Attachments

Margaret Dore Memo

Vote NO on AB 15

Submitted to the

California State Assembly

on

August 18, 2015
SECTION 1. Part 1.85 (commencing with Section 443) is added to Division 1 of the Health and Safety Code, to read:

PART 1.85. End of Life Option Act

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

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

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

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

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

(d) "Attending physician checklist and compliance form" means a form, as described in Section 443.22, identifying each and every requirement that must be fulfilled by an attending physician to be in good faith compliance with this part should the attending physician choose to participate.

(e) "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the individual's manner of communicating, if that person is available.

(f) "Consulting physician" means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease.

(g) "Department" means the State Department of Public Health.

(h) "Health care provider" or "provider of health care" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; any person certified pursuant to Division 2.5 (commencing with Section 1797) of this code; and any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of this code.

(i) "Informed decision" means a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual's life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

(1) The individual's medical diagnosis and prognosis.

(2) The potential risks associated with taking the drug to be prescribed.

(3) The probable result of taking the drug to be prescribed.

(4) The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.

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

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

(k) "Mental health specialist assessment" means one or more consultations between an individual and a mental health specialist for the purpose of determining that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

(l) "Mental health specialist" means a psychiatrist or a licensed psychologist.

(m) "Physician" means a doctor of medicine or osteopathy currently licensed to practice medicine in this state.

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

(o) "Qualified individual" means an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of this part in order to obtain a prescription for a drug to end his or her life.

(p) "Self-administer" means a qualified individual’s affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death.

(q) "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.

443.2. (a) An individual who is an adult with the capacity to make medical decisions and with a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are satisfied:

1. The individual’s attending physician has diagnosed the individual with a terminal disease.

2. The individual has voluntarily expressed the wish to receive a prescription for an aid-in-dying drug.

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

   A. Possession of a California driver license or other identification issued by the State of California.

   B. Registration to vote in California.

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

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

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

5. The individual has the physical and mental ability to self-administer the aid-in-dying drug.

(b) A person shall not be considered a "qualified individual" under the provisions of this part solely because of age or disability.

(c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker.

443.3. (a) An individual seeking to obtain a prescription for an aid-in-dying drug pursuant to this part shall submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. The attending physician shall directly, and not through a designee, receive all three requests required pursuant to this section.

(b) A valid written request for an aid-in-dying drug under subdivision (a) shall meet all of the following conditions:
(1) The request shall be in the form described in Section 443.11.

(2) The request shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug.

(3) The request shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief the individual is all of the following:

(A) An individual who is personally known to them or has provided proof of identity.

(B) An individual who voluntarily signed this request in their presence.

(C) An individual whom they believe to be of sound mind and not under duress, fraud, or undue influence.

(D) Not an individual for whom either of them is the attending physician, consulting physician, or mental health specialist.

(c) Only one of the two witnesses at the time the written request is signed may:

(1) Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual’s estate upon death.

(2) Own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides.

(d) The attending physician, consulting physician, or mental health specialist of the individual shall not be one of the witnesses required pursuant to paragraph (3) of subdivision (b).

443.4. (a) An individual may at any time withdraw or rescind his or her request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual’s mental state.

(b) A prescription for an aid-in-dying drug provided under this part may not be written without the attending physician directly, and not through a designee, offering the individual an opportunity to withdraw or rescind the request.

443.5. (a) Before prescribing an aid-in-dying drug, the attending physician shall do all of the following:

(1) Make the initial determination of all of the following:

(A) (i) Whether the requesting adult has the capacity to make medical decisions.

(ii) If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment.

(iii) If a mental health specialist assessment referral is made, no aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

(B) Whether the requesting adult has a terminal disease.

(C) Whether the requesting adult has voluntarily made the request for an aid-in-dying drug pursuant to Sections 443.2 and 443.3.

(D) Whether the requesting adult is a qualified individual pursuant to subdivision (o) of Section 443.1.

(2) Confirm that the individual is making an informed decision by discussing with him or her all of the following:

(A) His or her medical diagnosis and prognosis.

(B) The potential risks associated with ingesting the requested aid-in-dying drug.

(C) The probable result of ingesting the aid-in-dying drug.

(D) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it.

(E) The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control.
(3) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the provisions of this part.

(4) Confirm that the qualified individual’s request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, except for an interpreter as required pursuant to this part, whether or not the qualified individual is feeling coerced or unduly influenced by another person.

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

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

(B) Not ingesting the aid-in-dying drug in a public place.

(C) Notifying the next of kin of his or her request for an aid-in-dying drug. A qualified individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

(D) Participating in a hospice program.

(E) Maintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.

(6) Inform the individual that he or she may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner.

(7) Offer the individual an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the aid-in-dying drug.

(8) Verify, immediately before writing the prescription for an aid-in-dying drug, that the qualified individual is making an informed decision.

(9) Confirm that all requirements are met and all appropriate steps are carried out in accordance with this part before writing a prescription for an aid-in-dying drug.

(10) Fulfill the record documentation required under Sections 443.8 and 443.19.

(11) Complete the attending physician checklist and compliance form, as described in Section 443.22, include it in the individual’s medical record, and submit it to the State Department of Public Health.

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

(1) Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the qualified individual’s discomfort, if the attending physician meets all of the following criteria:

(A) Is authorized to dispense medicine under California law.

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

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

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

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

443.6. Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician shall perform all of the following:
(a) Examine the individual and his or her relevant medical records.

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

(c) Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision.

(d) If there are indications of a mental disorder, refer the individual for a mental health specialist assessment.

(e) Fulfill the record documentation required under this part.

**443.7.** Upon referral from the attending or consulting physician pursuant to this part, the mental health specialist shall:

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

(b) Determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.

(c) Determine that the individual is not suffering from impaired judgment due to a mental disorder.

(d) Fulfill the record documentation requirements of this part.

**443.8.** All of the following shall be documented in the individual’s medical record:

(a) All oral requests for aid-in-dying drugs.

(b) All written requests for aid-in-dying drugs.

(c) The attending physician’s diagnosis and prognosis, and the determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified individual.

(d) The consulting physician’s diagnosis and prognosis, and verification that the qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified individual.

(e) A report of the outcome and determinations made during a mental health specialist’s assessment, if performed.

(f) The attending physician’s offer to the qualified individual to withdraw or rescind his or her request at the time of the individual’s second oral request.

(g) A note by the attending physician indicating that all requirements under Sections 443.5 and 443.6 have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

**443.9.** (a) Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician shall submit to the State Department of Public Health a copy of the qualifying patient’s written request, the attending physician compliance form, and the consulting physician compliance form.

(b) Within 30 calendar days following the qualified individual’s death from ingesting the aid-in-dying drug, or any other cause, the attending physician shall submit the attending physician followup form to the State Department of Public Health.

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

**443.11.** (a) A request for an aid-in-dying drug as authorized by this part shall be in the following form:

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REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER, I,

................................................................., am an adult of sound mind and a resident of the State of California.

I am suffering from ..................., which my attending physician has determined is in its terminal phase and which has been medically confirmed.
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I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

............... I have informed one or more members of my family of my decision and taken their opinions into consideration.

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

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

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

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Signed:........................................

Dated:...........................................

DECLARATION OF WITNESSES

We declare that the person signing this request:

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

(b) voluntarily signed this request in our presence;

(c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and

(d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

............... Witness 1/Date

............... Witness 2/Date

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

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

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

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

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

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

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

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

X______ Interpreter's signature
(3) An interpreter whose services are provided pursuant to paragraph (2) shall not be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the person’s estate upon death. An interpreter whose services are provided pursuant to paragraph (2) shall meet the standards promulgated by the California Healthcare Interpreting Association or the National Council on Interpreting in Health Care or other standards deemed acceptable by the department for health care providers in California.

443.12. (a) A provision in a contract, will, or other agreement executed on or after January 1, 2016, whether written or oral, to the extent the provision would affect whether a person may make, withdraw, or rescind a request for an aid-in-dying drug is not valid.

(b) An obligation owing under any contract executed on or after January 1, 2016, may not be conditioned or affected by a qualified individual making, withdrawing, or rescinding a request for an aid-in-dying drug.

443.13. (a) (1) The sale, procurement, or issuance of a life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for a policy or plan contract may not be conditioned upon or affected by a person making or rescinding a request for an aid-in-dying drug.

(2) Pursuant to Section 443.18, death resulting from the self-administration of an aid-in-dying drug is not suicide, and therefore health and insurance coverage shall not be exempted on that basis.

(b) Notwithstanding any other law, a qualified individual’s act of self-administering an aid-in-dying drug shall not have an effect upon a life, health, or annuity policy other than that of a natural death from the underlying disease.

(c) An insurance carrier shall not provide any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage. For the purposes of this subdivision, “insurance carrier” means a health care service plan as defined in Section 1345 of this code or a carrier of health insurance as defined in Section 106 of the Insurance Code.

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

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

(c) Notwithstanding any other law, a health care provider shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractural liability, or medical staff action, sanction, or penalty or other liability for participating in this part, including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the act, providing information to an individual regarding this part, and providing a referral to a physician who participates in this part.

(d) (1) A request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of this part shall not provide the sole basis for the appointment of a guardian or conservator.

(2) No actions taken in compliance with the provisions of this part shall constitute or provide the basis for any claim of neglect or elder abuse for any purpose of law.

(e) (1) Participation in activities authorized pursuant to this part shall be voluntary. Notwithstanding Sections 442 to 442.7, inclusive, a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to this part is not required to take any action in support of an individual’s decision under this part.
(2) Notwithstanding any other law, a health care provider is not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate in activities authorized under this part, including, but not limited to, refusing to inform a patient regarding his or her rights under this part, and not referring an individual to a physician who participates in activities authorized under this part.

(3) If a health care provider is unable or unwilling to carry out a qualified individual’s request under this part and the qualified individual transfers care to a new health care provider, the individual may request a copy of his or her medical records pursuant to law.

443.15. (a) Subject to subdivision (b), notwithstanding any other law, a health care provider may prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under this part while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

(b) A health care provider that elects to prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating in activities under this part, as described in subdivision (a), shall first give notice of the policy prohibiting participation under this part to the individual or entity. A health care provider that fails to provide notice to an individual or entity in compliance with this subdivision shall not be entitled to enforce such a policy against that individual or entity.

(c) Subject to compliance with subdivision (b), the prohibiting health care provider may take action, including, but not limited to, the following, as applicable, against any individual or entity that violates this policy:

(1) Loss of privileges, loss of membership, or other action authorized by the bylaws or rules and regulations of the medical staff.

(2) Suspension, loss of employment, or other action authorized by the policies and practices of the prohibiting health care provider.

(3) Termination of any lease or other contract between the prohibiting health care provider and the individual or entity that violates the policy.

(4) Imposition of any other nonmonetary remedy provided for in any lease or contract between the prohibiting health care provider and the individual or entity in violation of the policy.

(d) Nothing in this section shall be construed to prevent, or to allow a prohibiting health care provider to prohibit, any other health care provider, employee, independent contractor, or other person or entity from any of the following:

(1) Participating, or entering into an agreement to participate, in activities under this part, while on premises that are not owned or under the management or direct control of the prohibiting provider or while acting outside the course and scope of the participant’s duties as an employee of, or an independent contractor for, the prohibiting health care provider.

(2) Participating, or entering into an agreement to participate, in activities under this part as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the prohibiting provider.

(e) In taking actions pursuant to subdivision (c), a health care provider shall comply with all procedures required by law, its own policies or procedures, and any contract with the individual or entity in violation of the policy, as applicable.

(f) For purposes of this section:

(1) "Notice" means a separate statement in writing advising of the prohibiting health care provider policy with respect to participating in activities under this part.

(2) "Participating, or entering into an agreement to participate, in activities under this part" means doing or entering into an agreement to do any one or more of the following:

(A) Performing the duties of an attending physician as specified in Section 443.5.
(B) Performing the duties of a consulting physician as specified in Section 443.6.

(C) Performing the duties of a mental health specialist, in the circumstance that a referral to one is made.

(D) Delivering the prescription for, dispensing, or delivering the dispensed aid-in-dying drug pursuant to paragraph (2) of subdivision (b) of, and subdivision (c) of, Section 443.5.

(E) Being present when the qualified individual takes the aid-in-dying drug prescribed pursuant to this part.

(3) "Participating, or entering into an agreement to participate, in activities under this part” does not include doing, or entering into an agreement to do, any of the following:

(A) Diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, or determining whether a patient has the capacity to make decisions.

(B) Providing information to a patient about this part.

(C) Providing a patient, upon the patient’s request, with a referral to another health care provider for the purposes of participating in the activities authorized by this part.

(g) Any action taken by a prohibiting provider pursuant to this section shall not be reportable under Sections 800 to 809.9, inclusive, of the Business and Professions Code. The fact that a health care provider participates in activities under this part shall not be the sole basis for a complaint or report by another health care provider of unprofessional or dishonorable conduct under Sections 800 to 809.9, inclusive, of the Business and Professions Code.

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

**443.16.** (a) A health care provider may not be sanctioned for any of the following:

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

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

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

(b) A health care provider that prohibits activities under this part in accordance with Section 443.15 shall not sanction an individual health care provider for contracting with a qualified individual to engage in activities authorized by this part if the individual health care provider is acting outside of the course and scope of his or her capacity as an employee or independent contractor of the prohibiting health care provider.

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

**443.17.** (a) Knowingly altering or forging a request for an aid-in-dying drug to end an individual’s life without his or her authorization or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug is punishable as a felony if the act is done with the intent or effect of causing the individual’s death.

(b) Knowingly coercing or exerting undue influence on an individual to request an aid-in-dying drug for the purpose of ending his or her life or to destroy a withdrawal or rescission of a request is punishable as a felony.

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

(d) Nothing in this section shall be construed to limit civil liability.

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

**443.18.** Nothing in this part may be construed to authorize a physician or any other person to end an individual’s life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law.
443.19. (a) The State Department of Public Health shall collect and review the information submitted pursuant to Section 443.9. The information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient’s family, and any medical provider or pharmacist involved with the patient under the provisions of this part. The information shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(b) On or before July 1, 2017, and each year thereafter, based on the information collected in the previous year, the department shall report the information collected from the attending physician follow-up form. The report shall include, but not be limited to, all of the following based on the information that is provided to the department and on the department’s access to vital statistics:

(1) The number of people for whom an aid-in-dying prescription was written.

(2) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those individuals.

(3) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death.

(4) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California.

(5) The number of physicians who wrote prescriptions for aid-in-dying drugs.

(6) Of people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:

(A) Age at death.

(B) Education level.

(C) Race.

(D) Sex.

(E) Type of insurance, including whether or not they had insurance.

(F) Underlying illness.

(c) The State Department of Public Health shall make available the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, as described in Section 443.22, by posting them on its Internet Web site.

443.20. A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.

443.21. Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.

443.22. (a) On or before January 1, 2019, the Medical Board of California shall develop, revise, and update an attending physician checklist and compliance form, a consulting physician compliance form, and an attending physician followup form, based on those provided in subdivision (b). Upon completion, the State Department of Public Health shall publish the updated forms on its Internet Web Site.

(b) Until the Medical Board of California develops and revises forms pursuant to subdivision (a), or January 1, 2019, whichever is later, the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form shall be in the following form:

PRINTER PLEASE NOTE: TIP-IN MATERIAL TO BE INSERTED

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section 443.19 to the Health
and Safety Code, imposes a limitation on the public’s right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

(a) Any limitation to public access to personally identifiable patient data collected pursuant to Section 443.19 of the Health and Safety Code as proposed to be added by this act is necessary to protect the privacy rights of the patient and his or her family.

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

(c) The statistical report to be made available to the public pursuant to subdivision (b) of Section 443.19 of the Health and Safety Code is sufficient to satisfy the public’s right to access.

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

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
Opinion 2.21 - Euthanasia

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

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

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

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

Terminal Uncertainty

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

By Nina Shapiro

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.
MONDAY, MAY 5, 2014

**Arizona Strengthens its Law Against Assisted Suicide**

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

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

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

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

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

Brewer signed the bill on Wednesday.
Mondaj, July 4, 2011

Idaho Strengthens Law Against Assisted-Suicide

By Margaret Dore

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

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

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

The legal director's articles included "Aid in Dying: Law, Geography and Standard of Care in Idaho," published in The Advocate, the official publication of the Idaho State Bar.[6] Responding to the editor, the new law was codified as Idaho Code Ann. Section 18-4017 and go into effect on July 1, 2011.[7]

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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Homicide; offering to assist in commission of suicide; repeal certain provisions

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Committees

HC: Judiciary Non-Civil
SC: Judiciary

First Reader Summary

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

Status History

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

The Associated Press

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

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

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

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http://www.houmatoday.com/article/20120424/WIRE/120429820
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 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.

Contributing writer Kathryn Alfisi can be reached at kalfisi@mac.com.

Notes
Two Elderly Women Arrested for Insurance Fraud

Los Angeles: The Los Angeles Police Department is asking the public's help in finding persons who may have been contacted by either of two women suspected in running a life insurance scam over the past several years. The women are 75-year-old Helen Golay and 73-year-old Olga Rutterschmidt. Both women were arrested today on federal mail fraud charges.

"These women tend to target homeless men," said LAPD Commander Harlan Ward. "They offer room and board in return for the man's signature, then open life insurance policies on the man, making themselves the beneficiaries."

Los Angeles police traffic investigators discovered the scam during the investigation of a fatal hit and run last year. One investigator casually mentioned in the squad room how unusual it was that two women had taken out large life insurance policies on a hit-and-run victim, 50-year-old Kenneth McDavid. Another investigator recalled having a similar case in 1999. When they compared notes, they found the beneficiaries in both cases were Golay and Rutterschmidt, and the hit-and-run victims were both homeless men.

The death investigations of both men, McDavid and Paul Vados, 73, were re-opened and assigned to Robbery Homicide Division. Investigators formed a task force involving the FBI, the United States Attorney's Office, the California Department of Insurance, the United States Postal Inspection Service, and the Los Angeles County District Attorney.

"The investigation brought us to this point today," said lead LAPD investigator Dennis Kilcoyne. "While we continue to investigate the deaths of these two men, we had to put a stop to the women's activity. We've watched them make contact with other men, we believe, for the purposes of setting up more life insurance policies."

Armed with federal search warrants and a criminal complaint, FBI special agents, Los Angeles police detectives, state insurance investigators, and postal inspectors searched 2 locations this morning. Rutterschmidt was arrested at her home at 1776 N. Sycamore Avenue in Hollywood, and Golay was arrested at the triplex she owns at 424 Ocean Park Boulevard, Santa Monica.
Both women were arraigned in a downtown federal court this afternoon.

Special agents from the FBI froze Golay and Rutterschmidt’s assets. Investigators estimated that the women had collected over $2.2 million in life insurance pay outs.

"Given the scope of this fraud and the fact that it may be more extensive, the FBI will continue to provide the necessary resources, either in Los Angeles or around the country, to this joint investigation," said J. Stephan Tidwell, who is the Assistant Director of the FBI in Los Angeles. "All of us in law enforcement share the common goals of providing justice to the victims and securing the integrity of the insurance system."

Sixteen policies had been taken out on Kenneth McDavid and three on Paul Vados.

"These two women appeared to be preying and profiting on the most vulnerable persons in our society," said State Insurance Commissioner John Garamendi. "The residents of California are also victims in these kinds of schemes through the higher premiums they pay. I am committed to prosecuting this type of fraud, and others like it, to the fullest extent."

Since the insurance forms are sent through the US Postal Service, the United States Postal Inspection Service was brought into the investigation.

"As members of the federal law enforcement community, the U.S. Postal Inspection Service is committed to cooperation between agencies in achieving our ultimate goal, to protect the American public from criminal attack," said Keith Tyner, Assistant Postal Inspector in Charge. Postal Inspectors aggressively investigate those who misuse our nation’s mail system to carry out their fraudulent schemes."

Detectives believe the women would trade room and board for as long as two years. Detectives found the store at which Rutterschmidt would order signature stamps of their targets’ signatures. Detectives believe the women used the rubber signature stamps to complete insurance forms.

According to state law, once a life insurance policy has been in force for 2 years and a day, the insurance company has a more difficult time contesting any apparent fraud in the opening of the policy.

Anyone with information in this case is asked to call Detectives Dennis Kilcoyne or Rosemary Sanchez at 213-485-2129. On weekends and during off-hours, call the 24-hour toll free number at 1-877-LAWFULL (529-3855), or the FBI’s hotline number at 310-477-6565.

May 19, 2006 | Permalink

Comments

Hi,
I think this is a great effort to improve communication between the police and the community and an excellent use of technology. Perhaps more of this mode of progressive forward thinking can be applied to other areas of policework.

Well done.

Posted by: Bobby | May 19, 2006 at 06:00 PM
This seems to be very common. In New York City I had a similar case years ago. They targeted homeless men that were "accident prone". Insured them using "key man" insurance in a non-existent company. One victim was struck by a City Bus and the insurance company paid one million dollars, no questions asked.

Posted by: Paul Caltabiano | May 20, 2006 at 05:38 AM
Just a comment, this blog is a great idea. I hope that you are successful with this campaign. Gets the public involved and returns that feeling of safety to "Joe Public." Good Job, keep it up. I hope every other department across America takes a page from your book, again great job.

Posted by: William Waters | May 20, 2006 at 11:58 AM
This is great!! Why are there not more of these?? Maybe there should be more of these on Friday and Saturdays nights. Maybe...
RCW 70.245.180

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), and70.245.200 (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:
   a. Suicide
   b. Assisted suicide
   c. Physician-assisted suicide
   d. Death with Dignity
   e. I-1000
   f. Mercy killing
   g. Euthanasia
   h. Secobarbital or Seconal
   i. Pentobarbital or Nembutal

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

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

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

Revised April 8, 2009
Chapter 127

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

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

127.800 s.1.01. Definitions.

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

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

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

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

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

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

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

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

(a) His or her medical diagnosis;

(b) His or her prognosis;

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

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

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

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

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

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

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

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 s.1.01; 1999 c.423 s.1]

Written Request for Medication to End One's Life in a Humane and Dignified Manner

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.
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 these 24 patients, both death and ingestion status are pending (Figure 2).

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

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

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

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

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

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

A procedure revision was made in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 20 of the 105 DWDA deaths during 2014. Among those 20 patients, time from ingestion until death ranged from eleven minutes to one hour.

- Eighty-three physicians wrote 155 prescriptions during 2014 (1-12 prescriptions per physician).
- During 2014, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

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

- 155 people had prescriptions written during 2014
- 11 people with prescriptions written in previous years ingested medication during 2014
- 94 ingested medication
- 37 did not ingest medication and subsequently died from other causes
- 24 ingestion and death status unknown
- 105 ingested medication
- 105 died from ingesting medication
- 0 regained consciousness after ingesting medication; died of underlying illness
- 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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (%)</td>
<td>56 (53.3)</td>
<td>397 (52.7)</td>
<td>453 (52.7)</td>
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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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<tr>
<td><strong>Age at death (years)</strong></td>
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<td></td>
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<tr>
<td>18-34 (%)</td>
<td>1 (1.0)</td>
<td>6 (0.8)</td>
<td>7 (0.8)</td>
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<td>35-44 (%)</td>
<td>2 (1.9)</td>
<td>16 (2.1)</td>
<td>18 (2.1)</td>
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<td>45-54 (%)</td>
<td>3 (2.9)</td>
<td>58 (7.7)</td>
<td>61 (7.1)</td>
</tr>
<tr>
<td>55-64 (%)</td>
<td>28 (26.7)</td>
<td>156 (20.7)</td>
<td>184 (21.4)</td>
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<tr>
<td>65-74 (%)</td>
<td>29 (27.6)</td>
<td>218 (28.9)</td>
<td>247 (28.8)</td>
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<tr>
<td>75-84 (%)</td>
<td>23 (21.9)</td>
<td>206 (27.3)</td>
<td>229 (26.7)</td>
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<td>85+ (%)</td>
<td>19 (18.1)</td>
<td>94 (12.5)</td>
<td>113 (13.2)</td>
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<td><strong>Median years (range)</strong></td>
<td>72 (29-96)</td>
<td>71 (25-96)</td>
<td>71 (25-96)</td>
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<tr>
<td><strong>Race</strong></td>
<td></td>
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<td></td>
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<tr>
<td>White (%)</td>
<td>100 (95.2)</td>
<td>731 (97.3)</td>
<td>831 (97.1)</td>
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<tr>
<td>African American (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
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<td>American Indian (%)</td>
<td>0 (0.0)</td>
<td>2 (0.3)</td>
<td>2 (0.2)</td>
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<td>Asian (%)</td>
<td>1 (1.0)</td>
<td>8 (1.1)</td>
<td>9 (1.1)</td>
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<tr>
<td>Pacific Islander (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
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<tr>
<td>Other (%)</td>
<td>2 (1.9)</td>
<td>1 (0.1)</td>
<td>3 (0.4)</td>
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<tr>
<td>Two or more races (%)</td>
<td>1 (1.0)</td>
<td>2 (0.3)</td>
<td>3 (0.4)</td>
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<td>Hispanic (%)</td>
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<td><strong>Marital Status</strong></td>
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<tr>
<td>Married (%)</td>
<td>48 (45.7)</td>
<td>347 (46.2)</td>
<td>395 (46.1)</td>
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<tr>
<td>Widowed (%)</td>
<td>26 (24.8)</td>
<td>172 (22.9)</td>
<td>198 (23.1)</td>
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<tr>
<td>Never married (%)</td>
<td>6 (5.7)</td>
<td>63 (8.4)</td>
<td>69 (8.1)</td>
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<td>Divorced (%)</td>
<td>25 (23.8)</td>
<td>169 (22.5)</td>
<td>194 (22.7)</td>
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<td>Unknown</td>
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<tr>
<td><strong>Education</strong></td>
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<tr>
<td>Less than high school (%)</td>
<td>6 (5.7)</td>
<td>45 (6.0)</td>
<td>51 (6.0)</td>
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<td>High school graduate (%)</td>
<td>23 (21.9)</td>
<td>164 (21.9)</td>
<td>187 (21.9)</td>
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<tr>
<td>Some college (%)</td>
<td>26 (24.8)</td>
<td>198 (26.4)</td>
<td>224 (26.2)</td>
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<tr>
<td>Baccalaureate or higher (%)</td>
<td>50 (47.6)</td>
<td>342 (45.7)</td>
<td>392 (45.9)</td>
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<td>Unknown</td>
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<tr>
<td><strong>Residence</strong></td>
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<tr>
<td>Metro counties (%)</td>
<td>46 (44.7)</td>
<td>315 (41.9)</td>
<td>361 (42.3)</td>
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<tr>
<td>Coastal counties (%)</td>
<td>6 (5.8)</td>
<td>57 (7.6)</td>
<td>63 (7.4)</td>
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<tr>
<td>Other western counties (%)</td>
<td>40 (38.8)</td>
<td>325 (43.3)</td>
<td>365 (42.7)</td>
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<tr>
<td>East of the Cascades (%)</td>
<td>11 (10.7)</td>
<td>54 (7.2)</td>
<td>65 (7.6)</td>
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<tr>
<td>Unknown</td>
<td>2</td>
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<td>5</td>
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<tr>
<td><strong>End of life care</strong></td>
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<tr>
<td>Hospice</td>
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<tr>
<td>Enrolled (%)</td>
<td>93 (93.0)</td>
<td>654 (90.0)</td>
<td>747 (90.3)</td>
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<tr>
<td>Not enrolled (%)</td>
<td>7 (7.0)</td>
<td>73 (10.0)</td>
<td>80 (9.7)</td>
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<td>Unknown</td>
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<td>Insurance</td>
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<td>Private (%)</td>
<td>37 (39.8)</td>
<td>452 (62.9)</td>
<td>489 (60.2)</td>
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<td>Medicare, Medicaid or Other Governmental</td>
<td>56 (60.2)</td>
<td>255 (35.5)</td>
<td>311 (38.3)</td>
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<td>None (%)</td>
<td>0 (0.0)</td>
<td>12 (1.7)</td>
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<td>47</td>
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<td>Characteristics</td>
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<td>1998-2013 (N=754)</td>
<td>Total (N=859)</td>
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<tr>
<td>-------------------------------------</td>
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<tr>
<td><strong>Underlying illness</strong></td>
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<tr>
<td>Malignant neoplasms (%)</td>
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<td></td>
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<tr>
<td>Lung and bronchus (%)</td>
<td>16 (15.2)</td>
<td>139 (18.5)</td>
<td>155 (18.1)</td>
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<tr>
<td>Breast (%)</td>
<td>7 (6.7)</td>
<td>57 (7.6)</td>
<td>64 (7.5)</td>
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<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>
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<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>
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<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>
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<tr>
<td>HIV/AIDS (%)</td>
<td>0 (0.0)</td>
<td>9 (1.2)</td>
<td>9 (1.1)</td>
</tr>
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<td>Other Illnesses (%)</td>
<td>9 (8.6)</td>
<td>44 (5.9)</td>
<td>53 (6.2)</td>
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<tr>
<td><strong>DWDA process</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>3 (2.9)</td>
<td>44 (5.9)</td>
<td>47 (5.5)</td>
</tr>
<tr>
<td>Patient informed family of decision (%)</td>
<td>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 care facility (%)</td>
<td>8 (7.6)</td>
<td>29 (3.9)</td>
<td>37 (4.3)</td>
</tr>
<tr>
<td>Hospital (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>3 (2.9)</td>
<td>5 (0.7)</td>
<td>8 (0.9)</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Lethal medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secobarbital (%)</td>
<td>63 (60.0)</td>
<td>403 (53.4)</td>
<td>466 (54.2)</td>
</tr>
<tr>
<td>Pentobarbital (%)</td>
<td>41 (39.0)</td>
<td>344 (45.6)</td>
<td>385 (44.8)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>1 (1.0)</td>
<td>7 (0.9)</td>
<td>8 (0.9)</td>
</tr>
<tr>
<td><strong>End of life concerns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Losing autonomy (%)</td>
<td>96 (91.4)</td>
<td>686 (91.5)</td>
<td>782 (91.5)</td>
</tr>
<tr>
<td>Less able to engage in activities making life enjoyable (%)</td>
<td>91 (86.7)</td>
<td>667 (88.9)</td>
<td>758 (88.7)</td>
</tr>
<tr>
<td>Loss of dignity (%)</td>
<td>75 (71.4)</td>
<td>504 (80.6)</td>
<td>579 (79.3)</td>
</tr>
<tr>
<td>Losing control of bodily functions (%)</td>
<td>52 (49.5)</td>
<td>376 (50.1)</td>
<td>428 (50.1)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>42 (40.0)</td>
<td>300 (40.0)</td>
<td>342 (40.0)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it (%)</td>
<td>33 (31.4)</td>
<td>178 (23.7)</td>
<td>211 (24.7)</td>
</tr>
<tr>
<td>Financial implications of treatment (%)</td>
<td>5 (4.8)</td>
<td>22 (2.9)</td>
<td>27 (3.2)</td>
</tr>
<tr>
<td><strong>Health-care provider present</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When medication was ingested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician</td>
<td>14</td>
<td>119</td>
<td>133</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
<td>6</td>
<td>238</td>
<td>244</td>
</tr>
<tr>
<td>No provider</td>
<td>4</td>
<td>76</td>
<td>80</td>
</tr>
<tr>
<td>Unknown</td>
<td>81</td>
<td>251</td>
<td>332</td>
</tr>
<tr>
<td>At time of death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing physician</td>
<td>14 (13.9)</td>
<td>107 (15.9)</td>
<td>121 (15.7)</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
<td>6 (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>
<tr>
<td><strong>Complications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regurgitated</td>
<td>0</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Seizures</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
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</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**

Regained consciousness after ingesting DWDA medications | 0 | 6 | 6

[Link to the full report](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf)
### Characteristics

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

---

<sup>1</sup> Unknowns are excluded when calculating percentages.

<sup>2</sup> Includes Oregon Registered Domestic Partnerships.

<sup>3</sup> Clackamas, Multnomah, and Washington counties.

<sup>4</sup> Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.

<sup>5</sup> Private insurance category includes those with private insurance alone or in combination with other insurance.

<sup>6</sup> 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.

<sup>7</sup> 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.

<sup>8</sup> Other includes combinations of secobarbital, pentobarbital, phenobarbital, and/or morphine.

<sup>9</sup> Affirmative answers only (“Don’t know” included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

<sup>10</sup> First asked in 2003. Data available for all 105 patients in 2014, 625 patients between 1998-2013, and 730 patients for all years.

<sup>11</sup> 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.

<sup>12</sup> 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.

<sup>13</sup> 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.

<sup>14</sup> Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.
Dear Editor,

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

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

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

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

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

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

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

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

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
503-494-5322
503-494-8573 (patient care)
503-494-4496 (fax)
toffler@ohsu.edu
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 15th, 2012

NAME: Heidi Pruzyinski

A notary in and for the
State of Washington, MASSACHUSETTS

ADDRESS: 85 Main St
Plymouth MA 02362

EXPIRY OF COMMISSION: June 22, 2016

PLACE SEAL HERE:
STATE OF OREGON

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.

/\ See attached signature page \/
KENNETH STEVENS, JR., MD.

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

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

KENNETH STEVENS, JR., MD.

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

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

OFFICIAL SEAL
SHERI A ACKER
NOTARY PUBLIC - OREGON
COMMISSION NO. 451866
MY COMMISSION EXPIRES SEPTEMBER 03, 2014
From: Kenneth Stevens [mailto:kennethstevensjr@gmail.com]
Sent: Monday, December 05, 2011 10:52 PM
To: Merquand, Ian; Connor, Maggie; DLI BSO 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 6% 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 a 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 psychological 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, without regard to a patient’s expected length of life:

A) Inpatient palliative care consultation and:
   - Outpatient palliative care consultation, office visits.
   - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.
   - Hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

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.
   - With an expected median survival of six months or less, as supported by peer-reviewed literature.

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, 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 pertain with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 98407 for individual counseling and 98453 for classes.
GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

Central serous retinopathy (362.41) is included on this line only for treatment when the condition has been present for 3 months or longer. Pars planitis (383.21) should only be treated in patients with 20/40 or worse vision.

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES


A) CSF are not indicated for primary prophylaxis of febrile neutropenia unless the primary chemotherapeutic regimen is known to produce febrile neutropenia at least 20% of the time. CSF should be considered when the primary chemotherapeutic regimen is known to produce febrile neutropenia 10-20% of the time; however, if the risk is due to the chemotherapy regimen, other alternatives such as the use of less myelosuppressive chemotherapy or dose reduction should be explored in this situation.
B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.
C) CSF are not indicated in patients who are acutely neutropenic but afebrile.
D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <1000/ml, 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

Lines 102,103,123-125,144,159,165,166,170,181,197,198,206-208,216,220,221,228,229,231,243,249,252,275-278,293,297,299,310-312,320,339-341,356,459,586,622

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

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

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

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

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

4-16-2012

Appendix, Tab 6, Affidavit of Kenneth Stevens, MD
Page 9 of 10
GUIDELINE NOTES FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

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

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76, 195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

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

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

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89, 384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1, 3, 4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

Dental 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, 330

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
AFFIDAVIT OF JEANETTE HALL
OPPOSING ASSISTED SUICIDE

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

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

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

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

Dated this 17th day of August 2012

Jeanette Hall

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

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

ADDRESS: 15105 SW 112th Ave, Beaverton, OR 97007
EXPIRY OF COMMISSION: September 28, 2012
PLACE SEAL HERE:

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

Affidavit of Jeanette Hall - Page 2

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Planning for old age at a premium

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

Jerry Large
Seattle Times staff columnist
Monday, I suggested exploring long-term health insurance as a way to deal with the cost of assisted living.

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

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

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

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

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

The only certainty is that nothing is universally true.

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

After Monday’s column, some readers were unsympathetic, a few suggested that if you couldn’t save enough money to see you through your old age, you shouldn’t expect society to bail you out.

At least a couple mentioned euthanasia as a solution.

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

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

If you are somewhere in the middle, you may want what the rich have, but be able to afford only what the poor get — and only until your money runs out, and then Medicaid will step in.

Insurance for long-term care is supposed to provide some security for people who are not quite...
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 14th day of June 2015

Kenneth Stevens, Jr., MD
Sherwood, Oregon
§ 15610.70. Undue influence

(a) "Undue influence" means excessive persuasion that causes another person to act or refrain from acting by overcoming that person's free will and results in inequity. In determining whether a result was produced by undue influence, all of the following shall be considered:

1. The vulnerability of the victim. Evidence of vulnerability may include, but is not limited to, incapacity, illness, disability, injury, age, education, impaired cognitive function, emotional distress, isolation, or dependency, and whether the influencer knew or should have known of the alleged victim's vulnerability.

2. The influencer's apparent authority. Evidence of apparent authority may include, but is not limited to, status as a fiduciary, family member, care provider, health care professional, legal professional, spiritual adviser, expert, or other qualification.

3. The actions or tactics used by the influencer. Evidence of actions or tactics used may include, but is not limited to, all of the following:

   A. Controlling necessaries of life, medication, the victim's interactions with others, access to information, or sleep.

   B. Use of affection, intimidation, or coercion.

   C. Initiation of changes in personal or property rights, use of haste or secrecy in effecting those changes, effecting changes at inappropriate times and places, and claims of expertise in effecting changes.

4. The equity of the result. Evidence of the equity of the result may include, but is not limited to, the economic consequences to the victim, any divergence from the victim's prior intent or course of conduct or dealing, the relationship of the value conveyed to the value of any services or consideration received, or the appropriateness of the change in light of the length and nature of the relationship.

(b) Evidence of an inequitable result, without more, is not sufficient to prove undue influence.

CREDIT(S)

(Added by Stats.2013, c. 668 (A.B.140), § 3.)
Original article

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

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Abstract

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

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

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

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

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1. Introduction

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

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 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.
NEWS RELEASE

Date: Sept. 9, 2010

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

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

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

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

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

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

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

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

The report also included the following findings:

- There was a marked increase in suicides among middle-aged women. The number of women between 45 and 64 years of age who died from suicide rose 55 percent between 2000 and 2006 — from 8.2 per 100,000 to 12.8 per 100,000 respectively.
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 any other cause. Suicide is the second leading cause of death among Oregonians ages 13-34, 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 1991 to 2007 and 2003 to 2007 data of Oregon Violent Death Reporting System (ORVDRS). This report presents main findings of suicide trends and risk factors in Oregon.

Key Findings

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

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

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

Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (28.6 per 100,000). White males had the highest suicide rates among all races/ethnicity (25.6 per 100,000). Firearms were the dominant mechanism of suicide among men (53%).

Approximately 27 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (43.7 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

Sukeide is an important public health problem in Oregon. Each year there are more than 550 Oregonians who died by suicide, and over 700 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon. It is also the leading cause of death among Oregonians aged 15-34, and the 28th leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 2006 alone, self-inflicted hospitalization charges exceeded $4,000 million dollars, and the estimated total lifetime cost of suicide in Oregon was over $70 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 behavior include biological, psychological, and social factors." This report provides the most current suicide statistics in Oregon, and it is based on the current suicide prevention programs and plans. It is a detailed description of suicide, examines risk factors associated with suicide, and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Methods, data sources and limitations

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


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

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

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

Key Findings

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

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

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

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

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

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

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

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

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 3rd 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 580 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.