sensationalizing_a_sad_case_ch/print.html
While it is easy to armchair quarterback the appropriateness of health care treatments, You can be the one that tells my 8 and 10 year old sons that their mother should not receive Tarceva because it is an "experimental treatment". The efficacy of all chemotherapy treatments are ALL poor. The first line chemo treatment (carboplatin/Paclitaxel) that my wife received had only a 35% likelihood of a positive response. That was 2 years and 8 months ago and she is still kicking. Her response to Tarceva has been an exceptional one, resulting in a significant reduction of the size and number of tumors in her remaining right lung. After a 3rd line chemo treatment failed 3 months ago, Tarceva is probably the only reason she is spending Christmas day with me and my boys. In fact, I expect that she will continue having a positive response to the Tarceva for at least a couple of months. Anyone with a loved one with a terminal disease would appreciate the added time.

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

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

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

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

Respectfully
Bob

Posted on 12/25/08 at 12:16AM
Footer