MEMORANDUM

TO: The Nebraska Judiciary Committee

FROM: Margaret Dore, Esq., MBA.
Choice is an Illusion, a nonprofit corporation

RE: Vote "No" LB 1056; No Assisted Suicide/Euthanasia

DATE: February 28, 2015

Partial Bill Analysis:

A. Patients May Have Years, Even Decades, to Live

The bill applies to persons diagnosed with a "terminal illness," as defined by the bill. Such persons may have years, even decades, to live due to the following reasons:

1. If Nebraska follows Oregon's interpretation of "terminal disease," the bill will legalize assisted suicide and euthanasia for persons with chronic conditions such as insulin dependent diabetes.

The bill states:

"Terminal illness means an incurable and irreversible illness that will, within reasonable medical judgment, result in death within six months."  

Oregon's law has a similar definition of "terminal disease," as follows:

"Terminal disease" means an incurable and

1 See LB 1056, §§ 2(14) & 3, attached hereto in the appendix at A-3 & A-4.

2 LB 1056, § 2(14), attached at A-3.
irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.\(^3\)

In Oregon, this similar definition is interpreted to include chronic conditions such as "chronic lower respiratory disease" and "diabetes mellitus." See the Oregon government report attached hereto at A-38 and A-39 (listing these conditions as "underlying illness[es]" for the purpose of assisted suicide).\(^4\)

Oregon doctor William Toffler explains:

> Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live.\(^5\)

If Nebraska enacts the proposed bill and follows Oregon’s lead, assisted suicide will be legalized for people with chronic conditions such as insulin dependent diabetes.

2. Doctor predictions of life expectancy can be wrong

Patients may also have years to live because doctor predictions of life expectancy can be wrong. This is due to misdiagnosis and the fact that predicting life expectancy is not an exact science.\(^6\) Consider John Norton, who was diagnosed with

\(^3\) Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-32.

\(^4\) The entire report is attached infra at A-33 to A-39.

\(^5\) Published Letter to the Editor, William Toffler MD, New Haven Register, February 24, 2014, ¶2. (My private copy is attached hereto at A-40. I verified the accuracy of the content with Dr. Toffler.)

\(^6\) See Jessica Firger, "12 million Americans misdiagnosed each year," CBS NEWS, 4/17/14 (attached at A-41); and Nina Shapiro, supra at footnote 7.
ALS (Lou Gehrig’s disease) at age 18. He was told that he would get progressively worse (be paralyzed) and die in three to five years. Instead, the disease progression stopped on its own.

In a 2012 affidavit, at age 74, he states:

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.

3. Treatment can lead to recovery

Patients may also have years to live because treatment can lead to recovery. Consider Oregon resident, Jeanette Hall, who was diagnosed with cancer in 2000 and made a settled decision to use Oregon’s law. Her doctor convinced her to be treated instead. In a 2012 affidavit, she states:

This last July, it was 12 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.

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8 Id., ¶ 1.
9 Id., ¶ 4.
10 Id., ¶ 5.
11 Affidavit of Kenneth Stevens, MD, attached at A-45 to A-51; Jeanette Hall discussed at A-45 to A-46.
12 Id.
13 Affidavit of Jeanette Hall, ¶¶ 5-9. attached at A-52 to A-53. Jeanette is still alive today, 15 years later.
after being fully informed by his or her attending physician of:

(a) The individual’s medical diagnosis and prognosis;

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

(c) The probable result of self-administering the medication;

(d) The possibility that he or she may choose not to obtain the medication, or may obtain the medication but may decide not to self-administer it; and

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

(9) Mental health specialist means a psychologist or psychiatrist licensed to practice in this state as provided in the Uniform Credentialing Act;

(10) Mental health specialist assessment means one or more consultations between an individual and a mental health specialist for the purpose of determining whether the individual has the capacity to make medical decisions and is not suffering from a psychiatric or psychological disorder or depression causing impaired decisionmaking;

(11) Physician means a person licensed to practice medicine or osteopathy in this state as provided in the Uniform Credentialing Act;

(12) Qualified individual means an adult who has the capacity to make medical decisions and has satisfied the requirements of the Patient Choice at End of Life Act to obtain a prescription for medication to end his or her life;

(13) Self-administer means some affirmative and voluntary act by a qualified individual to ingest medication to bring about his or her own peaceful and humane death; and

(14) Terminal illness means an incurable and irreversible illness that will, within reasonable medical judgment, result in death within six months.
Sec. 3. (1) An individual who is an adult with the capacity to make medical decisions and has a terminal illness may make a request to receive a prescription for aid-in-dying medication if all of the following conditions are satisfied:

(a) The individual’s attending physician has determined him or her to be suffering from a terminal illness;

(b) The individual has voluntarily expressed the wish to receive a prescription for aid-in-dying medication; and

(c) The individual has the physical and mental ability to self-administer the aid-in-dying medication.

(2) An individual may not be considered a qualified individual and is not eligible to receive aid-in-dying medication under the Patient Choice at End of Life Act solely because of age or disability.

Sec. 4. (1) An individual who is eligible to make a request under section 3 of this act and who seeks to receive a prescription for aid-in-dying medication shall make an oral request to his or her attending physician and submit a written request to his or her attending physician that satisfies the requirements of this section.

(2) A written request for aid-in-dying medication must be in substantially the form described in section 11 of this act and signed and dated by the individual seeking the medication in the presence of two witnesses in accordance with subsection (3) of this section.

(3) A written request for aid-in-dying medication under the Patient Choice at End of Life Act must be witnessed by at least two other adult persons who, in the presence of the requestor, attest that to the best of their knowledge and belief:

(a) The requestor has the capacity to make medical decisions;

(b) The requestor is acting voluntarily and without coercion to sign the request; and

(c) The witnesses satisfy the requirements of subsection (4) of this section.
Oregon Revised Statute

Chapter 127

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.897 were enacted as part of Ballot Measure 18 (1994) and were not provided by Legislative Counsel.

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

127.800 s.1.01. Definitions.

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

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

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

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

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

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

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

(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
   (a) His or her medical diagnosis;
   (b) His or her prognosis;
   (c) The potential risks associated with taking the medication to be prescribed;
   (d) The probable result of taking the medication to be prescribed; and
   (e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

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

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

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

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

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

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

(Section 2)

127.805 s.2.01. Who may initiate a written request for medication.

(1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and
OREGON DEATH WITH DIGNITY ACT:
2015 DATA SUMMARY

Oregon Public Health Division
February 4, 2016

For more information:
http://www.healthoregon.org/dwd
Contact: DWDA.info@state.or.us
Introduction
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. Data presented in this summary, including the number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of the medications (DWDA deaths), are based on required reporting forms and death certificates received by the Oregon Public Health Division as of January 27, 2016. More information on the reporting process, required forms, and annual reports is available at: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2015

Participation Summary and Trends
During 2015, 218 people received prescriptions for lethal medications under the provisions of the Oregon DWDA, compared to 155 during 2014 (Figure 1, above). As of January 27, 2016, the Oregon Public Health Division had received reports of 132 people who had died during 2015 from ingesting the medications prescribed under DWDA.

Since the law was passed in 1997, a total of 1,545 people have had prescriptions written under the DWDA, and 991 patients have died from ingesting the medications. From 1998 through 2013, the number of prescriptions written annually increased at an average of 12.1%; however, during 2014 and
2015, the number of prescriptions written increased by an average of 24.4%. During 2015, the rate of DWDA deaths was 38.6 per 10,000 total deaths.¹

A summary of DWDA prescriptions written and medications ingested are shown in Figure 2. Of the 218 patients for whom prescriptions were written during 2015, 125 (57.3%) ingested the medication; all 125 patients died from ingesting the medication without regaining consciousness. Fifty of the 218 patients who received DWDA prescriptions during 2015 did not take the medications and subsequently died of other causes.

Ingestion status is unknown for 43 patients prescribed DWDA medications in 2015. Five of these patients died, but they were lost to follow-up or the follow-up questionnaires have not yet been received. For the remaining 38 patients, both death and ingestion status are pending (Figure 2).

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1 Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2014 (34,160), the most recent year for which final death data are available.

Patient Characteristics

Of the 132 DWDA deaths during 2015, most patients (78.0%) were aged 65 years or older. The median age at death was 73 years. As in previous years, decedents were commonly white (93.1%) and well-educated (43.1% had at least a baccalaureate degree).

While most patients had cancer, the percent of patients with cancer in 2015 was slightly lower than in previous years (72.0% and 77.9%, respectively). The percent of patients with amyotrophic lateral sclerosis (ALS) was also lower (6.1% in 2015, compared to 8.3% in previous years). Heart disease increased from 2.0% in prior years to 6.8% in 2015.

Most (90.1%) patients died at home, and most (92.2%) were enrolled in hospice care. Excluding unknown cases, most (99.2%) had some form of health care insurance, although the percent of patients who had private insurance (36.7%) was lower in 2015 than in previous years (60.2%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (62.5% compared to 38.3%).

Similar to previous years, the three most frequently mentioned end-of-life concerns were: decreasing ability to participate in activities that made life enjoyable (96.2%), loss of autonomy (92.4%), and loss of dignity (75.4%).

DWDA Process

A total of 106 physicians wrote 218 prescriptions during 2015 (1-27 prescriptions per physician). During 2015, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements. During 2015, five patients were referred for psychological/psychiatric evaluation.

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. For 27 patients, either the prescribing physician or another healthcare provider was present at the time of death. Prescribing physicians were present at time of death for 14 patients (10.8%) during 2015 compared to 15.7% in previous years; 13 additional cases had other health care providers present (e.g. hospice nurse). Data on time from ingestion to death is available for only 25 DWDA deaths during 2015. Among those 25 patients, time from ingestion until death ranged from five minutes to 34 hours. For the remaining two patients, the length of time between ingestion and death was unknown.
Table 1. Characteristics and end-of-life care of 991 DWDA patients who have died from ingesting DWDA medications, by year, Oregon, 1998-2015

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
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<tr>
<td><strong>Sex</strong></td>
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</tr>
<tr>
<td>Male (%)</td>
<td>56 (42.4)</td>
<td>453 (52.7)</td>
<td>509 (51.4)</td>
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<tr>
<td>Female (%)</td>
<td>76 (57.6)</td>
<td>406 (47.3)</td>
<td>482 (48.6)</td>
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<td><strong>Age at death (years)</strong></td>
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<tr>
<td>18-34 (%)</td>
<td>1 (0.8)</td>
<td>7 (0.8)</td>
<td>8 (0.8)</td>
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<td>35-44 (%)</td>
<td>5 (3.8)</td>
<td>18 (2.1)</td>
<td>23 (2.3)</td>
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<td>45-54 (%)</td>
<td>2 (1.5)</td>
<td>61 (7.1)</td>
<td>63 (6.4)</td>
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<td>55-64 (%)</td>
<td>21 (15.9)</td>
<td>184 (21.4)</td>
<td>205 (20.7)</td>
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<td>65-74 (%)</td>
<td>41 (31.1)</td>
<td>247 (28.8)</td>
<td>288 (29.1)</td>
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<td>75-84 (%)</td>
<td>30 (22.7)</td>
<td>229 (26.7)</td>
<td>259 (26.1)</td>
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<td>85+ (%)</td>
<td>32 (24.2)</td>
<td>113 (13.2)</td>
<td>145 (14.6)</td>
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<tr>
<td><strong>Median years (range)</strong></td>
<td>73 (30-102)</td>
<td>71 (25-96)</td>
<td>71 (25-102)</td>
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<tr>
<td><strong>Race</strong></td>
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<tr>
<td>White (%)</td>
<td>122 (93.1)</td>
<td>831 (97.1)</td>
<td>953 (96.6)</td>
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<td>African American (%)</td>
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<td>American Indian (%)</td>
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<td>2 (0.2)</td>
<td>2 (0.2)</td>
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<tr>
<td>Asian (%)</td>
<td>4 (3.1)</td>
<td>9 (1.1)</td>
<td>13 (1.3)</td>
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<td>Pacific Islander (%)</td>
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<td>1 (0.1)</td>
<td>1 (0.1)</td>
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<tr>
<td>Other (%)</td>
<td>0 (0.0)</td>
<td>3 (0.4)</td>
<td>3 (0.3)</td>
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<td>Two or more races (%)</td>
<td>1 (0.8)</td>
<td>3 (0.4)</td>
<td>4 (0.4)</td>
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<td>Hispanic (%)</td>
<td>4 (3.1)</td>
<td>6 (0.7)</td>
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<td><strong>Marital status</strong></td>
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<td>Married (including Registered Domestic Partner) (%)</td>
<td>52 (39.7)</td>
<td>395 (46.1)</td>
<td>447 (45.3)</td>
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<tr>
<td>Widowed (%)</td>
<td>34 (26.0)</td>
<td>198 (23.1)</td>
<td>232 (23.5)</td>
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<td>Never married (%)</td>
<td>9 (6.9)</td>
<td>69 (8.1)</td>
<td>78 (7.9)</td>
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<td>Divorced (%)</td>
<td>36 (27.5)</td>
<td>194 (22.7)</td>
<td>230 (23.3)</td>
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<td><strong>Education</strong></td>
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<td>Less than high school (%)</td>
<td>7 (5.4)</td>
<td>51 (6.0)</td>
<td>58 (5.9)</td>
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<td>High school graduate (%)</td>
<td>31 (23.8)</td>
<td>187 (21.9)</td>
<td>218 (22.2)</td>
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<td>Some college (%)</td>
<td>36 (27.2)</td>
<td>224 (26.2)</td>
<td>260 (26.4)</td>
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<td>Baccalaureate or higher (%)</td>
<td>56 (43.1)</td>
<td>392 (45.9)</td>
<td>448 (45.5)</td>
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<td><strong>Residence</strong></td>
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<tr>
<td>Metro counties (Clackamas, Multnomah, Washington) (%)</td>
<td>64 (49.2)</td>
<td>361 (42.3)</td>
<td>425 (43.2)</td>
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<td>Coastal counties (%)</td>
<td>7 (5.4)</td>
<td>63 (7.4)</td>
<td>70 (7.1)</td>
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<td>Other western counties (%)</td>
<td>48 (36.9)</td>
<td>365 (42.7)</td>
<td>413 (42.0)</td>
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<td>East of the Cascades (%)</td>
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<td>Hospice</td>
<td>118 (92.2)</td>
<td>747 (90.2)</td>
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<td>Not enrolled (%)</td>
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<td><strong>Insurance</strong></td>
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<td>Private (alone or in combination) (%)</td>
<td>44 (36.7)</td>
<td>489 (60.2)</td>
<td>533 (57.2)</td>
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<td>Medicare, Medicaid or other governmental (%)</td>
<td>75 (62.5)</td>
<td>311 (38.3)</td>
<td>386 (41.4)</td>
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<td>None (%)</td>
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<tr>
<th>Characteristics</th>
<th>Malignant Tumor (%)</th>
<th>Lung and Bronchus (%)</th>
<th>Other (%)</th>
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<td><strong>Total</strong></td>
<td>159 (77.9)</td>
<td>567 (77.9)</td>
<td>723 (71.1)</td>
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<td><strong>1998-2014</strong></td>
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<td><strong>At time of death</strong></td>
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<tr>
<td><strong>End of life concerns</strong></td>
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<tr>
<td><strong>Referred for psychiatric evaluation</strong></td>
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<tr>
<td><strong>Patient informed family of decision</strong></td>
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<tr>
<td><strong>Patient died at Home</strong></td>
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<tr>
<td><strong>Assisted living or foster care facility</strong></td>
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<tr>
<td><strong>Long term care, Hospital</strong></td>
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<td><strong>Other</strong></td>
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### Characteristics

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<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
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<td>None</td>
<td>23</td>
<td>506</td>
<td>529</td>
</tr>
<tr>
<td>Unknown</td>
<td>105</td>
<td>330</td>
<td>435</td>
</tr>
</tbody>
</table>

### Other outcomes

- Regained consciousness after ingesting DWDA medications: 0/6/6

### Timing of DWDA event

<table>
<thead>
<tr>
<th>Duration (weeks) of patient-physician relationship</th>
<th>2015</th>
<th>1998-2014</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>9</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Range</td>
<td>1-1004</td>
<td>0-1905</td>
<td>0-1905</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>132</td>
<td>857</td>
<td>989</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
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<td>2</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration (days) between 1st request and death</th>
<th>2015</th>
<th>1998-2014</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
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<td>47</td>
<td>46</td>
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<tr>
<td>Range</td>
<td>15-517</td>
<td>15-1009</td>
<td>15-1009</td>
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<tr>
<td>Number of patients with information available</td>
<td>131</td>
<td>859</td>
<td>990</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
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<td>0</td>
<td>1</td>
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### Minutes between ingestion and unconsciousness

<table>
<thead>
<tr>
<th>2015</th>
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<th>Total</th>
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</thead>
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<tr>
<td>Range</td>
<td>2-15</td>
<td>1-38</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>25</td>
<td>506</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>107</td>
<td>353</td>
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</table>

### Minutes between ingestion and death

<table>
<thead>
<tr>
<th>2015</th>
<th>1998-2014</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Median</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Range</td>
<td>5mins-34hrs</td>
<td>1min-104hrs</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>25</td>
<td>511</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>107</td>
<td>348</td>
</tr>
</tbody>
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1. Unknowns are excluded when calculating percentages.
2. 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.
3. First recorded beginning in 2001. Since then, 40 patients (4.4%) have chosen not to inform their families, and 19 patients (2.1%) have had no family to inform. There was one unknown case in 2002, two in 2005, one in 2009, and 3 in 2013.
4. Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.
6. 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.
7. Six patients have regained consciousness after ingesting prescribed medications, and 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.

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Letter to editor, New Haven Register

1 message

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

Dear Editor,

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

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

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

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

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

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

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

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

William L. Toffler MD
Professor of Family Medicine
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Portland, OR 97239
503-494-5322
503-494-6573 (patient care)
503-494-4496 (fax)
toffler@ohsu.edu
12 million Americans misdiagnosed each year

By JESSICA FIRGER / CBS NEWS / April 17, 2014, 5:00 AM

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."

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 PRUZYNISKI

A notary in and for the
State of Washington MASSACHUSETTS

ADDRESS: 85 MAIN ST
Florence, MA 01062

EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

[Seal]

JOHN NORTON
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 Southwest Sherwood Rd

EXPIRY OF COMMISSION: Aug, 30, 2015

PLACE SEAL HERE:

[Seal]

Affidavit of Kenneth Stevens, Jr., MD - page 4
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A-48
STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.
GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONTD)

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

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

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES


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

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

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

D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <1000/ml, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.

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

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

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

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

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

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


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 supportive 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.
GUIDELINE NOTES FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

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

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76, 195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

Lines 79, 103, 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
THE UNDERSIGNED, being first duly sworn under oath, states:

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

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

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

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

Dated this 17th day of August 2012

Jeanette Hall

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

NAME: Jeanette Hall

A notary in and for the
State of Oregon

ADDRESS: 15405 SW Millan Ave
Tigard, OR 97224

EXPIRY OF COMMISSION: September 28, 2015

PLACE SEAL HERE:

OFFICIAL SEAL
SHEENA MARIE LESLIE
NOTARY PUBLIC - OREGON
COMMISSION NO. 452203
MY COMMISSION EXPIRES SEPTEMBER 28, 2015