Attachments

Margaret Dore Memo

Vote "No" on SF 1880

Submitted to the Minnesota Senate Health, Human Services and Housing Committee

March 16th 2016
A bill for an act
relating to health; adopting compassionate care for terminally ill patients;
proposing coding for new law in Minnesota Statutes, chapter 145.

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

Section 1. [145.871] COMPASSIONATE CARE.

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

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

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

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

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

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

(f) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's terminal illness.
(g) "Counseling" means one or more consultations as necessary between a 
psychiatrist or a psychologist and a patient for the purpose of determining that the patient 
is competent and not suffering from depression or any other psychiatric or psychological 
disorder that causes impaired judgment.
(h) "Health care provider" means a person licensed, certified, or otherwise authorized 
or permitted by law to administer health care or dispense medication in the ordinary 
course of business or practice of a profession, including but not limited to a physician, 
psychiatrist, psychologist, or pharmacist.
(i) "Health care facility" means a hospital, residential care home, nursing home, 
or rest home.
(j) "Informed decision" means a decision by a qualified patient to request and obtain 
a prescription for medication that the qualified patient may self-administer for aid in 
dying, that is based on an understanding and acknowledgment of the relevant facts and 
after being fully informed by the attending physician of:
(1) the patient's medical diagnosis and prognosis;
(2) the potential risks associated with self-administering the medication to be 
prescribed;
(3) the probable result of taking the medication to be prescribed;
(4) the feasible alternatives and health care treatment options, including but not 
limited to palliative care.
(k) "Medically confirmed" means the medical opinion of the attending physician 
has been confirmed by a consulting physician who has examined the patient and the 
patient's relevant medical records.
(l) "Palliative care" means health care centered on a terminally ill patient and the 
patient's family that:
(1) optimizes the patient's quality of life by anticipating, preventing, and treating the 
patient's suffering throughout the continuum of the patient's terminal illness;
(2) addresses the physical, emotional, social, and spiritual needs of the patient;
(3) facilitates patient autonomy, the patient's access to information, and patient 
choice; and
(4) includes but is not limited to discussions between the patient and a health care 
provider concerning the patient's goals for treatment options available to the patient, 
including hospice care and comprehensive pain and symptom management.
(m) "Patient" means a person who is under the care of a physician.
(n) "Pharmacist" means a person licensed under chapter 151.
(o) "Physician" means a person licensed to practice medicine and surgery under
chapter 147.
(p) "Psychiatrist" means a psychiatrist licensed under chapter 147.
(q) "Psychologist" means a psychologist licensed under section 148.907.
(r) "Qualified patient" means a competent adult who is a resident of Minnesota, has a
terminal illness, and has satisfied the requirements of this section in order to obtain aid
in dying.
(s) "Self-administer" means a qualified patient's act of ingesting medication.
(t) "Terminal illness" means the final stage of an incurable and irreversible medical
condition that an attending physician anticipates, within reasonable medical judgment,
will produce a patient's death within six months.

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

(1) is an adult;
(2) is competent;
(3) is a resident of Minnesota;
(4) has been determined by the person's attending physician to have a terminal
illness; and
(5) has voluntarily expressed a wish to receive aid in dying

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

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

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

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

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

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

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

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

REQUEST FOR MEDICATION TO AID IN DYING

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

I am a resident of Minnesota.

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

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

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

INITIAL ONE:

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

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

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

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

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

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

Signed: .......

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

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

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

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

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

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

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

...... 4. Is not a patient for whom I am the attending physician.

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

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

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

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

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

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

(1) make a determination that the patient:

(i) is an adult;

(ii) has a terminal illness;

(iii) is competent; and

(iv) has voluntarily requested aid in dying;

(2) require the patient to demonstrate residency in this state by presenting:

(i) Minnesota driver's license;

(ii) a valid voter registration record authorizing the patient to vote in this state;

(iii) evidence that the patient owns or leases property in this state; or
(iv) any other government-issued document that the attending physician reasonably believes demonstrates that the patient is a current resident of this state;

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

(i) the patient's medical diagnosis;

(ii) the patient's prognosis;

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

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

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

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

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

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

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

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

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

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

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

Subd. 10. Process. (a) After an attending physician and a consulting physician determine that a patient is a qualified patient, and after the qualified patient submits a second request for aid in dying according to subdivision 4, the attending physician shall:

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

Subd. 11. Medical record. With respect to a request by a qualified patient for aid in
dying, the attending physician shall ensure that the following items are documented or
filed in the qualified patient's medical record:
(1) the basis for determining that the qualified patient requesting aid in dying is an
adult and is a resident of the state;
(2) all oral requests by a qualified patient for medication for aid in dying;
(3) all written requests by a qualified patient for medication for aid in dying;
(4) the attending physician's diagnosis of the qualified patient's terminal illness and
prognosis, and a determination that the qualified patient is competent, is acting voluntarily,
and has made an informed decision to request aid in dying;
(5) the consulting physician's confirmation of the qualified patient's diagnosis and
prognosis, and confirmation that the qualified patient is competent, is acting voluntarily,
and has made an informed decision to request aid in dying;
(6) a report of the outcome and determinations made during counseling, if counseling was recommended and provided as required by subdivision 9;

(7) documentation of the attending physician's offer to the qualified patient to rescind the patient's request for aid in dying at the time the attending physician writes the qualified patient a prescription for medication for aid in dying; and

(8) a statement by the attending physician indicating that all requirements under this section have been met and indicating the steps taken to carry out the qualified patient's request for aid in dying, including the medication prescribed.

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

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

Subd. 14. Contract, will, or other instrument. (a) Any provision in a contract, will, insurance policy, annuity, or other agreement, whether written or oral, that is entered into on or after October 1, 2015, that would affect whether a person may make or rescind a request for aid in dying is not valid.

(b) Any obligation owing under any currently existing contract shall not be conditioned or affected by the making or rescinding of a request for aid in dying.

(c) On and after the effective date of this section, the sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any such policy shall not be conditioned upon or affected by the making or rescinding of a request for aid in dying.

(d) A qualified patient's act of requesting aid in dying or self-administering medication prescribed for aid in dying shall not:

(1) affect a life, health, or accident insurance or annuity policy, or benefits payable under the policy;

(2) be grounds for eviction from a person's place of residence or a basis for discrimination in the terms, conditions, or privileges of sale or rental of a dwelling or in the provision of services or facilities because of the patient's request for aid in dying;

(3) provide the sole basis for the appointment of a conservator or guardian; or

(4) constitute suicide for any purpose.

Subd. 15. Participate in provision of medication. (a) As used in this section, "participate in the provision of medication" means to perform the duties of an attending
physician or consulting physician, a psychiatrist, a psychologist, or a pharmacist according

to subdivisions 2 to 10, and does not include:

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

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

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

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

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

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

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

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

(1) diagnose a patient with a terminal illness;

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

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

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

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

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

Subd. 16. Criminal act. (a) Any person who without authorization of a patient
wilfully alters or forges a request for aid in dying, as described in subdivisions 4 and 5, or

Section 1.

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10.1 conceals or destroys a rescission of a request for aid in dying with the intent or effect of causing the patient's death, is guilty of attempted murder or murder.
10.2

(b) Any person who coerces or exerts undue influence on a patient to complete a request for aid in dying, as described in subdivisions 4 and 5, or coerces or exerts undue influence on a patient to destroy a rescission of the request with the intent or effect of causing the patient's death, is guilty of attempted murder or murder.
10.7

Subd. 17. Aid in dying. (a) Nothing in this section authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, assisting a suicide, or any other active euthanasia.
10.8

(b) Any action taken according to this section does not constitute causing or assisting another person to commit suicide.
10.9

(c) No report of a public agency may refer to the practice of obtaining and self-administering life-ending medication to end a qualified patient's life as "suicide" or "assisted suicide," and shall refer to the practice as "aid in dying."
10.10

Subd. 18. Civil damages. This section does not limit liability for civil damages resulting from negligent conduct or intentional misconduct by any person.
10.11

Subd. 19. Criminal prosecution. Nothing in this section precludes criminal prosecution under any provision of law for conduct that is inconsistent with this section.
mercy killing

Also found in: Thesaurus, Medical, Legal, Acronyms, Encyclopedia, Wikipedia.

mercy killing

Euthanasia.


mercy killing

Medicine) another term for euthanasia


eu•tha•na•sia (yu'ða ner 3a, -zi a, -zi a)

Euthanasia

Also called mercy killing, the act of putting to death painlessly or allowing to die, as by withholding medical measures from a person or animal suffering from an incurable, esp. a painful, disease or condition.

[1640–50; < New Latin < Greek euthanasia easy death]


Thesaurus

Switch to new thesaurus

Noun 1. mercy killing - the act of killing someone painlessly (especially someone suffering from an incurable illness)

⇒ euthanasia

← kill, putting to death, killing - the act of terminating a life

Based on WordNet 3.0, Farlex clipart collection. © 2003-2012 Princeton University, Farlex Inc.
Protecting People at Risk

There are many different types of abuse, including:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect by a caregiver and self-neglect
- Financial exploitation, most often by trusted persons
- Financial scams

Although each of these has its own definition, victims may suffer from multiple kinds of harm, such as being physically and emotionally abused, or being neglected by a caregiver who is also taking the victim's money.

How much of this is happening?

Nationally, research estimates that about 1 in 10 older adults is a victim of abuse, neglect and/or financial exploitation. Most of this happens in homes. The majority of perpetrators are family members and other trusted individuals.

In Minnesota, there were 20,000 reports of vulnerable adult abuse, neglect and financial exploitation reported to Adult Protective Services in 2011. The number rose to 32,000 in 2012 and 34,667 in 2013. But this does not tell the whole story. These cases do not include the ones that are reported directly to law enforcement or regulatory agencies, or those that go unreported. Unreported cases far outdistance the ones that are reported, for many reasons including a victim's:

- Embarrassment
- Fear of losing independence
- Not seeing themselves as victims or knowing where to get help
- Expecting not to be believed
- Poor physical health
- Psychological dependence on the perpetrator
- Reluctance to get a family member in trouble
- Cognitive limitations
- Cultural factors
- Longstanding family dynamics make it hard to think there is any way out

Perpetrators—Who would do such a thing?

This is a problem without boundaries. It affects people all around the globe, in all economic situations, and is often hidden from view or a deeply-held “family secret” for many years. Some perpetrators are pillars of the community... the people you would least expect.

- Family members
- Paid caregivers
- New “best friends” and “sweethearts”
- Neighbors, property managers, landlords
- Religious leaders and one’s fellow members
- Interpreters and translators
- Financial/insurance/real estate advisors/fiduciaries

People who are most at risk of abuse, neglect and exploitation

Among all those whom the law defines as vulnerable and among those we think are at risk because of the people who live with them, these individuals have the highest risk of intentional harm by others:

- People with cognitive disabilities
- People with limited sight and hearing
- People who are isolated, dependent on others
- People who have suffered a loss (especially loss of spouse)
- People who are confused by money matters
- People who are tired, lonely, fearful
- People who have trouble speaking English

Indicators

Warning signs for each type of abuse, neglect and exploitation are included on their individual pages. There are also some indicators that may be present in any type of victimization:

- The victim tells you s/he is being hit or left alone or threatened or robbed.
- The victim “explains away” signs of harm or exploitation by a caregiver.
- Sleep disturbances

http://elderjusticemn.org/know-the-basics/protecting-people-at-risk/
**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

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**In-gest** (In-jëst')

*transitive verb* *In-gest*~ed, *In-gest*~ing, *In-gests*

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:**
- *In-gest*~i*ble* adjective
- *Ingestion* *In-ges-tion* noun
- *Ingestive* *In-ges-tive* adjective

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*Ingest definition*

- *Ingest (In jest')*

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http://www.yourdictionary.com/ingest
Minnesota Statutes Annotated
Probate: Property; Estates; Guardianships; Anatomical Gifts (Ch. 524-539)
Chapter 524. Uniform Probate Code (Refs & Annos)
Article 2. Intestate Succession and Wills
Part 8. General Provisions Concerning Probate and Nonprobate Transfers

M.S.A. § 524.2-803

524.2-803. Effect of homicide on intestate succession, wills, joint assets, life insurance and beneficiary designations; emergency order

Effective: August 1, 2013

Currentness

(a) A surviving spouse, heir or devisee who feloniously and intentionally kills the decedent is not entitled to any benefits under the will or under this article, including an intestate share, an elective share, an omitted spouse's or child's share, homestead, exempt property, and a family allowance, and the estate of decedent passes as if the killer had predeceased the decedent. Property appointed by the will of the decedent to or for the benefit of the killer passes as if the killer had predeceased the decedent.

(b) Any joint tenant who feloniously and intentionally kills another joint tenant thereby effects a severance of the interest of the decedent so that the share of the decedent passes as the decedent's property and the killer has no rights by survivorship. This provision applies to joint tenancies in real and personal property, joint accounts in banks, savings associations, credit unions and other institutions, and any other form of co-ownership with survivorship incidents.

(c) A named beneficiary of a bond or other contractual arrangement who feloniously and intentionally kills the principal obligee is not entitled to any benefit under the bond or other contractual arrangement and it becomes payable as though the killer had predeceased the decedent.

(d) A named beneficiary of a life insurance policy who feloniously and intentionally kills the person upon whose life the policy is issued is not entitled to any benefit under the policy and the proceeds of the policy shall be paid and distributed by order of the court as hereinafter provided. If a person who feloniously and intentionally kills a person upon whose life a life insurance policy is issued is a beneficial owner as shareholder, partner or beneficiary of a corporation, partnership, trust or association which is the named beneficiary of the life insurance policy, to the extent of the killer's beneficial ownership of the corporation, partnership, trust or association, the proceeds of the policy shall be paid and distributed by order of the court as hereinafter provided.

Upon receipt of written notice by the insurance company at its home office that the insured may have been intentionally and feloniously killed by one or more named beneficiaries or that the insured may have been intentionally and feloniously killed by one or more persons who have a beneficial ownership in a corporation, partnership, trust or association, which is the named beneficiary of the life insurance policy, the insurance company shall, pending court order, withhold payment of the policy proceeds to all beneficiaries. In the event that the notice has not been received by the insurance company before payment of the policy proceeds, the insurance company shall be fully and finally discharged and released from any and all responsibility under the policy to the extent that the policy proceeds have been paid.

The named beneficiary, the insurance company or any other party claiming an interest in the policy proceeds may commence an action in the district court to compel payment of the policy proceeds. The court may order the insurance company to pay the policy proceeds to any person equitably entitled thereto, including the deceased insured's spouse, children, issue, parents,
**undue influence**

*noun*  **LAW**

influence by which a person is induced to act otherwise than by their own free will or without adequate attention to the consequences.

Translations, word origin, and more definitions

Undue influence legal definition of undue influence
legal-dictionary.thefreedictionary.com/undue+influence ▼

Undue Influence. A judicially created defense to transactions that have been imposed upon weak and vulnerable persons that allows the transactions to be set ...

What is undue influence? definition and meaning
www.businessdictionary.com/definition/undue-influence.html ▼

Exercise of undue influence is characterized often by excessive insistence, superiority of physical power, mind, or will, or pressure applied due to authority, position, or relationship in relation to the strength of the person submitting to it.

Undue Influence Definition - Duhaime.org
www.duhaime.org ▼

About 530,000 results (0.44 seconds)

Undue influence - Wikipedia, the free encyclopedia

In jurisprudence, undue influence is an equitable doctrine that involves one person ..., in probate law, undue influence is generally defined as a testator's loss of ...

undue influence Definition in the Cambridge English ...
dictionary.cambridge.org/.../undue_influence ▼

In exercise of undue influence, the influencing individual is able to gain an advantage.

Undue influence - Wikipedia

In jurisprudence, undue influence is an equitable doctrine that involves one person ..., in probate law, undue influence is generally defined as a testator's loss of ...

Undue influence Definition in the Cambridge English ...
dictionary.cambridge.org/.../undue_influence ▼

In exercise of undue influence, the influencing individual is able to gain an advantage.

Undue influence Law & Legal Definition
definitions.uslegal.com ▼

Undue influence is a term often used in will contests to refer to outside pressures which negate the free will of the testator (will maker), so that the maker of the ...

Undue influence | Wex Legal Dictionary | Encyclopedia | LII ...
https://www.law.cornell.edu/.../undue_influence ▼

The use of undue influence by one party over another puts the free will of one of the parties entering the ... To prove undue influence, a party must show that one party to the contract is a person with weaknesses which make ...

Undue influence - e-lawresources.co.uk
e-lawresources.co.uk/Undue_Influence.php ▼
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 on a series of vacations, including a cruise to the Caribbean, a trip to

http://www.seattleweekly.com/content/printVersion/553991/
Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Every morning when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he’s OK," she explains.
The issue of elder abuse made front-page news in 2009 when famed philanthropist Brooke Astor’s son, Anthony Marshall, was convicted on 14 of 16 counts for financially exploiting his mother, stealing millions of dollars from her.

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

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

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

“It was such a horrible story. This widow by herself with nobody looking after her, and then he convinces her that her family is trying to take advantage of her,” Robinson says. Cases such as Goode’s and Astor’s are all too common, say experts, yet the issue of elder abuse often goes unnoticed.

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

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

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

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

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

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

Another finding, from a 2011 report on New York State elder abuse prevalence, revealed that major financial exploitation was self-reported at a rate of 41 per 1,000 older residents surveyed, higher than other forms of abuse. [3] ([bar-resources/publications/washington-lawyer/articles/february-2015-elder-abuse.cfm#ftnref3])

Misplaced Trust
Traci Tait often deals with elder abuse cases at her job as assistant Bar counsel with the D.C. Office of Bar Counsel. Tait handled the Goode case, which in many ways was not that different from the many cases concerning the elderly that are taken by Bar Counsel. However, the U.S. Attorney’s Office also became involved with the Goode case, and Tait ended up
working collaboratively with the FBI.

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

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

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

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

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

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

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

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

**The Silent Crime**

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

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

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

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

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

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

Mary Ann Parker also works for LCE, but as an attorney for the Office of the D.C. Long Term-Care Ombudsman Program, which monitors individuals in long-term care facilities in the District, including nursing homes, group homes, and assisted living facilities, as well as people who are getting a high level of service at home through the Medicaid waiver.

Parker says the program received about 50 complaints within the last year or two concerning elder physical or sexual abuse or neglect. The complaints take a lot of investigation and, similar to financial exploitation, it can be difficult to prove that abuse or neglect had taken place.

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

Judge Sets Plea Entry for Sept. 6

News sources
BEND, Ore.

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

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

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

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

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

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

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

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

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

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

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

State and court documents show Middleton, who suffered from Lou Gehrig’s disease, moved into Sawyer’s home in July 2008, months after naming her trustee of his estate, The Bulletin reported Saturday. Middleton deeded his home to the trust and directed her to make it a rental until the real estate market improved.

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than $200,000, the documents show, and it was deposited into an account for one of Sawyer’s businesses, Starboard LLC, and $90,000 of that was transferred to two other Sawyer companies, Genesis Futures and Tami Sawyer PC.
Oregon Revised Statute

Chapter 127

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

Please browse this page or download the statute for printing - (or read the statute at https://www.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 the attending physician or consulting physician, a patient has the ability to make and communicate health care decisions to his or her attending physician and 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 a 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>
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<th>Characteristics</th>
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<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>
<td>Male (%)</td>
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<tr>
<td>75-84 (%)</td>
<td>30 (22.7)</td>
<td>229 (26.7)</td>
<td>259 (26.1)</td>
</tr>
<tr>
<td>85+ (%)</td>
<td>32 (24.2)</td>
<td>113 (13.2)</td>
<td>145 (14.6)</td>
</tr>
<tr>
<td>Median years (range)</td>
<td>73 (30-102)</td>
<td>71 (25-96)</td>
<td>71 (25-102)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (%)</td>
<td>122 (93.1)</td>
<td>831 (97.1)</td>
<td>953 (96.6)</td>
</tr>
<tr>
<td>African American (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>American Indian (%)</td>
<td>0 (0.0)</td>
<td>2 (0.2)</td>
<td>2 (0.2)</td>
</tr>
<tr>
<td>Asian (%)</td>
<td>4 (3.1)</td>
<td>9 (1.1)</td>
<td>13 (1.3)</td>
</tr>
<tr>
<td>Pacific Islander (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>0 (0.0)</td>
<td>3 (0.4)</td>
<td>3 (0.3)</td>
</tr>
<tr>
<td>Two or more races (%)</td>
<td>1 (0.8)</td>
<td>3 (0.4)</td>
<td>4 (0.4)</td>
</tr>
<tr>
<td>Hispanic (%)</td>
<td>4 (3.1)</td>
<td>6 (0.7)</td>
<td>10 (1.0)</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married (including Registered Domestic Partner) (%)</td>
<td>52 (39.7)</td>
<td>395 (46.1)</td>
<td>447 (45.3)</td>
</tr>
<tr>
<td>Widowed (%)</td>
<td>34 (26.0)</td>
<td>198 (23.1)</td>
<td>232 (23.5)</td>
</tr>
<tr>
<td>Never married (%)</td>
<td>9 (6.9)</td>
<td>69 (8.1)</td>
<td>78 (7.9)</td>
</tr>
<tr>
<td>Divorced (%)</td>
<td>36 (27.5)</td>
<td>194 (22.7)</td>
<td>230 (23.3)</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school (%)</td>
<td>7 (5.4)</td>
<td>51 (6.0)</td>
<td>58 (5.9)</td>
</tr>
<tr>
<td>High school graduate (%)</td>
<td>31 (23.8)</td>
<td>187 (21.9)</td>
<td>218 (22.2)</td>
</tr>
<tr>
<td>Some college (%)</td>
<td>36 (27.7)</td>
<td>224 (26.2)</td>
<td>260 (26.4)</td>
</tr>
<tr>
<td>Baccalaureate or higher (%)</td>
<td>56 (43.1)</td>
<td>392 (45.9)</td>
<td>448 (45.5)</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro counties (Clackamas, Multnomah, Washington) (%)</td>
<td>64 (49.2)</td>
<td>361 (42.3)</td>
<td>425 (43.2)</td>
</tr>
<tr>
<td>Coastal counties (%)</td>
<td>7 (5.4)</td>
<td>63 (7.4)</td>
<td>70 (7.1)</td>
</tr>
<tr>
<td>Other western counties (%)</td>
<td>48 (36.9)</td>
<td>365 (42.7)</td>
<td>413 (42.0)</td>
</tr>
<tr>
<td>East of the Cascades (%)</td>
<td>11 (8.5)</td>
<td>65 (7.6)</td>
<td>76 (7.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>End of life care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>118 (92.2)</td>
<td>747 (90.2)</td>
<td>865 (90.5)</td>
</tr>
<tr>
<td>Not enrolled (%)</td>
<td>10 (7.8)</td>
<td>81 (9.8)</td>
<td>91 (9.5)</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>31</td>
<td>35</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private (alone or in combination) (%)</td>
<td>44 (36.7)</td>
<td>489 (60.2)</td>
<td>533 (57.2)</td>
</tr>
<tr>
<td>Medicare, Medicaid or other governmental (%)</td>
<td>75 (62.5)</td>
<td>311 (38.3)</td>
<td>386 (41.4)</td>
</tr>
<tr>
<td>None (%)</td>
<td>1 (0.8)</td>
<td>12 (1.5)</td>
<td>13 (1.4)</td>
</tr>
<tr>
<td>Unknown</td>
<td>12</td>
<td>47</td>
<td>59</td>
</tr>
</tbody>
</table>

### Characteristics

#### Underlying Illness

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung and bronchus (%)</td>
<td>23 (17.4)</td>
<td>154 (18.0)</td>
<td>177 (17.9)</td>
</tr>
<tr>
<td>Breast (%)</td>
<td>9 (6.8)</td>
<td>64 (7.5)</td>
<td>73 (7.4)</td>
</tr>
<tr>
<td>Colon (%)</td>
<td>7 (5.3)</td>
<td>54 (6.3)</td>
<td>61 (6.2)</td>
</tr>
<tr>
<td>Pancreas (%)</td>
<td>7 (5.3)</td>
<td>56 (6.5)</td>
<td>63 (6.4)</td>
</tr>
<tr>
<td>Prostate (%)</td>
<td>5 (3.8)</td>
<td>35 (4.1)</td>
<td>40 (4.0)</td>
</tr>
<tr>
<td>Ovary (%)</td>
<td>3 (2.3)</td>
<td>33 (3.9)</td>
<td>36 (3.6)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>41 (31.1)</td>
<td>271 (31.7)</td>
<td>312 (31.6)</td>
</tr>
<tr>
<td>Amyotrophic lateral sclerosis (%)</td>
<td>8 (6.1)</td>
<td>71 (8.3)</td>
<td>79 (8.0)</td>
</tr>
<tr>
<td>Chronic lower respiratory disease (%)</td>
<td>6 (4.5)</td>
<td>38 (4.4)</td>
<td>44 (4.5)</td>
</tr>
<tr>
<td>Heart disease (%)</td>
<td>9 (6.8)</td>
<td>17 (2.0)</td>
<td>26 (2.6)</td>
</tr>
<tr>
<td>HIV/AIDS (%)</td>
<td>0 (0.0)</td>
<td>9 (1.1)</td>
<td>9 (0.9)</td>
</tr>
<tr>
<td>Other illnesses (%)</td>
<td>14 (10.6)</td>
<td>54 (6.3)</td>
<td>68 (6.9)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

#### DWDA process

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred for psychiatric evaluation (%)</td>
<td>5 (3.8)</td>
<td>47 (5.5)</td>
<td>52 (5.3)</td>
</tr>
<tr>
<td>Patient informed family of decision (%)</td>
<td>126 (95.5)</td>
<td>729 (93.2)</td>
<td>855 (93.5)</td>
</tr>
<tr>
<td>Patient died at Home (patient, family or friend) (%)</td>
<td>118 (90.1)</td>
<td>810 (94.6)</td>
<td>928 (94.0)</td>
</tr>
<tr>
<td>Long term care, assisted living or foster care facility (%)</td>
<td>9 (6.9)</td>
<td>37 (4.3)</td>
<td>46 (4.7)</td>
</tr>
<tr>
<td>Hospital (%)</td>
<td>0 (0.0)</td>
<td>1 (0.1)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Other (%)</td>
<td>4 (3.1)</td>
<td>8 (0.9)</td>
<td>12 (1.2)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

#### End of life concerns

<table>
<thead>
<tr>
<th>Concern</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less able to engage in activities making life enjoyable (%)</td>
<td>127 (96.2)</td>
<td>758 (88.7)</td>
<td>885 (89.7)</td>
</tr>
<tr>
<td>Losing autonomy (%)</td>
<td>121 (92.4)</td>
<td>782 (91.5)</td>
<td>903 (91.6)</td>
</tr>
<tr>
<td>Loss of dignity (%)</td>
<td>98 (75.4)</td>
<td>579 (79.3)</td>
<td>677 (78.7)</td>
</tr>
<tr>
<td>Losing control of bodily functions (%)</td>
<td>46 (35.7)</td>
<td>428 (50.1)</td>
<td>474 (48.2)</td>
</tr>
<tr>
<td>Burden on family, friends/caregivers (%)</td>
<td>63 (48.1)</td>
<td>342 (40.0)</td>
<td>405 (41.1)</td>
</tr>
<tr>
<td>Inadequate pain control or concern about it (%)</td>
<td>37 (28.7)</td>
<td>211 (24.7)</td>
<td>248 (25.2)</td>
</tr>
<tr>
<td>Financial implications of treatment (%)</td>
<td>3 (2.3)</td>
<td>27 (3.2)</td>
<td>30 (3.1)</td>
</tr>
</tbody>
</table>

#### Health care provider present (collected 2001-present)

<table>
<thead>
<tr>
<th>Provider</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=789)</th>
<th>Total (N=921)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing physician</td>
<td>15</td>
<td>133</td>
<td>148</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
<td>13</td>
<td>243</td>
<td>256</td>
</tr>
<tr>
<td>No provider</td>
<td>6</td>
<td>81</td>
<td>87</td>
</tr>
<tr>
<td>Unknown</td>
<td>98</td>
<td>332</td>
<td>430</td>
</tr>
</tbody>
</table>

#### When medication was ingested

<table>
<thead>
<tr>
<th>Provider</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=789)</th>
<th>Total (N=921)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing physician</td>
<td>14 (10.8)</td>
<td>121 (15.7)</td>
<td>135 (15.0)</td>
</tr>
<tr>
<td>Other provider, prescribing physician not present</td>
<td>13 (10.0)</td>
<td>268 (34.7)</td>
<td>281 (31.2)</td>
</tr>
<tr>
<td>No provider</td>
<td>103 (79.2)</td>
<td>383 (60.6)</td>
<td>486 (53.9)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>17</td>
<td>19</td>
</tr>
</tbody>
</table>

---

1. [Link to Oregon Public Health Division's website](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf)
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2015 (N=132)</th>
<th>1998-2014 (N=859)</th>
<th>Total (N=991)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complications</strong>&lt;sup&gt;6&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regurgitated</td>
<td>2</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<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>
<tr>
<td><strong>Other outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regained consciousness after ingesting DWDA medications&lt;sup&gt;7&lt;/sup&gt;</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

### Timing of DWDA event

#### Duration (weeks) of patient-physician relationship

<table>
<thead>
<tr>
<th>Duration</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>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

#### Duration (days) between 1st request and death

<table>
<thead>
<tr>
<th>Duration</th>
<th>2015</th>
<th>1998-2014</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>45</td>
<td>47</td>
<td>46</td>
</tr>
<tr>
<td>Range</td>
<td>15-517</td>
<td>15-1009</td>
<td>15-1009</td>
</tr>
<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>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

#### Minutes between ingestion and unconsciousness<sup>6</sup>

<table>
<thead>
<tr>
<th>Duration</th>
<th>2015</th>
<th>1998-2014</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<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>25</td>
<td>506</td>
<td>531</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>107</td>
<td>353</td>
<td>460</td>
</tr>
</tbody>
</table>

#### Minutes between ingestion and death<sup>6</sup>

<table>
<thead>
<tr>
<th>Duration</th>
<th>2015</th>
<th>1998-2014</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Range</td>
<td>5mins-34hrs</td>
<td>1min-104hrs</td>
<td>1min-104hrs</td>
</tr>
<tr>
<td>Number of patients with information available</td>
<td>25</td>
<td>511</td>
<td>536</td>
</tr>
<tr>
<td>Number of patients with information unknown</td>
<td>107</td>
<td>348</td>
<td>455</td>
</tr>
</tbody>
</table>

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

<sup>2</sup> Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson’s disease and Huntington’s disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.

<sup>3</sup> 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.

<sup>4</sup> Affirmative answers only ("Don’t know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

<sup>5</sup> First asked in 2003. Data available for 130 patients in 2015, 730 patients between 1998-2014, and 860 patients for all years.

<sup>6</sup> A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

<sup>7</sup> 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.
Letter to editor, New Haven Register

Sun, Feb 23, 2014 at 7:23 PM

William Toffler <toffler@ohsu.edu>
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.noassistedsuicidectconnecticut.org/2014/02/oregons-new-assisted-suicide-report.html

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

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

William L. Toffler MD
Professor of Family Medicine
3181 SW Sam Jackson Park Road
Portland, OR 97239
503-494-5322
503-494-8573 (patient care)
503-494-4496 (fax)
toffler@ohsu.edu
12 million Americans misdiagnosed each year

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 16th, 2012

NAME: Heidi Pruzyńska
A notary in and for the
State of Washington MASSACHUSETTS

ADDRESS: 85 MAIN ST
Plumfield MA 01062
EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

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:

Affidavit of Kenneth Stevens, Jr., MD - page 4

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STATEMENT OF INTENT FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

STATEMENT OF INTENT 1: PALLIATIVE CARE

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

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

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

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

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

Some examples of covered palliative care treatments include:

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

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

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

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

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

STATEMENT OF INTENT 3: INTEGRATED CARE

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

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

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

Central serous retinopathy (362.41) is included on this line only for treatment when the condition has been present for 3 months or longer. Pars planitis (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 <1000 mcL, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.

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

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

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

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

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

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


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

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

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

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

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

4-16-2012
GUIDELINE NOTES FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

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

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

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

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

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

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

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

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

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

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

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

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

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

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

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

Ventricular assist devices are not covered for destination therapy.

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

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

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
AFFIDAVIT OF JEANETTE HALL
OPPOSING ASSISTED SUICIDE

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

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

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

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

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: 1505 SW Lumina Ave

EXPIRY OF COMMISSION: September 12, 2013

PLACE SEAL HERE:

Affidavit of Jeanette Hall - Page 2
BEFORE THE LEGISLATURE OF THE
STATE OF NEW YORK

IN RE NEW YORK BILLS

DECLARATION OF KENNETH
STEvens, MD

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

1. I am a doctor in Oregon where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have published articles in medical journals and written chapters for books on medical topics. This has been for both a national and international audience. I work in both hospital and clinical settings. I have treated thousands of patients with cancer.

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

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

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

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

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

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

8. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.
9. Finally, I have been asked to comment on generally accepted medical practice regarding the administration of prescription drugs to a patient.

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

Signed under penalty of perjury, this 6th day of January, 2016.

Kenneth Stevens, Jr., MD
Sherwood, Oregon
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.
Derek Humphry to be Keynote Speaker at 2011 Annual Meeting

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

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

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

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

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 suicide debate heated up in 1997. The plan, recently hailed as one of the nation's top

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

B. Wagner, J. Müller, A. Maercker

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

World Suicide Prevention Day is September 10

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

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

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

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

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

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

The report also included the following findings:

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

Oregon Health Authority
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 8\(^{th}\) leading cause of death among all ages in Oregon\(^5\). The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars\(^3,5\). 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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\(^1\) Oregon Healthy Teens 2009-11\(^{th}\) Grade Results. 


