MEMORANDUM

TO: The New York State Legislature

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

RE: Vote "No" on Assisted Suicide and Euthanasia Bills A. 10059 and S. 7579

DATE: May 31, 2016

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I. INTRODUCTION

I am a lawyer in Washington State where physician-assisted suicide and euthanasia are legal. Our law is based on a similar law in Oregon. Both laws are similar to the proposed bills, A. 10059 and S. 7579.

The bills are titled “Medical Aid in Dying.” There is, however, no requirement that patients be dying. “Eligible” patients may have years, even decades, to live. The bills are also sold as a promotion of patient choice and control. The bills are instead stacked against the patient and a recipe for elder abuse. Finally, the bills are deceptively written; they are not what they appear to be. I urge you to vote “No.”

II. FACTUAL AND LEGAL BACKGROUND

A. Definitions: Physician-Assisted Suicide; Assisted Suicide; and Euthanasia.

The American Medical Association (AMA) defines physician-assisted suicide as occurring 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." The AMA gives this example:

[A] physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.4

"Assisted suicide" is a general term in which the assisting person is not necessarily a physician. "Euthanasia," by contrast, is the direct administration of a lethal agent with the intent to cause another person's death.5

B. Withholding or Withdrawing Treatment Is Not Assisted Suicide or Euthanasia.

Withholding or withdrawing treatment ("pulling the plug") is not assisted suicide or euthanasia when the purpose is to withhold or remove burdensome treatment -- as opposed to an intent to kill the patient. More importantly, the patient does not necessarily die. Consider this quote from an article in Washington state regarding a man removed from a ventilator:

[I]nstead of dying as expected, [he] slowly began to get better.6

C. The AMA Rejects Assisted Suicide and Euthanasia.

The AMA rejects assisted suicide and euthanasia, stating

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3 The AMA Code of Medical Ethics, Opinion 2.211, Physician-Assisted Suicide. (Attached hereto at A-13).

4 Id.

5 Opinion 2.21, Euthanasia. (Attached hereto at A-14).

6 Nina Shapiro, "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?," The Seattle Weekly, January 14, 2009. (Article attached hereto at A-15; quote attached at A-17).
they are:

[F]undamentally incompatible with the physician's role as healer, would be
difficult or impossible to control, and would
pose serious societal risks.\(^7\)

D. Elder Abuse Includes the Neglect, 
Financial Exploitation and Murder 
of Older Adults

Elder abuse is a problem throughout the United States,
including New York.\(^8\) Perpetrators are often family members who
start out with small crimes, such as stealing jewelry and blank
checks, before moving on to larger items or to coercing victims
to sign over deeds to their homes, to change their wills or to
liquidate their assets.\(^9\)

Perpetrators can also be calculating criminals. Consider
Melissa Ann Shepard, the "Internet Black Widow," whose past
crimes include: (1) killing her husband who was "heavily drugged"
when she ran him over with her car; (2) administering a "noxious
substance and failing to provide the necessaries of life" to
another husband; and (3) suspicious circumstances surrounding the

\(^7\) See AMA Code of Medical Ethics, Opinions 2.211 and 2.21, supra at A-13
and A-14).

\(^8\) Met Life Mature Market Institute, Broken Trust: Elders, Family and
Finances," March 2009, available at
https://www.metlife.com/assets/cao/nni/publications/studies/mni-study-broken-t
rust-elders-family-finances.pdf; Anemona Hartocollis, "Manhattan Doctor is
Accused of Fleecing Mother Out of $800,000, The New York Times, January 24,
2008 (Attached at A-18); and Robert D. McFadden, "Anthony D. Marshall, Astor
Son Who Was Convicted in Swindle, Dies at 90," The New York Times, December 1,

\(^9\) Met Life Mature Market Institute, supra.
death of yet another husband. A recent article states:

[These men] sought companionship and found instead . . . someone who siphoned their savings, slipped drugs into their food and, in the case of one man, ran him over . . . and left him dead on a dirt road.

D. Victims Do Not Report

Elder abuse is a largely hidden problem, in part, due to the reluctance of victims to report. In the United States, it’s estimated that only 1 in 14 cases ever comes to the attention of the authorities. In another study, it was 1 out of 25 cases.

Reasons for the lack of reporting include:

Older adults . . . feel ashamed or embarrassed to tell anyone they are being abused by someone they trust. They may fear retaliation or punishment, or they may have concerns about having to move from their home or community.

Many . . . don’t want to report their own child as an abuser.

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12 Nat’l Center on Elder Abuse, http://www.ncea.aoa.gov/Library/Data/

13 Id.


III. THE BILLS

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

The bills apply to persons with a "terminal illness," which is defined as having less than six months to live. Such persons may, in fact, have years, even decades, to live. This is due to misdiagnosis and the fact that predicting life expectancy is not an exact science. Consider John Norton, who was diagnosed with ALS at age 18. He was told that he would get progressively worse (be paralyzed) and die in three to five years. Instead, the disease progression stopped on its own. In a 2012 affidavit, at age 74, he states:

If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.

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16 The bills, § 2899-d.17, state:

"Terminal illness" means an illness that will, within reasonable medical judgment, result in death within six months, whether or not treatment is provided.

Attached hereto at A-2 and A-8.

17 See Jessica Firger, "12 million Americans misdiagnosed each year," CBS NEWS, 4/17/14 (attached at A-27); and Nina Shapiro, "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?", The Seattle Weekly, January 14, 2009. (Excerpts attached hereto at A-15 through A-17).


19 Id., ¶ 1.

20 Id., ¶ 1.

21 Id., ¶ 5.
B. How the Bills Work

The bills have an application process to obtain the lethal dose, which includes a request form with two required witnesses.\(^2\) One of the witnesses is allowed to be the patient’s heir, who will benefit financially from the patient’s death.\(^2\) Once the lethal dose is issued by the pharmacy, there is no required oversight.\(^2\) The cause of death is reported on the death certificate as a terminal illness.\(^2\)

C. A Comparison to Probate Law

When signing a will, having an heir act as a witness can support a finding of undue influence. Washington’s probate code, for example, states that when one of two witnesses is a taker under the will, there is a rebuttal presumption that the taker/witness:

\[
\text{procured the gift by duress, menace, fraud, or undue influence.} \quad 26
\]

The bills’ lethal dose request process, which allows the patient’s heir to act as a witness on the lethal dose request form, invites coercion.

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\(^2\) Bills, § 2899.1 (Attached hereto at A-3 to A-5, and A-9 to A-11).

\(^2\) Id., at A-4 and A-10.

\(^2\) See the bills in their entirety, at A-1 through A-12.

\(^2\) See the bills, at A-6 and A-12, § 2899-q.2.

D. Other People are Allowed to Communicate on the Patient's Behalf

The proposed bills require a patient to have "capacity." This is a relaxed standard in which other people are allowed to communicate on behalf of the patient to his or her physician. The bills state:

"Capacity" or "capacity to make an informed decision means the ability . . . to communicate health care decisions to a physician, including communication through persons familiar with the patient's manner of communicating . . . .

There is no requirement that the communicating person be the patient's designated agent, for example, through a power of attorney. The communicating person could also be the patient's heir or a new "best friend." With someone else allowed to communicate for the patient, the patient's choice and control is not guaranteed.

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27 § 2899-d.15 (requiring a "qualified individual" to have "capacity"). (Attached at A-2 and A-8).

28 § 2899-d.3 states:

"Capacity" or "capacity to make an informed decision" means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision and to communicate health care decisions to a physician, including communication through persons familiar with the patient's manner of communicating if those persons are available. (Emphasis added).

Attached at A-1 and A-7.

29 See both bills in their entirety, at A-1 through A-12.

30 Id.
E. There is a Complete Lack of Oversight at the Death

There is no required oversight when the lethal dose is administered.\textsuperscript{31} No doctor, not even a witness is required to be present at the death.\textsuperscript{32}

Without oversight, the opportunity is created for someone else to administer the lethal dose to the patient without his or her consent, and with no one else to know what happened. The drugs used are water and alcohol soluble, such that they can be administered to a sleeping or restrained person.\textsuperscript{33} The prior lethal dose request provides the alibi.

Possible motivations include an inheritance or other financial benefit as was the case with the Internet Black Widow, Melissa Ann Shepard.\textsuperscript{34} Medical professionals too, can have financial motives, for example, to cover up malpractice. Darker motives include the occasional health care professional who just

\textsuperscript{31} See proposed bills in their entirety, attached hereto at A-1 to A-12.

\textsuperscript{32} Id.

\textsuperscript{33} The drugs used for assisted suicide in Oregon and Washington include Secobarbital and Pentobarbital (Nembutal), which are water and alcohol soluble. See "Secobarbital Sodium Capsules, Drugs.Com, at http://www.drugs.com/pr/secobarbital-sodium.html and http://www.drugs.com/pr/pentobarbital-sodium.html. See also Oregon’s government report, page 6, attached at A-32 (listing these drugs).

\textsuperscript{34} Supra at pp. 3-4. See also article attached hereto at A-25.
likes to kill people. Even if the patient struggled, who would know?

F. Individual “Opt Outs” are Not Allowed

The proposed bills do not allow an individual to opt out of their provisions. Consider, for example, an older woman with a house and a bank account, concerned that her unemployed son will push her to assisted suicide. A possible deterrent is a will provision stating that the son will be disinherited if she dies under the bills. No such provision, however, is valid. The bills state:

No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication or take any other action under this article, shall be valid. (Emphasis added).

So much for personal choice and control.

G. If New York Follows Washington State, the Death Certificate Will Report a Natural Death Without Even a Hint That the Actual Cause of Death Was Assisted Suicide or Euthanasia

The proposed bills state:

Action taken in accordance with this article shall not be construed for any purpose to


36 Bills, § 2899-o.2(a), attached hereto at A-5 and A-11.
constitute suicide, assisted suicide, attempted suicide, promoting a suicide attempt, mercy killing [another term for euthanasia], or homicide under the law, including as an accomplice or accessory or otherwise. (Emphasis added).\textsuperscript{37}

The bills also state that the cause of death on the death certificate will be the patient’s “underlying terminal illness.”\textsuperscript{38}

In Washington State, similar language is interpreted by the Washington State Department of Health to require the death certificate to list a natural death without even a hint that the actual cause of death was assisted suicide or euthanasia. The Department’s “Death Certificate Instructions for Medical Examiners, Coroners and Prosecuting Attorneys,” states:

Washington’s [law] . . . 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 [Washington’s law], 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 [Washington’s law] was used,\textsuperscript{37}

\textsuperscript{37} § 2899-o.1.(b), attached hereto at A-5 and A-11.

\textsuperscript{38} § 2899.q.2, attached hereto at A-6 and A-12.
such as:

a. Suicide
b. Assisted suicide
c. Physician-assisted suicide
d. Death with Dignity
e. I-1000 [Washington’s law was passed by I-1000]
f. Mercy killing
g. Euthanasia
h. Secobarbital or Seconal
i. Pentobarbital or Nembutal (Emphasis added.)

If New York enacts the proposed bills and follows Washington’s example, death certificates will list a natural death caused by a terminal illness. The significance is a legal inability to prosecute homicide, even in the case of an outright murder for the money. The cause of death will be a “terminal illness” as a matter of law.

H. The “Rule of Lenity” Requires That Conflicting Criminal Provisions Be Construed in Favor of Potential Defendants

New York follows the rule of lenity, which gives defendants the benefit of the doubt when criminal statutes contain ambiguous provisions. People v. Walters, 30 Misc.3d 737, 745 (2010).

The rule is relevant to the proposed bills, which contain conflicting provisions. For example, in § 2899-m, doctors and other participants in a patient’s death, who act in good faith, “shall not be subject to civil or criminal liability or

39 A copy of the Washington State Department of Health death certificate instruction is attached hereto at A-33.
professional disciplinary action."  In the very next paragraph, there is the opposite idea, that "[n]othing in this section shall limit criminal or civil liability." With the rule of lenity, the bills will likely be construed in favor of potential defendants (doctors, heirs, etc). Once again, the patient will be unprotected.

IV. OTHER CONSIDERATIONS

A. Compassion & Choices' Mission is to Promote Suicide

Passage of the proposed bills is being spearheaded by the suicide advocacy group, Compassion & Choices, which was formed in 2004 as the result of a merger/takeover of two other organizations. One of these organizations was the former Hemlock Society, originally formed by Derek Humphry.

In 2011, Humphry was the keynote speaker at Compassion & Choices' annual meeting here in Washington State. He was also

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40 Attached hereto at A-5 and A-11.

41 Id.

42 Ian Dowbiggin, A Concise History of Euthanasia 146 (2007) ("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices."). Accord. Compassion & Choices Newsletter attached at A-82 ("Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion in Dying to become Compassion & Choices").

43 Id.

44 Compassion & Choices Newsletter, regarding Humphry’s October 22, 2011 speaking date. (Attached hereto at A-34)
in the news as a promoter of mail-order suicide kits.\footnote{See Jack Moran, "Police kick in door in confusion over suicide kit," The Register-Guard, September 21, 2011 ("A spotlight was cast on the mail-order suicide kit business after a 29-year-old Eugene man committed suicide in December using a helium hood kit. The Register-Guard traced the $60 kit to [the company, which] has no website and does no advertising; clients find [the] address through the writings of Humphry.") (Emphasis added)} This was after a depressed 29 year old man used one of the kits to kill himself.\footnote{Id.} Compassion & Choices’ newsletter, promoting Humphry’s presentation, references him as “the father of the modern movement for choice.”\footnote{Compassion & Choices Newsletter, at A-34.} Compassion & Choices’ mission is to promote suicide.

B. “Beware of Vultures”: Compassion & Choices’ Mission is Financial, Involving “Millions, Maybe Billions of Dollars”

In 2013, Montana State Senator Jennifer Fielder published an article titled “Beware of Vultures,” discussing Compassion & Choices.\footnote{Published as Communication from Your State Senator, "Beware of Vultures," by Montana State Senator Jennifer Fielder, Sanders County Ledger, http://www.scledger.net, page 2, 6-4-13 (Internet re-publication is attached hereto at A-35).} The article said:

“Where does all the lobby money come from?”
If it really is about a few terminally ill people who might seek help ending their suffering, why was more money spent on promoting assisted suicide than any other issue in Montana? . . .

Could it be that convincing an ill person to end [his or her] life early will help health insurance companies save a bundle on what would have been ongoing medical treatment? .

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\footnote{45}{See Jack Moran, "Police kick in door in confusion over suicide kit," The Register-Guard, September 21, 2011 ("A spotlight was cast on the mail-order suicide kit business after a 29-year-old Eugene man committed suicide in December using a helium hood kit. The Register-Guard traced the $60 kit to [the company, which] has no website and does no advertising; clients find [the] address through the writings of Humphry.") (Emphasis added)}
\footnote{46}{Id.}
\footnote{47}{Compassion & Choices Newsletter, at A-34.}
\footnote{48}{Published as Communication from Your State Senator, "Beware of Vultures," by Montana State Senator Jennifer Fielder, Sanders County Ledger, http://www.scledger.net, page 2, 6-4-13 (Internet re-publication is attached hereto at A-35).}
How much financial relief would pension systems see? Would vulnerable old people be encouraged to end their [lives] unnecessarily early by those seeking financial gain?

When considering the financial aspects of assisted suicide, it is clear that millions, maybe billions of dollars, are intertwined with the issue being marketed as "Compassion and Choices". Beware.

C. Compassion & Choices" Mission is to Reduce Access to Cures

For more information, see Bradley Williams (with Margaret Dore), "Assisted suicide is not legal, not the answer," The Missoulian, August 21, 2014. (Attached hereto at A-37).

D. Physician-Assisted Suicide Can Be Traumatic for Family Members

In 2012, a research study was released addressing trauma suffered by persons who had witnessed a legal assisted suicide in Switzerland. The study found that one out of five family members or friends present at an assisted suicide was traumatized. These people, experienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.


Id.
E. My Clients Were Traumatized by Legal Assisted Suicide in Washington State and Oregon

In Washington and Oregon, I have had two cases where my clients suffered trauma in connection with legal assisted suicide. In the first case, one side of the family wanted my client’s father to take the lethal dose, while the other side did not. The father spent the last months of his life caught in the middle and torn over whether or not he should kill himself. My client, his adult daughter, was severely traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it is not clear that administration of the lethal dose was voluntary. A man who was present told my client that my client’s father had refused to take the lethal dose when it was delivered, stating, "You're not killing me. I'm going to bed," but then he (the father) took the lethal dose the next night when he was intoxicated on alcohol. My client, although he was not present at the death, was traumatized over the incident, and also by the sudden loss of his father.

F. Any Study Claiming that Oregon’s Law is Safe, is Invalid

In 2011, the lack of supervision over administration of the lethal dose in Oregon prompted Montana State Senator Jeff Essmann to observe that any studies claiming that Oregon’s law is safe are invalid. He stated:

[All] the protections end after the prescription is written. [The proponents]
admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is [taken on a voluntary basis].

So frankly, any of the studies that come out of the state of Oregon’s experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.51

V. CONCLUSION

In the best of circumstances, victims of elder abuse are unlikely to report that they are being abused. The proposed bills allow the abuse to be taken to a whole new level. Don’t be fooled. Vote “No” on A. 10059 and S. 7579.

Respectfully Submitted,
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STATE OF NEW YORK

10059

IN ASSEMBLY

May 10, 2016

Introduced by M. of A. PAULIN, GOTTFRIED, DINOWITZ, GALEF, HEVESI,
STECK, ZEBROWSKI, BLAKE -- Multi-Sponsored by -- M. of A. BRAUNSTEIN,
CROUCH, DUPREY, SKARTADOS -- read once and referred to the Committee
on Health

AN ACT to amend the public health law, in relation to a terminally ill
patient's request for and use of medication for medical aid in dying

The People of the State of New York, represented in Senate and Assem-
blv, do enact as follows:

Section 1. This act shall be known and may be cited as the "medical
aid in dying act".

§ 2. The public health law is amended by adding a new article 28-F to
read as follows:

ARTICLE 28-F
MEDICAL AID IN DYING

Section 2899-d. Definitions.

2899-e. Written request for medication.
2899-f. Request process.
2899-g. Attending physician responsibilities.
2899-h. Right to rescind request; requirement to offer opportu-
nity to rescind.
2899-i. Consulting physician responsibilities.
2899-j. Confirmation of capacity; referral.
2899-k. Medical record documentation requirements.
2899-l. Form of written request and witness attestation.
2899-m. Protection and immunities.
2899-n. Permissible refusals and prohibitions.
2899-o. Relation to other laws and contracts.
2899-p. Safe disposal of unused medications.
2899-q. Death certificate.
2899-r. Reporting.
2899-s. Penalties.
2899-t. Severability.

§ 2899-d. Definitions. As used in this article:

1. "Adult" means an individual who is eighteen years of age or older.

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [ ] is old law to be omitted.

A 10059

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2. "Attending physician" means the physician who has primary responsi-
bility for the care of the patient and treatment of the patient's terminal
disease.

3. "Capacity" or "capacity to make an informed decision" means the
ability to understand and appreciate the nature and consequences of
health care decisions, including the benefits and risks of and alternatives
to any proposed health care, and to reach an informed decision and
to communicate health care decisions to a physician, including communi-
cation through persons familiar with the patient's manner of communicat-
ing 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 a person's terminal illness.

5. "Health care facility" means a general hospital, nursing home, or
residential health care facility as defined in section twenty-eight
hundred one of this chapter.

6. "Health care provider" means a person licensed, certified, or
authorized by law to administer health care or dispense medication in
the ordinary course of business or practice of a profession.

7. "Informed decision" means a decision by a patient who is suffering
from a terminal illness to request and obtain a prescription for medica-
tion that the patient may self-administer to end the patient's life that
is based on an understanding and acknowledgment of the relevant facts
and that is made after being fully informed of:

(a) the patient's medical diagnosis and prognosis;
(b) the potential risks associated with taking the medication to be
prescribed;
(c) the probable result of taking the medication to be prescribed;
(d) the possibility that the patient may choose not to obtain the
medication, or may obtain the medication but may decide not to self-ad-
minister it; and

http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A10059&term=2015&Text=Y
(e) the feasible alternatives or additional treatment opportunities, including palliative care and hospice care.

8. "Medical aid in dying" means the medical practice of a physician prescribing medication to a qualified individual that the individual may choose to self-administer to bring about death.

9. "Medically confirmed" means the medical opinion of the attending physician that a patient has a terminal illness has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

10. "Medication" means medication prescribed by a physician under this article.

11. "Mental health professional" means a physician, nurse practitioner, physician assistant or psychologist, licensed or certified under the education law acting within his or her scope of practice who is qualified by training and experience, certification or board certification or eligibility, to make a determination under section twenty-eight hundred ninety-nine of this article; provided that in the case of a nurse practitioner or physician assistant, the professional shall have a collaborative agreement or collaborative relationship with or be supervised by the attending physician or consulting physician.

12. "Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members to relieve pain and suffering and to enhance the patient’s quality of life, including hospice care under article forty of this chapter.

A. 18059

13. "Patient" means a person who is eighteen years of age or older under the care of a physician.


15. "Qualified individual" means a patient with a terminal illness who has capacity, has made an informed decision, and has satisfied the requirements of this article in order to obtain a prescription for medication.

16. "Self-administer" means a qualified individual’s affirmative, conscious, and voluntary act of using medication under this article.

17. "Terminal illness" means an illness that will, within reasonable medical judgment, result in death within six months, whether or not treatment is provided.

§ 2899-o. Written request for medication. 1. A patient may make a written request for and consent to self-administer medication for the purpose of ending his or her life in accordance with this article if the patient:

(a) has been determined by the attending physician to have a terminal illness and which has been medically confirmed by a consulting physician; and

(b) voluntarily expresses the request for medication.

2. No person shall qualify for medical aid in dying under this article solely because of age or disability.

§ 2899-p. Request process. 1. Oral and written request. A patient wishing to request medication under this article shall make an oral request and submit a written request to the patient's attending physician.

2. A written request signed and witnessed. (a) A request for medication under this article shall be signed and dated by the patient and witnessed by at least two adults who, in the presence of the patient, attest to the best of his or her knowledge and belief the patient has capacity, is acting voluntarily, and is not being coerced to sign the request. The written request shall be in substantially the form described in section twenty-eight hundred ninety-nine of this article.

(b) One of the witnesses shall be an adult who is not:

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

(2) a person who at the time the request is signed would be entitled to any portion of the estate of the patient upon 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 treatment or is a resident.

(c) The attending physician, consulting physician and, if applicable, the mental health professional who provides a capacity determination of the patient under this article shall not be a witness.

§ 2899-q. Attending physician responsibilities. 1. The attending physician shall:

(a) make the determination of whether a patient has a terminal illness, has capacity, has made an informed decision and has made the request voluntarily and without coercion;

(b) inform the patient of the requirement under this article for confirmation by a consulting physician, and refer the patient to a consulting physician under the patient’s request;

(c) refer the patient to a mental health professional pursuant to section twenty-eight hundred ninety-nine of this article if the attending physician believes that the patient lacks capacity to make an informed decision.

A. 18059
A. Løø59

http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=410059&term=2015&text=Y
which my attending physician has determined is a terminal illness, which
has been medically confirmed by a consulting physician.
I have been fully informed of my diagnosis and prognosis, the nature
of the medication to be prescribed and potential associated risks, the
expected result, and the feasible alternatives or treatment opportu-
nities including palliative care and hospice care.
I request that my attending physician prescribe medication that will
end my life if I choose to take it, and I authorize my attending physi-
cian to contact another physician or any pharmacist about my request.

INITIAL ONE:
( ) I have informed or intend to inform my family of my decision.
( ) 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 or decline
to use the medication at any time.
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I understand the importance of this request, and I expect to die if 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 being coerced, and I
accept full responsibility for my actions.

Signed:

Dated:

DECLARATION OF WITNESSES

I declare that the person signing this "Request for Medication to End
My Life":
(a) is personally known to me or has provided proof of identity;
(b) voluntarily signed the "Request for Medication to End My Life" in
my presence or acknowledged to me that he or she signed it; and
(c) to the best of my knowledge and belief, has capacity and is not
being coerced to sign the "Request for Medication to End My Life".
I understand that the attending physician or consulting physician of the person
signing the "Request for Medication to End My Life" or, if applicable,
the mental health professional who provides a capacity determination of
the person signing the "Request for Medication to End My Life" at the
time the "Request for Medication to End My Life" was signed.

Witness 1, Date:

Witness 2, Date:

NOTE: Only one of the two witnesses may (i) be a relative (by blood,
marrriage or adoption) of the person signing the "Request for Medication
to End My Life", (ii) be entitled to any portion of the person's estate
upon death under any will or by operation of law, or (iii) own, operate,
or be employed at a health care facility where the person is receiving
treatment or is a resident.

2. (a) The "Request for Medication to End My Life" shall be written in
the same language as any conversations, consultations, or interpreted
conversations or consultations between a patient and at least one of his
or her attending or consulting physicians.

(b) Notwithstanding paragraph (a) of this subdivision, the written
"Request for Medication to End My Life" may be prepared in English even
when the conversations or consultations or interpreted conversations or
consultations were conducted in a language other than English if the
English language form includes an attached declaration by the Interpre-
ter of the conversation or consultation, which shall be in substantially
the following form:

INTERPRETER'S DECLARATION

I, [insert name of interpreter], am fluent in English and
[insert target language].
On [insert date], at approximately [insert time], I read the "Request
for Medication to End My Life" to [name of patient] in [insert target
language].
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[Name of patient] affirmed to me that he/she understood the content of
the "Request for Medication to End My Life" and affirmed his/her desire
to sign the "Request for Medication to End My Life" voluntarily and
without coercion and that the request to sign the "Request for Medica-
tion to End My Life" followed discussions with his/her attending and
consulting physicians.
I declare that I am fluent in English and [insert target language] and
further declare under penalty of perjury that the foregoing is true and
correct and that false statements made herein are punishable.

Executed at [insert city, county, and state] on this [insert day of
month] of [insert month], [insert year].

[Signature of Interpreter]

[Printed name of Interpreter]
(c) An interpreter whose services are provided under paragraph (b) of this subdivision shall not (i) be related to the patient who signs the "Request for Medication to End My Life" by blood, marriage or adoption, (ii) be entitled at the time the "Request for Medication to End My Life" is signed by the patient to any portion of the estate of the patient upon death under any will or by operation of law, or (iii) be an owner, operator or employee of a health care facility where the patient is receiving treatment or is a resident.

2899-o. Protection and immunities. 1. A physician, pharmacist, other health care professional or other person shall not be subject to civil or criminal liability or professional disciplinary action by any government entity for taking any reasonable good-faith action or refusing to act under this article, including, but not limited to: (a) engaging in discussions with a patient relating to the risks and benefits of end-of-life care; (b) acting in the circumstances described in this article; (c) providing a patient, upon request, with a referral to another health care provider; (d) being present when a qualified individual self-administers medication; (e) refraining from acting to prevent the qualified individual from self-administering such medication; or (f) exerting to resuscitate the qualified individual after he or she self-administers such medication.

2. Nothing in this section shall limit civil or criminal liability for negligence, recklessness or intentional misconduct.

§ 2899-o. Permissible referrals and prohibitions. 1. (a) A physician, nurse, pharmacist, other health care provider or other person shall not be under any duty, by law or contract, to participate in the provision of medication to a patient under this article.

(b) If a health care provider is unable or unwilling to participate in the provision of medication to a patient under this article and the patient transfers care to a new health care provider, the prior health care provider shall transfer or arrange for the transfer, upon request, of a copy of the patient's relevant medical records to the new health care provider.

2. A private health care facility may prohibit the prescribing, dispensing, ordering or self-administering of medication under this article while the patient is being treated in or while the patient is residing in the health care facility if:

(a) the prescribing, dispensing, ordering or self-administering is contrary to a formally adopted policy of the facility that is expressly based on sincerely held religious beliefs or moral convictions central to the facility's operating principles; and

(b) the facility has informed the patient of such policy prior to admission or as soon as reasonably possible.

3. Where a facility has adopted a prohibition under this subdivision, in a patient who wishes to use medication under this article requests, the patient is informed by the facility transferred promptly to another health care facility that is reasonably accessible under the circumstances and willing to permit the prescribing, dispensing, ordering and self-administering of medication under this article with respect to the patient.

4. A health care facility has adopted a prohibition under this subdivision, any health care provider or employee of the facility who violates the prohibition may be subject to sanctions otherwise available to the facility provided the facility has previously notified the board of the existence or employee of the prohibition in writing.

§ 2899-o. Relation to other laws and contracts. 1. (a) A patient who requests medication under this article shall not, because of that request, be considered to be a person who is suicidal, and self-administering medication under this article shall not be deemed to be suicide, for any purpose.

(b) Action taken in accordance with this article shall not be construed for any purpose to constitute suicide, assisted suicide, attempted suicide, promoting a suicide attempt, mercy killing, or homicide under the law, including as an accomplice or accessory or otherwise.

2. (a) No provision in a contract, will or other agreement, whether written or oral, is void to the extent the provision would affect whether a person may make or rescind a request for medication or take any other action under this article, shall be valid.

(b) No obligation owing under any contract shall be conditioned or governed by the making or rescinding of a request by a person for medication or taking any other action under this article.

3. (a) A person and his or her beneficiaries shall not be denied benefits under a life insurance policy for actions taken in accordance with this article.

(b) The sale, procurement or issuance of a life or health insurance or annuity policy, or the rate charged for a policy may not be conditioned upon or affected by a patient making or rescinding a request for medication under this article.

4. An insurer shall not provide any information in communications made to a patient about the availability of medication under this article absent a request by the patient or by his or her attending physician upon the request of such patient. Any communication shall not include both the denial of coverage for treatment and information as to the availability of medication under this article.

5. The sale, procurement, or issue of any professional malpractice insurance policy on the rate charged for the policy shall not be conditioned on any provision in a contract, will or other agreement, whether written or oral, is void to the extent the provision would affect whether a person may make or rescind a request for medication or take any other action under this article.
§ 2899-a. Safe disposal of unused medications. The department shall make regulations providing for the safe disposal of unused medications prescribed, dispensed or ordered under this article.

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§ 2899-q. Death certificate. 1. If otherwise authorized by law, the attending physician may sign the qualified individual's death certificate.

2. The cause of death listed on a qualified individual's death certificate who dies after self-administering medication under this article shall be the underlying/terminal illness.

§ 2899-r. Reporting. 1. The commissioner shall annually review a sample of the records maintained under section twenty-eight hundred ninety-nine of this article. The commissioner shall adopt regulations establishing reporting requirements for physicians taking action under this article to determine utilization and compliance with this article. The information collected under this section shall not constitute a public record available for public inspection and shall be confidential and collected and maintained in a manner that protects the privacy of the patient, his or her family, and any health care provider acting in connection with such patient under this article, except that such information may be disclosed to a governmental agency as authorized or required by law relating to professional discipline, protection of public health or law enforcement.

2. The commissioner shall prepare a report annually containing relevant data regarding utilization and compliance with this article and shall post such report on the department's website.

§ 2899-s. Penalties. 1. Nothing in this article shall be construed to limit professional discipline or civil liability resulting from conduct in violation of this article, negligent conduct, or intentional misconduct by any person.

2. Conduct in violation of this article shall be subject to applicable criminal liability under state law, including, where appropriate and without limitation, offenses constituting homicide, forgery, coercion, and related offenses, or federal law.

§ 2899-t. Severability. If any provision of this article or any application of any provision of this article, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, that shall not affect the validity or effectiveness of any other provision of this article or of any other application of any provision of this article, which can be given effect without that provision or application; and to that end, the provisions and applications of this article are severable.

§ 3. This act shall take effect immediately.

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STATE OF NEW YORK

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IN SENATE

May 10, 2016

Introduced by Sens. SAVINO, HOYLMAN -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law, in relation to a terminally ill patient's request for and use of medication for medical aid in dying

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. This act shall be known and may be cited as the "medical aid in dying act".

§ 2. The public health law is amended by adding a new article 28-F to read as follows:

ARTICLE 28-F

MEDICAL AID IN DYING

Section 2899-d. Definitions.

2899-e. Written request for medication.

2899-f. Request process.

2899-g. Attending physician responsibilities.

2899-h. Right to rescind request; requirement to offer opportunity to rescind.

2899-i. Consulting physician responsibilities.

2899-j. Confirmation of capacity; referral.

2899-k. Medical record documentation requirements.

2899-l. Form of written request and witness attestation.

2899-m. Protection and immunity.

2899-n. Permissible refusals and prohibitions.

2899-o. Relation to other laws and contracts.

2899-p. Safe disposal of unused medications.

2899-q. Death certificate.

2899-r. Reporting.

2899-s. Penalties.

2899-t. Severability.

§ 2899-d. Definitions. As used in this article:

1. "Adult" means an individual who is eighteen years of age or older.

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [ ] is old law to be omitted.

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8. "Medical aid in dying" means the medical practice of a physician prescribing medication to a qualified individual that the individual may choose to self-administer to bring about death.

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

10. "Medication" means medication prescribed by a physician under this article.

11. "Mental health professional" means a physician, nurse practitioner, physician assistant or psychologist, licensed or certified under the education law acting within his or her scope of practice and who is qualified, by training and experience, certification, or board certification or eligibility, to make a determination under section twenty-eight hundred ninety-nine of this article; provided that in the case of a nurse practitioner or physician assistant, the professional shall not have a collaborative agreement or collaborative relationship with or be supervised by the attending physician or consulting physician.

12. "Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care under article forty of this chapter.

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13. "Patient" means a person who is eighteen years of age or older under the care of a physician.

14. "Physician" means an individual licensed to practice medicine in New York State.

15. "Qualified individual" means a patient with a terminal illness, who has capacity, has made an informed decision, and has satisfied the requirements of this article in order to obtain a prescription for medication.

16. "Self-administer" means a qualified individual's affirmative, conscious, and voluntary act of using medication under this article.

17. "Terminal illness" means an illness that will, within reasonable medical judgment, result in death within six months, whether or not treatment is provided.

§ 2899-a. Written request for medication. 1. A patient may make a written request for and consent to self-administer medication for the purpose of ending his or her life in accordance with this article if the patient:

(a) has been determined by the attending physician to have a terminal illness and which has been medically confirmed by a consulting physician; and

(b) voluntarily expresses the request for medication.

2. No person shall qualify for medical aid in dying under this article solely because of age or disability.

§ 2899-f. Request process. A patient wishing to request medication under this article shall make an oral request and submit a written request to the patient's attending physician.

2. Written request signed and witnessed. (a) A request for medication under this article shall be signed and dated by the patient and witnessed by at least two adults who, in the presence of the patient, attest that the best of his or her knowledge and belief the patient has capacity, is acting voluntarily, and is not being coerced to sign the request. The written request shall be in substantially the form described in section twenty-eight hundred ninety-nine of this article.

(b) One of the witnesses shall be an adult who is not:

(i) a relative or other derivative of the patient by blood, marriage or adoption;

(ii) a person who at the time the request is signed would be entitled to any portion of the estate of the patient upon death under any will or by operation of law; or

(iii) an owner, operator or employee of a health care facility where the patient is receiving treatment or is a resident.

(c) The attending physician, consulting physician and, if applicable, the mental health professional who provides a capacity determination of the patient under this article shall not be a witness.

§ 2899-g. Attending physician responsibilities. 1. The attending physician shall:

(a) make the determination of whether a patient has a terminal illness, has capacity, has made an informed decision and has made the request voluntarily and without coercion;

(b) inform the patient of the requirement under this article for confirmation by a consulting physician, and refer the patient to a consulting physician upon the patient's request;

(c) refer the patient to a mental health professional pursuant to section twenty-eight hundred ninety-nine of this article if the attending physician believes that the patient lacks capacity to make an informed decision;

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live care and hospice care;
(f) discuss with the patient the importance of:
(i) having another person present when the patient takes the medication; and
(ii) not taking the medication in a public place;
(g) inform the patient that he or she may rescind the request for medication at any time and in any manner;
(h) fulfill the medical record documentation requirements of section twenty-eight hundred ninety-nine-k of this article; and
ensure that all appropriate steps are carried out in accordance with this article before writing a prescription for medication.
2. Upon receiving confirmation from a consulting physician under section twenty-eight hundred ninety-nine-l of this article, and subject to section twenty-eight hundred ninety-nine-i of this article, the attending physician who makes the determination that the patient has a terminal illness, has capacity, and has made a request for medication as provided in this article, may personally, or by referral to another physician, prescribe or order appropriate medication in accordance with the patient's request under this article, and at the patient's request, facilitate the filling of the prescription and delivery of the medication to the patient.
3. In accordance with the direction of the prescribing or ordering physician and the consent of the patient, the patient may self-administer the medication to himself or herself. A health care professional or other person shall not administer the medication to the patient.
§ 2809-b. Right to rescind request; requirement to offer opportunity to rescind. 1. A patient may at any time rescind his or her request for medication under this article without regard to the patient's capacity.
2. A prescription for medication may not be written without the attending physician offering the qualified individual an opportunity to rescind the request.
§ 2809-i. Consulting physician responsibilities. Before a patient who is requesting medication may receive a prescription for medication under this article, a consulting physician must:
1. examine the patient and his or her relevant medical records;
2. confirm, in writing, to the attending physician: (a) that the patient has a terminal illness; (b) that the patient is making an informed decision; (c) that the patient has capacity, or provide documentation that the consulting physician has referred the patient for a determination under section twenty-eight hundred ninety-nine-i of this article; and (d) that the patient is acting voluntarily and without coercion.
§ 2809-l. Confirmation of capacity; referral. 1. If the attending physician or the consulting physician believes that the patient may lack capacity, the attending physician or consulting physician shall refer the patient to a mental health professional for a determination of whether the patient has capacity. The referring physician shall advise the patient that the report of the mental health professional will be provided to the attending physician, and to the consulting physician if he or she is the physician who requested the determination.
2. A mental health professional who evaluates a patient under this section shall, in writing, to the physician who requested the evaluation, his or her conclusions about whether the patient has capacity to make an informed decision. If the written report is provided to the consulting physician, the consulting physician shall promptly provide a copy of the report to the attending physician. If the mental health professional determines that the patient lacks capacity to make an informed decision, the patient shall not be deemed a qualified individual, and the attending physician shall not prescribe medication to the patient.
§ 2809-k. Medical record documentation requirements. An attending physician shall document or file the following in the patient's medical record:
1. the dates of all oral requests by the patient for medication under this article;
2. the written request by the patient for medication under this article;
3. the attending physician's diagnosis and prognosis, determination of capacity, and determination that the patient is acting voluntarily and without coercion, and has made an informed decision;
4. if applicable, written confirmation of capacity under section twenty-eight hundred ninety-nine-i of this article; and
5. a note by the attending physician indicating that all requirements under this article have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed or ordered.
§ 2809-l. Form of written request and witness attestation. A request for medication under this article shall be in substantially the following form:
REQUEST FOR MEDICATION TO END MY LIFE
I, , am an adult who has capacity, which means I understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision and to communicate health care decisions to a physician.
I am suffering from a terminal illness, which has been medically confirmed by a consulting physician.
I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives or treatment opportunities including palliative care and hospice care.

I request that my attending physician prescribe medication that will end my life if I choose to take it, and I authorize my attending physician to contact another physician or any pharmacist about my request.

INITIAL ONE:

( ) I have informed or intend to inform my family of my decision.

( ) I have not decided 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 or decline to use the medication at any time.

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I understand the importance of this request, and I expect to die if 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 being coerced, and I accept full responsibility for my actions.

Signed:

Dated:

DECLARATION OF WITNESSES

I declare that the person signing this "Request for Medication to End My Life":

(a) is personally known to me or has provided proof of identity;
(b) voluntarily signed the "Request for Medication to End My Life" in my presence or acknowledged to me that he or she signed it; and
(c) is not under the influence of drugs or alcohol that impairs judgment or the capacity of that person to sign the "Request for Medication to End My Life".

I am not the attending physician or consulting physician of the person signing the "Request for Medication to End My Life" or, if applicable, the mental health professional who provides a capacity determination of the person signing the "Request for Medication to End My Life" at the time the "Request for Medication to End My Life" was signed.

Witness 1, Date:

Witness 2, Date:

NOTE: Only one of the two witnesses may (i) be a relative (by blood, marriage or adoption) of the person signing the "Request for Medication to End My Life", (ii) be entitled to any portion of the person's estate upon death under any will or by operation of law, or (iii) own, operate, or be employed at a health care facility where the person is receiving treatment or is a resident.

2. (a) The "Request for Medication to End My Life" shall be written in the same language as any conversations, consultations, or interpreted conversations or consultations between a patient and at least one of his or her attending or consulting physicians.
(b) Notwithstanding paragraph (a) of this subdivision, the written "Request for Medication to End My Life" may be prepared in English even if the conversations or interpreted conversations or consultations were conducted in a language other than English if the English language form includes an attached declaration by the interpreter of the conversation or consultation, which shall be in substantially the following form:

INTERPRETER'S DECLARATION

[insert name of interpreter], an fluent in English and [insert target language],

On [insert date], at approximately [insert time], I read the "Request for Medication to End My Life" to [name of patient] in [insert target language].

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[Name of patient] affirmed to me that he/she understood the content of the "Request for Medication to End My Life" and affirmed his/her desire to sign the "Request for Medication to End My Life" voluntarily and without coercion and that the request to sign the "Request for Medication to End My Life" followed discussions with his/her attending and consulting physicians.

I declare that I am fluent in English and [insert target language] and further declare under penalty of perjury that the foregoing is true and correct and that false statements made herein are punishable.

Executed at [insert city, county and state] on this [insert day of month] of [insert month], [insert year].

[Signature of Interpreter]

[Printed name of Interpreter]

[Address of Interpreter]
(c) An interpreter whose services are provided under paragraph (b) of this subdivision shall not (i) be related to the patient who signs the "Request for Medication to End My Life" by blood, marriage or adoption, (ii) be entitled at the time the "Request for Medication to End My Life" is signed by the patient to any portion of the estate of the patient unless the provision is by will or by operation of law, or (iii) be an owner, operator, or employee of a health care facility where the patient is receiving treatment or is a resident.

§ 2899-b. Protection and immunities. 1. A physician, pharmacist, other health care professional or other person who is subject to civil or criminal liability or professional disciplinary action by any governmental entity for taking any reasonable good-faith action or refusing to act under this article, including, but not limited to: (a) engaging in discussion with a patient relating to the rights and benefits of end-of-life options in the circumstances described in this article, (b) providing a patient, upon request, with a referral to another health care provider, (c) being present when a qualified individual self-administers medication, (d) participating in activities to prevent the qualified individual from self-administering such medication, or (e) refraining from acting to resuscitate the qualified individual after he or she self-administers such medication.

2. Nothing in this section shall limit civil or criminal liability for negligence, recklessness or intentional misconduct.

§ 2899-c. Permissible refusals and prohibitions. 1. (a) A physician, nurse, pharmacist, other health care provider or other person shall not have the duty to participate by law or contract to participate in the provision of medication to a patient under this article.

(b) If a health care provider is unable or unwilling to participate in the provision of medication to a patient under this article and the patient is a resident of a health care facility, the health care provider shall transfer or arrange for the transfer, upon request, of a copy of the patient's relevant medical records to the new health care provider.

2. (a) A private health care facility may prohibit the prescribing, dispensing, ordering or self-administering of medication under this article while the patient is being treated in or while the patient is residing in the health care facility if:

(i) the prescribing, dispensing, ordering or self-administering is contrary to a formally adopted policy of the facility that is expressly based on sincerely held religious beliefs or moral convictions central to the facility's operating principles; and

(ii) the facility has informed the patient of such policy prior to admission or as soon as reasonably possible.

(b) Where a facility has adopted a prohibition under this subdivision, if a patient who wishes to use medication under this article requests, the patient shall be transferred promptly to another health care facility that is reasonably accessible under the circumstances and willing to provide the prescribing, dispensing, ordering and self-administering of medication under this article with respect to the patient.

3. Where a health care facility has adopted a prohibition under this subdivision, any health care provider or employee of the facility who provides the medication may be subject to sanctions otherwise available to the facility, provided the facility has previously notified the health care provider or employee of the prohibition in writing.

§ 2899-d. Relation to other laws and contracts. 1. (a) A patient who requests medication under this article shall not, because of that request, be considered to be a person who is suicidal, and self-administering medication under this article shall not be deemed to be suicide, for any purpose.

(b) Action taken in accordance with this article shall not be construed for any purpose to constitute suicide, assisted suicide, attempted suicide, promoting a suicide attempt, mercy killing, or homicide under the law, including as an accomplice or accessory or otherwise.

2. (a) No provision in a contract, will or other agreement, written or oral, to the extent that provision would affect whether a person may make or rescind a request for medication or take any other action under this article, shall be valid.

(b) No obligation, under any contract shall be conditioned or affected by the making or rescinding of a request by a person for medication or taking any other action under this article.

(c) Rights of any person or his or her beneficiaries shall not be denied benefits under a life insurance policy for actions taken in accordance with this article.

(b) The sale, procurement or issuance of a life or health insurance or annuity policy, or the rate charged for a policy may not be conditioned upon or affected by a patient making or rescinding a request for medication under this article.

4. An insurer shall not provide any information in communications made to a patient about the availability of medication under this article unless the provider is the patient or by his or her attending physician upon the request of such patient. Any communication shall not include both the denial of coverage for treatment and information as to the availability of medication under this article.

5. The sale, procurement, or issue of any professional malpractice insurance policy or the rate charged for the policy shall not be conditioned upon or affected by whether the insured does or does not take or participate in any action under this article.
§ 2099-q. Death certificate. 1. If otherwise authorized by law, the
attending physician may sign the qualified individual's death certif-
icate.
2. The cause of death listed on a qualified individual's death certif-
icate, who dies after self-administering medication under this article
will be the underlying terminal illness.

§ 2099-r. Reporting. 1. The commissioner shall annually review a
sample of the records maintained under section twenty-eight hundred
ninety-nine-a of this article. The commissioner shall adopt regulations
establishing reporting requirements for physicians taking action under
this article to determine utilization and compliance with this article.
The information collected under this section shall not constitute a
public record available for public inspection and shall be confidential
and collected in a manner that protects the privacy of
the patient, his or her family, and any health care provider acting in
connection with such patient under this article, except that such inform-
ination may be disclosed to a governmental agency as authorized or
required by law relating to professional discipline, protection of
public health or law enforcement.
2. The commissioner shall prepare a report annually containing rele-
vant data regarding utilization and compliance with this article and
shall post such report on the department's website.

§ 2099-s. Penalties. 1. Nothing in this article shall be construed to
limit professional discipline or civil liability resulting from conduct
in violation of this article, negligent conduct, or intentional miscon-
duct by any person.
2. Conduct in violation of this article shall be subject to applicable
criminal liability under state law, including, where appropriate and
without limitation, offenses constituting homicide, forgery, coercion,
and related offenses, or federal law.

§ 2099-t. Severability. If any provision of this article or any appli-
cation of any provision of this article, is held to be invalid, or to
violate or be inconsistent with any federal law or regulation, that
shall not affect the validity or effectiveness of any other provision of
this article, or of any other application of any provision of this arti-
cle, which can be given effect without that provision or application;
and to that end, the provisions and applications of this article are
severable.

§ 3. This act shall take effect immediately.
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.

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

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

"I just kept going and going," says Clayton. "You kind of don't notice how long it's been." She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. "I had to have cancer to have nice hair," she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip...
to Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

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

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

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

**In one sense**, six months is an arbitrary figure. "Why not four months? Why not eight months?" asks Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, adding that medical literature does not define the term "terminally ill." The federal Medicare program, however, has determined that it will pay for hospice care for patients with a prognosis of six months or less.

"That's why we chose six months," explains George Eighmy, 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.
Manhattan Doctor Is Accused of Fleecing Mother Out of $800,000

By ANEMONA HARTOCOLLIS
Published: January 24, 2000

Prosecutors are calling it an Astor copycat case.

As with Brooke Astor, the late socialite and philanthropist, there is a son who took care of his elderly mother, and relatives who claim that he mistreated her.

In the latest case, an Upper East Side doctor, Robin O. Motz, 68, has been accused of swindling his mother, Minnie, 94, a retired librarian and the widow of a Columbia University astronomy professor, out of her last $800,000. Prosecutors said Dr. Motz spent the money on luxuries like vacations, a country house and fancy clothes.

"It's a mini-Astor case," Daniel Castleman, chief of investigations with the Manhattan district attorney's office, said on Wednesday in announcing Dr. Motz's indictment on grand larceny and money-laundering charges.

As in the Astor case — in which Anthony D. Marshall, Mrs. Astor's son, has pleaded not guilty to stealing millions of dollars from her — much remains in dispute.

Dr. Motz, who pleaded not guilty on Wednesday at an arraignment in State Supreme Court, insisted through his lawyer, Sean Dwyer, that he was only trying to do the right thing for his mother.

Mr. Dwyer described Dr. Motz, who has a part-time practice in Englewood, N.J., and is affiliated with NewYork-Presbyterian/Columbia hospital, as a "dedicated physician and compassionate son," and contended that "there is a lot more to this story than meets the eye." He declined to go into detail.

Dr. Motz, who was released on condition that he post $200,000 cash bail by Monday, said only, "I never comment to the press."

In a telephone interview on Wednesday from her home in California, Dr. Motz's sister, Julie, endorsed the prosecutor's Astor analogy, saying that news accounts of the Astor case had emboldened her and her niece, Nicole Motz, to take their suspicions of mistreatment to the district attorney.

"We're upper middle class, intellectual people," Ms. Motz said. "I think people think this sort of thing doesn't happen in families like that, that it's somehow a lower-economic tragedy. Of course we do have the example of the Astors, don't we?"

She said that her mother had been reluctant to think ill of her son at first but then testified against him before the grand jury that indicted him. Prosecutors said that while Mrs. Motz had been immobilized by physical disabilities, she was still mentally alert.
Ms. Motz said the family has been unraveling since her father, Lloyd Motz, died in 2004 at the age of 94.

She said relations with her brother were strained because she was an “energy healer,” and he did not approve of her practice of alternative medicine.

In 2004, prosecutors said, Dr. Motz persuaded his mother to rewrite her will so that instead of giving equal shares to him and his sister, Ms. Motz was disinherited.

Ms. Motz said the second will also disinherited Dr. Motz’s daughter, Nicole, while giving small bequests to his two sons. Ms. Motz said Dr. Motz, who lives on East 84th Street, tried to put their mother’s Upper Manhattan apartment in his name, but was prevented from doing so by a provision in her father’s will.

She said Nicole Motz, a physical therapist in Tenafly, N.J., had been very close to her grandmother, giving a 90th birthday party for her, but that Dr. Motz persuaded his mother to bar his daughter from her apartment.

Prosecutors said Mrs. Motz’s financial plight came to light when Dr. Motz had a dispute with a home health aide and stopped paying her salary and the maintenance on his mother’s apartment.

Mrs. Motz was threatened with eviction, prosecutors said. A social worker at her building investigated, and realized that she had run out of money, prosecutors said. She was not evicted.
Anthony D. Marshall, Astor Son Who Was Convicted in Swindle, Dies at 90

By ROBERT D. McFADDEN  DEC. 1, 2014

Anthony D. Marshall, the only son of the philanthropist-socialite Brooke Astor, who with one of her former lawyers was found guilty of criminal charges that they swindled millions from his mother after she was stricken with Alzheimer's disease, died on Sunday in Manhattan. He was 90.

Kenneth E. Warner, a lawyer for Mr. Marshall, said he died at NewYork-Presbyterian Hospital.

Mr. Marshall was a United States ambassador to several countries and an operative for the Central Intelligence Agency as well as an author and a Tony Award-winning Broadway producer.

But after a lifetime of public service and creative accomplishments, his life was turned upside down by allegations of mistreatment of his mother and mismanagement of her affairs. In a six-month trial that captivated New York with clashing accounts of tawdry greed and filial devotion, a parade of witnesses who included boldface names from the worlds of society, politics and finance as well as maids and nurses took turns castigating and defending
Mr. Marshall and the lawyer, Francis X. Morrissey Jr., who did estate planning for Mrs. Astor.

Concluding 12 days of deliberations on Oct. 8, 2009, a jury in State Supreme Court in Manhattan convicted Mr. Marshall on 14 of 16 counts, including first-degree grand larceny for giving himself a $1 million retroactive raise for managing his mother’s finances. Mr. Morrissey was found guilty of fraud and conspiracy and of forging Mrs. Astor’s signature on an amendment to her will.

The jury found that both men had taken advantage of Mrs. Astor’s failing mental health to gain control over her fortune by inducing her to change her will several years before she died in 2007 at age 105.

In December 2009, Justice A. Kirke Bartley Jr., who presided at the trial, sentenced both men to one to three years in prison, but allowed them to remain free pending appeals. Mr. Marshall’s conviction carried up to 25 years, but legal experts said his age and physical ailments had a bearing on the sentence.

In March 2013, more than three years after the trial, a state appeals court affirmed the convictions of Mr. Marshall and Mr. Morrissey on the major charges, saying that “the record amply supports the jury’s determination.” The court also rejected a claim that Mr. Marshall should not be incarcerated because of his advanced age and poor health. In June 2013, the men began serving their sentences at the Fishkill Correctional Facility, 70 miles north of New York City, which has a medical unit like a skilled nursing center.

But two months later, the State Parole Board approved Mr. Marshall’s request for medical parole, ruling that he was so sick and frail as to be eligible for release under the state’s so-called compassionate release law. Since the law went into effect in 1992, hundreds of state inmates have been granted parole. A transcript of his parole hearing disclosed that he had expressed regret over the case.
Internet Black Widow Melissa Ann Shepard arrested in Halifax

Shepard, 80, charged with breaching her release conditions

By Cassie Williams, CBC News Posted: Apr 12, 2016 2:37 PM AT Last Updated: Apr 12, 2016 2:59 PM AT

Less than a month after she agreed to abide by certain rules following her release from prison, an 80-year-old woman dubbed the Internet Black Widow has been charged with breaching those conditions.

Melissa Ann Shepard is accused of accessing the internet at the Halifax Central Library on Spring Garden Road, in violation of conditions imposed by a Nova Scotia provincial court in March.

Police said that at 3:40 p.m. on Monday a community response officer saw her using the internet on a computer. The officer arrested her and took her to the police station.

There, officers say, they found she had with her "a device capable of accessing the internet," in violation of her court conditions.

She was charged with three counts of breaching a recognizance and released on conditions that she not visit any libraries in the Halifax Regional Municipality. She's due in court May 24.

High risk to re-offend

Shepard left prison last month after serving her full sentence for administering a noxious substance and failing to provide the necessaries of life to Fred Weeks, who was her newlywed husband. Weeks fell ill at a bed-and-breakfast in Cape Breton in September 2012, just a few days after marrying Shepard.

Halifax police allege she is a high risk to re-offend. Shepard has agreed to 22 temporary conditions but will fight longer term restrictions to her freedom in court this fall.

Her current conditions include not accessing the internet, abiding by a curfew, providing an up-to-date photo of herself to police and that she not possess any drugs for which she doesn't have a prescription.

She must also inform police of any romantic involvements so officers can tell prospective boyfriends of her criminal past.

Criminal past

Shepard has a long history with the law.

In 1991, she was convicted of manslaughter and served two years of a six-year prison term after killing her husband, Gordon Stewart, on a deserted road near Halifax. Stewart, from P.E.I., was heavily drugged when she ran over him twice with a car.

Shortly after she was released from prison, she travelled to Florida and met Robert Friedrich at a Christian retreat.

They married in Nova Scotia in 2000. A year later, Friedrich's family noticed his health was faltering. He
had mysterious fainting spells and slurred speech and was in and out of hospitals.

Friedrich's family also alleged his money had started to disappear. Friedrich died in 2002 of cardiac arrest. No one was charged.

In 2005, Shepard was sentenced to five years in prison on a slew of charges stemming from a relationship she had with another Florida man she met online.

She pleaded guilty to seven charges, including three counts of grand theft from a person 65 years or older, two counts of forgery and two counts of using a forged document.

With files from Blair Rhodes
Like the men before him, Melissa Ann Shepard’s last victim fell for her in more than one sense of the word.

When Fred Weeks met Shepard in 2012, they were both in their late 70s and living in the same retirement community in the picturesque Canadian coastal province of Nova Scotia. The start of their romance was simple, according to court documents cited by the BBC: Shepard knocked on Weeks’s door and told him that she was lonely. She’d heard that he was lonely, too.

From there, the dalliance took on a familiar rhythm, one unbeknownst to the smitten Weeks at the time. After being wed in a civil union ceremony in his living room, the BBC reported, the couple embarked on their honeymoon across neighboring Newfoundland.

It was then that things started to go amiss for the man, who had lost his first, and longtime, wife just one year before. His mind became hazy while driving on the journey, unable to distinguish between gears and forgetting how to start the car. Soon, his condition worsened: He needed a wheelchair and couldn’t put on his shoes.

Upon the newlyweds’ return to Nova Scotia, they checked into a bed and breakfast, where Weeks told the owner of the establishment, Cheryl Chambers, that they were both ill and had been up “vomiting all night.”

Chambers told the CBC investigative program “The Fifth Estate” that only one of them appeared to be sick.
"Mr. Weeks didn't look well at all. He looked a little green, very gaunt-looking," she recounted. "Mrs. Weeks, on the other hand, she was beautifully groomed, in a lovely red suit."

The next day, Weeks fell out of bed, hit the hardwood floor and had to be hospitalized. Doctors found him heavily drugged — the result, it was later found, of Shepard spiking his coffee with tranquilizers.

This act of "administering a noxious substance" (reduced from an earlier charge of attempted murder) landed her nearly three years in Canadian federal prison in 2013. It was just the latest in a long rap sheet of crimes as numerous as the last names she had accumulated over the years.

Now, the alarm is being sounded around Shepard once more. Last Friday, she completed her sentence for the offense against Weeks and was released from a federal women's prison in Nova Scotia.

Melissa "Millie" Ann was born a Russell, but made herself by turns a Shepard, a Stewart, a Friedrich and a Weeks. All but her first known husband, Russell Shepard (the two later divorced), would become victims of a methodical, practiced ruse.

All were elderly men who had recently lost their spouses. They sought companionship and found instead in the hazel-eyed Shepard someone who siphoned their savings, slipped drugs into their food and, in the case of one man, ran him over with a car and left him dead on a dirt road.

Of all Shepard's monikers, "Black Widow" is the one that has stuck over the decades in the news media. It befits someone who has been convicted of manslaughter, theft and forgery in connection with spontaneous marriages and subsequent illnesses and deaths.

(Romances aside, she also has 30 fraud convictions since 1977.)

Each time she struck, the headlines lamented her ever-growing web.

The Halifax Regional Police advised Friday, upon Shepard's release, that "a high risk offender is residing in our community." Authorities have ordered her not to use the Internet, to report any changes to her appearance and to abide by an 11 p.m. curfew. Any romantic relationships must also be reported to the police, so that prospective partners can be informed of her history.

These conditions offer little comfort to Alex Strategos, 84, whom Shepard dated in 2005.

"I don't think she should be released," Strategos told the BBC. "What she was, she still is — she's the Black Widow. Some guys better watch out, that's all I can say."
Adult Abuse

Adult Abuse Defined

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

Abusers

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

Reporting Abuse

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

You Can Help

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

Who to Call

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

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

Remember, the person you are worried about can refuse intervention. The merely eccentric will be left in peace. And your identity will be protected, because reports are confidential.
12 million Americans misdiagnosed each year

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

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

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

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

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

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.
SWEARING HAVING ME AT
MASSACHUSETTS, USA
ON, AUGUST 15, 2012

NAME: Heloï Przybylski

A notary in and for the
State of Washington, Massachusetts.

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

PLACE SEAL HERE:

AFFIDAVIT OF JOHN NORTON- Page 3
West's RCWA 11.12.160

C
WEST'S REVISED CODE OF WASHINGTON ANNOTATED
TITLE 11. PROBATE AND TRUST LAW
CHAPTER 11.12. WILLS
11.12.160. Interested witness—Effect on will

(1) An interested witness to a will is one who would receive a gift under the will.

(2) A will or any of its provisions is not invalid because it is signed by an interested witness. Unless there are at least two other subscribing witnesses to the will who are not interested witnesses, the fact that the will makes a gift to a subscribing witness creates a rebuttable presumption that the witness procured the gift by duress, menace, fraud, or undue influence.

(3) If the presumption established under subsection (2) of this section applies and the interested witness fails to rebut it, the interested witness shall take so much of the gift as does not exceed the share of the estate that would be distributed to the witness if the will were not established.

(4) The presumption established under subsection (2) of this section has no effect other than that stated in subsection (3) of this section.

Current with 2008 Legislation effective through September 30, 2008

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> With 2 witnesses, one of whom is interested, the presumption of undue influence, etc., is created. 

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<td>Heart disease (%)</td>
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<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>
<tr>
<td><strong>DWDA process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<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 (83.4)</td>
<td>855 (88.5)</td>
</tr>
<tr>
<td>Patient died at</td>
<td>118 (90.1)</td>
<td>810 (94.6)</td>
<td>928 (94.0)</td>
</tr>
<tr>
<td>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>
<tr>
<td><strong>Lethal medication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secobarbital (%)</td>
<td>114 (86.4)</td>
<td>466 (54.2)</td>
<td>580 (58.5)</td>
</tr>
<tr>
<td>Pentobarbital (%)</td>
<td>1 (0.8)</td>
<td>385 (44.8)</td>
<td>386 (39.0)</td>
</tr>
<tr>
<td>Phenobarbital/chloral hydrate/morphine sulfate mix (%)</td>
<td>16 (12.1)</td>
<td>0 (0.0)</td>
<td>16 (1.6)</td>
</tr>
<tr>
<td>Other (combination of above and/or morphine) (%)</td>
<td>1 (0.8)</td>
<td>8 (0.9)</td>
<td>9 (0.9)</td>
</tr>
<tr>
<td><strong>End of life concerns</strong></td>
<td>(N=132)</td>
<td>(N=859)</td>
<td>(N=991)</td>
</tr>
<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>
<tr>
<td><strong>Health care provider present (collected 2001-present)</strong></td>
<td>(N=132)</td>
<td>(N=789)</td>
<td>(N=921)</td>
</tr>
<tr>
<td>When medication was ingested</td>
<td>(N=132)</td>
<td>(N=789)</td>
<td>(N=921)</td>
</tr>
<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><strong>Unknown</strong></td>
<td>98</td>
<td>332</td>
<td>430</td>
</tr>
<tr>
<td>At time of death</td>
<td></td>
<td></td>
<td></td>
</tr>
<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 (45.6)</td>
<td>486 (53.9)</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>2</td>
<td>17</td>
<td>19</td>
</tr>
</tbody>
</table>

Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys:
Compliance with the Death with Dignity Act

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

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

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

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

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

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

“I found myself wondering, Where does all the money come from? If it really is about a few terminally ill people who might seek help ending their suffering, why was more money spent on promoting assisted suicide than any other issue in Montana?”

By Senator Jennifer Fielder

As we wrangled through the budget this spring, the beautiful state capital began to feel like a big, ripe carcass with a dark cloud of vultures circling about.

The magnitude of money in government attracts far more folks who want to be on the receiving end than it does those who just want fair and functional government. Until that ratio improves, it may be impossible to rein in unnecessary regulation and spending.

Special interest groups spent over $6 million dollars on lobbyists to pressure Montana legislators during the 2013 session. Seems like a lot of money, until you compare it to the billions of taxpayer dollars at stake. Does the average taxpayer stand a chance against organized forces like that?

As your Senator one of my main duties is to sort out who wants your money, or a change in a law, and why. Getting to the bottom of it takes work. It would certainly help if well intentioned citizens would do a little more research before clamoring onto any particular bandwagons as well.

We have to be careful not to be fooled by catchy slogans, shallow campaign propaganda, biased media reports, or plays on our emotions which, too often, conceal a multitude of hidden agendas.

For example, it seems odd that the top lobby spender in Montana this year was Compassion and Choices, a “nonprofit” group that spent $160,356 advocating for legalization of assisted suicide. The second biggest spender was MEA-MFT, the teachers and public employees union who spent $120,319 pushing for state budget increases.

I earned a reputation for asking a lot of questions. I certainly didn’t take this job to rubber stamp anything. It’s my duty to determine whether a proposal relates to an essential, necessary service of fair and functional government, or if it is motivated by piles of money to be gained from ill-advised government decisions.

In Oregon and Washington State, where assisted suicide is legal, there is no oversight over administration of the lethal dose. Even if the patient struggled, who would know? See here regarding Washington State.

Legalization especially invites abuse of seniors, for example, in an inheritance situation. See here.

In Oregon, Medicaid uses coverage incentives to steer patients to suicide. See here.

Some jurisdictions without legal assisted suicide already have a significant problem with palliative care abuse by some doctors and nurses. See e.g. here. If you can’t control the abuse now, when assisted suicide is not legal, why would you give these doctors and nurses even more power to abuse patients by legalizing it?

Being steered to suicide,
"Choice" Is An Illusion: Beware of Vultures: Senator Jennifer Fielder on Compassion & Choices

You see, there is so much money in government that almost everything in government is about the money. The usual tactic is to disguise a ploy as "the humane thing to do".

Some groups work very hard to provide factual information about their issue. Others stoop to the lowest of lows to invoke heart wrenching emotions, twisted half-truths, or outright lies. You really have to look carefully for all the angles.

Assisted suicide is another issue that can be highly emotional. There are deep and valid concerns on both sides of this life and death debate. But I found myself wondering, "Where does all the lobby money come from?" If it really is about a few terminally ill people who might seek help ending their suffering, why was more money spent on promoting assisted suicide than any other issue in Montana?

Could it be that convincing an ill person to end their life early will help health insurance companies save a bundle on what would have been ongoing medical treatment? How much would the government gain if it stopped paying social security, Medicare, or Medicaid on thousands of people a few months early? How much financial relief would pension systems see? Why was the proposed law to legalize assisted suicide [SB 220] written so loosely? Would vulnerable old people be encouraged to end their life unnecessarily early by those seeking financial gain?

When considering the financial aspects of assisted suicide, it is clear that millions, maybe billions of dollars, are intertwined with the issue being marketed as "Compassion and Choices". Beware.

Public issues are not easy, and they are not always about money. But often times they are. If we want fair and functional government, we need to look deeper than most people are willing to look...

***


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killed and/or abused is not "choice."

"Choice" is an Illusion.

FIGHT ASSISTED SUICIDE IN CALIFORNIA

Click on the photo to learn more about assisted suicide in California.

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- New Montana Ad: Whose Choice?
- Terminal Uncertainty
- Preventing Abuse and Exploitation: A Personal Shift in Focus
- Aid in Dying: Not Legal in Idaho; Not About Choice
- "Death with Dignity": What Do We Advise Our Clients?
- Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice
- Death with Dignity: What do we Tell our Clients?

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Click on the photo to view website.

KANSAS AGAINST ASSISTED SUICIDE

Click on the banner to view website.

UTAH AGAINST ASSISTED SUICIDE

http://www.choiceillusion.org/2013/12/beware-of-vultures-senator-jennifer.html
Assisted suicide is not legal, not the answer

By BRADLEY WILLIAMS

I take exception to the opinion by two members of the former Hemlock Society, now known as “Compassion & Choices.” The opinion of July 25 implies that assisted suicide is legal in Montana, which is not true.

I am the president of Montanans Against Assisted Suicide. We are in litigation against the Montana Medical Examiners Board. As part of that litigation, we got the board to remove a position paper from its website implying that assisted suicide is legal. Assisted suicide is not legal.

The “treatment” of suicide

As part of our litigation with the board, we also obtained an affidavit from Dr. Ken Stevens, of Oregon, which is one of the few states in which assisted suicide is legal. His affidavit describes how, in Oregon, that state’s Medicaid program uses legal assisted suicide to steer patients to suicide. This is through coverage incentives. The program will not necessarily cover a treatment to cure a disease or to extend a patient’s life. The program will cover the patient’s suicide. In other words, with legal assisted suicide, desired treatments are displaced with the “treatment” of suicide.

Back ing the establishment

The former Hemlock Society, Compassion & Choices, touts itself as the great promoter of individual choice. But if you take a closer look, its actual mission is to back the medical-government establishment.

Consider the well-publicized case of Oregon cancer patient Barbara Wagner. In 2008, Oregon’s Medicaid program declined to cover “Tarceva,” a cancer drug recommended by her doctor, and offered to cover her suicide instead, terming it “aid in dying.” Wagner was devastated.

“It was horrible,” Wagner told ABCNews.com. The drug’s manufacturer subsequently gave Tarceva to Wagner without charge. She, nonetheless, died a short time later.

I recently asked Stevens about Tarceva. He told me that some of his patients had taken it and that for some of them it was beneficial. This was in terms of survival and better quality of life. He also told me that it can be difficult to know how a particular cancer patient will do on a particular cancer drug. He said that there are always some patients who live longer than expected, sometimes 10 or even 20 years longer, depending on the type of cancer. He said, “This is because there are always some people who beat the odds.” Barbara Wagner had wanted to be one of those people.

After Wagner’s death, Compassion & Choices stepped forward to show its true colors. Specifically, its president, Barbara Coombs Lee, published an opinion in Oregon’s largest paper taking issue with Wagner’s choice to try and live. Coombs Lee argued that Wagner should have instead given up hope and accepted her pending death. But, this was not Wagner’s choice.

In a KATU TV interview (katu.com/news/special-reports/26119539.html), Wagner had said: “I’m not ready. I’m not ready to die... I’ve got things I’d still like to do.”

A public policy to discourage cures

Coombs Lee’s opinion piece also argued for a public policy change to discourage people from seeking cures. This would presumably be through coverage incentives. For example, she said: “The burning public policy question is whether we inadvertently encourage patients to act against their own self-interest, chase an unattainable dream of cure, and foreclose the path of acceptance that curative care has been exhausted.”

Coombs Lee is a former “managed care executive.” See (maasdocuments.files.wordpress.com/2014/08/coombsleebio.pdf)

Your choice is not assured by their legislation. Don’t be fooled by their double-speak.

Bradley Williams is president of Montanans Against Assisted Suicide (montanansagainstassistedsuicide.org), a grassroots group and a Montana nonprofit public benefit association. MAAS welcomes everyone opposed to assisted suicide regardless of their views on other issues.

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.

- Oregon cancer patient Barbara Wagner who was denied Tarceva cancer drug by Oregon’s Medicaid program, but was offered coverage for “aid in dying” suicide instead
Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

B. Wagner\textsuperscript{a,*}, J. Müller\textsuperscript{b}, A. Maercker\textsuperscript{c}

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\section*{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.

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