Attachments

Margaret Dore Memo

“NO” on H.1991

Submitted to the

Joint Committee on Public Health
The Commonwealth of Massachusetts

In the One Hundred and Eighty-Ninth General Court
(2015-2016)

An Act affirming a terminally ill patient’s right to compassionate aid in dying.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 Section 1: The General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after Chapter 201F the following new chapter:-

3 CHAPTER 201G

4 MASSACHUSETTS COMPASSIONATE CARE FOR THE TERMINALLY ILL ACT

5 Section 1. Definitions.

6 The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

8 “Adult” means an individual who is 18 years of age or older.
“Aid in Dying” means the medical practice of a physician prescribing lawful medication to a qualified patient, which the patient may choose to self-administer to bring about a humane and dignified death.

“Attending physician” means the physician who has primary responsibility for the care of a terminally ill patient.

“Capable” means having the capacity to make informed, complex health care decisions; understand the consequences of those decisions; and to communicate them to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.

“Consulting physician” means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a terminally ill patient’s condition.

“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.

“Guardian” means a person who has qualified as a guardian of an incapacitated person pursuant to court appointment and includes a limited guardian, special guardian and temporary guardian, but excludes one who is merely a Guardian ad litem (as defined in Chapter 190B, Article V, Section 5-101). Guardianship does not include a Health Care Proxy (as defined by Chapter 201D of the Massachusetts General Laws).
“Health care provider” means a person licensed, certified, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.

“Incapacitated person” means an individual who for reasons other than advanced age or minor, has a clinically diagnosed condition that results in an inability to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance. This term shall follow as described by Chapter 190B, Article V, Section 5-101).

“Informed decision” means a decision by a qualified patient to request and obtain a prescription for medication pursuant to this chapter 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:

(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 or additional treatment opportunities, including but not limited to palliative care as defined in Ch. 111 § 227.
“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.

“Palliative care” means a health care treatment as defined in palliative care as defined in Ch. 111 § 227, including interdisciplinary end-of-life care and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient’s quality of life, including hospice.”

“Patient” means an individual who has received health care services from a health care provider for treatment of a medical condition.

“Physician” means a doctor of medicine or osteopathy licensed to practice medicine in Massachusetts by the board of registration in medicine.

“Qualified patient” means a capable adult who is a resident of Massachusetts, has been diagnosed as being terminally ill, and has satisfied the requirements of this chapter.

“Resident” means an individual who demonstrates residency in Massachusetts by means that include but are not limited to:

(a) Possession of a Massachusetts driver’s license;

(b) Proof of registration to vote in Massachusetts;

(c) Proof that the individual owns or leases real property in Massachusetts;

(d) Proof that the individual has resided in a Massachusetts health care facility for at least 3 months;
(e) Computer-generated bill from a bank or mortgage company, utility company, doctor, or hospital;

(f) A W-2 form, property or excise tax bill, or Social Security Administration or other pension or retirement annual benefits summary statement dated within the current or prior year;

(g) A Medicaid or Medicare benefit statement; or

(h) Filing of a Massachusetts tax return for the most recent tax year;

"Self-administer" means a qualified patient's act of ingesting medication obtained pursuant to this chapter.

"Terminally ill" means having a terminal illness or condition which can reasonably be expected to cause death within 6 months, whether or not treatment is provided.

Section 2. Terminally ill patient's right to request aid in dying and obtain prescription for medication pursuant to this chapter.

(1) A terminally ill patient may request aid in dying and a prescription for medication they can chose to self-administer if the patient:

(a) is a competent adult;

(b) is a resident of Massachusetts;

(c) has been determined by the patient's attending physician and by a consulting physician to be terminally ill; and
has voluntarily expressed the wish to receive medication which the patient may choose to self-administer to bring about a humane and dignified death.

(2) A person may not qualify under this chapter if they have a guardian.

(3) A person may not qualify under this chapter solely because of age or disability.

Section 3. Form of the written request. Request process -- witness requirements.

(1) A patient wishing to receive a prescription for medication pursuant to this chapter shall submit a written request to the patient's attending physician in substantially the form set form in Section 4.

(2) A valid written request must be witnessed by at least two individuals who, in the presence of the patient, attests that to the best of their knowledge and belief that patient is:

(a) competent;
(b) acting voluntarily; and
(c) not being coerced to sign the request.

(3) At least one of the witnesses shall be a person who is not:

(a) a relative of the patient by blood, marriage, or adoption;
(b) a person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; and
(c) an owner, operator, or employee of a health care facility where the qualified patient is
receiving medical treatment or is a resident.

(4) The patient's attending physician at the time the request is signed shall not serve as a witness.

(5) If the patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility.

Section 4. Form of Written Request and Witness Declaration.

REQUEST FOR MEDICATION PURSUANT TO THE MASSACHUSETTS COMPASSIONATE CARE FOR THE TERMINALLY ILL ACT

I, . . . . . . . . . . . . . . , am an adult of sound mind and a resident of the State of Massachusetts. I am suffering from . . . . . . . . . . . , which my attending physician has determined is a terminal illness or condition which can reasonably be expected to cause death within 6 months. This diagnosis has been medically confirmed as required by law.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control.

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

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

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

I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time. I understand the full import of this request and I expect to die if and when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility. I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

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

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

DECLARATION OF WITNESSES

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

Witness 1

Witness 2

Initials

Initials

1. Is personally known to us or has provided proof of identity;

2. Signed this request in our presence on the date of the person's signature;

3. Appears to be of sound mind and not under duress, fraud, or undue influence; and

4. Is not a patient for whom either of us is the attending physician.

Printed Name of Witness 1: ..............
Section 5. Right to rescind request -- requirement to offer opportunity to rescind.

(1) A qualified patient may at any time rescind the qualified patient's request for medication.

(2) A prescription for medication under this chapter may not be written without the attending physician offering the patient an opportunity to rescind the request for medication.

Section 6. Attending physician responsibilities.

(1) The attending physician shall:

(a) make the initial determination of whether an adult patient:

(i) is a resident of this state;

(ii) is terminally ill;

(iii) is competent; and

(iv) has voluntarily made the request for aid in dying.

(b) ensure that the patient is making an informed decision by discussing with the patient:

(i) his or her medical diagnosis;

(ii) his or her prognosis;
(iii) the potential risks associated with taking the medication to be prescribed;

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

(v) the feasible alternatives or additional treatment opportunities, including but not

limited to palliative care as defined in Ch. 111 § 227.

(c) refer the patient to a consulting physician to medically confirm the diagnosis and

prognosis and for a determination that the patient is competent and is acting voluntarily;

(d) refer the patient for counseling pursuant to section 8;

(e) recommend that the patient notify the patient's next of kin;

(f) counsel the patient about the importance of:

(i) having another person present when the patient takes the medication prescribed

pursuant to this chapter; and

(ii) not taking the medication in a public place;

(h) inform the patient that the patient may rescind the request for medication at any time

and in any manner;

(i) verify, immediately prior to writing the prescription for medication, that the patient is

making an informed decision;

(j) fulfill the medical record documentation requirements of section 14;

(k) ensure that all appropriate steps are carried out in accordance with this chapter before
writing a prescription for medication for a qualified patient; and

(l) (i) dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under law to dispense and has a current drug enforcement administration certificate; or

(ii) with the qualified patient's written consent:

(A) contact a pharmacist, inform the pharmacist of the prescription, and

(B) deliver the written prescription personally, by mail, or by otherwise permissible electronic communication to the pharmacist, who will dispense the medications directly to either the patient, the attending physician, or an expressly identified agent of the patient. Medications dispensed pursuant to this paragraph (l) shall not be dispensed by mail or other form of courier.

(2) The attending physician may sign the patient's death certificate which shall state, "Self-administered due to a terminal diagnosis of (the underlying terminal disease)," as the cause of death.

Section 7. Consulting physician confirmation.

(1) Before a patient may be considered a qualified patient under this chapter the consulting physician shall:

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

(b) confirm in writing the attending physician's diagnosis that the patient is suffering from a terminal illness; and
(c) verify that the patient:

(i) is capable;

(ii) is acting voluntarily; and

(iii) has made an informed decision.

Section 8. Counseling referral.

(1) An attending physician shall refer a patient who has requested medication under this chapter to determine that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. The counselor must submit a final written report to the prescribing physician.

(2) The medication may not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

Section 9. Informed decision required.

A qualified patient may not receive a prescription for medication pursuant to this chapter unless the patient has made an informed decision as defined in section 1. Immediately before writing a prescription for medication under this chapter the attending physician shall verify that the qualified patient is making an informed decision.

Section 10. Family notification recommended -- not required.
The attending physician shall recommend that a patient notify the patient's next of kin of the patient's request for medication pursuant to this chapter. A request for medication under shall not be denied because a patient declines or is unable to notify the next of kin.

Section 11. Right to rescind request -- requirement to offer opportunity to rescind.

(1) A qualified patient may at any time rescind the request for medication pursuant to this chapter without regard to the qualified patient's mental state.

(2) A prescription for medication pursuant to this chapter may not be written without the attending physician offering the qualified patient an opportunity to rescind the request for medication.

Section 12. Medical record documentation requirements.

The following items must be documented or filed in the patient's medical record:

(1) the determination and the basis for determining that a patient requesting medication pursuant to this chapter is a qualified patient;

(2) all oral requests by a patient for medication;

(3) all written requests by a patient for medication made pursuant to sections 3 through 5;

(4) the attending physician's diagnosis, prognosis, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;

(5) unless waived as provided in section 8, the consulting physician's diagnosis, prognosis, and verification that the patient is competent, is acting voluntarily, and has made an informed decision;
(6) the reasons for waiver of confirmation by a consulting physician, if a waiver was made;

(7) a report of the outcome and determinations made during counseling, if performed

(8) the attending physician's offer before prescribing the medication to allow the qualified patient to rescind the patient's request for the medication; and

(9) a note by the attending physician indicating:

(a) that all requirements under this chapter have been met; and

(b) the steps taken to carry out the request, including a notation of the medication prescribed.

Section 13. Disposal of unused medications.

Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means.

Section 14. Data Collection.

Physicians are required to keep a record of the number of requests; number of prescriptions written; number of requests rescinded; and the number of qualified patients that took the medication under this chapter. This data shall be reported to the Department of Public Health annually, which will subsequently be made available to the public.

Section 15. Effect on wills, contracts, insurance, annuities, statutes and regulations.
(1) Any provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication pursuant to this chapter, is not valid.

(2) A qualified patient's act of making or rescinding a request for aid in shall not: provide the sole basis for the appointment of a guardian or conservator.

(3) A qualified patient's act of self-administering medication obtained pursuant to this act shall not constitute suicide or have an effect upon any life, health, or accident insurance or annuity policy.

(4) Actions taken by health care providers and patient advocates supporting a qualified patient exercising his or her rights pursuant to this chapter, including being present when the patient self-administers medication, shall not for any purpose, constitute elder abuse, neglect, assisted suicide, mercy killing, or homicide under any civil or criminal law or for purposes of professional disciplinary action.

(5) State regulations, documents and reports shall not refer to the practice of aid in dying under this chapter as" suicide" or "assisted suicide."

Section 16. Provider Participation

(1) A health care provider may choose whether to voluntarily participate in providing to a qualified patient medication pursuant to this act and is not under any duty, whether by contract, by statute, or by any other legal requirement, to participate in providing a qualified patient with the medication.
(2) A health care provider or professional organization or association may not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in providing medication to a qualified patient pursuant to this chapter.

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

(4) (a) Health care providers shall maintain and disclose to consumers upon request their written policies outlining the extent to which they refuse to participate in providing to a qualified patient any medication pursuant to this act.

(b) The required consumer disclosure shall at minimum:

(i) include information about the Massachusetts Compassionate Care for the Terminally Ill Act;

(ii) identify the specific services in which they refuse to participate;

(iii) clarify any difference between institution-wide objections and those that may be raised by individual licensed providers who are employed or work on contract with the provider;

(iv) describe the mechanism the provider will use to provide patients a referral to another provider or provider in the provider's service area who is willing to perform the specific health care service;
(v) describe the provider’s policies and procedures relating to transferring patients to
other providers who will implement the health care decision;
(vi) inform consumers that the cost of such transfer will be borne by the transferring
provider;
(vii) describe the internal and external consumer complaint processes available to persons
affected by the provider’s objections.

(c) The consumer disclosure shall be provided:
(i) to any person upon the request;
(ii) to a patient or resident or their authorized appointed health care agents, guardians,
surrogate decision-maker upon admission or at the time of initial receipt of health care.

(1) Purposely or knowingly altering or forging a request for medication pursuant to this
chapter without authorization of the patient or concealing or destroying a rescission of a request
for medication is punishable as a felony if the act is done with the intent or effect of causing the
patient's death.

(2) A person who coerces or exerts undue influence on a patient to request medication to
end the patient's life, or to destroy a rescission of a request, shall be guilty of a felony punishable
by imprisonment in the state prison for not more than three years or in the house of correction for
not more than two and one-half years or by a fine of not more than one thousand dollars or by
both such fine and imprisonment.
(3) Nothing in this act limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct inconsistent with the provisions of this act.

Section 18. Claims by governmental entity for costs incurred.

A governmental entity that incurs costs resulting from a qualified patient self-administering medication in a public place while acting pursuant to this chapter may submit a claim against the estate of the person to recover costs and reasonable attorney fees related to enforcing the claim.

Section 19. Construction.

Nothing in this chapter may be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, assisted suicide, or active euthanasia.

Section 20. Severability.

If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.
Opinion 2.211 - Physician-Assisted Suicide

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

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

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

Opinion 2.21 - Euthanasia

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

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

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

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

Terminal Uncertainty
Washington’s new “Death With Dignity” law allows doctors to help people commit suicide—once they’ve determined that the patient has only six months to live. But what if they’re wrong?
By Nina Shapiro
published: January 14, 2009

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

That was almost four years ago.

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

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

"I just kept going and going," says Clayton. "You kind of don't notice how long it's been." She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. "I had to have cancer to have nice hair," she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip to...
Seattle Terminal Uncertainty - Seattle Weekly

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 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.
The Associated Press

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

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

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

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

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Georgia General Assembly

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

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

Footnotes
3/7/2012 Modified Structured Rule; 3/7/2012 Immediately transmitted to Senate; 3/29/2012 House agrees to the Senate Substitute as House amended; 3/29/2012 Senate agreed to House amendment to Senate substitute
**“CHOICE”**

**ILLUSION**

A human rights organization, working to keep assisted suicide and euthanasia out of your state and out of your life.

---

**Idaho Strengthens Law Against Assisted-Suicide**

By Margaret Dore

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

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

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

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

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

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

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“Choice” Is An Illusion: Arizona Strengthens Its Law Against Assisted Suicide

Kyra Dore

MONDAY, MAY 5, 2014

Arizona Strengthens its Law Against Assisted Suicide

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

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

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

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

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

Brewer signed the bill on Wednesday.

Labels: assisted suicide

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DONATE NOW TO FIGHT ASSISTED SUICIDE AND EUTHANASIA.

Margaret Dore, Esq., MBA.
"Big money propaganda is drowning out the facts about legal assisted suicide/euthanasia. Funds are desperately needed to fight back. Please consider a generous donation to make this possible. Click on the photo to donate. THANK YOU."

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MARGARET DORE BLOG

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WELCOME

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

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

In Oregon and Washington
New Mexico court strikes down ruling that allowed assisted suicide

Decision a blow to right-to-die movement in one of few states permitting euthanasia

By Valerie Richardson - The Washington Times - Tuesday, August 11, 2015

The New Mexico Court of Appeals handed a defeat to the right-to-die movement Tuesday by striking down a lower-court ruling establishing physician-assisted suicide.

The three-judge panel ruled 2-1 that the district court had erred when it determined that "aid in dying is a fundamental liberty interest."

"We conclude that aid in dying is not a fundamental liberty interest under the New Mexico Constitution," said Judge Timothy L. Garcia in the majority opinion.

Catherine Glenn Foster, Alliance Defending Freedom litigation counsel, praised the court’s decision to reverse the two-year-old Bernalillo County District Court decision.

"Suffering patients need compassionate care and quality medical treatment, not encouragement to commit suicide – and especially not through doctors who pledge to 'do no harm,'" said Ms. Foster in a statement.

"New Mexico law clearly criminalizes deliberate assistance in someone else's suicide," she said. "The court was right to reverse the lower court’s decision which invented a right to doctor-prescribed death that does not exist. Families will now have the opportunity to honor and cherish their loved ones in their final days."

Physician-assisted suicide is legal in Oregon, Vermont and Washington, and Montana courts have recognized it as a valid defense for homicide charges.

The New Mexico lower court ruled in January 2013 that a 1963 state law making assisted suicide a fourth-degree felony in the state was invalid as it applied to doctors who administer a lethal dose of medication to medically competent, terminally ill patients.
Former New Mexico Attorney General Gary King filed the appeal, arguing that the right-to-die issue should be decided by the state legislature and not the court, while the New Mexico ACLU supported the lower court's decision.

The case involved two University of New Mexico doctors treating a patient, Aja Riggs, with terminal uterine cancer. The physicians filed suit seeking a declaration that they would not be prosecuted for assisting in the patient's death.

In her dissent, Judge Linda M. Vanzi said, "I conclude that, although the State's interests in preserving life and preventing suicide may be compelling or substantial in the abstract, these broadly stated general interests are insufficient to justify infringing the right to aid in dying."

Ms. Riggs, 51, told the Albuquerque Journal in January that her cancer is in remission.

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Each year in the U.S., approximately 12 million adults who seek outpatient medical care are misdiagnosed, according to a new study published in the journal BMJ Quality & Safety. This figure amounts to 1 out of 20 adult patients, and researchers say in half of those cases, the misdiagnosis has the potential to result in severe harm.

Previous studies examining the rates of medical misdiagnosis have focused primarily on patients in hospital settings. But this paper suggests a vast number of patients are being misdiagnosed in outpatient clinics and doctors’ offices.

"It's very serious," says CBS News chief medical correspondent Dr. Jon LaPook. "When you have numbers like 12 million Americans, it sounds like a lot -- and it is a lot. It represents about 5 percent of the outpatient encounters."

Getting 95 percent right be good on a school history test, he notes, "but it's not good enough for medicine, especially when lives are at stake."

More from Morning Rounds with Dr. LaPook

For the paper, the researchers analyzed data from three prior studies related to diagnosis and follow-up visits. One of the studies examined the rates of misdiagnosis in primary care settings, while two of the studies looked at the rates of colorectal and lung cancer screenings and subsequent diagnoses.

To estimate the annual frequency of misdiagnosis, the authors used a mathematical formula and applied the proportion of diagnostic errors detected in the data to the number of all outpatients in the U.S. adult population. They calculated the overall annual rate of misdiagnoses to be 5.08 percent.
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 Przyynski
[Signature]
A notary in and for the
State of Massachusetts

ADDRESS: 85 Main St
Florence, MA 01062
EXPIRY OF COMMISSION: June 22, 2016

PLACE SEAL HERE:

[Seal]

Heidi Przyynski
MA COMMISSION SERIES
MA NOTARY PUBLIC
Elder abuse is a growing problem that's underreported

BY MADELINE MCNEILLY

Abuse and neglect of our commonwealth’s senior population is far more common than we may want to think and is a growing problem. A U.S. Administration on Aging study estimates that up to 1 million elderly are physically abused, neglected or financially exploited each year. But officials acknowledge that it is underreported, unrecognized and difficult to gauge the scope of its prevalence. Many factors affect reporting such as the victim’s fear of retaliation, apprehension to prosecute family members, or lack of capacity to describe the crime or perpetrator.

Massachusetts has had an elder abuse reporting law for 27 years. When protective services were first created in 1984, a total of 1,529 reports were investigated. This year, in Massachusetts, an estimated 19,554 reports will be investigated. That’s more than two new abuse filings every hour every day.

Persons who, as a result of their professions, are more likely to hear about or see abuse are required to report suspected cases. Mandated reporters include doctors, social workers, public safety officials and senior center staff. However, any person with responsible cause to believe that an elder is being abused, neglected or exploited should report the abuse.

When actor Mickey Rooney, 91, a victim of elder abuse, testified to Congress in March 2011, he spoke for many who are silenced by isolation and fear. His experience proves elder abuse happens to people from all walks of life. Rooney urged no one should feel alone and helpless, help is available.

Knowing the warning signs of abuse is a first step toward protecting our elders:

E Elder abuse occurs when a caregiver, family members, or other person with a duty to care for an elder mistreats, neglects, or exploits a person 60 or older.

E Elder abuse knows no boundaries. Elder abuse happens in every city and town and victims can be poor or wealthy, educated or illiterate, healthy or sick, men or women.

E Elder abuse is a family issue. In most cases, spouses, children or relatives caring for the older person are the abusers.

E Abuse can be physical or sexual, such as hitting, pushing, shoving, or forcing an elder to suffer through unwanted sexual advance or assault.
E Abuse can be neglect, such as withholding food, medicine, personal care, companionship or needed services.

E Abuse can be financial exploitation, such as using or living off an elder’s income or assets without their permission.

E Abuse can be emotional, verbal or psychological.

E Threats of abuse or abandonment, intimidation of an elder can also be defined as elder abuse.

E Self-neglect is characterized as the behavior of an elderly person that threatens his/her own health and safety. It generally manifests itself in an older person as refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication and safety precautions. Often, it is the result of dementia or mental illness.

Elders are vulnerable to a variety of physical, emotional, and financial abuses, whether through their own frailty or at the hands of others. Our highest priority is to protect seniors from any kind of harm and to bring a strong sense of personal security to their day-to-day lives. Once regarded as primarily social activity centers, senior centers are a vital community resource that provides support, guidance, and security to the city’s frail and disabled elderly.

For the city of Attleboro, the Rev. Larson Senior Center is the community resource center for older adults and their families. We are the first point of contact for comprehensive delivery of social services and a vital link to the state’s elder services network. Caregivers can receive information on services such as home meal delivery, home health care and counseling which assists them with daily elder care issues they may be experiencing.

More than 3,000 seniors participated or benefited by the senior center’s services and activities provided by Rev. Larson Senior Center this past year. Being socially isolated has been associated with higher elder abuse rates. Every day, senior center staff and volunteers make friendly visits, provide telephone reassurance or deliver hot meals to hundreds of homebound elders. Along with a nutritious meal, drivers serve as a cheerful welcome presence each day while also keeping a watchful eye on an elder’s health and safety.

Thanks to state Rep. Betty Poirier, a bill was passed and signed into law designating Councils on Aging as mandated reporters under Massachusetts elder Abuse laws. This has had a dramatic impact on protecting elders from abuse and exploitation. It is extremely important that front line agencies such as the Council on Aging remove all barriers that could inhibit reporting in such critical cases. Thankfully, this legislation accomplishes that task, but more work needs to be done.

We don’t know all the details about why the abuse occurs. We do know that help is available for victims. Concerned people, like you, can spot the warning signs of a possible problem, and make a call for help if an elder is in need of assistance. In the greater Fall River/Taunton/Attleboro area, Bristol Elder Services is the designated protective service agency.

They have trained case managers that investigate all reports of abuse and neglect. All suspected cases should be reported directly to Bristol Elder Services at 1-508-675-2101 or toll free to the statewide hotline at 1-800-922-2275.

If you know of a possible elder abuse situation and are unsure as to how to proceed, please do not hesitate to contact your local council on aging and speak with a trained elder specialist. In Attleboro, we can be reached at 508-223-2235.
Elder-abuse cases on the rise in Massachusetts

By Jaclyn Reiss/Daily News correspondent
MetroWest Daily News
Posted Feb 19, 2011 @ 12:07 AM

BOSTON — Social workers, senior care advocates and lawyers are warning that incidents of elder abuse are outpacing state programs and funding aimed at protecting the elderly.

"The protective services agencies have to use other funds to supplement what they get from the Legislature to make this program work," Alan Norman, executive director at Massachusetts 1 Care, said at a State House forum this week.

Since 2008, Norman said he has seen a 31 percent increase in elder abuse - to 20,000 reported cases last year. Over those three years funding for protective service increased by 1.6 percent.

He said the $15.25 million budgeted for prevention programs this year will likely fall $3 million.

That money funds services such as an elder abuse hotline, which fields up to 15,000 calls per year from care managers to investigate and help protect seniors and a program to help elders at risk for exploitation keep track of finances, Norman said.

Those attending Wednesday’s forum, hosted by state Sen. Catherine Clark and state Rep. Paul Ryan, both Melrose Democrats, warned that there are many more unreported cases of elder abuse - which include assault, denial of basic needs and self-neglect.

They cited a study from Cornell University’s Weill Medical College that there are an estimated 20,000 unreported cases for every one that is brought forward.

Middlesex District Attorney Gerald Leone said while more people report cases of elder abuse to the office, he wants to raise awareness through social programs to prevent abuse before it happens.

"It’s the reported instances we hear about, but that’s just the tip of the iceberg," he said. "If we intervene and prevent before the abuse or before it becomes tragic, that’s really what I want to happen." 

Marian Ryan, senior counsel to the Middlesex district attorney’s family protection bureau, said adult children who reside at their parental home are the number one source of abuse, but are the hardest to prosecute because their parents are unwilling to report on their actions.

"For all the reasons we love our children, that doesn’t change when you’re 85 and your 46-year-old son with a substance abuse problem is causing a problem and abusing you," Ryan said.

Ryan also said that seniors do not report abusers for fear of being taken out of their home.

In an interview, Westborough Police Chief Alan Gordon said he periodically receives reports of senior abuse, especially family members taking money from their relatives. Many cases require extended follow-through by police and social service agencies.

"It turns into a big family fight when (the perpetrators) should be concerned about the elder person’s health and well-being, they’re more interested in what they can get out of it," he said.
A challenge the police face is determining if victim-reported abuse is real or possibly imagined because of a mental issue such as Alzheimer's.

"We'll get a complaint from the actual person claiming that they're being denied access to medicine or food or other parts of house, but when we go over there, everything is right there," Gordon said. "We take every complaint seriously, but we have to look at all things."

Senior caregivers also face enormous challenges working in a frustrating environment, said Scott Plumb, senior vice president of the Massachusetts Senior Care Association, which trains caregivers to exercise patience with seniors in assisted living and nursing homes.

"It can be a stressful place because the patients get sicker and sicker, and most caregivers have multiple jobs and can be tired and short-tempered," Plumb said. "What we focus on is running training programs for direct care workers."

Plumb said that Massachusetts is the first state to establish an elder abuse offender registry with the Department of Public Health and requires all geriatric organizations to cross-reference this registry before hiring new employees.

"Elder abuse in the community and economic recessions are usually carefully linked together," Plumb said. "From our perspective, we take this very seriously."

Comments (9)

maer
1 year ago
Report Abuse
You must be logged in to report abuse.

Westboro Police Chief Alan Gordon is quoted? Seriously? He and former chief Glenn Parker did nothing to help my mother, Peggy Revene, when complaint abuse, neglect and financial exploitation were made to them.

The following are recent emails from WPD Chief Alan Gordon who has for almost 7 years 'held for safekeeping' my mother's jewelry. Too bad he did nothing to keep the safety of my mother.

The following are emails from Westboro Police Chief, Alan Gordon relating to my mother, Peggy Revene. Gordon has 'held' for safekeeping my mother's jewelry at Westboro Police Department for almost SEVEN years. He never investigated the theft of the jewelry and never investigated the abuse of my mother who passed away on Jan 16, 2011. The jewelry isn't important, my mother was.

Date: Sat, 5 Feb 2011 13:14:27 -0500
From: agordon@town.westborough.ma.us
Subject: RE: Anne E. Revene

Whomever is appointed as executor of your mothers estate will be supplied with the answers to your questions. You should direct any further inquiries to this person:

Please describe the rings in detail and provide any photographs available.
When were the rings reported stolen and what investigation was done?
What was the date that Beverly Loss turned the rings into you and what explanation did you provide for having possession of my mother's property. What investigation was done.
When and by what means of communication did Laurie Raphaelson request you hold them for safekeeping?
How, with specifics, have the rings been kept and who has had access to my mother's property?
Elder abuse and neglect complaints are on the rise in Massachusetts

By Steve Adams
GateHouse News Service
Posted Sep 06, 2010 @ 02:04 PM

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Outgrowing its home: Bristol Elder Services moving to new location
Elder abuse on the rise

BOSTON — Complaints of elder abuse and neglect have risen statewide in recent years while resources to investigate them have failed to keep pace.

Case workers investigated about 16,000 reports of elder abuse or neglect in the year ending June 30, 2009, the most recent statistics available. The data cover people 60 and older in private living environments.

"It could be the economy. It could be any number of reasons," said Deborah Fogarty, director of protective services for the state Executive Office of Elder Affairs. "We have a rapidly growing population of people who are 60 and over."

Only when an extreme case of neglect is alleged, as in the case of a 68-year-old Hanover man charged this week with allowing his 93-year-old father to live in squalor, does elder abuse attract widespread attention.

Prosecutors say John T. Hallinan, 68, left his father duct-taped to a chair while he went to work. Police found the elderly man lying in a diaper on the floor in extremity, with sores on his feet.

Hallinan has been charged with assault and battery on a disabled person over 60.

Massachusetts law defines elder abuse as physical, emotional and sexual abuse, caretaker neglect, self-neglect and financial exploitation of a person 60 or older.

There are 22 regional agencies in Massachusetts in charge of investigating cases of elder abuse, and they have a total of 179 case workers assigned to investigate complaints.

After someone files a report of abuse, it is screened by a supervisor at one of the local protective service agencies to determine whether it is covered by the elder abuse law. Cases then are assigned to three priority levels from emergency to routine response.

Emergency cases call for contacting the alleged victim within five hours and visiting within 24 hours. Routine responses involve a home visit within five days.

Protective service agencies can assist elders with medical, legal, psychological, financial and housing assistance. In extreme cases of abuse, they refer cases to local district attorneys.

But investigations can come to an end if the senior refuses to answer the door or declines assistance.

"Self-determination is one of the underlying philosophies," Fogarty said. "If an elder has the capacity to make decisions and declines an investigation, they have that right."

Educating members of the community on how to spot signs of elder abuse is a priority of the state and local agencies, Fogarty said. A housekeeper visiting the Hanover residence reported the alleged abuse Aug. 29 after finding the 93-year-old man bound to a chair with duct tape.

Agencies hold public events around the state in June to commemorate World Elder Abuse Awareness Day. They also have worked with local banks and trained employees to spot signs of financial exploitation, such as seniors withdrawing large sums of money frequently.

WHAT TO WATCH FOR:

According to the World Health Organization, the population of those aged 60 and older will more than double by 2025. And older people, in general, tend to be more vulnerable to abuse. Some such instances happen in places like nursing homes, others in homes. Wherever it is, here are some things to look for if you're worried an elder you know is being abused.

To report suspected elder abuse or neglect, locals can contact the statewide Elder Abuse Hotline at 800-922-2275.

Signs of physical abuse

A-38
Definition of ingest at YourDictionary.com

Ingest (In jest)

transitive verb

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

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

Related Forms:
- Ingestion in-ges'-tion noun
- Ingestive in-ges'-tive adjective

Ingest (In-jëst)

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

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

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

Related Forms:
- Ingest'ible adjective
- Ingestion in-ges'-tion noun
- Ingestive in-ges'-tive adjective

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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.
Oregon Public Health Division

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 155 people had prescriptions written during 2014
- 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
- 11 people with prescriptions written in previous years ingested medication in 2014

---

Table 1. Characteristics and end-of-life care of 857 DWDA patients who have died from ingesting a lethal dose of medication as of February 2, 2015, by year, Oregon, 1998-2014

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2014 (N=105)</th>
<th>1998-2013 (N=754)</th>
<th>Total (N=859)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (%)</td>
<td>56 (53.3)</td>
<td>397 (52.7)</td>
<td>453 (52.7)</td>
</tr>
<tr>
<td>Female (%)</td>
<td>49 (46.7)</td>
<td>357 (47.3)</td>
<td>406 (47.3)</td>
</tr>
<tr>
<td><strong>Age at death (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-34 (%)</td>
<td>1 (1.0)</td>
<td>6 (0.8)</td>
<td>7 (0.8)</td>
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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>
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<td>55-64 (%)</td>
<td>28 (26.7)</td>
<td>156 (20.7)</td>
<td>184 (21.4)</td>
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<td>65-74 (%)</td>
<td>29 (27.6)</td>
<td>218 (28.9)</td>
<td>247 (28.8)</td>
</tr>
<tr>
<td>75-84 (%)</td>
<td>23 (21.9)</td>
<td>206 (27.3)</td>
<td>229 (26.7)</td>
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<td>85+ (%)</td>
<td>19 (18.1)</td>
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<td>113 (13.2)</td>
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<td>Median years (range)</td>
<td>72 (29-96)</td>
<td>71 (25-96)</td>
<td>71 (25-96)</td>
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<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>831 (97.1)</td>
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<td>Asian (%)</td>
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<td>9 (1.1)</td>
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<td>Pacific Islander (%)</td>
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<td>Other (%)</td>
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<td>Two or more races (%)</td>
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<td>Hispanic (%)</td>
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<td><strong>Marital Status</strong></td>
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<tr>
<td>Married (%)</td>
<td>48 (45.7)</td>
<td>347 (46.2)</td>
<td>395 (46.1)</td>
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<td>Widowed (%)</td>
<td>26 (24.8)</td>
<td>172 (22.9)</td>
<td>198 (23.1)</td>
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<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>
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<td><strong>Education</strong></td>
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<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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<tr>
<td>High school graduate (%)</td>
<td>23 (21.9)</td>
<td>164 (21.9)</td>
<td>187 (21.9)</td>
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<td>Some college (%)</td>
<td>26 (24.8)</td>
<td>198 (26.4)</td>
<td>224 (26.2)</td>
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<td>Baccalaureate or higher (%)</td>
<td>50 (47.6)</td>
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<td>392 (45.9)</td>
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<td>Metro counties (%)</td>
<td>46 (44.7)</td>
<td>315 (41.9)</td>
<td>361 (42.3)</td>
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<td>Coastal counties (%)</td>
<td>6 (5.8)</td>
<td>57 (7.6)</td>
<td>63 (7.4)</td>
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<tr>
<td>Other western counties (%)</td>
<td>40 (38.8)</td>
<td>325 (43.3)</td>
<td>365 (42.7)</td>
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<td>East of the Cascades (%)</td>
<td>11 (10.7)</td>
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<td><strong>End of life care</strong></td>
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<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>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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<tr>
<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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<tr>
<td>None (%)</td>
<td>0 (0.0)</td>
<td>12 (1.7)</td>
<td>12 (1.5)</td>
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<td>Characteristics</td>
<td>2014 (N=105)</td>
<td>1998-2013 (N=754)</td>
<td>Total (N=859)</td>
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<tr>
<td>--------------------------------------------</td>
<td>--------------</td>
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<tr>
<td><strong>Underlying Illness</strong></td>
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<tr>
<td>Malignant neoplasms (%)</td>
<td>72 (68.6)</td>
<td>596 (79.4)</td>
<td>668 (78.0)</td>
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<td>Lung and bronchus (%)</td>
<td>16 (15.2)</td>
<td>139 (18.5)</td>
<td>155 (18.1)</td>
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<td>Breast (%)</td>
<td>7 (6.7)</td>
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<td>Colon (%)</td>
<td>5 (4.8)</td>
<td>49 (6.5)</td>
<td>54 (6.3)</td>
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<tr>
<td>Pancreas (%)</td>
<td>9 (8.6)</td>
<td>47 (6.3)</td>
<td>56 (6.5)</td>
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<tr>
<td>Prostate (%)</td>
<td>2 (1.9)</td>
<td>33 (4.4)</td>
<td>35 (4.1)</td>
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<td>Ovary (%)</td>
<td>5 (4.8)</td>
<td>28 (3.7)</td>
<td>33 (3.9)</td>
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<tr>
<td>Other (%)</td>
<td>28 (26.7)</td>
<td>243 (32.4)</td>
<td>271 (31.7)</td>
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<td><strong>Amyotrophic lateral sclerosis (%)</strong></td>
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<td></td>
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<tr>
<td>Chronic lower respiratory disease (%)</td>
<td>4 (3.8)</td>
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<td>38 (4.4)</td>
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<td>Heart Disease (%)</td>
<td>3 (2.9)</td>
<td>14 (1.9)</td>
<td>17 (2.0)</td>
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<td>HIV/AIDS (%)</td>
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<td>9 (1.1)</td>
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<tr>
<td>Other illnesses (%)</td>
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<td>53 (6.2)</td>
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<td><strong>DWDA process</strong></td>
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<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>3 (2.9)</td>
<td>44 (5.9)</td>
<td>47 (5.5)</td>
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<tr>
<td>Patient informed family of decision (%)</td>
<td>95 (90.5)</td>
<td>634 (93.6)</td>
<td>729 (93.2)</td>
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<td>Patient died at</td>
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<td></td>
<td></td>
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<tr>
<td>Home (patient, family or friend) (%)</td>
<td>94 (89.5)</td>
<td>716 (95.3)</td>
<td>810 (94.6)</td>
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<tr>
<td>Long term care, assisted living or foster care facility (%)</td>
<td>8 (7.6)</td>
<td>29 (3.9)</td>
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<td>Hospital (%)</td>
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<td>1 (0.1)</td>
<td>1 (0.1)</td>
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<tr>
<td>Other (%)</td>
<td>3 (2.9)</td>
<td>5 (0.7)</td>
<td>8 (0.9)</td>
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<tr>
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<tr>
<td><strong>Lethal medication</strong></td>
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</tr>
<tr>
<td>Secobarbital (%)</td>
<td>63 (60.0)</td>
<td>403 (53.4)</td>
<td>466 (54.2)</td>
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<tr>
<td>Pentobarbital (%)</td>
<td>41 (39.0)</td>
<td>344 (45.6)</td>
<td>385 (44.8)</td>
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<td>Other (%)</td>
<td>1 (1.0)</td>
<td>7 (0.9)</td>
<td>8 (0.9)</td>
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<tr>
<td><strong>End of life concerns</strong></td>
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<tr>
<td>Losing autonomy (%)</td>
<td>96 (91.4)</td>
<td>686 (91.5)</td>
<td>782 (91.5)</td>
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<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>
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<tr>
<td>Loss of dignity (%)</td>
<td>75 (71.4)</td>
<td>504 (80.6)</td>
<td>579 (79.3)</td>
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<tr>
<td>Losing control of bodily functions (%)</td>
<td>52 (49.5)</td>
<td>376 (50.1)</td>
<td>428 (50.1)</td>
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<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>42 (40.0)</td>
<td>300 (40.0)</td>
<td>342 (40.0)</td>
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<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>
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<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>
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<td></td>
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</tr>
<tr>
<td>Prescribing physician</td>
<td>14</td>
<td>119</td>
<td>133</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
<td>6</td>
<td>238</td>
<td>244</td>
</tr>
<tr>
<td>No provider</td>
<td>4</td>
<td>76</td>
<td>80</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>81</td>
<td>251</td>
<td>332</td>
</tr>
<tr>
<td>At time of death</td>
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<tr>
<td>Prescribing physician (%)</td>
<td>14 (13.9)</td>
<td>107 (15.9)</td>
<td>121 (15.7)</td>
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<tr>
<td>Other provider, prescribing physician not present (%)</td>
<td>6</td>
<td>263 (39.2)</td>
<td>269 (34.8)</td>
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<td>No provider</td>
<td>81 (80.2)</td>
<td>301 (44.9)</td>
<td>382 (49.5)</td>
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<td>4</td>
<td>13</td>
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<td><strong>Complications</strong></td>
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<td>1</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>487</td>
<td>507</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>85</td>
<td>244</td>
<td>329</td>
</tr>
<tr>
<td><strong>Other outcomes</strong></td>
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<tr>
<td>Regained consciousness after ingesting DWDA medications</td>
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### Characteristics

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

1. Unknowns are excluded when calculating percentages.
2. Includes Oregon Registered Domestic Partnerships.
4. Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.
5. Private insurance category includes those with private insurance alone or in combination with other insurance.
6. Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson’s disease and Huntington’s disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.
7. First recorded beginning in 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 4 in 2013. Other includes combinations of secobarbital, pentobarbital, phenobarbital, and/or morphine.
8. Affirmative answers only ("Don’t know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.
10. 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.
11. 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.
12. 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.
13. 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.

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Section 2-505. [Who May Witness.]

(a) An individual generally competent to be a witness may act as a witness to a will.

(b) The signing of a will by an interested witness shall not invalidate the will or any provision of it except that a devise to a witness or a spouse of such witness shall be void unless there are 2 other subscribing witnesses to the will who are not similarly benefited thereunder or the interested witness establishes that the bequest was not inserted, and the will was not signed, as a result of fraud or undue influence by the witness.
Section 16. (a) Subject to appropriation, the department shall develop a coordinated system of protective services for elderly persons who are determined to be abused. In planning this system, the department shall require input from other protective service agencies and other agencies currently involved in the provision of social, health, legal, nutritional and other services to the elderly, as well as elderly advocacy organizations.

(b) Within this protective services system, the department shall establish a mechanism for the receipt of reports made pursuant to section fifteen which shall operate and be accessible on a twenty-four hour per day basis. If the department or its designated agency has reasonable cause to believe that an elderly person has died as a result of abuse, the death shall be reported immediately to the district attorney of the county in which the abuse occurred. Within forty-five days of the receipt of a report made pursuant to subsection (a) of said section fifteen, the department or its designated agency shall notify the reporter, in writing, of its response to the report. Such notification shall be made to a person who makes a report pursuant to subsection (c) of said section fifteen if said reporter so requests.

(c) Subject to appropriation, the department shall designate at least one local agency to act on behalf of the department with a geographic area as defined by the department. The department may designate any public agency or private nonprofit organization which has the capacity to implement a service plan through direct access to social, health and mental health services. The department shall utilize existing resources and services of public and nonprofit private agencies in providing protective services. The department shall insure that assessment, evaluation and service delivery shall be provided through the designated local agency closest to the elderly person's community.
Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys:
Compliance with the Death with Dignity Act

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

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

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

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

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

1 Under state law, the State Registrar of Vital Statistics “shall prepare and issue such detailed instruction as may be required to secure the uniform observance of its provisions and the maintenance of a perfect system of registration. ... The State Registrar shall carefully examine the certificates received monthly from the local registrars, county auditors, and clerks of the court and, if any are incomplete or unsatisfactory, the State Registrar shall require such further information to be furnished as may be necessary to make the record complete and satisfactory.” RCW 43.70.160.
Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

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ABSTRACT

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

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

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

Conclusion: A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although 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 60000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient’s home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient’s home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.

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AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

1. I am a doctor in Oregon USA 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. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify for the court 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 twelve years.

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

8. Today, for patients under the Oregon Health Plan (Medicaid), there is also a financial incentive to commit suicide: 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 at page SI-1.

Affidavit of Kenneth Stevens, Jr., MD - page 2
9. Under the Oregon Health Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient’s treatment. For 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 at page GN-4).

10. 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.

11. 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.

12. 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.

13. 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.
14. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Canada, your government health plan could follow a similar pattern. If so, the plan will pay for a patient to die, but not to live.

SWORN BEFORE ME at Sherwood
Oregon, USA
on September 18, 2012

NAME: Jessica Borgo

A notary in and for the State of Oregon

ADDRESS: 16100 S Tuatulah-Sherwood Rd

EXPIRY OF COMMISSION: Aug. 30, 2015

PLACE SEAL HERE:

Affidavit of Kenneth Stevens, Jr., MD - page 4
STATEMENT OF INTENT: PALLIATIVE CARE

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

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

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

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

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and 99453 for classes.
**GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)**

b) Suspected Crohn's disease: upper and lower endoscopy, small bowel follow through

2) Radiological evidence of lack of stricture

3) Only covered once during any episode of illness

4) FDA approved devices must be used

5) Patency capsule should not be used prior to procedure

**GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS**

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

**GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES**


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

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

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

D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic 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 <1000mcL, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.

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

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

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

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

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

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


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

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have 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.

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GUIDELINE NOTE
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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 125,144,165,166,170,182,207,208,220,221,243,276,278,292,312,339
PET Scans are covered for diagnosis of the following cancers only:
• Solitary pulmonary nodules and non-small cell lung cancer
• Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.
PET scans are covered for the initial staging of the following cancers:
• Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
• Head and neck cancer when initial MRI or CT is equivocal

4-16-2012
Letter noting assisted suicide raises questions


By Susan Harding and KATU Web Staff July 30, 2008

SPRINGFIELD, Ore. - Barbara Wagner has one wish - for more time.

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

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

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

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

An unfortunate interpretation?

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

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

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

He said the state has a financial incentive to offer death instead of life: Chemotherapy drugs such as Tarceva cost $4,000 a month while drugs for assisted suicide cost less than $100.
Death Drugs Cause Uproar in Oregon

By SUSAN DONALDSON JAMES  
Aug. 6, 2008

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

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

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

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

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

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

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

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

Letter's Impact 'Devastating'

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

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

"I'm not too good today," said Wagner, a Springfield great-grandmother. "But I'm opposed to the [assisted suicide] law. I haven't considered it, even at my lowest point."

A lifelong smoker, she was diagnosed with lung cancer in 2005 and quit. The state-run Oregon Health Plan generously paid for thousands of dollars worth of chemotherapy, radiation, a special bed and a wheelchair, according to Wagner.

http://abcnews.go.com/Health/story?id=5517492&page=1
The cancer went into remission, but in May, Wagner found it had returned. Her oncologist prescribed the drug Tarceva to slow its growth, giving her another four to six months to live.

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

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

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

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

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

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

Playing With 'My Life'

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

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

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

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

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

The state also regularly evaluates and updates approvals for cancer treatments. "We look as exhaustively as we can with good peer review evidence," she said.

The health plan takes "no position" on the physician-assisted suicide law, according to spokesman Jim Sellers.
NEWS RELEASE

Date: Sept. 9, 2010
Contact: Christine Stone, Oregon Public Health Information Officer; 971-673-1282, desk; 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. (For 2007)

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

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

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

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

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

The report also included the following findings:

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

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


Executive Summary

Suicide is one of Oregon's most persistent, yet largely preventable, public health problems. Suicide is the leading cause of injury death—there are more deaths due to suicide in Oregon than due to cancer. 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, policies, and planning. We analyzed mortality data from 1981 to 2007 and 2007 to 2007 data of Oregon Violent Death Reporting System (OVDRS). This report presents main findings of suicide trends and risk factors in Oregon.

Key Findings

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

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

Suicide rates among women ages 45-64 rose 35 percent from 8.2 per 100,000 in 2000 to 12.8 per 100,000 in 2007.

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

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

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

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

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

Suicide is an important public health problem in Oregon. Each year there are more than 250 Oregonians killed by suicide, and more than 1,800 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon, with more deaths due to suicide than car accidents. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all ages in Oregon. The cost of suicide is enormous; in 2006 alone, self-inflicted hospitalization charges exceeded 1.6 billion dollars, and the estimate of 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, provides suicide prevention programs and plans, a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1985 to 2007 and 2003 to 2007 data from the Oregon Violent Death Reporting System (OVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Methods, data sources and limitations

Suicide is a death resulting from the intentional use of force against oneself. In this report, suicide deaths are identified according to International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of death on death certificates. Suicide was considered with codes 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.1,2 In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts.3,4 Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon.2 The cost of suicide is enormous. In 2010, self-inflicted injury hospitalization charges exceeded 41 million dollars, and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.3,4,5 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."6 This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

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4 Wright D., Millet L., et al, Oregon Injury and Violence Prevention Program Report for 2011 Data year, Oregon Health Authority.
Re: "NO" on H.1991; My patient suicidal after watching Brittany Maynard video.

Dear Legislators:

I am a doctor whose young adult patient became actively suicidal after watching a Brittany Maynard video.

I urge you to vote against legalizing assisted suicide so as to not encourage other young adults to seek this path.

In the first week of December 2014, a mother brought in her twenty year old son for an emergency appointment. She had told me that he had been acting oddly and talking about death.

During the appointment, I asked the young man if he had a plan. He said "yes" that he had watched Ms. Maynard's video, that he was very impressed and identified with her and that he thought it was a good idea for him to die like her. He also told me that after watching the video he had been surfing the internet looking for ways to obtain suicide drugs.

He was actively suicidal and agreed to go to the hospital, where he stayed for five weeks until it was determined that he was sufficiently safe from self-harm to go home.

Legal assisted suicide sends the wrong message to young people. I urge you to vote "no" on H.1991.

Thank you.

Will Johnston MD

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Don't Rob Them of Hope Brittany

Brittany Maynard plans to kill herself on November 1 because she has a brain tumor. She should think of her fellow sufferers.

An Australian whose wife died of a similar disease, Denis Strangman, wrote her the open letter below, originally published on October 24, 2014. Ms. Maynard subsequently died on November 1st as previously announced. The exact details of her death, including whether it was voluntary, are not known.

I am very sorry to read that you have a brain tumor, and especially that you plan to kill yourself.

Although we live on different continents thousands of miles apart, and belong to different generations, I sympathise with your situation, though not with your plans. I am glad that you say your proposed suicide date is not “set in stone.” I sincerely hope you will quietly forget about it and choose life. Do not be stampeded in trying to meet your “deadline” by “Compassion and Choices” or other advocates for assisted suicide.

You say you are speaking to fellow “millenials.” I don’t think they have yet invented a catchy title for us septuagenarians but you and I are fellow humans, and I would like to tell you about my own experiences in the world of brain tumors. You see, we have something in common – those terrible words “glioblastoma multiforme,” the most lethal of the primary, malignant brain tumors. I lost my wife Marg, aged 55, to this same type of brain tumor some years ago.

Marg accepted her diagnosis and was willing to try any reasonable treatment. Like you she endured embarrassing steroid-induced weight gain from the Decadron, and she lost her hair. Marg lived in hope of a reversal of her condition, while she and I shared a belief that eventually she would be going to a better place. She did pass away, only 11 months after diagnosis, leaving behind myself and our five children.

After my wife passed I became an advocate for brain tumor patients and their caregivers and helped establish the International Brain Tumour Alliance, which I chaired from 2005 to earlier this year. It is a coordinating group for national brain tumor support and advocacy groups around the world. During these nine years I have travelled extensively to meet with patients and their caregivers in Asia, North America, Europe, and even Africa.

About 200,000 people develop a glioblastoma brain tumor each year. Unlike you and my late wife, most are totally unaware of the nature of their illness because of the desperately inadequate health systems of the countries in which they live. Some of them can only crawl to a pathetically inadequate village health centre to spend their last days.
We who live in the developed countries will likely receive a diagnosis and be offered the best standard treatment available. Unfortunately, there has only been one major breakthrough in treating this specific type of tumor in the past 30 years. That is the development and clinical trial verification of the “Stupp protocol” of combined radiation therapy and the drug temozolomide (Temodar/Temodal). Even this therapy is likely to benefit only about 26 percent of those who undertake it. My wife was the first patient in our city to try that therapy but it did not work for her.

In travelling the world I have attended most of the important scientific conferences where brain tumor researchers explain their research – Edinburgh, Berlin, Yokohama, Washington, Chicago, San Francisco, Paris, Amsterdam, and so on. I have no medical credentials of my own, but I know from these conferences and from reading the scientific literature that literally hundreds of scientists throughout the world are working on a cure for this disease. I have met many of these dedicated investigators. Several research groups and companies are also conducting trials for possible new therapies for those with a glioblastoma brain tumor. I would be glad to discuss these if you wish.

In meeting and talking with brain tumor patients the common characteristic I have discovered is their reliance on hope. Many live in hope that a “breakthrough” is just around the corner and they will be the first to benefit from it. That is a perfectly legitimate approach, particularly given rapid developments in understanding the genomics of brain tumours.

Others sustained by hope are aware of the long-term survivors of this disease – those fortunate few who were given a poor prognosis, like you and my wife, but have survived for years. I have met a number of these people in North America and Europe. They do not know why they are the lucky few, but they relish the days they have been given.

Researchers trying to discover the common characteristics of long-term brain tumor patients have found, for example, that people around your age, 29, have greater prospects for longer survival and a greater capacity to deal with the medical treatments. I hope you have been told about this.

Still others live in the hope that, if they do not confound medical expectations, they will acquit themselves well in the final weeks of their lives – that they will love and be loved, say things to loved ones that have been left unsaid for too long, and bring peace to themselves and those around them. I have found that, with the help of decent supportive care, this too is a reasonable thing to hope for.

A question that troubles me is whether you have considered the effect your example and statements may have on the tens of thousands of fellow brain tumor patients who are sustained by these hopes. I think that none of us has a right to take that hope away from them. If your story does not make them feel that they should kill themselves, it can certainly make them worry that this idea is lodging itself more firmly in the minds of their friends, relatives and society itself – including those able-bodied “millennials” who already have such a hard time dealing with
notions of illness and disability.

I have to tell you in all honesty that in the private online discussion groups for brain tumour patients which I have observed for years, as opposed to the open forums anyone can join, your peers overwhelmingly express prayers and sympathy for you but reject your approach. The drive to approve assisted suicide as a “solution” for patients like them does not ease their burden but aggravates it.

It is certainly not too late for you to decide on a different course. I respectfully ask you to consider this, for yourself and on behalf of your fellow sufferers throughout the world who have chosen to live with hope in their hearts.

Denis Strangman lives in Canberra, Australia. He is the former chair of the International Brain Tumour Alliance.
KILLING CANCER

60 Minutes follows brain cancer patients in a Duke University clinical trial of a therapy that uses a re-engineered polio virus to kill cancer cells

MAR 29 SCOTT PELLEY

Editor's Note: For more information on the Duke University polio trial or other brain cancer trials, click here or call 919-684-5301

The following script is from "Killing Cancer" which aired on March 29, 2015. Scott Pelley is the correspondent. Michael Radutsky and Denise Schrier Cetta, producers.

The long war on cancer has left us well short of victory. Radiation flashed on in the 19th century, chemotherapy began to drip in the 20th but, for so many, 100 years of research adds up to just a few more months of life. Well tonight, you're about to discover for the 21st century that may be a big leap forward --awakening the power of the body's immune system.

For 10 months, we've been inside an experimental therapy at Duke University. Some of the patients there use words that doctors don't use, like "miracle" and "cure." And that's remarkable, because these patients were handed a death sentence, a relentless brain cancer called glioblastoma. To beat it, researchers are doing something that many thought was crazy, they are infecting the tumors with polio -- the virus that has crippled and killed for centuries.

In just a moment, polio will be dripped into the brain of 58-year-old Nancy Justice. Her glioblastoma tumor was discovered in 2012. Surgery, chemotherapy and radiation bought her two and a half years, but the tumor came roaring back. Now, the virus in this syringe, which mankind has fought to eradicate from the earth, is the last chance she has in the world.

same as Britteny Magnan